

$(\$2,000) + CHF (\$2,300) + CHF * COPD$   
Interaction  $(\$1,400) = \$9,200$ .

In determining the risk score, notice that all the coefficients are added together (demographic characteristics and risk factors). Also, there is additional payment in the model for the interaction between COPD and CHF.

The total predicted expenditures equal \$9,200, which is divided by \$5,300 to arrive at a 1.74 risk factor estimate. The \$5,300 amount is average cost for a Medicare beneficiary in fee-for-service.

An actual payment estimate requires a ratebook that is not available until May 2003. If that rate book were available, you would multiply the risk factor by the rescaled county capitation amounts for the enrollee (Part A and Part B amounts). For more information on this model go to [www.cms.hhs.gov/healthplans/riskadj/](http://www.cms.hhs.gov/healthplans/riskadj/).

If the applicant is proposing risk sharing, the arrangement must be described in detail. The applicant should include examples that illustrate the risk sharing arrangement. The shared risk of gain and loss between us and the participating organization must be symmetrical, and the organization must always remain at significant financial risk.

Because we intend to implement any approved demonstrations as soon as possible, we do not intend to make any significant changes to the payment system used under the M+C program, which would be used to make payments under this demonstration. Thus, we will use the same risk-adjustment method developed for M+C plans to be used beginning in January 2004, except the payment amount will be fully risk-adjusted. The reporting systems used under the M+C data will also apply. If the applicant believes it is necessary to modify any aspects of the payment process, the application should request the modification and provide a detailed justification for the request.

#### Network

Since the key to a successful disease management product is the composition of the provider network employed by the applicant, and the effectiveness of the network providers' care management, the applicant should describe the structure of the proposed network it would use, and the structure of its existing networks, to the extent applicable. If possible, the applicant should illustrate with a diagram the layering of networks (PSO, HMO, etc.) and describe the important differences in contracting provisions in each network. For the proposed capitated disease management demonstration, the

applicant should describe which networks would be used, how existing networks would be modified for Medicare users, and if necessary, how existing networks will be expanded.

As noted above, beneficiaries electing to receive case management through this demonstration would agree, as a condition for doing so, to receive services through the case management provider.

#### Claims Processing

The application should contain a discussion of the methods for processing and paying claims in the demonstration, including in-network and out-of-network services. The applicant should indicate whether existing claims processing systems used in commercial business will be used or whether new systems must be developed for the Medicare demonstration.

If there are any interface requirements for Medicare intermediaries and carriers, this should be noted and discussed. Estimates of effort required to establish payment protocols should also be included.

#### Budget Neutrality

This demonstration must be budget neutral. This means that the expected costs that we incur under the demonstration can be no more than the expected costs were the demonstration not to occur. The applicant must submit a budget neutrality calculation in the application. Using the proposed payment methodology (including any risk sharing arrangements), the applicant should estimate our payments with and without the demonstration for each year of the demonstration. Applicants must use both FFS and M+C expenses calculated on a county basis for the without-demonstration baseline for comparison to the with-demonstration costs. The calculation should indicate how the estimates were derived. If risk sharing is proposed, there should be three calculations of budget neutrality—optimistic or best-case assumptions, expected or normal assumptions, and pessimistic or worst-case assumptions. The risk-sharing proposal must include a 2 percent full-risk corridor above and below a targeted Medical-Loss-Ratio. In addition, prior to awards, CMS will work with applicants to determine whether the proposed Medical-Loss-Ratio is set at a level where the risk-sharing arrangement is projected to be budget neutral.

The applicant should include a revenue and expense statement showing calendar year 2003 estimated per member per month Medicare revenue

and member premium; benefit expenses (hospital inpatient, hospital outpatient, professional, other Medicare services, and non-Medicare services); and administrative expense. The statement should show any copay credits for the various services.

If risk sharing is proposed, we will share risk only on medical benefit expenses. Administrative expense must be reasonable and consistent with prior practices. The applicant should describe a reconciliation process to be used to determine savings or losses. The administrative cost will not be guaranteed and should be recovered from savings. A reconciliation based on the participating organizations' accumulated medical claims expenses must include an independent audit, funded by the organization, verifying the calculations.

#### Medigap Issues

Many Medicare beneficiaries have health insurance that supplement Medicare, such as a Medicare supplement (Medigap) policy or coverage through an employer-sponsored group plan. Thus, to be enrolled in the demonstration, beneficiaries must be informed about supplemental health insurance, including Medigap policies and protections. With respect to Medigap policies, a beneficiary who enrolls in the demonstration would generally have the following protections:

- Under section 1882(s)(3)(B)(iii) of the Social Security Act, if an individual is enrolled in an organization operating under demonstration project authority and enrollment ceases under the same circumstances that would permit an individual to disenroll from a Medicare+Choice plan as set forth in 1851(e)(4), (for example, contract termination, moving out of the service area), the individual has a right to purchase certain Medigap policies (generally Plan A, B, C, or F) on a guaranteed issue basis.

- Under section 1882(s)(3)(B)(v) of the Social Security Act, if an individual has a Medigap policy and drops the Medigap policy to enroll, for the first time, in a M+C plan or *any similar organization operating under demonstration project authority* (emphasis added) and the beneficiary disenrolls during the first 12 months of such enrollment, the individual has the right to buy his or her former Medigap policy, if it is still available from the same insurance company. If the former policy is not still available, the individual has the right to buy Plan A, B, C, or F.