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CMS Holds Open Meeting on Medicare Advantage Regions

July 22, 2004

The Centers for Medicare & Medicaid Services ("CMS") held an open public meeting in Chicago on July 21, 2004 to present several proposed regional options for Medicare Advantage ("MA") regional plans and prescription drug plans (PDPs) under the Medicare Modernization Act ("MMA"). Crowell & Moring's Ken Bruntel and Robyn Diaz were in attendance. Under the MMA, the Secretary of Health and Human Services ("HHS") is required to announce the number of regions, which will be the basis for service areas in which plans will offer products, by January 1, 2005. Participating plans will be required to serve the entire region, and to ensure that beneficiary premiums do not vary within a region.

The purpose of the meeting was to explain the methodology used by CMS and its contractor, RTI Health Services and Social Policy Research ("RTI"), to conduct a market survey and analysis to determine how the regions should be established. The statute requires that CMS establish between 10 and 50 regions, and that those regions maximize availability of MA plans to MA eligibles, especially those in rural areas. The MMA suggests that PDP regions should be the same as MA regions to the extent practicable, but permits differences from the MA regions if it would result in improved access to drug benefits for beneficiaries. The materials presented at the conference can be found here. The panelists did not, for the most part, elaborate on or depart from the materials.

CMS and RTI presented several possible options for the regions, ranging in size from 50 state-based regions to 10 multi-state regions based on CMS administrative regions, with several multistate region options (based on a variety of factors) in between. The panelists explained that the options presented were by no means the only possibilities, and emphasized the need for public feedback.

Much of the meeting consisted of question and answer sessions, during which most industry representatives expressed their support for 50 state-based MA regions. Many industry representatives expressed doubt about the willingness of plans to offer products in larger regions, citing concerns about differences among states with regard to licensing and trademark laws. Many commenters also stated that provider networks are currently state-based, and therefore state-based regions would cause the least disruption to current market activity and reduce costs of entry into MA regions. Several commenters expressed doubts about whether rural providers would be willing to join networks without charging premium rates. Beneficiary advocates and CMS representatives countered that that 50 state-based regions would do little to encourage increased participation in some states, such as the northern Great Plains states.

Potential PDP regions were also presented. In addition to the 50 state-based regions and the 10 regions based on CMS's current organization, several additional regions the relied principally on population and drug utilization were discussed. The panelists noted that the data on drug utilization might not reflect utilization by Medicare and dual eligibles. Much of the discussion focused on whether MA and PDP regions should be the same, particularly because larger PDP regions would likely yield economies of scale and most of the concerns about state-based networks and other considerations did not affect PDPs. The CMS

panelist suggested that larger PDP regions could, in effect, be proposed by combining CMS-determined regions in one or more bids.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.