

through this network is a condition of participation in the demonstration.

D. Payment

For the managed care and PACE-type models, we plan to use risk-adjusted ESRD capitation payment rates being developed for the demonstration. These rates are part of the development of the "selected significant conditions" model for M+C risk adjustment. A similar set of payment rates for ESRD is planned for the M+C program in 2005. This risk adjuster will factor a greater number of comorbidities into the payment. The capitation payment method would depend on an organization's ability to submit data for relevant diagnoses recorded during hospital inpatient stays, hospital outpatient visits and physician visits. For the proposed new payment methodology for M+C ESRD, see <http://www.cms.hhs.gov/healthplans/rates/2004/45day-section-b.asp>. The actual ESRD risk-adjusted payment rates for 2004 will be available on our Web site in the near future.

The methodology will pay separate payment rates for dialysis, transplant, and post-transplant modalities. The organization would submit monthly data indicating the modality status for enrollees. The developmental phase for the demonstration would offer a period when CMS and organizations would be able to work together to establish the operational requirements of specific payment options. There will be no phase-in of the risk adjusted ESRD rates for the demonstration—payment will begin with one hundred percent, or full, risk adjustment. The actual payment amount will be reduced by five percent, which will be available later depending on performance on quality measures.

III. Fee-for-Service Bundled Payment Model

This delivery and payment model is appropriate for organizations such as disease management companies, dialysis facilities, and integrated health systems that will conduct disease management for ESRD patients and provide dialysis services under a new bundled payment methodology. Organizations will be expected to coordinate all services utilized by patients receiving dialysis through the organization. They will not be responsible for providing services other than disease management and dialysis services, and Medicare will process and pay all claims on a fee-for-service basis.

However, the organizations will be partially at risk for expenses incurred by Medicare for patients who receive dialysis services through the organization. Annually, we will conduct

a reconciliation, wherein patients' total Medicare costs will be compared to what their risk-adjusted payment amounts would be. (See Financial Risk, below.) For the purposes of the reconciliation, organizations will be accountable for a patient's Medicare expenses until a patient either begins to receive dialysis services in another dialysis facility or in a nursing home, that is, the patient's care is no longer managed by the organization. (As an example, if a patient receiving services in a demonstration dialysis facility is admitted to a hospital and then returns to the facility for dialysis, the Medicare cost for the hospital stay will be counted as part of the demonstration organization's expenses.) Under this payment option, the maximum amount of incurred gain or loss for the organization will be equivalent to the total amount of the add-on payment for the expanded bundle.

The organization would identify distinct facilities that will participate in the demonstration. To minimize favorable selection, all, or nearly all, patients treated within the set of facilities that are included in the demonstration would be paid for under the bundled rate. The beneficiaries would be informed that the organization is participating in a new payment and disease management project. The organization would make special arrangements for those patients who choose to opt out of the demonstration. An acceptable arrangement would involve placing a patient who chooses to opt out in another facility, while ensuring that location and transportation arrangements are convenient for the patient. If this condition is not met, we would make arrangements for these people to continue in the facility under a separate payment from the demonstration. In addition, we would not include dialysis patients in the demonstration who are members of M+C plans.

The demonstration payment for the bundle is constructed as an add-on to the otherwise applicable specific composite rate payment for each geographic area, as listed in the CMS Program Memorandum for February 1, 2001 (Transmittal A-01-19). The expanded bundle add-on includes payment for several classes of drugs: Erythropoietin, Levocarnitine, phosphate binders, iron supplements, and Vitamin D analogs; necessary laboratory tests; and radiology. (See appendix I for a full list of items under the bundled payment.) Applicants for this option will have the choice of also including vascular access services in the expanded bundle add-on. Nearly all

routine dialysis services are included in the bundle. Other items and services will be separately billable outside the bundle. Organizations will not be able to bill separately for items in the bundle.

The Medicare add-on payment for the expanded bundle not including vascular access services is \$71.63 per session. The add-on payment for the bundle including vascular access services is \$86.63. (These numbers include a one percent deduction for Medicare savings.) These payments do not include any potential co-payments and were calculated on Medicare claims data from July 2000 through December 2001, and will be used exclusively for this demonstration. We will update the payment for the expanded bundle to reflect changes in Medicare payment levels.

The add-on bundle rates include payment for disease management services. Organizations must provide a detailed description of the disease management services they will provide, including information on their proposed interventions, the type and number of patients to whom each intervention is targeted, and the frequency with which such interventions are expected. Applicants should also describe how these services will increase quality and reduce costs.

In accordance with the withhold for quality, five percent will be subtracted from the bundled payment rate. As described below, the five percent will be available later depending on performance on quality measures.

In rare circumstances when patients use other dialysis facilities, the organization will be responsible for reimbursing the facility at Medicare fee-for-service payment levels. It will have received the bundled payment on behalf of the beneficiary who is temporarily absent from the geographic area. Applicants should consider in their proposals what constitutes a temporary absence. The organization will continue to provide disease management services and coordinate other Medicare services while the patient is away.

Applicants proposing the fee-for-service option with the bundled dialysis payment should be aware that the implementation period will be at least six months, because of significant bill-paying systems changes. We will update the payment for the expanded bundle on an annual basis to reflect changes in Medicare payment levels. Facilities will be able to participate under this option for patients receiving home dialysis services under Method I. Demonstration payments will not be made for Method II home dialysis patients.