*CENTERS FOR MEDICARE AND MEDICAID SERVICES,*
*DEPARTMENT OF HEALTH AND HUMAN SERVICES*

**OPEN DOOR FORUM**

# FACTORS FOR DETERMINING MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN REGIONS TO MAXIMIZE BENEFICIARY CHOICE

**OCTOBER 22, 2004**

# OBJECTIVES FOR TODAY'S OPEN DOOR FORUM

- Provide an overview of goals for establishing regions and report on public comments and steps we're taking to ease market entry and reduce uncertainty
- Review previously identified factors for configuring MA regional and PDP regions and discuss newly identified factors
- Solicit input from participants on these factors or any other factors that we should take into consideration and sources of data for those sources
- Solicit input from participants on the relative priority of the various factors
- Provide information for written comment process and next steps

# GOALS FOR ESTABLISHING REGIONS

- **Improve access to a choice of high quality, low-cost MA plans nationally**

- **We want MA regional plans to work and believe they will:**
  - **We're working within statutory requirements to ease potential market entry issues and reduce uncertainty**
  - **We want to hear from the public so the regional configuration maximizes access for beneficiaries**

# MEDICARE MODERNIZATION ACT (MMA) REQUIREMENTS

- The MMA directed the Secretary to establish MA regions that:
  - Are no fewer than 10 or more than 50 in the states and the District of Columbia
  - Maximize the availability of MA regional plans to all eligible individuals regardless of health status, especially those in rural areas
  - Territories

# CONFERENCE REPORT

**Additional guidance from MMA Conference report:**

- **Regions should contain at least one state**
- **States should not be divided across regions**
- **Multi-state MSAs should be included in a single region**

# PUBLIC COMMENTS

- CMS received numerous comments on regions following the public meeting as well as through the Title I and II regulation comments:
  - Received a range of comments -- from supporting fewer multi-state regions to single-state regions
  - Few comments suggested alternative factors or approaches in considering the size of region
- Through public comments and discussions we have heard consistent issues raised on both sides:
  - Creating single state regions would perpetuate status quo and not improve access in rural areas;
  - Creating larger regions may be difficult for plans without licenses in a multi-state region as well as the potential risk of enrolling more beneficiaries than the plan can effectively serve
- Several large plans contacted the Administrator directly to support multi-state regions

# BENEFICIARY-FOCUSED COMMENTS

- Aim to minimize confusion
- Support “nesting”
- Oppose splitting states

# STEPS WE'RE TAKING TO INCREASE PLAN PARTICIPATION

- **Beyond the incentives in the MMA such as risk corridors, bonus payments, and retention funds, CMS is taking steps to ease MA and PDP market entry as well as reduce uncertainty:**
  - **Developing appropriate MA regional access standards**
  - **Providing flexibility in quality reporting**
  - **Providing bidders data set**
  - **Performing extensive outreach through Open Door Forums on technical issues**
  - **CMS will use licensure waiver for MAs and PDPs**

# MA REGIONAL PLAN FACTORS PREVIOUSLY IDENTIFIED

- As we move forward, we will consider the key factors previously identified and discussed at the public meeting in Chicago in July:
  - Commercial market predictors for a Medicare PPO market
  - Number of Medicare beneficiaries needed for plan viability
  - Risk adjusted payment rates

# PREDICTORS FOR A MA REGIONAL PLAN MARKET

- Looked at the presence and market penetration of risk-bearing commercial PPOs
- Considered presence of primary care physicians and size of commercial existing provider networks

# MINIMUM AND MAXIMUM PPO ENROLLMENT

- **Each region should include a minimum number of beneficiaries to ensure plan viability through risk spreading and to provide economies of scale**

- **There are also maximum regional size considerations to account for expanded capacity (Infrastructure challenge for plans in taking on large numbers of new beneficiaries in short period of time)**

# PAYMENT RATES AND HEALTH STATUS

- Used weighted state-level estimated 2005 MA payment rates alone
- Used 2001 health status scores alone, measured by the HCC risk adjustment model
- Simulated payments - incorporated state-wide risk scores by 2005 MA payment rates

# NEW MA REGIONAL FACTORS FOR CONSIDERATION

- **Since the public meeting, we have identified additional factors to consider in designing MA regions:**
  - **Natural market areas**
  - **Initial maximum capacity of plans and infrastructure considerations (including solvency requirements)**
  - **State licensure**
  - **Rural Medicare population**
  - **MA market penetration**

# NATURAL MARKET AREA FACTORS

- Patient care-seeking patterns
  - MSAs
  - Dartmouth Atlas Health Referral Regions
- Provider networks
- Similar cost structures
- We could design regions to reflect locations where plans currently operate to minimize need for plans to obtain licensure in new states

# INITIAL MAXIMUM CAPACITY OF PLANS

- As described above, there may be infrastructure challenges in taking on large numbers of new beneficiaries in the short run:
  - Plans may need time to expand capacity
  - May need to limit region size to ensure that plans have capacity to serve all who wish to enroll
  - Capitalization concerns may also limit region size

# STATE LICENSURE AND SOLVENCY

- **The MMA preempted all state laws except for state licensure and solvency requirements**
- **MA regional plans need to be licensed in each state in which they operate. Plans, however, have a waiver from having licenses in each state as long as they are licensed in at least one state and have applied for a license in other states in the region**

# RURAL MEDICARE BENEFICIARIES AND MA MARKET PENETRATION

- **Additional new data were obtained to provide:**
  - **The proportion of elderly living in rural counties**
  - **Current MA plan market penetration (indicates the presence of plans operating as state-licensed Medicare plans and identifies geographic areas where there are no plans)**

# PUBLIC INPUT ON MA REGIONS

- **What other factors, not yet identified, should CMS consider in developing MA regions?**
- **What is the relative importance/priority of the various factors? That is, which factors will best encourage plan entry and continued participation?**
- **What additional data sources are available for top priority factors?**

# MEDICARE MODERNIZATION ACT (MMA)

**MMA directed the Secretary to establish PDP regions that:**

- **Are established and revised in a manner consistent with MA regions**
- **Are the same as MA regions (to the extent practicable) unless different regions would improve beneficiary access to prescription drugs**
- **Are treated separately from territories. Statute provides the authority for Secretary to establish separate PDP regions for territories (separate from the 10-50 regions in the states and DC)**

# PDP FACTORS PREVIOUSLY IDENTIFIED

- **Eligible Population**
  - **Is there a minimum needed to spread risk as well as to obtain drug price discounts from manufacturers?**
- **Medicare prescription drug expenditures**

# NEW PDP FACTORS FOR CONSIDERATION

- We will also consider new factors for considering PDP regions:
  - Initial maximum capacity of plans and infrastructure considerations
  - State licensure and solvency requirements
  - MA market penetration
  - Beneficiary perspectives, such as simplifying outreach and education through "nesting" regions
  - Is there a maximum number because of:
    - Infrastructure challenge for plans in taking on large numbers of new beneficiaries in short period of time
    - Capacity issues such as customer service, production of I.D. cards, development of mail order prescription capacity

# PUBLIC INPUT ON PDP REGIONS

- What other factors, not yet identified, should CMS consider in developing regions?
- What is the relative importance/priority of the various factors? That is, which factors will best encourage plan entry and continued participation?
- What data sources are available for top priority factors?

# SUMMARY AND WRITTEN PUBLIC COMMENTS

- **Summary**
- **Need for subsequent public input (1-week comment period)**