Agenda for the Open Public Meeting:
Establishing Regions for Medicare Advantage Regional Plans and Prescription Drug Plans under the Medicare Modernization Act

Wednesday, July 21, 2004
Rosemont Conference Center/Donald E. Stephens Convention Center
Chicago, IL

8:00 – 9:00	Registration
9:00 -- 9:15	Introductions and Welcome from CMS
9:15 – 9:30	Purpose of the Meeting
9:30 – 10:15	Overview of the MMA requirements, RTI methodology for the development of options (including the data and variables used for market analysis) and general findings during consultations.
10:15 – 10:45	Coffee Break
10:45 – 11:45	Presentation of Options for Medicare Advantage Plan Regions
11:45 – 12:30	Q&A on for Medicare Advantage Plan Regions
12:30 – 1:15	Break and Collect Box Lunches
1:15 – 2:00	Presentation of Options for Prescription Drug Plan Regions
2:00 – 2:45	Q&A on Options for Prescription Drug Plan Regions
2:45 – 3:00	Coffee Break
3:00 – 3:45	Presentation on overlap between MA and PDP Regions with Q&A
3:45 – 4:00	Summary and Wrap Up, including logistics for submitting additional comments

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[Notices]
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4069-N]

Medicare Program; Open Public Meeting To Discuss Definitions of Regions for Regional Medicare Preferred Provider Organizations and Prescription Drug Plans Under the Medicare Modernization Act--July 21, 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meeting.

SUMMARY: This notice announces a public meeting to provide beneficiaries, advocacy groups, managed care organizations, trade associations, potential prescription drug plans (PDPs), pharmacy benefit managers, providers, practitioners, and other interested parties an opportunity to ask questions and raise issues regarding options for the definition of regions for Medicare Advantage (MA) regional plans and PDPs under provisions of the Medicare, Prescription Drug, Improvement and Medicare Modernization Act of 2003 (MMA). The legislation requires that we implement these MMA provisions in 2006. The purpose of the meeting is to provide information about a variety of region definition options being considered both for regional MA plans and PDPs and to allow for public comment on these options.

DATES: Meeting Date: The meeting is scheduled for Wednesday, July 21, 2004 from 9 a.m. until 4 p.m., c.d.s.t. Comment Deadline: Written comments must be received by 5 p.m., August 5, 2004.

ADDRESSES: The meeting will be held in Chicago, IL, at the Rosemont Conference Center/Donald E. Stephens Convention Center, (located on the grounds of O'Hare airport) at 555 North River Road, Rosemont, IL. The phone number for the Rosemont Conference Center is (847) 692-2220. The meeting will be organized by CMS' contractor, RTI International.

Written Statements and Requests:

We will accept written questions about meeting logistics or requests for meeting materials either before the meeting or up to 14 days after the meeting. Written submissions must be sent to: RTI International, ATTN: Nathan West, MPA, RTI Health Services and Social Policy Research, 3040 Cornwallis Rd. Research Triangle Park, North Carolina 27709, Telephone Number: (919) 485-2661, Fax Number: (919) 990-8454, e-mail: medicaremeeting@rti.org.

Public Comments: Public comments should be sent to Angela Porter via e-mail to APorter@cms.hhs.gov or fax to Angela Porter at (410) 786-9963; or you may mail public comments to her at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mailstop S1-05-06, Baltimore, Maryland 21244.

FOR FURTHER INFORMATION CONTACT: RTI International staff at medicaremeeting@rti.org, or Nathan West at (919) 485-2661.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare, Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Pub. L. 108-173, enacted on December 8, 2003) requires a number of changes to the Medicare program including the addition of Medicare prescription drug insurance plans (PDPs), as well as the addition of new regional Medicare Advantage (MA) plans. To implement both new programs, we must define appropriate regions for MA regional plans under section 1858(a)(2)(D) of the Social Security Act (the Act) added by section 221 of the MMA, and for PDPs under section 1860(D)-(11)(a) of the Act, added by section 101 of the MMA.

A. Medicare Advantage Regions

Title II of the MMA makes changes to the Medicare+Choice (M+C) program under Part C, which it renames as the Medicare Advantage program. Existing M+C plans, now known as MA plans, are now referred to as ``local MA plans''. Title II of MMA also establishes new MA regional plans, which would encourage private plans to serve Medicare beneficiaries in larger regions.

The new MA regional plan program will begin in 2006. The legislation calls for the creation of between 10 and 50 MA regions within the 50 States and the District of Columbia by January 1, 2005. Plans that opt to participate in the program are required to serve an entire MA region and are encouraged to offer services in more than one region. The legislation states that MA regions should maximize the availability of regional plans to all eligible individuals regardless of health status. The MMA conference report further clarifies these requirements by providing additional considerations for configuring the regions. To the extent possible, each MA region should include at least one State and not divide a State across regions.

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Metropolitan Statistical Areas (MSAs) that span more than one State should be included in a single region. Furthermore, the conference report suggests that the required market study determine the best configuration of regions to maximize plan participation as well as the availability of plans to beneficiaries.

These statutory requirements and MMA conference report guidelines have several implications for the definition of MA regional areas. Geographic regions must be defined to meet multiple objectives and satisfy multiple constraints. Demographic data on the distribution of the aged population must be considered in conjunction with market factors that would impact insurance-supplier response. Incentives

provided for in the legislation have the potential to offset unfavorable factors in the MA region and must also be considered in the analysis of these heterogeneous regions. In addition, the sizes and configuration of regions will themselves impact the entry behavior of plans.

B. Regional Definition for PDPs

Title I of the MMA establishes a prescription drug insurance benefit under a new Part D of Medicare and is intended to provide prescription drug coverage for beneficiaries enrolled in traditional Medicare FFS or MA plans. The law also provides for premium, deductible, and co-payment subsidies for certain low-income beneficiaries. The PDPs are effective in 2006.

To provide access to options for Medicare beneficiaries in all geographic areas, Medicare PDPs are intended to be regional in scope. Since private companies (with a public subsidy) will operate the PDPs, offering a plan in a region will be voluntary on the part of the plan operators. A plan must offer the same benefits and charge the same premiums and co-payments to all eligible beneficiaries in its region regardless of how the plan's costs vary within a region. If less than two full-risk plans are offered in a region (one of which must be a PDP), then we will approve any reduced risk plans that have applied to serve the region. In any regions or parts of regions that still lack two plans, we will arrange for a non-risk-bearing fallback plan to be offered.

The success of the Part D benefit will depend on the willingness of private plan operators to offer plans in the various regions and therefore, at least in part, on the region definitions selected by CMS. Implications for regional definition for PDPs include the trade-off of conforming to existing markets versus encouraging plan choice in areas projected to be underserved.

The MMA mandates that there be between 10 and 50 PDP regions. In addition, we will establish regions for the territories as required in section 1860D-11(a)(2)(C) of the Act. We must define these regions by January 1, 2005. The legislative guidelines for the definition of regions are the same for regional MA plans. The MMA requires that PDP regions be the same as with MA regions ``to the extent practicable.'' However, the PDP regions do not necessarily need to be identical to the MA regions if it can be shown that a different configuration of regions for PDPs improves beneficiaries' access to prescription drugs.

II. Meeting Topics and Format

The meeting will address the following topics:

A presentation of proposed regional definitions for MA Regional Plans, followed by public comments and a question and answer period.

A presentation of proposed regional definitions for PDPs, followed by public comments and a question and answer period.

Time for participants to ask questions or offer individual comments will be limited according to the number of registered participants.

The agenda will include presentations by CMS and RTI International (CMS'' contractor) staff. We are interested in an open dialogue on the topic of defining regions for regional MA plans and PDPs under the MMA legislation, and believe that an active discussion will help us more clearly identify the key issues for consideration. In this public

meeting, we plan to engage in a discussion of the scenarios for MA regional and PDP region configurations, particularly on regional scenarios where PDP and regional MA definitions may, or may not, overlap.

III. Registration

Registration for this public meeting is required and will be on a first-come, first-served basis, limited to two attendees per organization up to the 1,000 person capacity of the meeting room. A waiting list will be available for additional requests. The registration deadline will be July 14, 2004. Registration can be accomplished through three mechanisms:

1. A special on-line meeting Web site set up specifically for this meeting: http://frwebgate.access.gpo.gov/cgi-bin/leaving.cgi?from=leavingFR.html&log=linklog&to=https://register.rti.org/medicaremeeting/. 2. A specific meeting e-mail address: medicaremeeting@rti.org.

3. By contacting Nathan West, RTI International, at (919) 485-2661.

A confirmation notice will be sent to attendees upon finalization of registration. Information on hotel accommodations will be provided to registered individuals as part of their confirmation notice. General information regarding meeting logistics will also be available on the meeting Web site at http://frwebgate.access.gpo.gov/cgi-bin/leaving.cgi?from=leavingFR.html&log=linklog&to=https://register.rti.org/medicaremeeting/.

Persons who are not registered in advance will not be guaranteed attendance due to space limitations. Attendees will be provided with meeting materials at the time of the meeting.

To submit written questions regarding logistics of the meeting or to requests material before the meeting, see instructions for Written Statements and Requests under the ADDRESSES section of this notice.

Written public comments are preferred following the meeting and will be accepted until August 5, 2004. See instructions for Public Comments under the ADDRESSES section of the notice.

(Authority: Sections 1851 through 1859 of the Social Security Act (42 U.S.C. 1395w-21 through 1395w-28)) (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare--Hospital Insurance Program; and No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: May 19, 2004.
Mark B. McClellan,
Administrator, Centers for Medicare & Medicaid Services.
[FR Doc. 04-12048 Filed 5-27-04; 8:45 am]

BILLING CODE 4120-01-P

Medicare Prescription Drug, Improvement and Modernization Act of 2003

Sections on Establishing PDP and PPO Regions

Title I

SEC. 1860D-11. (a) ESTABLISHMENT OF PDP REGIONS; SERVICE AREAS-

(1) COVERAGE OF ENTIRE PDP REGION- The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

(2) ESTABLISHMENT OF PDP REGIONS-

(A) IN GENERAL- The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1858(a)(2).

(B) RELATION TO MA REGIONS- To the extent practicable, PDP regions shall be the same as MA regions under section 1858(a)(2). The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

(C) AUTHORITY FOR TERRITORIES- The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

Title II

SEC. 1858. (a) REGIONAL SERVICE AREA; ESTABLISHMENT OF MA REGIONS-

(1) COVERAGE OF ENTIRE MA REGION- The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1854(h) shall not apply to such a plan.

(2) ESTABLISHMENT OF MA REGIONS-

(A) MA REGION- For purposes of this title, the term `MA region' means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) ESTABLISHMENT-

(i) INITIAL ESTABLISHMENT- Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) PERIODIC REVIEW AND REVISION OF SERVICE AREAS- The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) REQUIREMENTS FOR MA REGIONS- The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) NUMBER OF REGIONS- There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) MAXIMIZING AVAILABILITY OF PLANS- The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) MARKET SURVEY AND ANALYSIS- Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

Medicare Prescription Drug, Improvement and Modernization Act of 2003

Conference Agreement

Title I

a. PDP Regions. New Section 1860D-11 of the conference agreement provides for the establishment of PDP regions. The service area for a plan includes an entire PDP region. The Secretary shall establish, and may revise PDP regions in a manner that is consistent with the requirements for establishment and revision of MA regions. To the extent practicable, PDP regions shall be the same as MA regions. The Secretary may establish different regions if the Secretary determines that it would improve access to drug benefits. The Secretary will establish PDP regions for the territories. A plan can be offered in more than one PDP region, including all PDP regions.

Title II

[§1858(a)(2)]. No later than January 1, 2005 the Secretary will establish and publish a list of MA regions. There will be between 10 and 50 regions within the 50 states and the District of Columbia. Before establishing the MA regions, the Secretary will conduct a market survey and analysis, including an examination of current insurance markets. The regions should maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially beneficiaries residing in rural areas. To the extent possible, each region should include at least one State, should not divide States across regions, and should include multi-State Metropolitan Statistical Areas in a single region. The Secretary may periodically review MA regions and, based on the review, revise the regions to be more appropriate. An MA regional plan may be offered in more than one region including all regions.

Options for Regional Medicare Advantage (MA) Preferred Provider Organizations (PPOs) and Prescription Drug Plans (PDPs) Under the Medicare Modernization Act (MMA)

Presented at

Rosemont Conference Center
Chicago, IL
July 21, 2004

P.O. Box 12194 · 3040 Cornwallis Road · Research Triangle Park, NC 27709
Phone: 919-541-7146 · Fax: 919-541-6683 · tjh@rti.org · www.rti.org

PURPOSE OF THE MEETING

Presented by

Thomas Hoerger

RTI INTERNATIONAL

Importance of Meeting

- Presenting an array of options – no decisions have been made.
- Options reflect result of outreach with interested parties – this is your chance to influence the final region design.
- CMS is committed to addressing issues, getting questions answered, and ensuring successful implementation.

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Importance of this Meeting

- There are no easy, obvious options.
- Making a decision will involve tradeoffs.
- Input and feedback with be critical in identifying the best possible options.
- Thank for you taking the time to attend and provide critical input and feedback.

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Goals for the Public Meeting

- Present methodology and draft regional options.
- Gather input and feedback from a broad spectrum of interested parties on possible regional options for MA regional plans and PDPs.
- Identify advantages and disadvantages of possible options.
- Identify issues to be considered by CMS in narrowing and choosing among options.
- Identify possible new options.

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Additional Comments on Meeting Goals

- The MA and PDP regional options presented today are not final.
- Regional development continues to be a work in progress. More options and refinements of these options will be developed throughout the summer.
- The public is invited to comment on regional options and issues after the meeting today (comment period is 7/21/04 – 8/5/04).
- Regions will be announced by CMS sometime in late Fall 2004.

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Meeting Format

- The meeting agenda is included in the front of the materials packet.
- Timing of breaks and lunch is listed on the agenda.
- Sessions will be followed by questions and answers.
- During the question and answer periods we will respond to verbal and written questions.

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Meeting Format Cont.

- If you want to ask a question, please line up behind the microphones in the aisles.
- We can also respond to written questions. If you would like to submit a written question, please fill out and submit a question card to RTI staff.
- Please limit follow up questions – we want to give everyone an opportunity to ask questions.

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Some terms and acronyms….

- Medicare Modernization Act – MMA
  - the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
- Medicare Advantage – MA
  - the new name for the Medicare Part C (formerly the Medicare +Choice program).
- MA Regional Plans
  - the private PPO plans that would be offered in an entire “region”.

RTI INTERNATIONAL

Some terms and acronyms….

- Prescription Drug Plans – PDPs
  - private plans that would offer prescription drug insurance under the MMA.
- MA-PDs
  - prescription drug plans offered by MA plans.
- Region
  - between 10 and 50 geographic areas nationally to be determined by CMS, that will make up the service areas for either the MA Regional Plans, PDPs, or both.

RTI INTERNATIONAL

METHODS FOR THE DEVELOPMENT OF REGIONAL OPTIONS

Presented by
Elisabeth Root, Lee Mobley and Nathan West

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MMA Legislation

- Medicare Modernization Act (MMA) calls for the establishment of regions for both MA regional plans and PDPs.
- Regions will be the basis for service areas in which participating MA regional plans and PDP plans will offer their product.
- Regions will also be the basis for determining premiums, benefits, and payments.

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MMA Legislation

- Participating MA regional plans and PDPs must serve the entire region.
- Beneficiary premiums for MA regional plans and PDPs cannot vary within the region.
- Regions will not apply to MA local plans (there is a two year moratorium on CMS approval of new local PPOs in 2006 and 2007).

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Legislation on Establishing MA Regional PPOs

- In establishing the Medicare Advantage regions, the HHS Secretary is required to maximize availability of regional plans to all eligible individuals regardless of health status.
- The Secretary may establish between 10 and 50 regions.
- Once established, the Secretary may revise the regions.

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Legislation on Establishment of PDPs

- Congressional intent was to define the PDP regions to be consistent with MA regions.
- PDP regions are to be the same as MA regions “to the extent practicable.”
- However, the PDP regions do not necessarily need to be identical to the MA regions if it can be shown that a different configuration of regions for PDPs improves beneficiaries’ access to prescription drugs.
- The HHS Secretary may also establish PDP regions for territories.

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MMA Conference Agreement

- Considering the MMA conference language, MA and PDP regions should:
  - Contain at least one state
  - Not divide states across regions
  - Include multi-state MSAs in a single region.

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MMA Conference Agreement, Continued

- We can't achieve all of the conference agreement criteria simultaneously.
- For example, is it better to:
  - Keep states intact, and split MSAs?
  - Split states, and keep MSAs intact?
- The following map shows the MSAs that cross state boundaries.
- Keeping all multi-state MSAs within a single region would result in a few "mega" regions.

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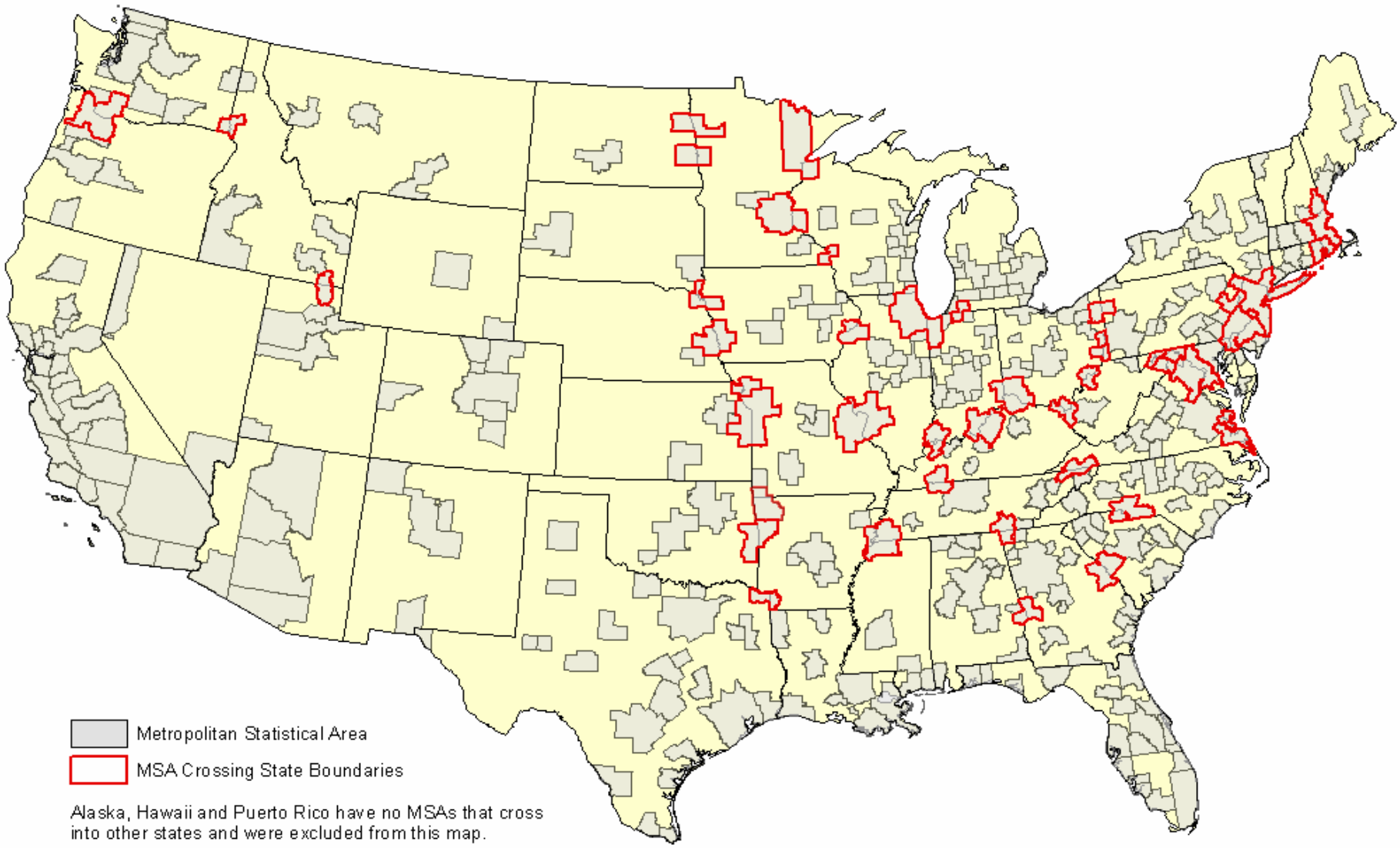
Metropolitan Statistical Areas Crossing State Boundaries, December 2003



Criteria for Developing Options

- MMA Legislation
- MMA Conference Agreement language
- General criteria such as Medicare population and demographics
- MA plan specific criteria
- PDP specific criteria
- Input and feedback from stakeholders

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Developing Options

- Consider existing geographic regions.
  - e.g., Census, CMS, states
- Choose regions to satisfy simple criteria.
  - e.g., pick 10 regions, minimize population differences, only combine contiguous states
- Analyze multiple criteria.
  - Group similar areas with respect to various factors such as number of Medicare eligibles.

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Major Data Sources Used in the Development of Regional Options

- Geographic distribution of Medicare eligibles (from CMS)
- Medicare FFS and MA payment rates (from CMS)
- Medicare CMS-HCC health status scores (from CMS)
- Medicare patient flow data (from CMS)
- Commercial PPO market activity, penetration and provider networks (from InterStudy)
- Prescription drug utilization, costs, and retail pharmacy locations (from Novartis, IMS, Scott-Levin, ESRI)

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Data Manipulation

- A comprehensive Access database was developed for this project that linked the available data by geographic or other identifiers.
  - Most commonly county, but sometimes PPO plan ID number and state.
- Database was then “queried” to identify geographic areas that met specified conditions based on key factors.

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Analytic Approach

- Define key factors important to potential regional option from the available data.
- Some factors, such as minimum Medicare eligible population and Medicare health status scores, were common to the development of both MA and PDP regions.
- Other factors were specific to the development of either MA or PDP regions.
- Data were analyzed using measures such as coefficient of variation (c.v.).
  - The c.v. is a measure of relative spread in a set of measurements.

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General Factors for MA and PDP Regions

- Regions should consist of contiguous states.
- Minimum population.
- Minimum existing provider/plan penetration.
- Include an urban/rural mix.
- Preserve existing Medicare beneficiary flows between states.

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Factors Considered in Developing MA Plan Regions

- Market size: number of potential Medicare eligibles.
- Current Medicare managed care penetration.
- Current commercial PPO activity, including market penetration, current service areas and network size.
- Projected Medicare payment rates.
- Costs of building supplier networks.
- Cost/disease risk.

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Factors Considered in Developing PDP Regions

- Market size: number of potential Medicare eligibles.
- Estimates of prescription drug utilization and costs.
- Markets served by potential suppliers.
- Access to retail pharmacies.
- Costs of building supplier networks.
- Cost/disease risk.

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Drawing Regional Boundaries

- Once the most important factors for MA and PDP regions were defined, then threshold, minimum and/or median values for criteria variables were defined.
- With the values, the database was queried to identify geographic areas meeting the specified conditions.
- Resulting potential regions were mapped using GIS software.

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Evaluating and Comparing Options

- Develop criteria in conjunction with CMS and outreach.
- Use exploratory statistical visualization techniques to view spatial distribution of criteria variables.
- Mapping provides important reality check.

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Outreach and Stakeholder Comment

- CMS will use feedback from a wide range of stakeholders in the development and evaluation of potential regional options.
- Feedback will be gathered in multiple ways:
  - Early comment from a limited number of stakeholder consultations.
  - Public meeting and comment period.
  - Comments following the public meeting.

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Early Consultations

- Shortly after the contract award, RTI and CMS began to gather information and suggestions from a limited number of stakeholders.
- These early consultations were designed to identify key issues and evaluation factors important to the development of regional options.

Early Consultations

- Groups
  - Managed Care Organizations: National and Regional, and Trade Associations
  - Potential PDPs, including insurers, PBMs, MCOs and Trade Associations
  - Rural Health Organizations
  - Beneficiary Advocates

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Initial Feedback on MA Regional Options

- We heard support for both:
  - State-based regions; and,
  - Larger regions based on groups of contiguous states.
- Principal concern was related to potential difficulties in developing provider networks within large multi-state regions.
- Also, concerns were raised regarding the ability of plans to offer a single beneficiary premium in an entire multi-state region, and account for region-wide cost variations.

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Initial Feedback on MA Regional Options

- Support for 50 state-based regions focused on:
  - States as a common current boundary for commercial PPOs.
  - Many existing provider networks are state-based.
  - Differences among states in terms of licensure, capital, trademark, and other requirements would make multi-state regions difficult and more costly to implement.
  - Drawing smaller regions might encourage local plans to participate as regional plans.

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Initial Feedback on MA Regional Options

- Support for 50 state-based regions also focused on:
  - Network development in rural and other traditionally underserved areas would be difficult, if not impossible, in some areas.
  - If these “difficult” areas were combined (under larger multi-state regions) with currently served areas, the result might be to reduce access to managed care.
  - Belief that these concerns would be mitigated somewhat by CMS flexibility on network adequacy and access standards.

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Initial Feedback on MA Regional Options

- Support for 50 state-based regions also focused on:
  - State based regions would cause the least disruption to current PPO market activity, thus lowering the costs of entry into the MA regional market.
  - Result: CMS would most likely see more MA regional plan participants.

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Initial Feedback on MA Regional Options

- Support for fewer, multi-state regions focused on:
  - A perception that the goal of the MA regional plans was to create something "different" from local MA plans.
  - To provide improved choice of plans to traditionally underserved areas.
  - Since multi-state regions could potentially offer large number of potential enrollees, this might be sufficient incentive to attract managed care to traditionally underserved areas.

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Initial Feedback on MA Regional Options

- Support for fewer, multi-state regions also focused on:
  - MA regions based on states would result in continued managed care participation in certain states – states with larger supply of providers, higher historic payment rates, lower risk scores.
  - MA regions based on 50 states therefore would do little to encourage managed care to participate in some states, such as heavily rural states, and hence continue the status quo.

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Initial Feedback on PDP Regional Options

- Support for 50 state-based regions focused on:
  - Improved ability of potential PDPs to manage risk on as small a scale as the MMA allows.
  - Since there is uncertainty about many aspects of PDPs (e.g. accepting risk), smaller regions might be more manageable.

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Initial Feedback on PDP Regional Options

- Support for fewer, multi-state regions focused on:
  - Larger regions bring larger potential numbers of enrollees.
  - Large enrollee populations would improve the PDP's ability to negotiate favorable prices from drug manufacturers and wholesalers.

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Initial Feedback on PDP Regional Options

- Support for fewer, multi-state regions focused on:
  - Pharmacy supply basically operates around national networks.
  - Therefore, developing access to supplier networks is not seen as a problem (compared to MA).

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Summary

- Outreach so far has been very valuable.
- We will continue to gather feedback and input beyond this meeting.
- Support exists among stakeholders for both large multi-state regions and smaller state-based regions.

OPTIONS FOR MA REGIONS

Presented by

Leslie Greenwald

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Principal Evaluation Criteria for MA Regions

- Size of Medicare eligible population.
- PPO characteristics:
  - Network size.
  - Number of risk bearing PPOs.
  - PPO market penetration.
- Combination of high risk scores (worse health status) and low MA payment rates.

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Range of Options for MA Regions

- Presentation will show 5 possible options for MA regions:
  - 50 state-based regions.
  - 10 multi-state regions based on CMS administrative regions.
  - 11 multi-state regions based on equal Medicare eligible population.
  - 24 multi-state regions based on median PPO activity.
  - 41 multi-state regions based on minimum PPO activity.
- These are not the only possible options – work to refine and identify additional options will continue through the summer.
- These options are intended to show a range of possibilities, and prompt discussion.

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Option 1: 50 State-Based MA Regions

- Define MA regional plan regions according to the 50 States.
- Represents the largest number of regions allowed under the MMA.
- We will show state level data for the key evaluation factors.

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Total Number of Medicare Eligibles (MA Map 1)

- Large variation in population.
- Low numbers of Medicare eligibles in some states (e.g., WY, ND, SD, MT).
- Based on our consultations, a minimum of about 200,000 Medicare eligibles likely needed to support a regional PPO.
- High numbers of Medicare eligibles in other states (e.g., CA, FL, TX, NY).

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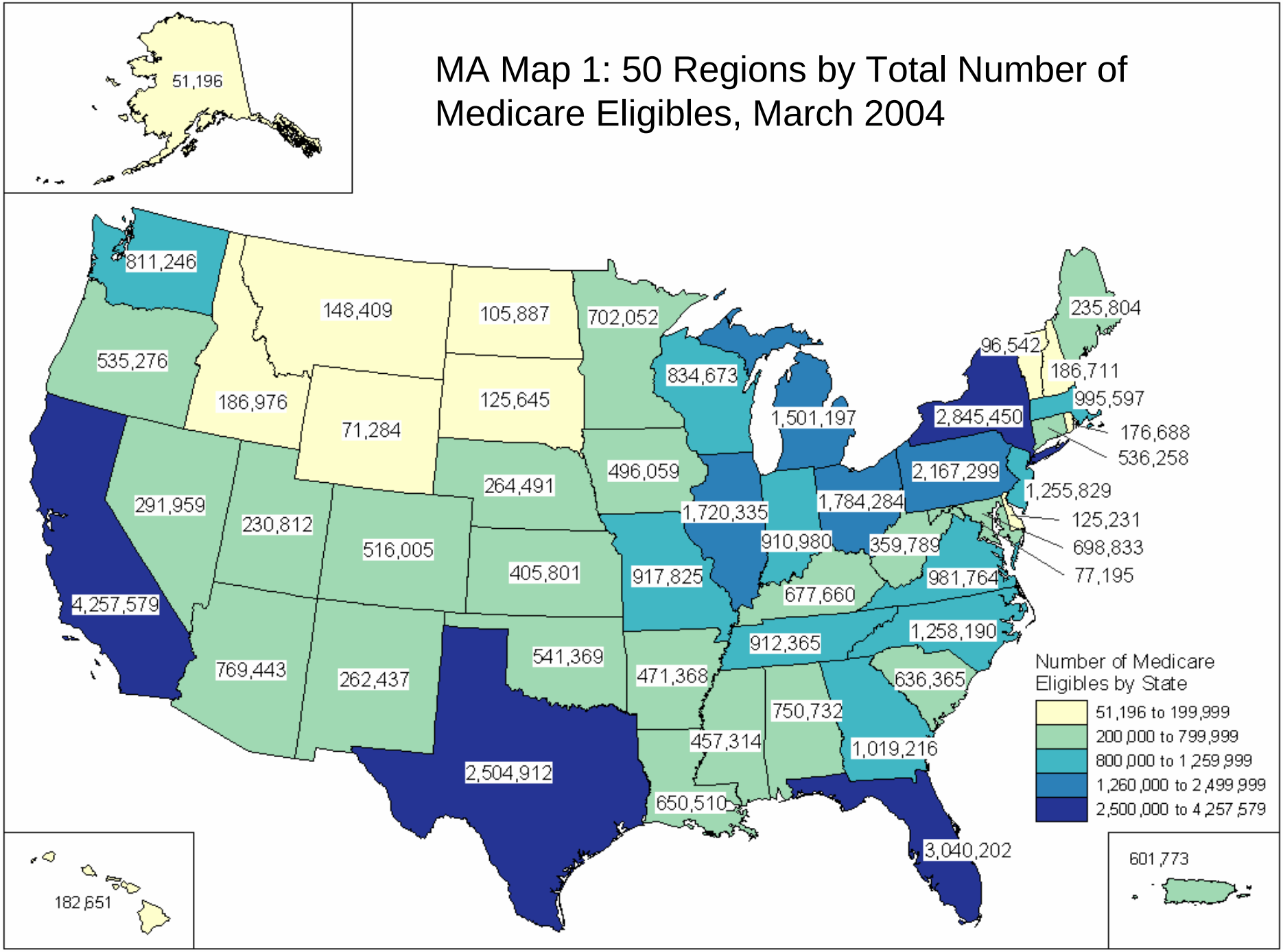
MA Map 1: 50 Regions by Total Number of Medicare Eligibles, March 2004



Number of Commercial Risk Bearing PPOs (MA Map 2)

- Little or no presence of commercial PPOs in 8 states, and Puerto Rico.
- Particularly high numbers of commercial PPOs in a number of populous states (e.g. CA, FL, NY)

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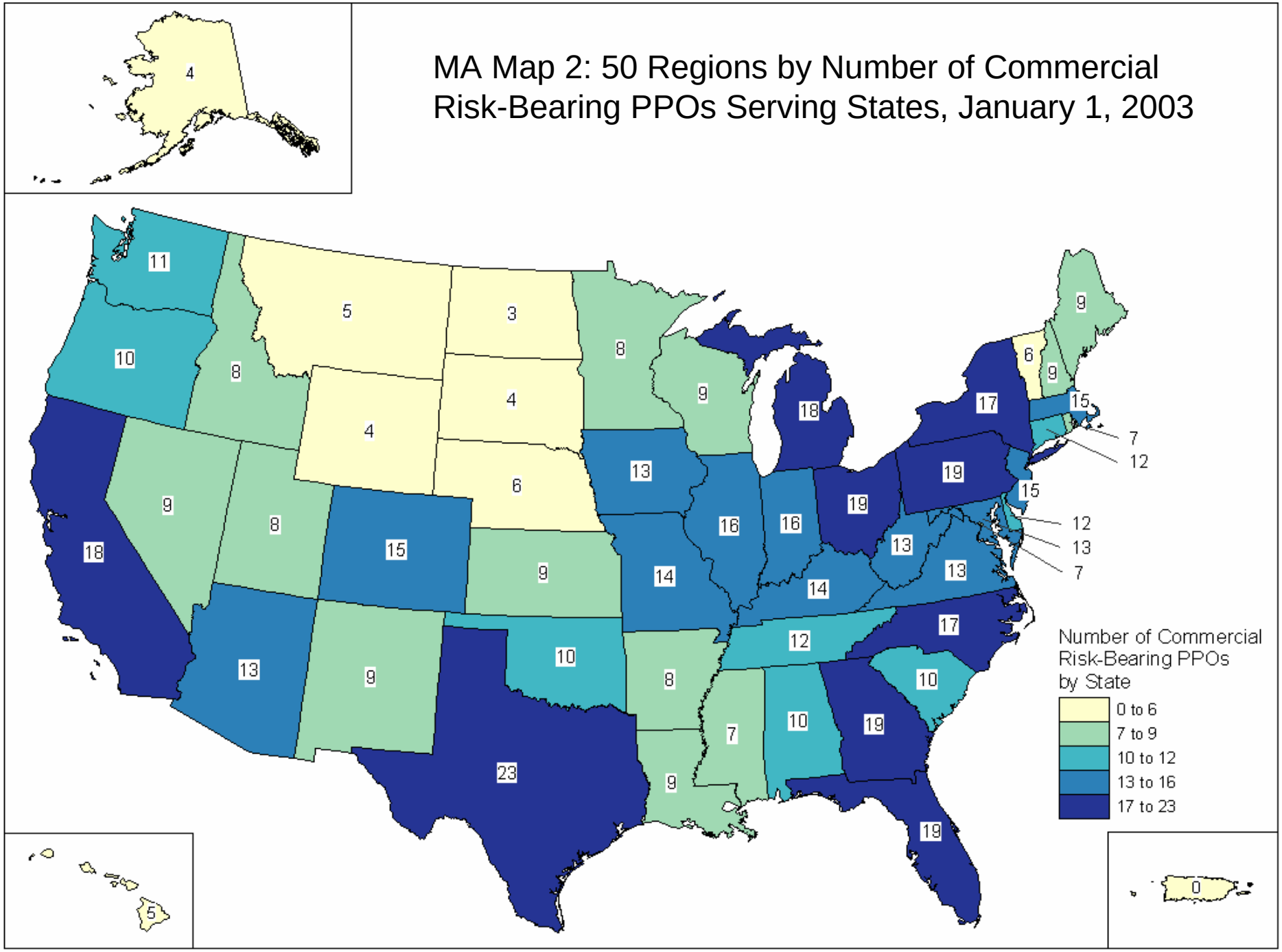
MA Map 2: 50 Regions by Number of Commercial Risk-Bearing PPOs Serving States, January 1, 2003
4
11
10
8
5
3
4
8
9
18
17
9
6
9
15
7
12
19
15
12
13
7
9
8
18
15
9
13
16
16
19
13
13
14
14
17
12
10
13
9
10
8
7
10
19
9
23
19
Number of Commercial Risk-Bearing PPOs by State
0 to 6
7 to 9
10 to 12
13 to 16
17 to 23
5
0

PPO Market Penetration by State (MA Map 3)

- Six states have relatively little PPO market penetration, including two states (CA and NY) that have among the highest number of PPOs.
  - PPO market penetration is the number of PPO enrollees divided by the total population.
- Six states (NV, NE, MN, IL, LA, and AK) have the highest levels of PPO market penetration.

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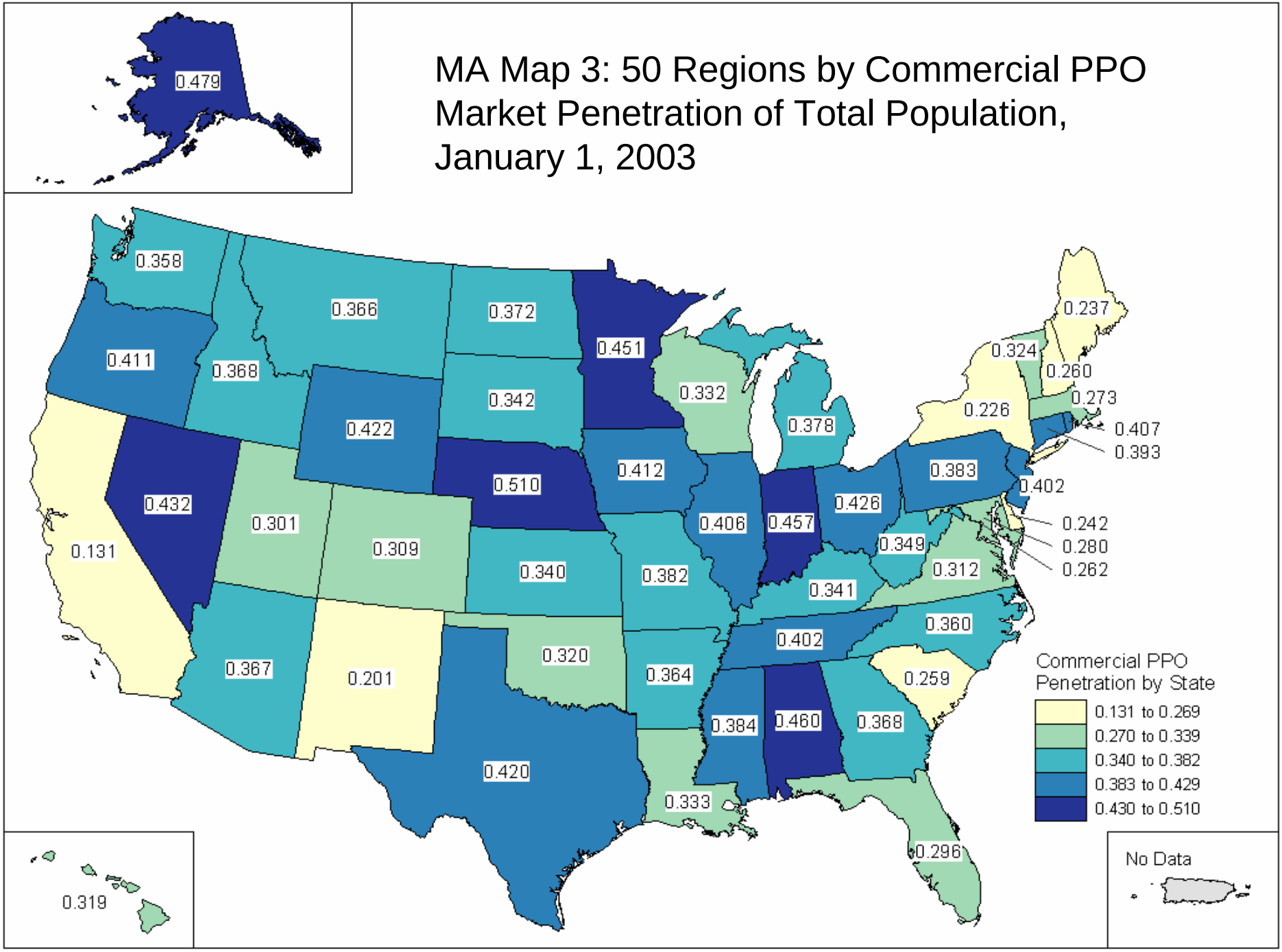
MA Map 3: 50 Regions by Commercial PPO Market Penetration of Total Population, January 1, 2003



Median Commercial PPO Provider Network Size (MA Map 4)

- Seven states have very low (less than 200) median PPO provider network size among commercial plans serving the state.
- Three states (CA, NY and MA) have large median provider network sizes (between 3,086 and 7,774 members).

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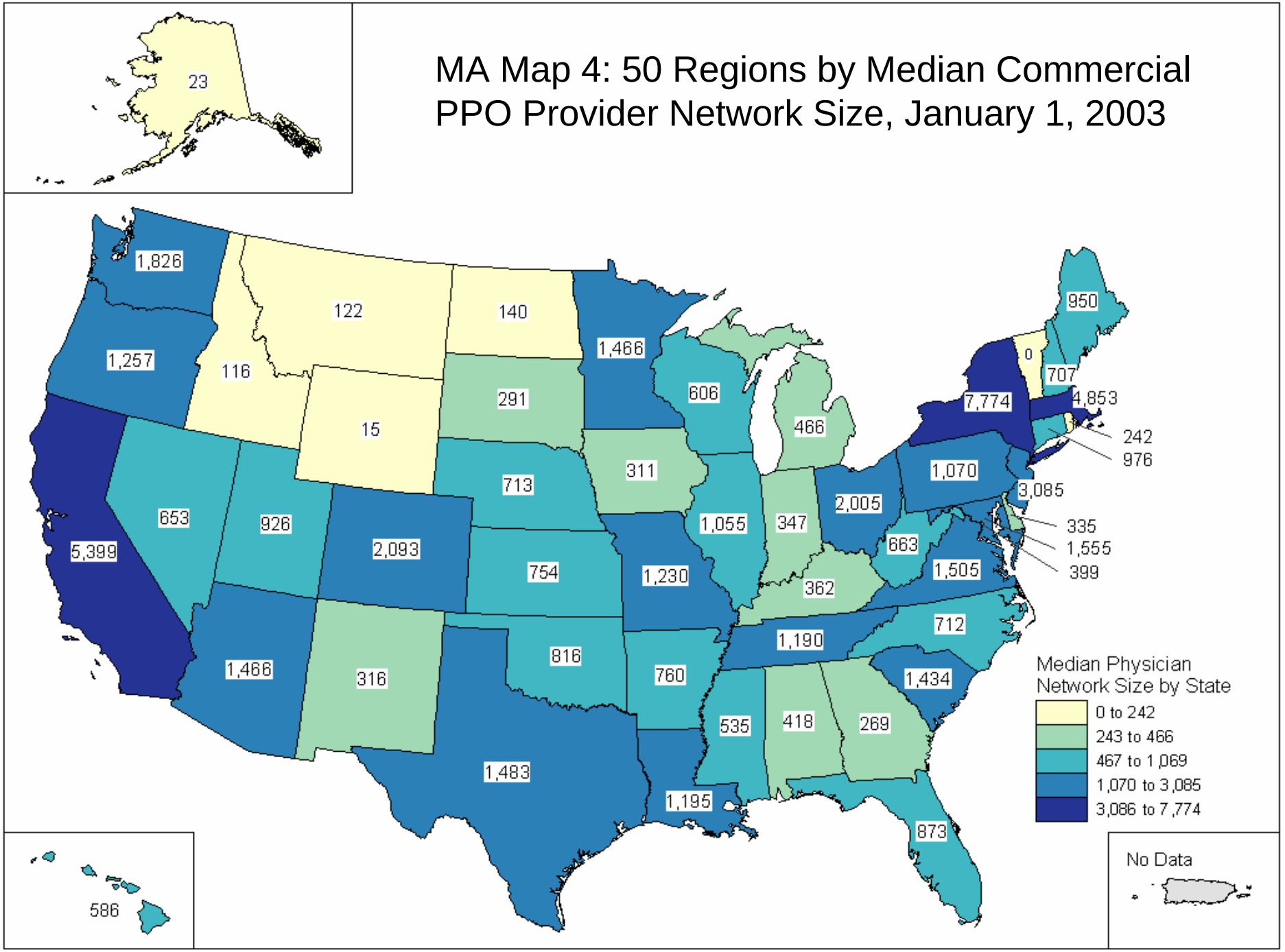
MA Map 4: 50 Regions by Median Commercial PPO Provider Network Size, January 1, 2003
23
1,826
1,257
122
116
140
15
1,466
291
606
466
311
713
1,055
347
2,005
1,070
950
0
707
7,774
4,853
242
976
3,085
335
1,555
399
653
926
2,093
754
1,230
362
663
1,505
5,399
1,466
316
816
760
1,190
712
1,434
535
418
269
1,483
1,195
873
586
Median Physician Network Size by State
0 to 242
243 to 466
467 to 1,069
1,070 to 3,085
3,086 to 7,774
No Data

Median Number of Primary Care Physicians (PCPs) per 1000 Population in PPOs (MA Map 5)

- Five states (GA, VT, ID, WY, and AK) have very low (less than 10) median numbers of PCPs per 1000 population enrolled in PPOs.
- One state (New York) has a large median number (117) of networked primary care physicians per 1000 population enrolled in PPOs.
- Five other states (CA, CO, ME, OH, and HI) have between 42 and 70 median numbers of PCPs per 1000 population enrolled in PPOs.

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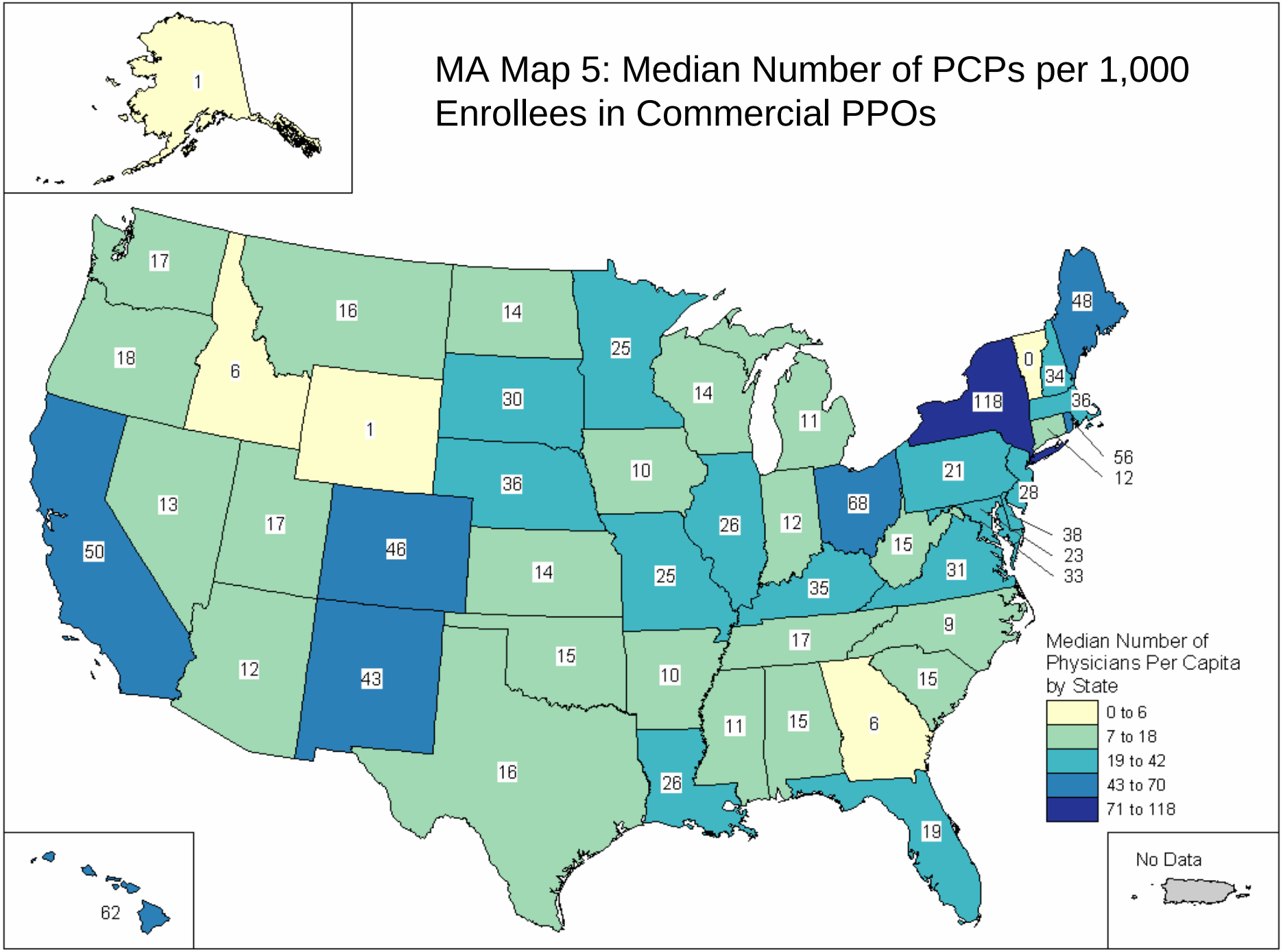
MA Map 5: Median Number of PCPs per 1,000 Enrollees in Commercial PPOs
1
17
18
6
16
14
25
30
1
14
11
48
0
34
118
36
56
12
21
28
10
36
68
26
12
13
17
46
50
14
25
35
15
31
38
23
33
9
17
15
12
43
15
10
11
15
6
16
26
19
62
Median Number of Physicians Per Capita by State
0 to 6
7 to 18
19 to 42
43 to 70
71 to 118
No Data

Estimated MA 2005 Risk Rates (MA Map 6)

- Estimated MA risk adjusted county payment rates were population weighted to create state level rates.
- These rates provide an indication of the relative payment levels that might be expected in each state.
- Eight states and PR, including a cluster of Northern Great Plains states, have the lowest payment rates in the country (between $507.09 and $639.99).
- TX and LA have the highest estimated rates (between $750 and $845.79).
- Another large group of states (AK, CA, FL, MD, DC, NJ, NY and MA) have rates of between $695 and $749.99.

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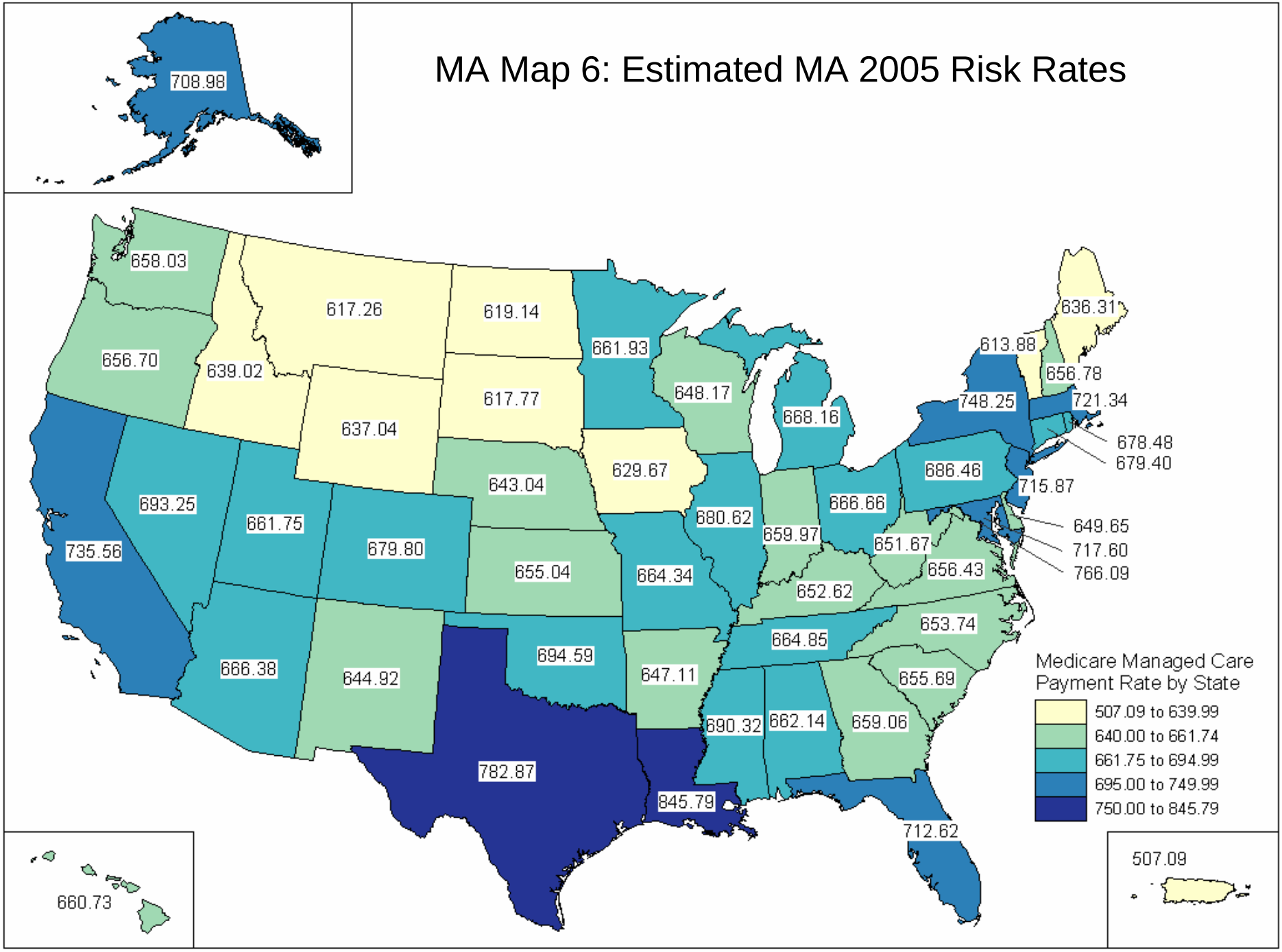
MA Map 6: Estimated MA 2005 Risk Rates



CMS-HCC Health Status Scores (MA Map 7)

- The CMS-HCC health status scores are used when beneficiaries enroll in MA plans.
- Scores used here are a reasonable proxy for the predicted health status of Medicare FFS beneficiaries.
- Six Northern Great Plains states and AK have the lowest scores (from 0.88 - 0.91).
- Also, there are large clusters of relatively healthy beneficiaries across most of Midwest and Southwest.
- States with the highest scores (least healthy) are FL, NY, MA, NJ, PA and RI, and the District of Columbia.

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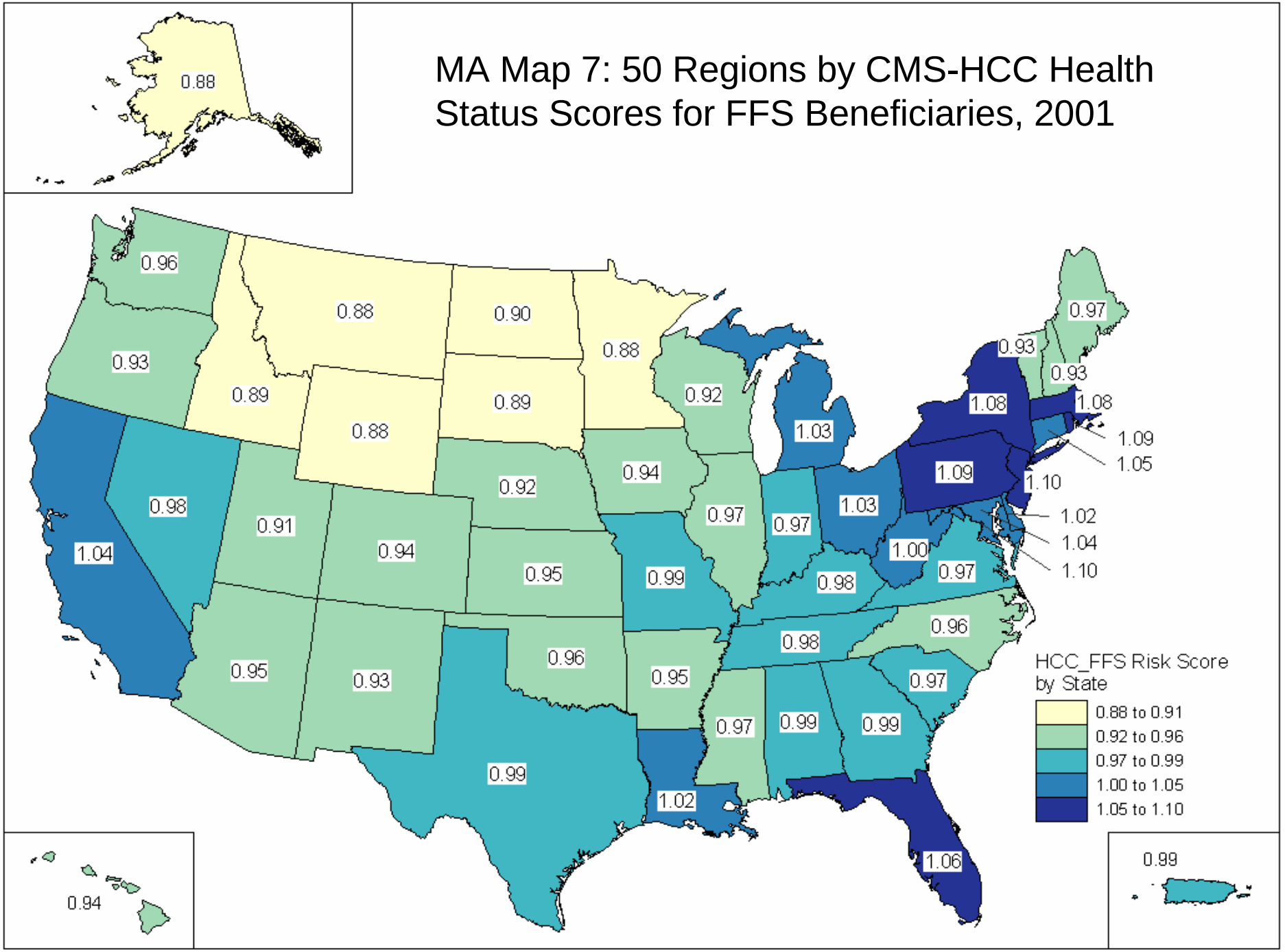
MA Map 7: 50 Regions by CMS-HCC Health Status Scores for FFS Beneficiaries, 2001
0.88
0.96
0.93
0.89
0.88
0.88
0.90
0.89
0.88
0.92
0.94
0.92
0.98
0.91
0.94
1.04
0.95
0.99
0.97
0.97
1.03
1.09
1.10
1.02
1.04
1.10
1.00
0.97
0.98
0.96
0.98
0.97
0.95
0.93
0.96
0.95
0.97
0.99
0.99
0.99
1.02
1.06
0.97
0.93
0.93
1.08
1.08
1.09
1.05
HCC_FFS Risk Score by State
0.88 to 0.91
0.92 to 0.96
0.97 to 0.99
1.00 to 1.05
1.05 to 1.10
0.94
0.99

Simulated 2005 MA Monthly Payments (MA Map 8)

- These figures combine the two primary components of current MA payments: county risk payment rates and health status scores.
  - Health status scores here were calculated on FFS beneficiaries.
- These figures offer an estimate of per enrollee payment rates for a state.
- Based on 2005 risk payment rates, and enrolling average FFS beneficiaries, eight states and D.C. might see enrollee payments of more than $750 per managed care enrollee, per month (CA, TX, LA, FL, PA, NJ, NY, MA and D.C.).
- Note that because of the MA payment methodology, these payment rates compare favorably to FFS.

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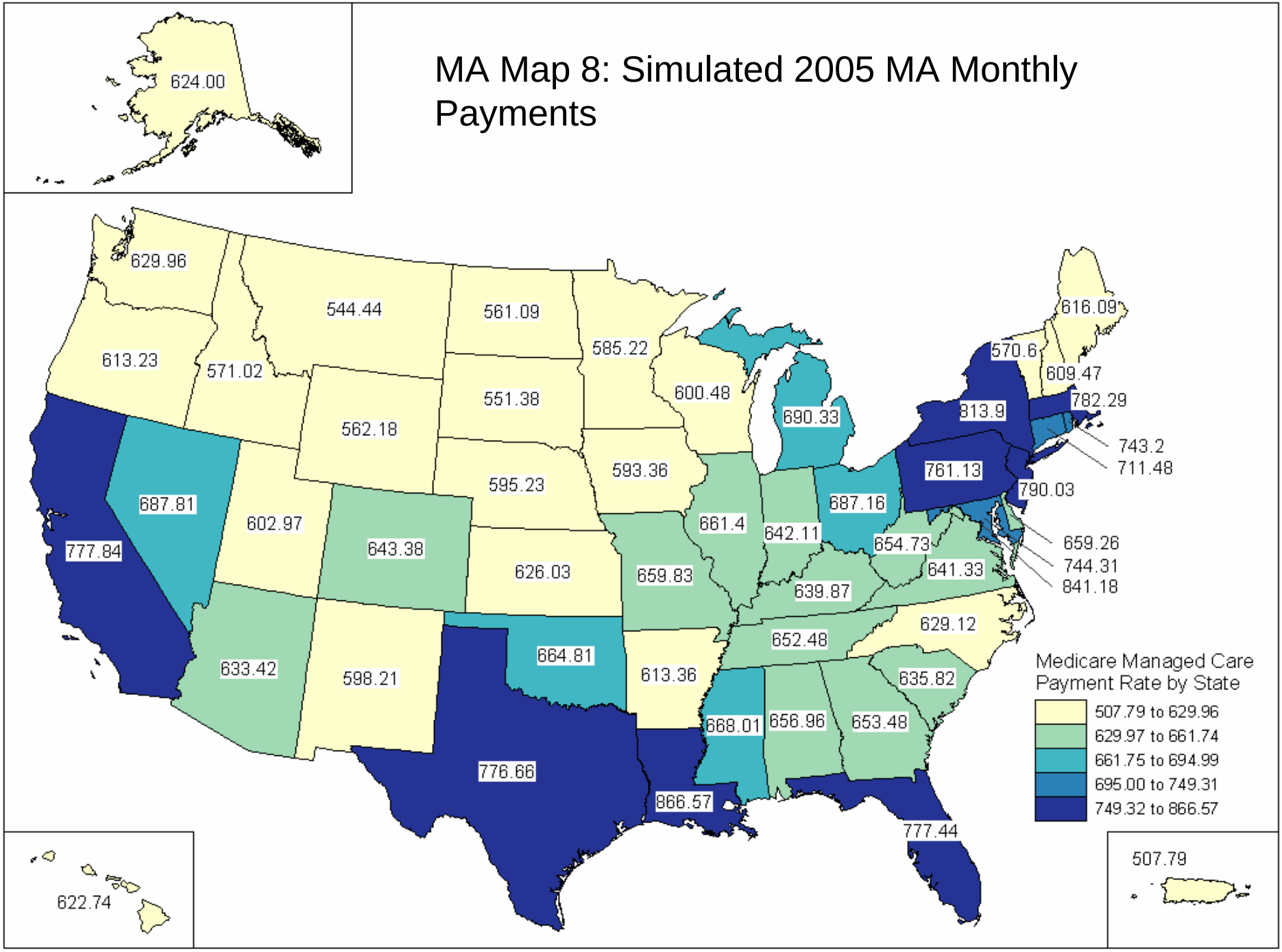
MA Map 8: Simulated 2005 MA Monthly Payments



Option 1: 50 State-Based Region Summary

- Strong managed care industry preference, based on regulatory, “health care is local,” network development, rapid start-up, and greater small plan participation perspective.
- The number of eligibles in 11 of 50 states and DC too small to sustain regional PPO.
- Larger variation in risk scores and payment rates.
- Option does not join states with lower and higher payment rates, creating state “outliers.”
- Option ignores states in the Northern Great Plains with difficult PPO markets, i.e., few PPOs, low PPO penetration, and smaller physician networks.

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Option 2: 10 CMS Administrative Regions

- MA Map 9 shows the 10 CMS regions by number of commercial risk-bearing PPOs.
- Enrollment in commercial PPO plans high across the regions, relative to other options.
- To check geographic distribution of current PPOs, MA Map 10 shows commercial PPO penetration by county.
  - In developing options, we used either median state PPO penetration rates of 0.383, or minimum PPO penetration rates 0.226.

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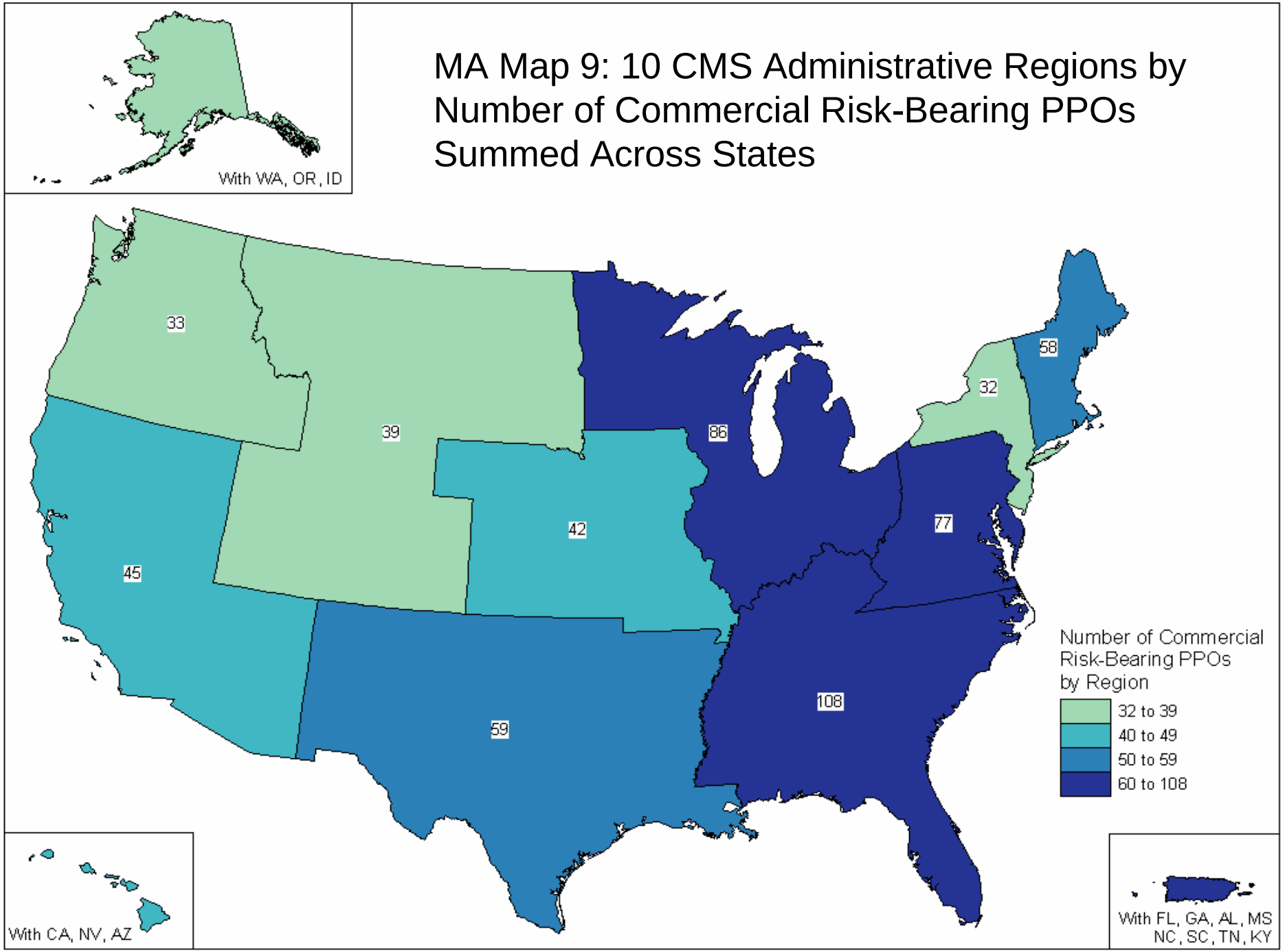
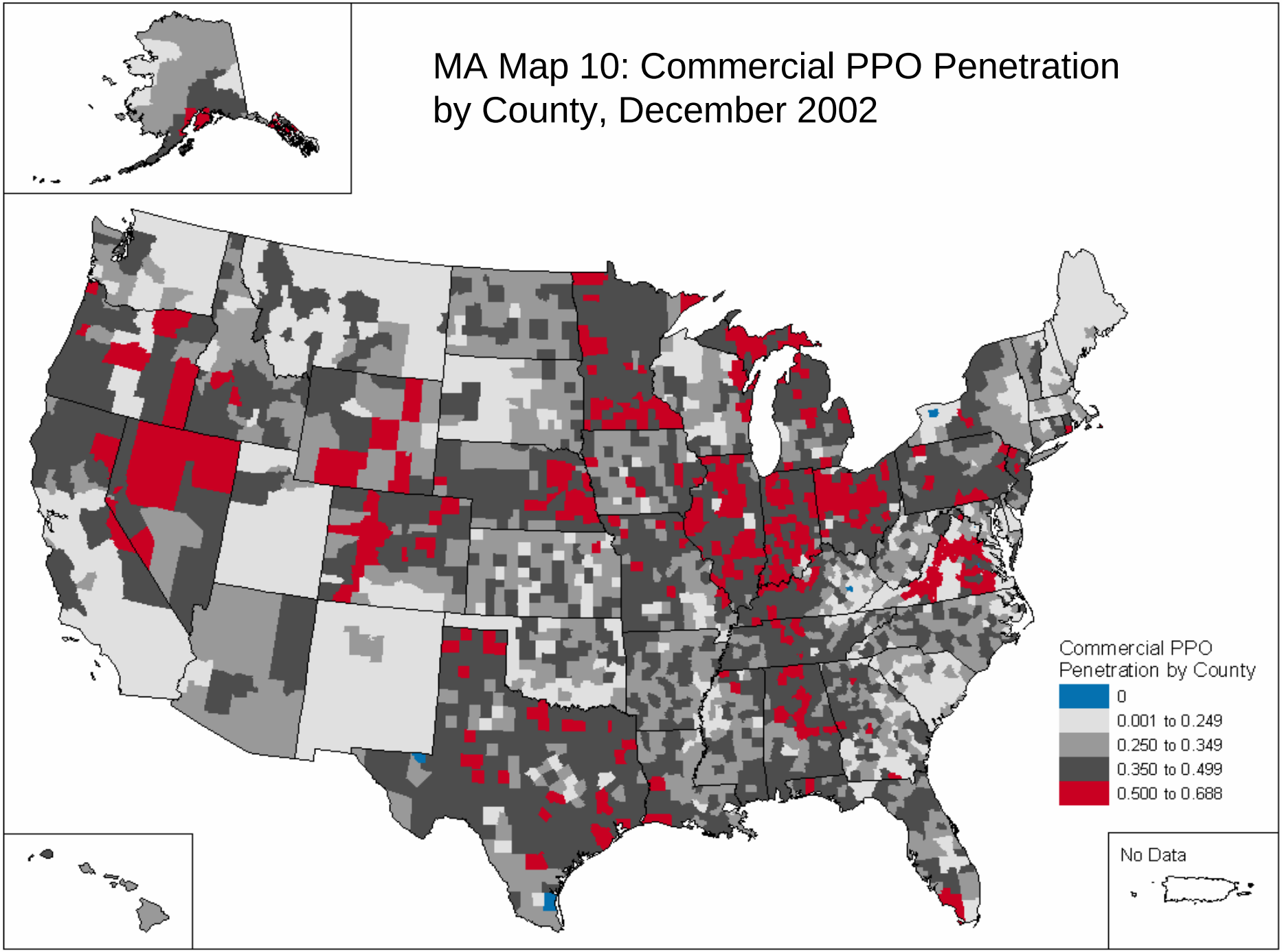
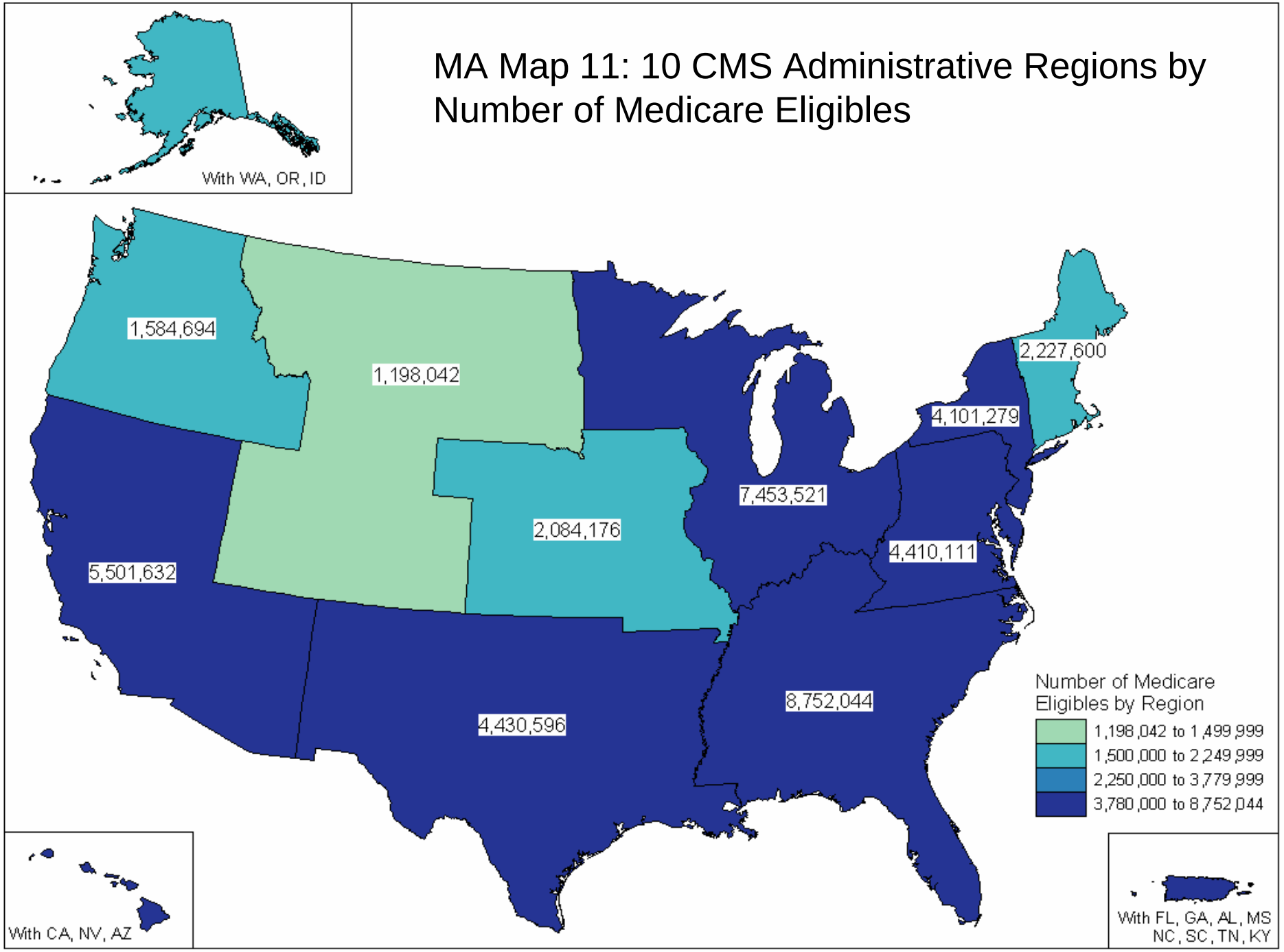
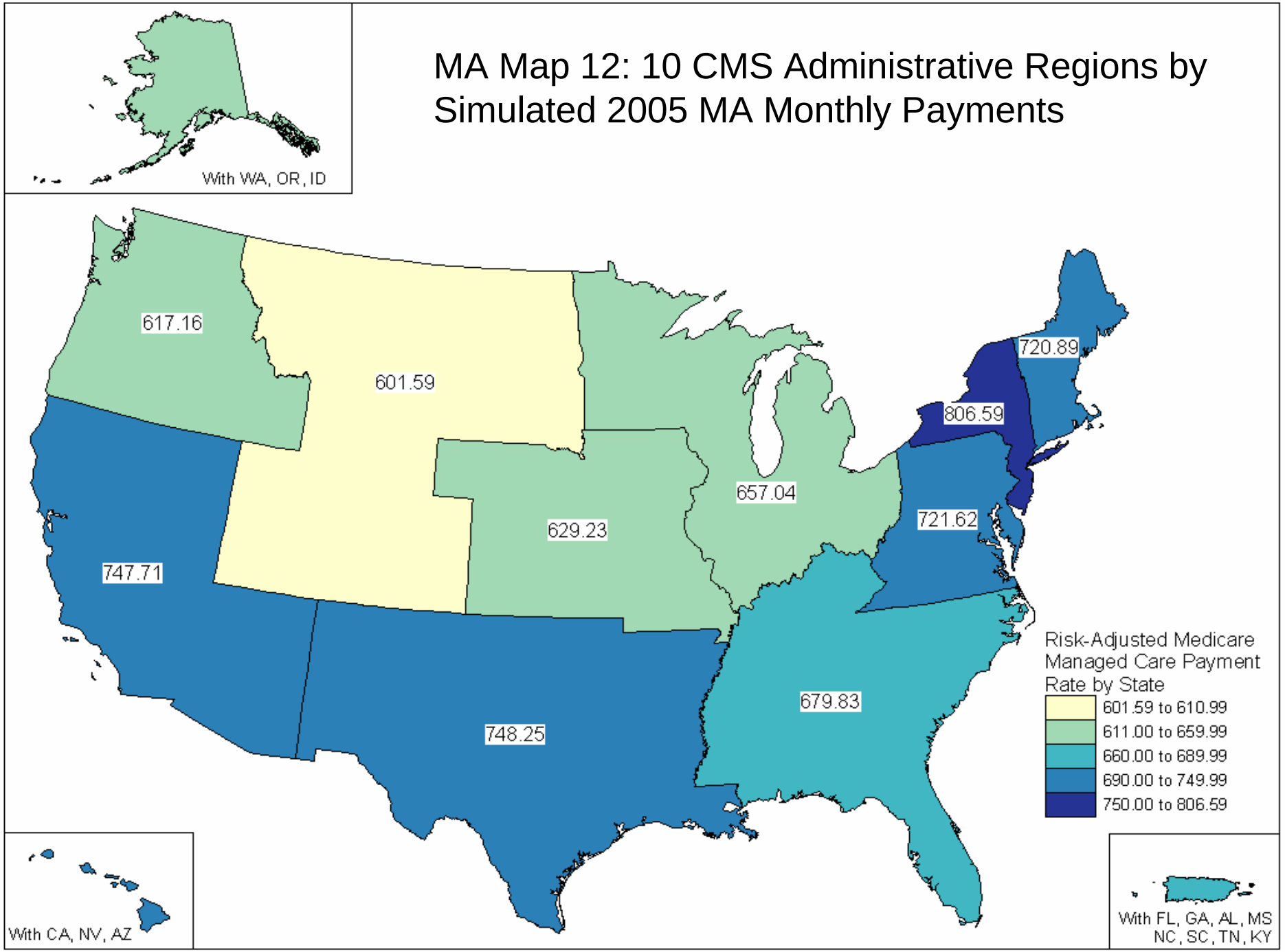

With WA, OR, ID
MA Map 9: 10 CMS Administrative Regions by Number of Commercial Risk-Bearing PPOs Summed Across States
33
39
45
42
59
86
108
32
58
77
Number of Commercial Risk-Bearing PPOs by Region
32 to 39
40 to 49
50 to 59
60 to 108
With CA, NV, AZ
With FL, GA, AL, MS NC, SC, TN, KY

MA Map 10: Commercial PPO Penetration by County, December 2002



MA Map 11: 10 CMS Administrative Regions by Number of Medicare Eligibles




MA Map 12: 10 CMS Administrative Regions by Simulated 2005 MA Monthly Payments
With WA, OR, ID
617.16
601.59
657.04
720.89
806.59
721.62
629.23
747.71
679.83
748.25
Risk-Adjusted Medicare Managed Care Payment Rate by State
601.59 to 610.99
611.00 to 659.99
660.00 to 689.99
690.00 to 749.99
750.00 to 806.59
With CA, NV, AZ
With FL, GA, AL, MS NC, SC, TN, KY

Option 2: 10 CMS Administrative Regions Summary

- All 10 CMS regions have sufficient eligibles to sustain PPO (MA Map 11).
  - But variation in eligibles is between 1.2 million and 8.8 million.
- Lower variation in estimated 2005 payment rates (MA Map 12) relative to the 50 state-based option.
- Option does not consider Medicare patient flows.
- Physician network size in some regions is too small (e.g. upper Midwest).

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Option 3: 11 Regions with More Equal Population Size and Number of Commercial PPOs

- Maintains a small number of regions based on population size rather than CMS administrative borders.
- Combines areas with low PPO penetration, few PPOs and a small physician network size into several regions with states that had higher numbers.

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Option 3: 11 Regions with More Equal Population Size and Number of Commercial PPOs -- Method

- Begin with a map of the Medicare eligible population per State, which has a median of 571,571. Largest is CA. Smallest is AK.
- Because CA is large, we tried to build regions of about comparable size (3.5 - 4 million).
- Clustered together contiguous States, building up populations to about this size, resulting in 11 established regions (Map 11).
- Minimum population size is 2.2 million (the North Central area), maximum is 4.8 million (CA and HI).
- The median eligible population is 4.1 million; the coefficient of variation (CV) is 0.19. This CV is much lower than CV from 50 States option (1.04), and CV for the 10 CMS regions (0.63).

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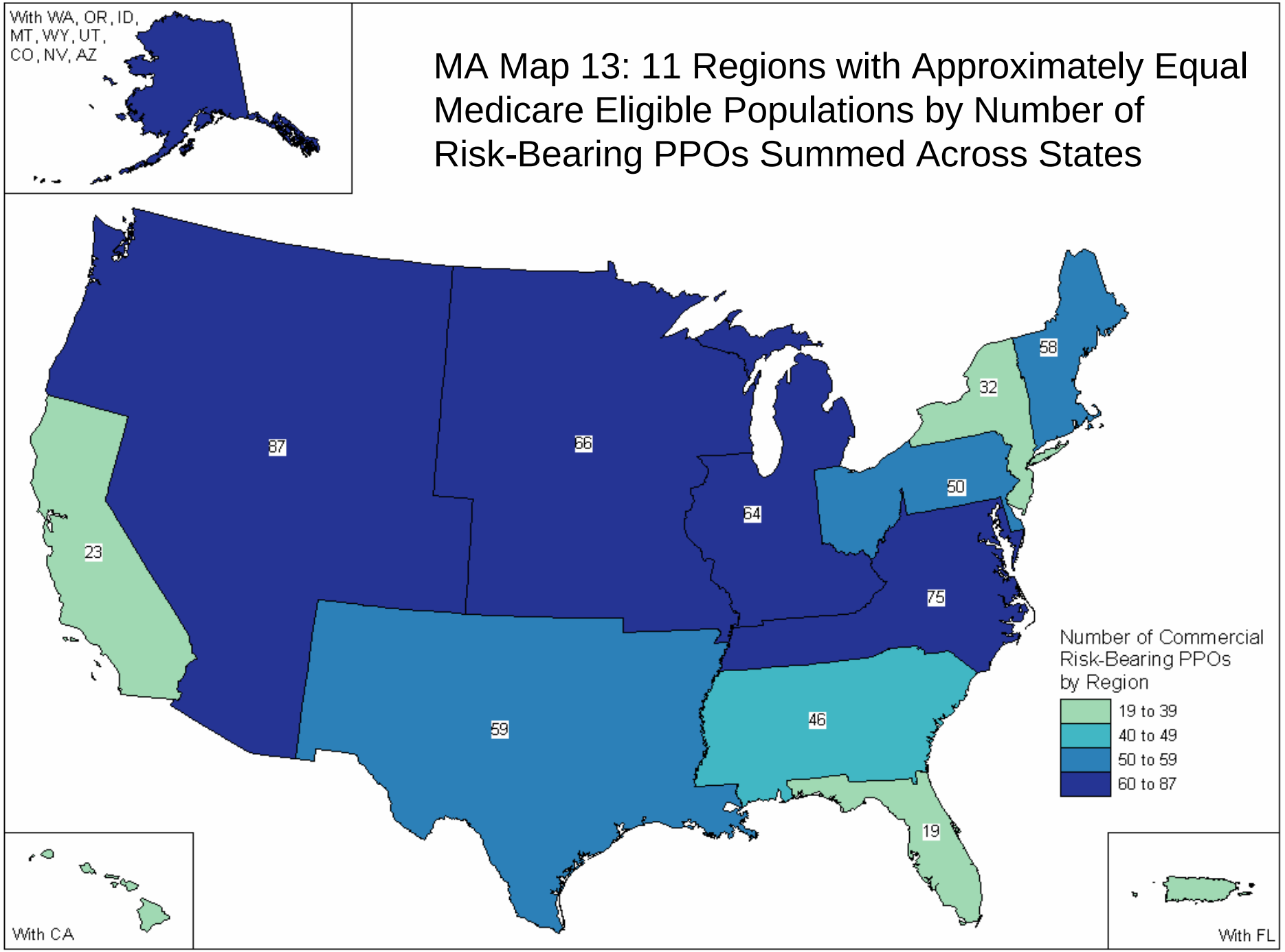
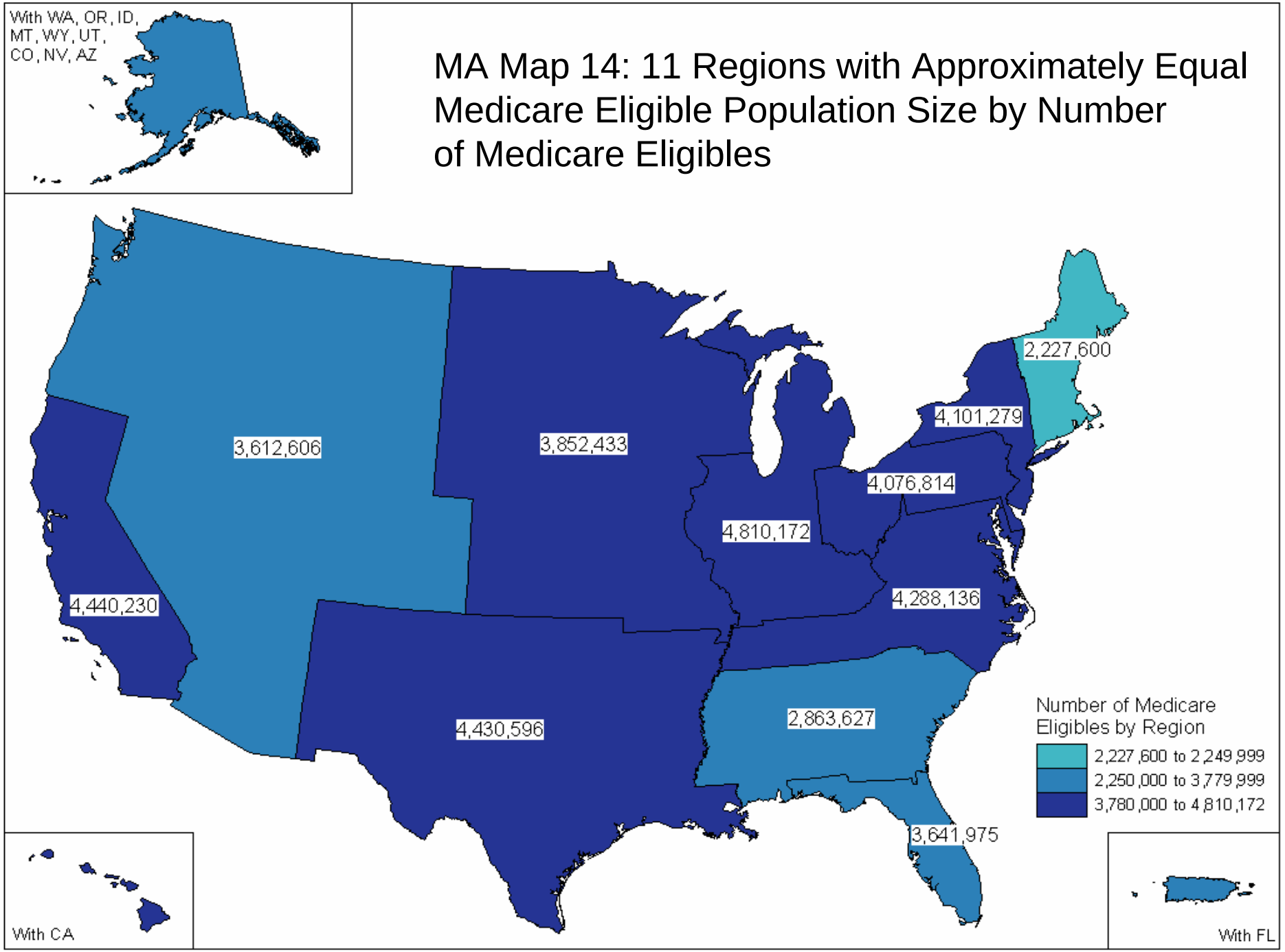
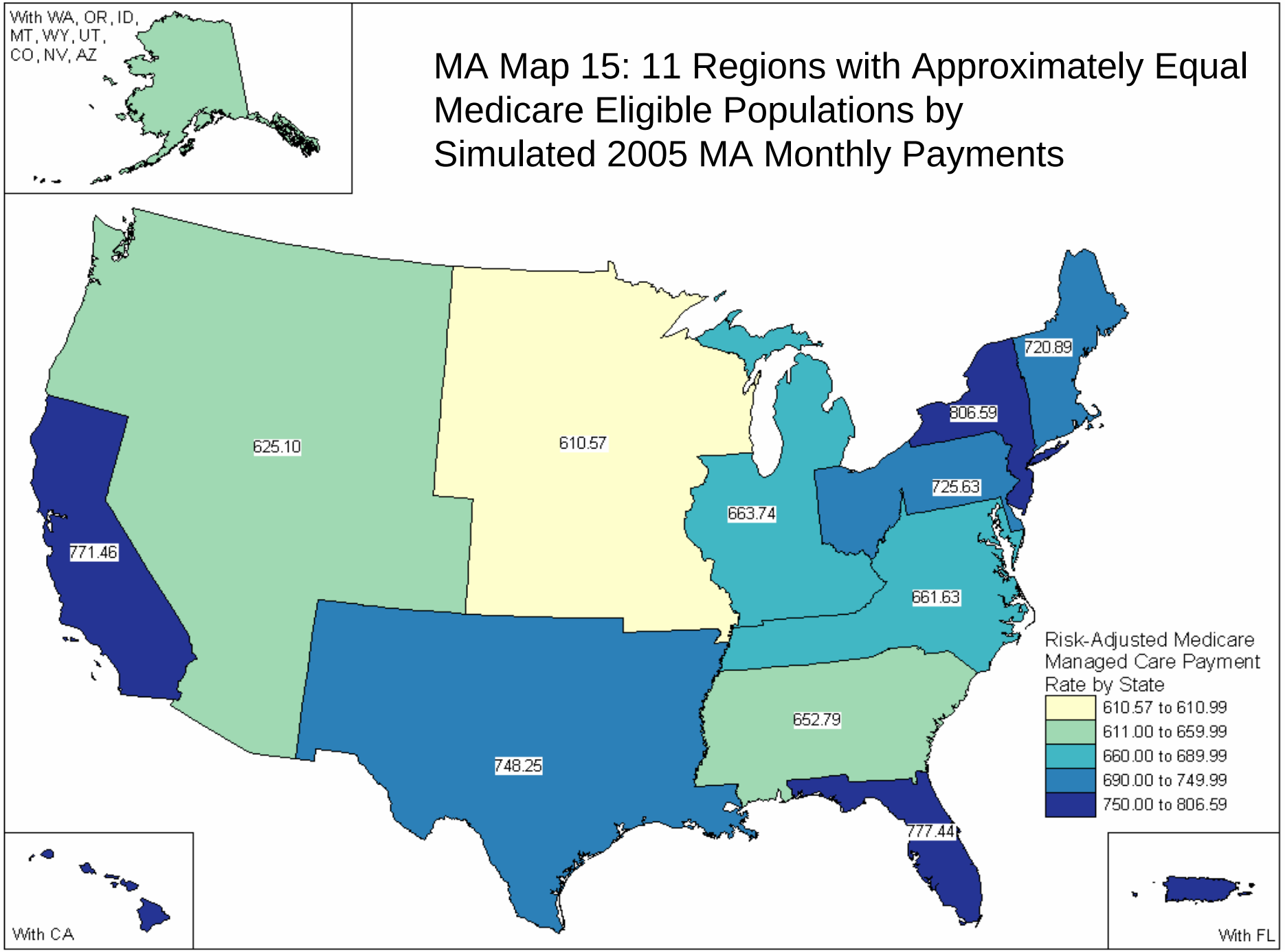

With WA, OR, ID, MT, WY, UT, CO, NV, AZ
MA Map 13: 11 Regions with Approximately Equal Medicare Eligible Populations by Number of Risk-Bearing PPOs Summed Across States
87
66
23
64
50
58
32
75
59
46
19
Number of Commercial Risk-Bearing PPOs by Region
19 to 39
40 to 49
50 to 59
60 to 87
With CA
With FL


With WA, OR, ID, MT, WY, UT, CO, NV, AZ
MA Map 14: 11 Regions with Approximately Equal Medicare Eligible Population Size by Number of Medicare Eligibles
3,612,606
3,852,433
2,227,600
4,101,279
4,076,814
4,810,172
4,440,230
4,288,136
4,430,596
2,863,627
3,641,975
Number of Medicare Eligibles by Region
2,227,600 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 4,810,172
With CA
With FL


With WA, OR, ID, MT, WY, UT, CO, NV, AZ
MA Map 15: 11 Regions with Approximately Equal Medicare Eligible Populations by Simulated 2005 MA Monthly Payments
625.10
610.57
720.89
306.59
725.63
663.74
771.46
661.63
652.79
748.25
777.44
Risk-Adjusted Medicare Managed Care Payment Rate by State
610.57 to 610.99
611.00 to 659.99
660.00 to 689.99
690.00 to 749.99
750.00 to 806.59
With CA
With FL

Option 3: 11 Regions with More Equal Population Size and Number of Commercial PPOs -- Summary

- 11 regions have sufficient population to support a regional PPO.
- Variation in risk scores and payment rates across regions is minimal.
- Does not address stakeholder regulatory concerns associated with multi-state regions.
- Similar to other multi-state regional options, does not address stakeholder concerns associated with large regions.
- Creates one very large region in the west.

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Option 4: 24 Regions Based on Median Standards in Current PPO Markets

- In this option, regions were defined starting with places of demonstrated PPO penetration/viability.
- General idea was to define possible regions around core areas with current PPO plans on the assumption that probable MA regional plan entrants would be organizations with established PPO provider networks.
- Used markets with current Medicare PPO demonstration sites as a guide.

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Option 4: 24 Regions Based on Median Standards in Current PPO Markets: Method

- Variables we considered in defining these core areas:
  - number of commercial PPOs serving constituents in the state
  - number of commercial PPOs based in the state
  - commercial PPO penetration of total population
  - minimum existing PPO physician network size

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Option 4: 24 Regions Based on Median Standards in Current PPO Markets: Method

- Medium and minimum values were developed based on the Medicare PPO demonstration. Specific values were:

Variable	Median Value	Minimum Value
Number of commercial PPOs serving the state	29	17
Number of commercial PPOs based in the state	17	3
Commercial PPO penetration rate	0.383	0.226
PPO provider network size	N/A	242

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Option 4: 24 Regions Based on Median Standards in Current PPO Markets: Method

- In this option, used median values for current PPO markets.
- Select states with: number of PPOs with constituents in state ≥29 OR number of PPOs based in state ≥ 17 OR total penetration of all PPOs is ≥0.383; AND,
- Average physician network size is ≥ 242 .
- Initial Result: 23 selected core states.
- Proceeded to combine states not selected with other states, based on observed Medicare patient flows (1999 CMS data).

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Option 4: 24 Regions Based on Median Standards in Current PPO Markets: Method

- States were assigned to regions as follows:

Core State	Combined with:
OR	AK, WA, ID, MT
CA	NV, HI, and AZ
CO	UT and WY
MA	ND, SD, and WI
NE	IA
MO	KS
TX	NM, OK, AR
MA	ME, RI, NH, VT
MD	DE, DC, VA, WV
GA	SC
LA	MS
AL, FL, NY, PA, CT, NJ, IN, OH, IL, KY, NC, TN, MI	None (stand alone as regions)

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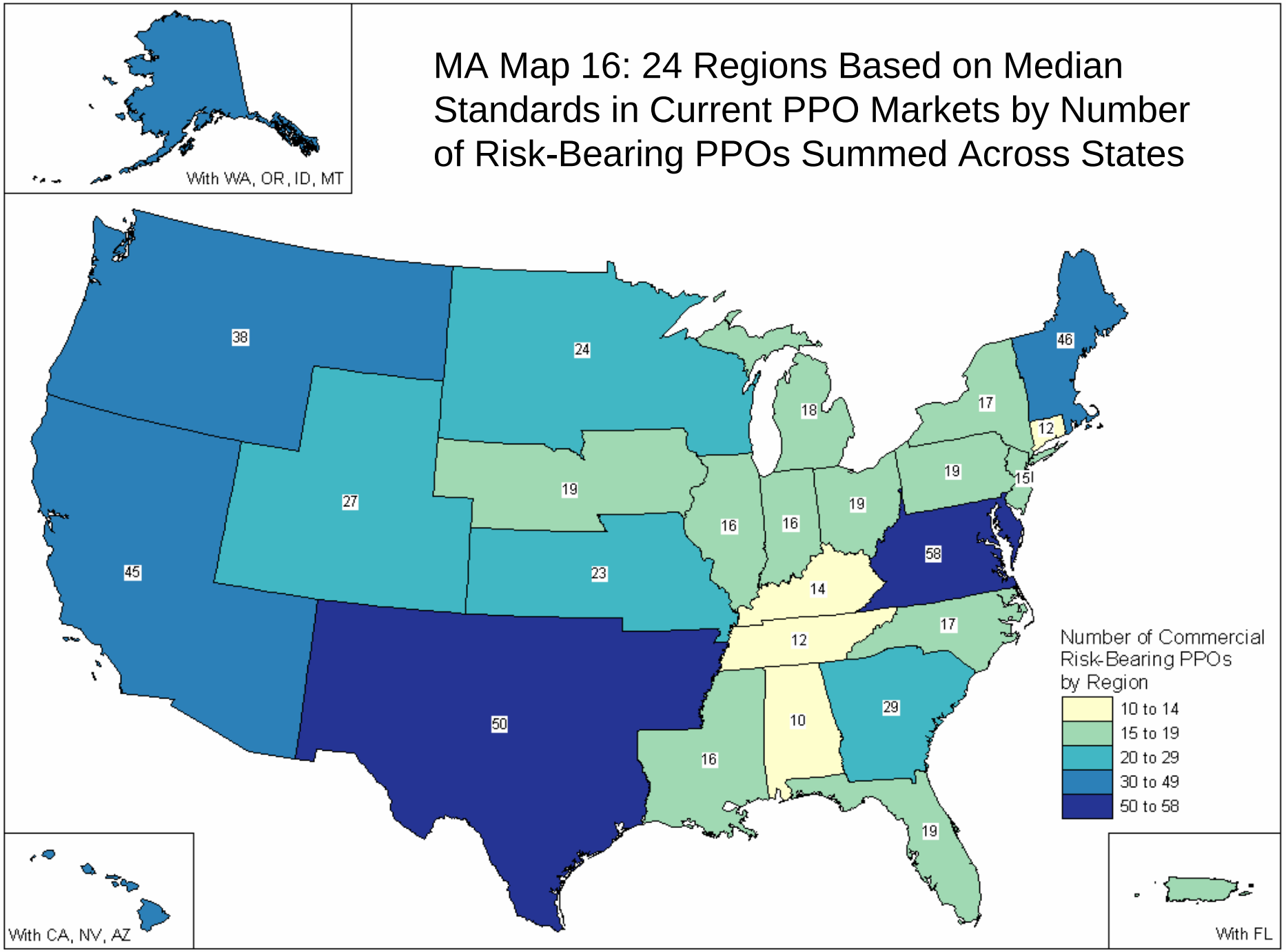
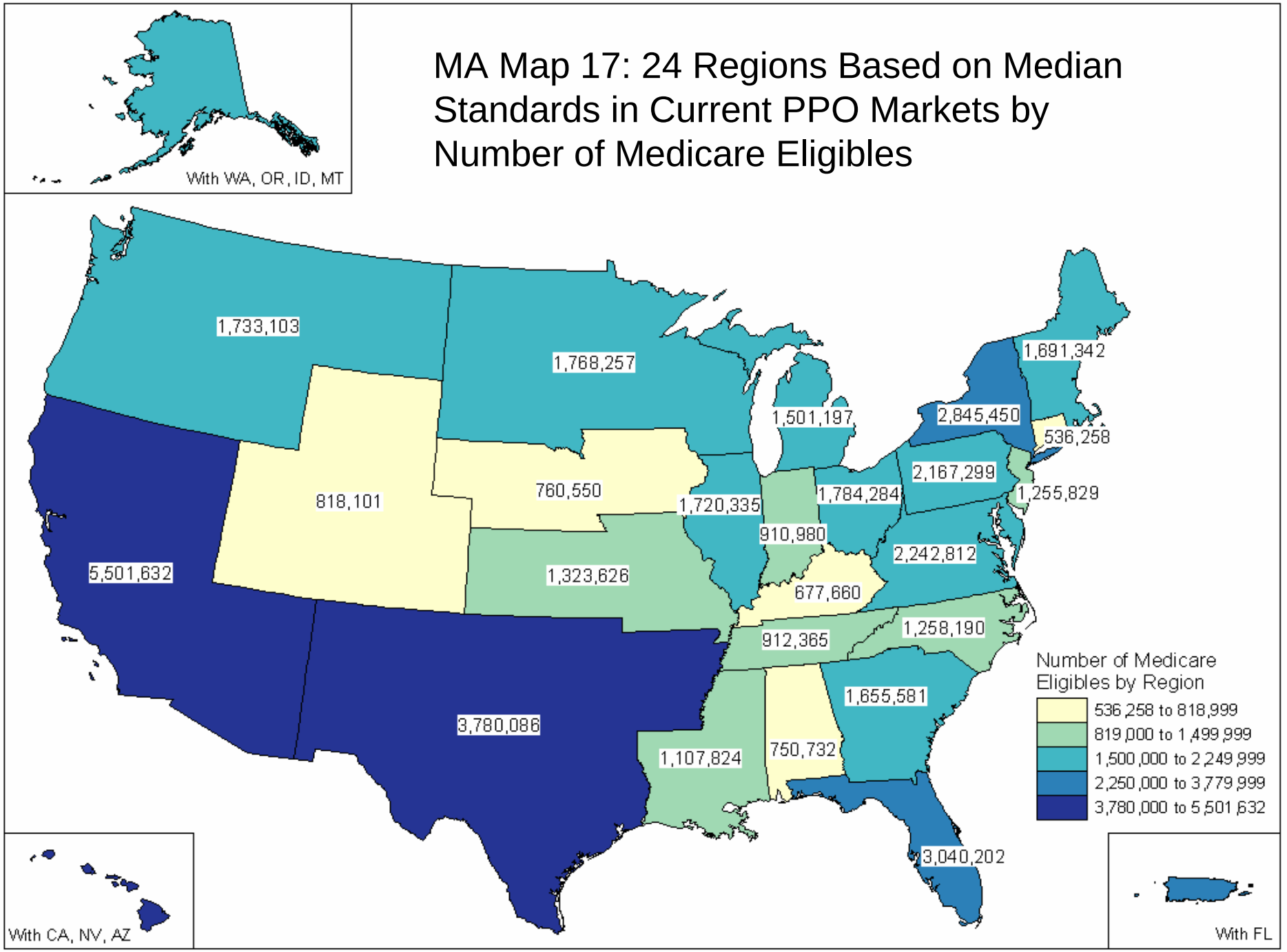
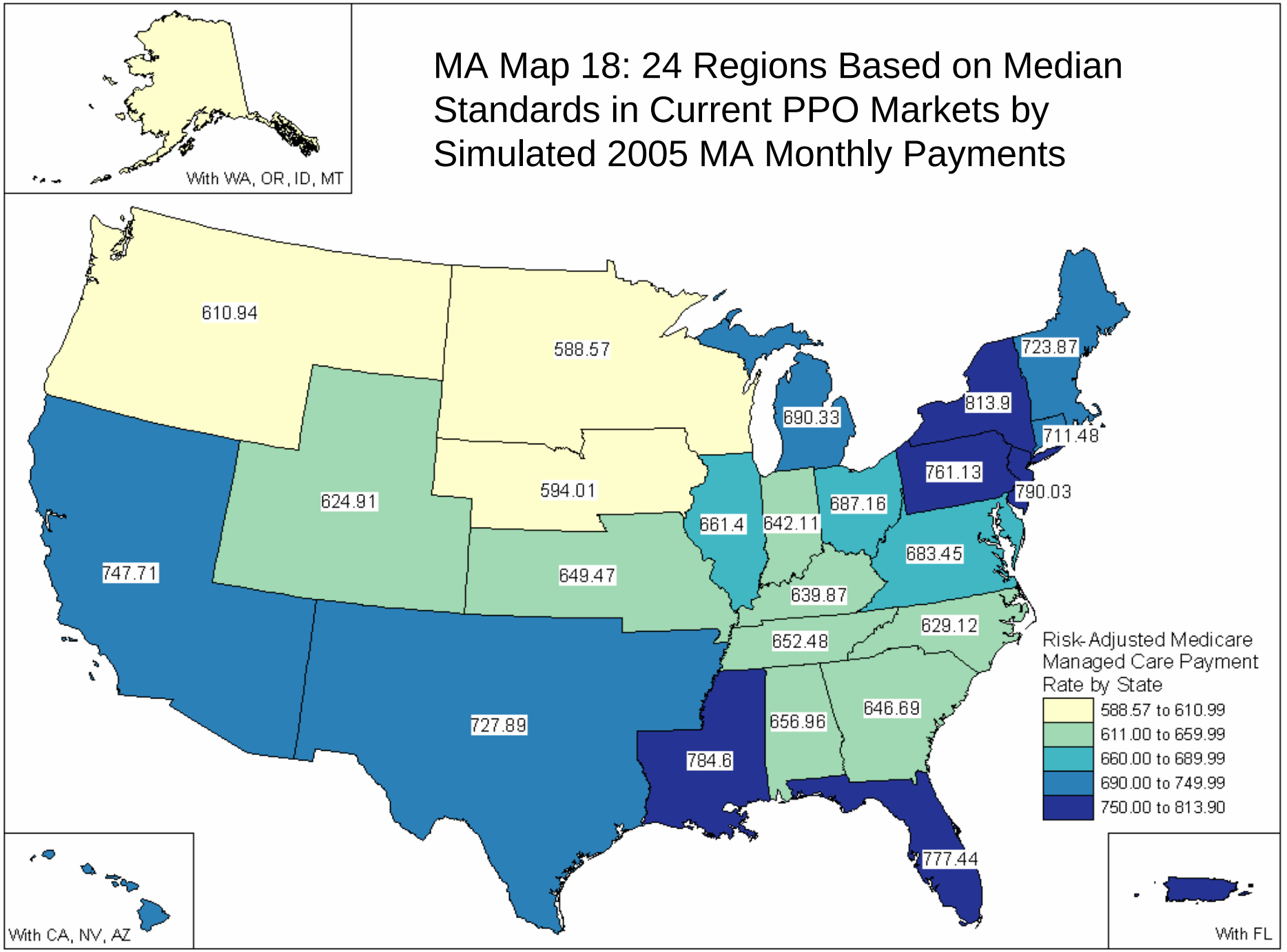

With WA, OR, ID, MT
MA Map 16: 24 Regions Based on Median Standards in Current PPO Markets by Number of Risk-Bearing PPOs Summed Across States
38
24
46
18
17
12
19
15
27
19
19
16
16
58
45
23
14
12
17
50
10
29
16
19
Number of Commercial Risk-Bearing PPOs by Region
10 to 14
15 to 19
20 to 29
30 to 49
50 to 58
With CA, NV, AZ
With FL


MA Map 17: 24 Regions Based on Median Standards in Current PPO Markets by Number of Medicare Eligibles
With WA, OR, ID, MT
1,733,103
1,768,257
1,501,197
2,845,450
1,691,342
536,258
2,167,299
1,255,829
760,550
818,101
1,720,335
1,784,284
910,980
2,242,812
5,501,632
1,323,626
677,660
912,365
1,258,190
1,655,581
3,780,086
1,107,824
750,732
3,040,202
Number of Medicare Eligibles by Region
536,258 to 818,999
819,000 to 1,499,999
1,500,000 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 5,501,632
With CA, NV, AZ
With FL


MA Map 18: 24 Regions Based on Median Standards in Current PPO Markets by Simulated 2005 MA Monthly Payments
With WA, OR, ID, MT
610.94
588.57
624.91
594.01
747.71
649.47
727.89
690.33
661.4
642.11
687.16
639.87
652.48
656.96
646.69
784.6
723.87
813.9
711.48
761.13
790.03
683.45
629.12
777.44
Risk-Adjusted Medicare Managed Care Payment Rate by State
588.57 to 610.99
611.00 to 659.99
660.00 to 689.99
690.00 to 749.99
750.00 to 813.90
With CA, NV, AZ
With FL

Option 4: 24 Regions Based on Median Standards in Current PPO Markets -- Summary

- Eligible population is sufficient in every region to support regional PPOs.
- States with low numbers of PPOs, commercial PPO penetration or small provider network size were combined with states with higher rates so all regions meet median criteria on these variables.
- Minimal variation in risk scores and payment.

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Option 5: 41 Regions Based on Minimum Standards in Current PPO Markets

- Option followed a similar approach to 24 region approach in combining areas with low PPO penetration, few PPOs and a small provider network size with areas with higher rates.
- However, we have “relaxed” the standards under which we defined core PPO markets using minimum rather than median values (see methodology for 24 region option).
- This change results in an option with a greater number of regions.

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Option 5: 41 Regions Based on Minimum Standards in Current PPO Markets: Methods

- With the relaxed selection criteria relative to the 24 region approach, we found 44 states and DC to use as core states.
- We also added to the criterion that the Medicare eligible population in each region should be at least 200,000 beneficiaries.

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Option 5: 41 Regions Based on Minimum Standards in Current PPO Markets: Methods

- States were assigned to regions as follows:

Core State	Combined with:
WA	ID, MT
MN	ND
CO	WY
NH	VT
AK	HI
SD	NE
DE, DC	MD
RI	MA
OR, CA, NV, AZ, NM, UT, KS, OK, TX, IA, MS, AR, LA, WI, IL, MI, MO, OH, KY, TN, LA, AL, GA, FL, NC, SC, VA, WV, PA, NY, NJ, CT, MA	None (stand alone as regions)

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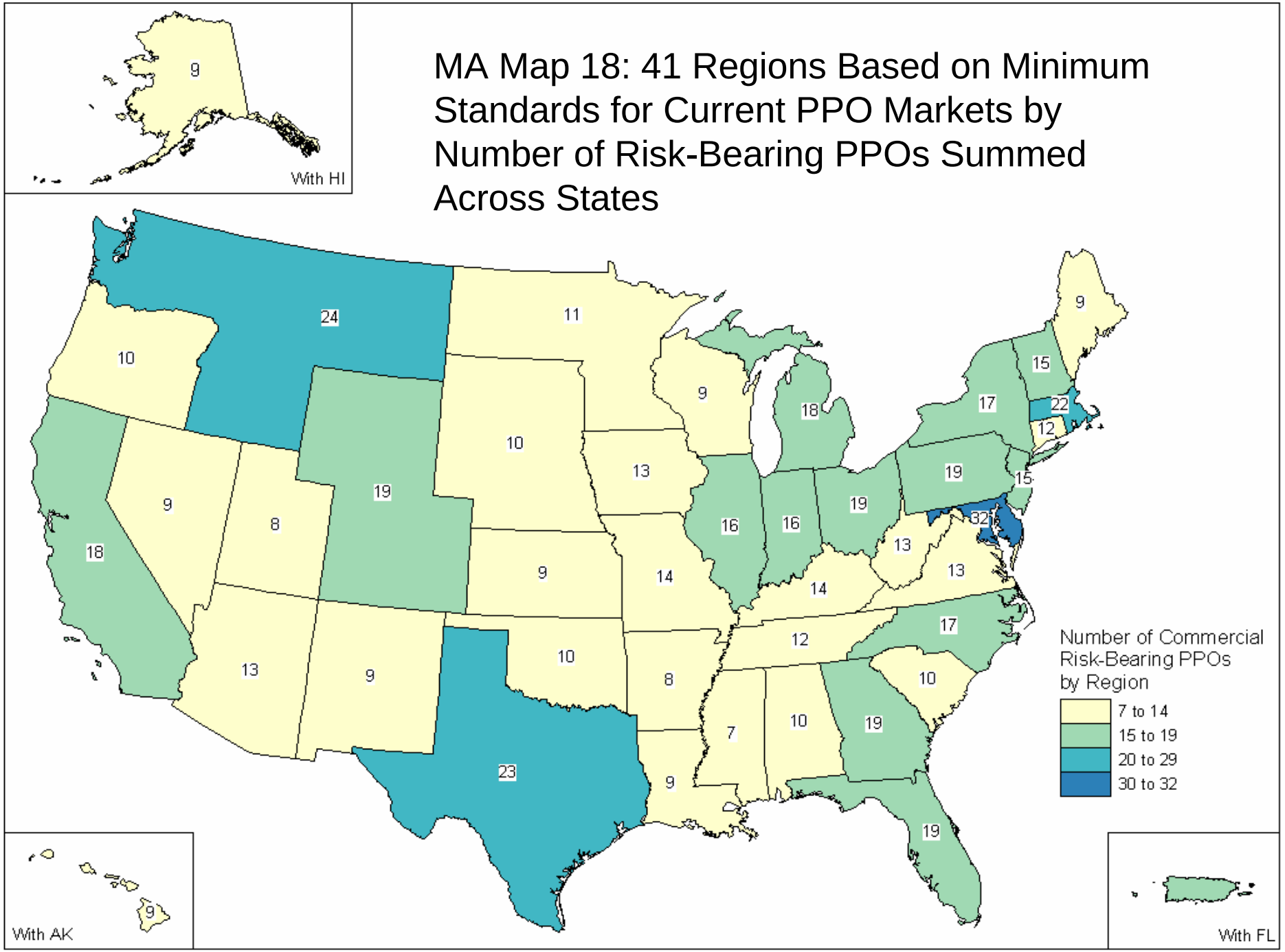
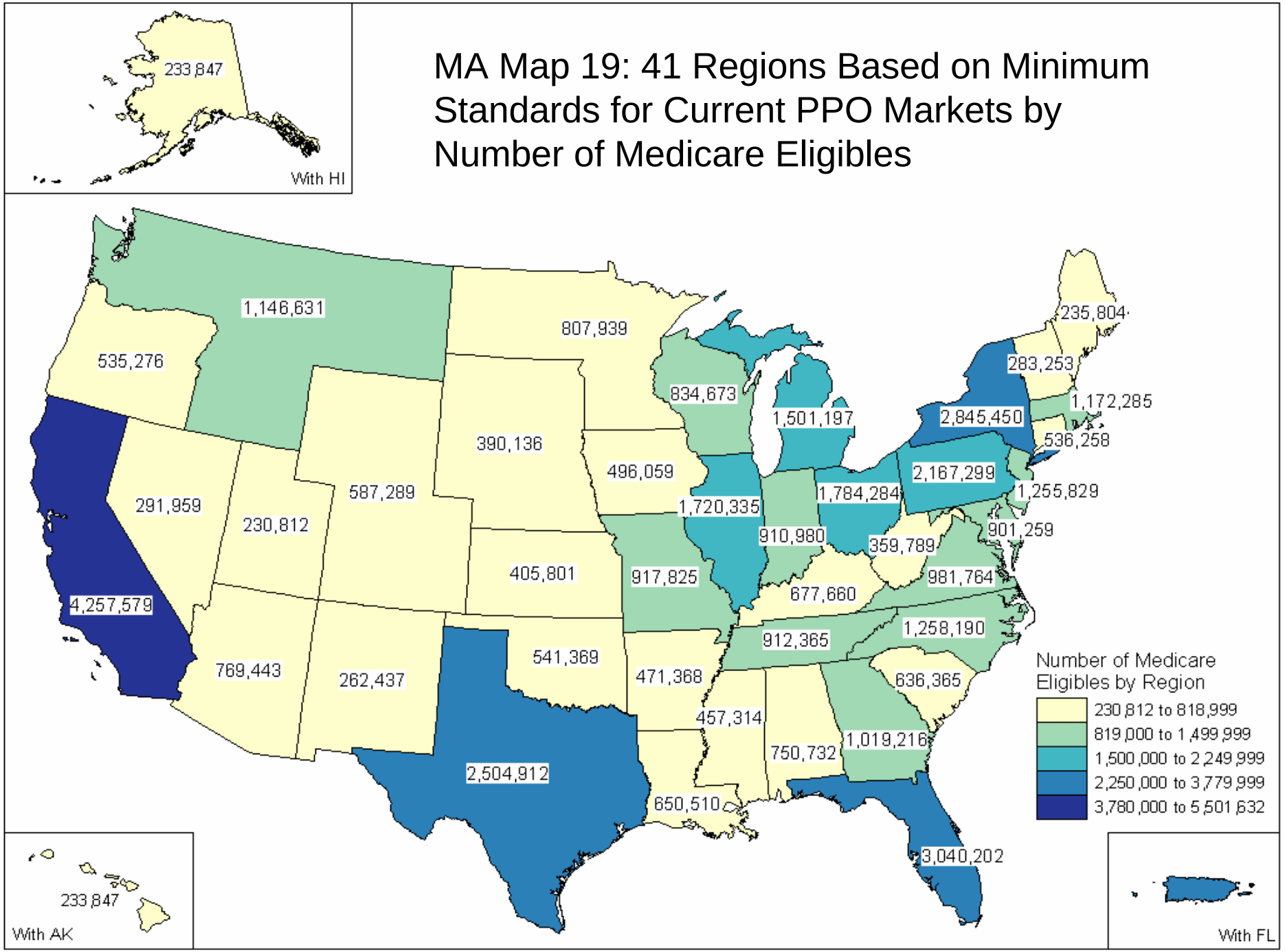
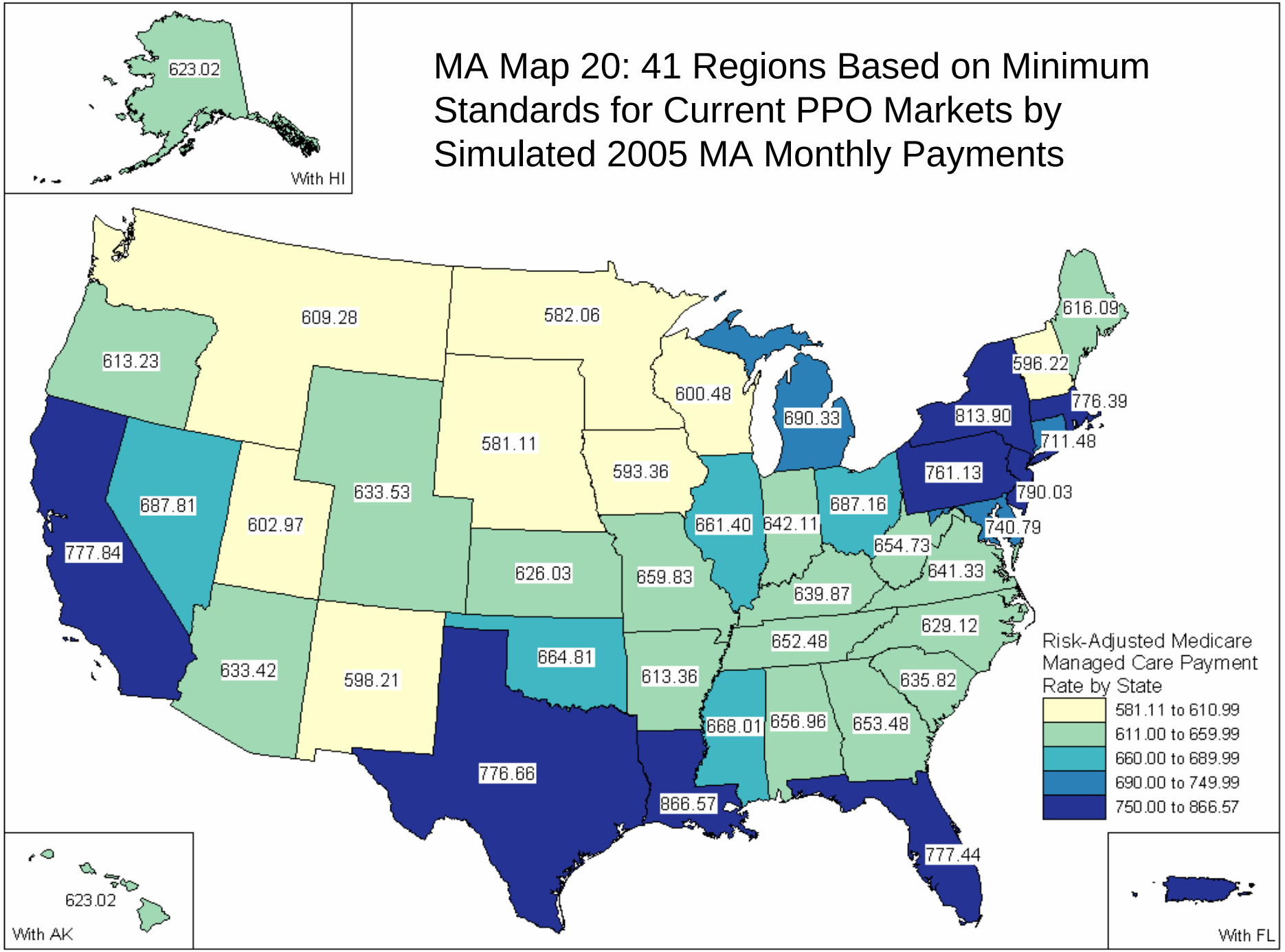

MA Map 18: 41 Regions Based on Minimum Standards for Current PPO Markets by Number of Risk-Bearing PPOs Summed Across States
9
With HI
24
11
9
10
10
13
18
17
15
22
12
19
15
9
19
8
16
16
19
32
18
9
14
13
13
14
12
17
13
9
10
8
10
7
10
19
23
9
19
Number of Commercial Risk-Bearing PPOs by Region
7 to 14
15 to 19
20 to 29
30 to 32
9
With AK
With FL


MA Map 19: 41 Regions Based on Minimum Standards for Current PPO Markets by Number of Medicare Eligibles
233,847
With HI
1,146,631
535,276
807,939
834,673
1,501,197
235,804
283,253
2,845,450
1,172,285
536,258
390,136
496,059
2,167,299
1,784,284
1,255,829
587,289
291,959
230,812
1,720,335
910,980
359,789
901,259
405,801
917,825
981,764
677,660
4,257,579
912,365
1,258,190
541,369
769,443
262,437
471,368
636,365
457,314
1,019,216
750,732
2,504,912
650,510
3,040,202
Number of Medicare Eligibles by Region
230,812 to 818,999
819,000 to 1,499,999
1,500,000 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 5,501,632
233,847
With AK
With FL


MA Map 20: 41 Regions Based on Minimum Standards for Current PPO Markets by Simulated 2005 MA Monthly Payments
623.02
With HI
609.28
582.06
613.23
600.48
690.33
616.09
596.22
776.39
813.90
711.48
581.11
593.36
761.13
790.03
687.81
633.53
687.16
602.97
661.40
642.11
740.79
654.73
777.84
626.03
659.83
641.33
639.87
629.12
652.48
664.81
633.42
598.21
613.36
635.82
668.01
656.96
653.48
776.66
866.57
777.44
Risk-Adjusted Medicare Managed Care Payment Rate by State
581.11 to 610.99
611.00 to 659.99
660.00 to 689.99
690.00 to 749.99
750.00 to 866.57
623.02
With AK
With FL

Option 5: 41 Regions Based on Minimum Standards in Current PPO Markets -- Summary

- Combines areas with low PPO penetration, few PPOs and a small physician network size with contiguous areas with higher numbers.
- Regions meet the minimum standards for network size and numbers of PPOs; two regions, however, have lower than the minimum PPO penetration rates.
- Medicare eligible population is sufficient in all regions to support a regional PPO plan.
- Larger variation in risk scores and payment rates across regions, similar to the variation with the 50 state-based option.

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Summary of MA Regional Options Presented

- Five possible MA Regional Options presented:
  - 50 state-based regions.
  - 10 multi-state regions based on CMS Administrative regions.
  - 11 multi-state regions based on equal Medicare eligible population.
  - 24 multi-state regions based on median current PPO market activity.
  - 41 multi-state regions based on minimum current PPO market activity.

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Additional Issues to be Considered: U.S. Territories

- Territories could be assigned to regions on the basis of Medicare patient flows.
- We have good data on flows for Guam, Puerto Rico, and the US Virgin Islands.
  - Guam flows to HI and CA
  - Puerto Rico flows to FL and NY
  - Virgin Islands flow to a number of states
- Of the territories, Puerto Rico might have enough Medicare eligibles to stand alone, if population is the only criteria, with about 600,000 eligibles.

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Additional Issues to be Considered: Multi-State MSAs

- All of the 5 MA regional options presented include multi-state MSAs that would be split.
  - 50 regions: 44 split MSAs.
  - 10 CMS regions: 21 split MSAs.
  - 11 regions: 15 split MSAs.
  - 24 regions: 25 split MSAs.
  - 41 regions: 40 split MSAs.

RTI INTERNATIONAL

OPTIONS FOR PDP REGIONS

Presented by

Thomas Hoerger

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Principal Evaluation Criteria for PDP Regions

- Minimum number of Medicare eligibles: 400,000 to support two PDPs
  - Assumption could be lowered if PDP organizations serve multiple regions and could obtain discounts based on multi-region enrollment.
  - Or, if lower PDP take-up rates are assumed (e.g., 40-50 percent), might need larger region of around 1 million eligibles.

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Principal Evaluation Criteria for PDP Regions

- The number of retail pharmacies per 100,000 was considered for regions with at least 400,000 eligibles.
- Another important criterion may be projected utilization of prescription drugs
  - Because of uncertainty about managing the risk for the new PDP product, we may want to minimize variation within a region.

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Principal Evaluation Criteria for PDP Regions

- Because of lack of experience among PDPs in managing a Medicare prescription drug benefit, some stakeholders advocated for smaller PDP regions.
  - May want to consider regions with only the minimum 400,000 eligible population.

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Range of Options for PDP Regions

- Presentation will show 6 possible options for PDP regions:
  - 50 state-based regions.
  - 10 multi-state regions based on CMS Administrative Regions.
  - 11 multi-state regions based on equal Medicare eligible population.
  - 32 multi-state regions based on drug utilization and Medicare eligible population of 1.1 million.
  - 34 multi-state regions based on drug utilization and minimum Medicare eligible population of 400,000.
  - 37 multi-state regions based on minimum Medicare eligible population of 400,000.

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Range of Options for PDP Regions

- These are not the only possible options.
- Work to refine and identify additional options will continue through the summer.
- These options are intended to show a range of possibilities, and prompt discussion.

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Option 1: 50 State-Based PDP Regions

- Defines PDP Regional Plan regions as the 50 States.
- Represents the largest number of regions allowed under the MMA.
- We will show state level data for the key evaluation factors.

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Average Number of Retail Pharmacies per 100,000 Persons (PDP Map 1)

- State average number of retail pharmacies per 100,000 persons ranges from 8.8 (CO) to 26.0 (ND).
- Southwest area and Pacific Northwest have lowest average number of retail pharmacies per 100,000.
- Six states (ND, AR, AL, WV, VT and MS) have the highest number of retail pharmacies.

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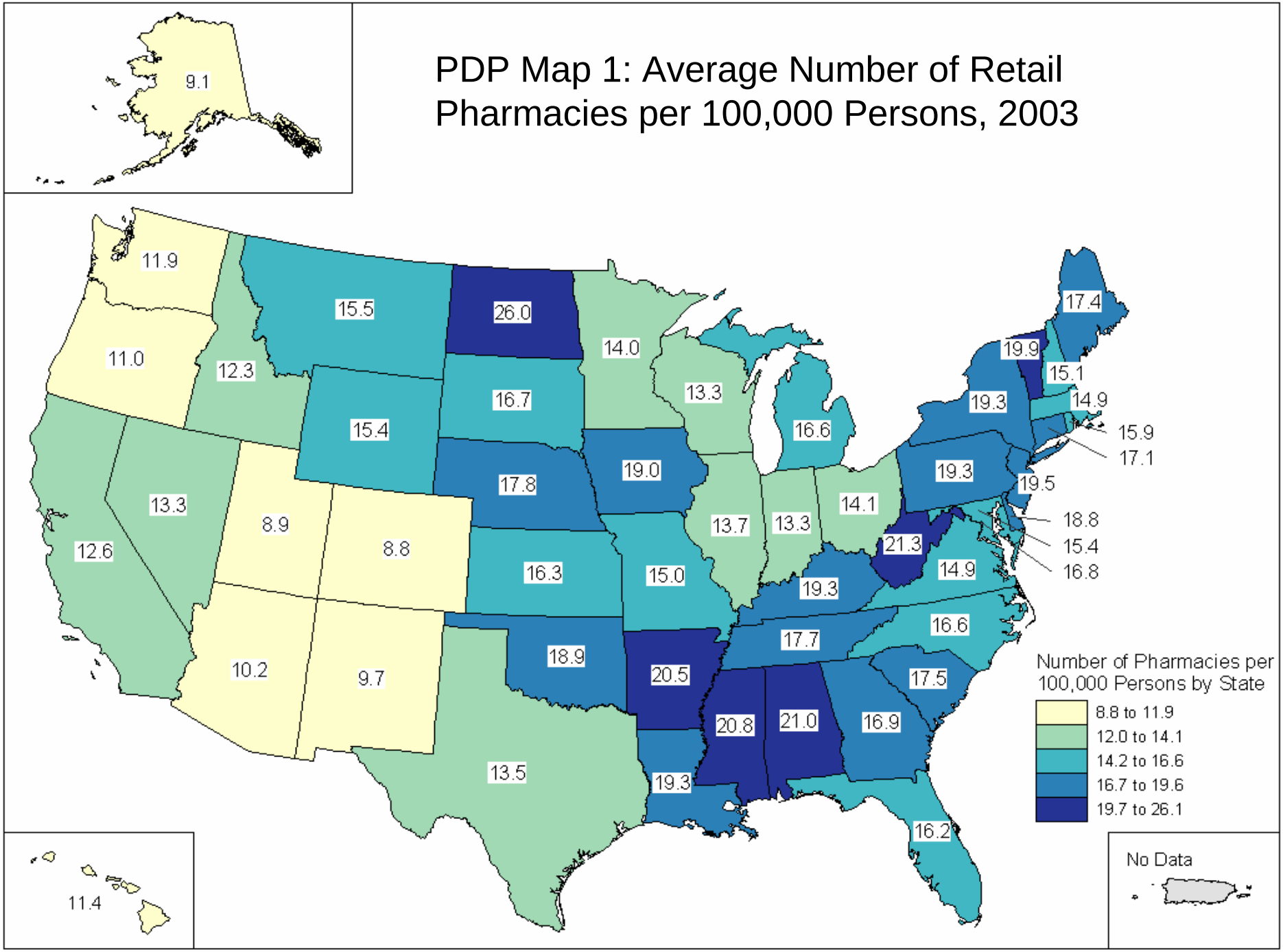
PDP Map 1: Average Number of Retail Pharmacies per 100,000 Persons, 2003
9.1
11.9
11.0
12.3
15.5
26.0
14.0
13.3
16.6
17.4
19.9
15.1
19.3
14.9
15.9
17.1
15.4
16.7
19.0
17.8
19.3
19.5
13.3
8.9
8.8
12.6
13.7
13.3
14.1
18.8
15.4
16.8
21.3
14.9
16.3
15.0
19.3
16.6
17.7
18.9
20.5
17.5
10.2
9.7
20.8
21.0
16.9
13.5
19.3
16.2
Number of Pharmacies per 100,000 Persons by State
8.8 to 11.9
12.0 to 14.1
14.2 to 16.6
16.7 to 19.6
19.7 to 26.1
11.4
No Data

Average Number of Prescriptions per Capita (PDP Map 2)

- State average number of prescriptions per capita ranges from 7.05 (AK) to 17.30 (TN).
- Southwest, Pacific Northwest, and CA have the lowest number of prescriptions per capita.
- Four states (WV, KY, TN and AL) have the highest number of prescriptions per capita.

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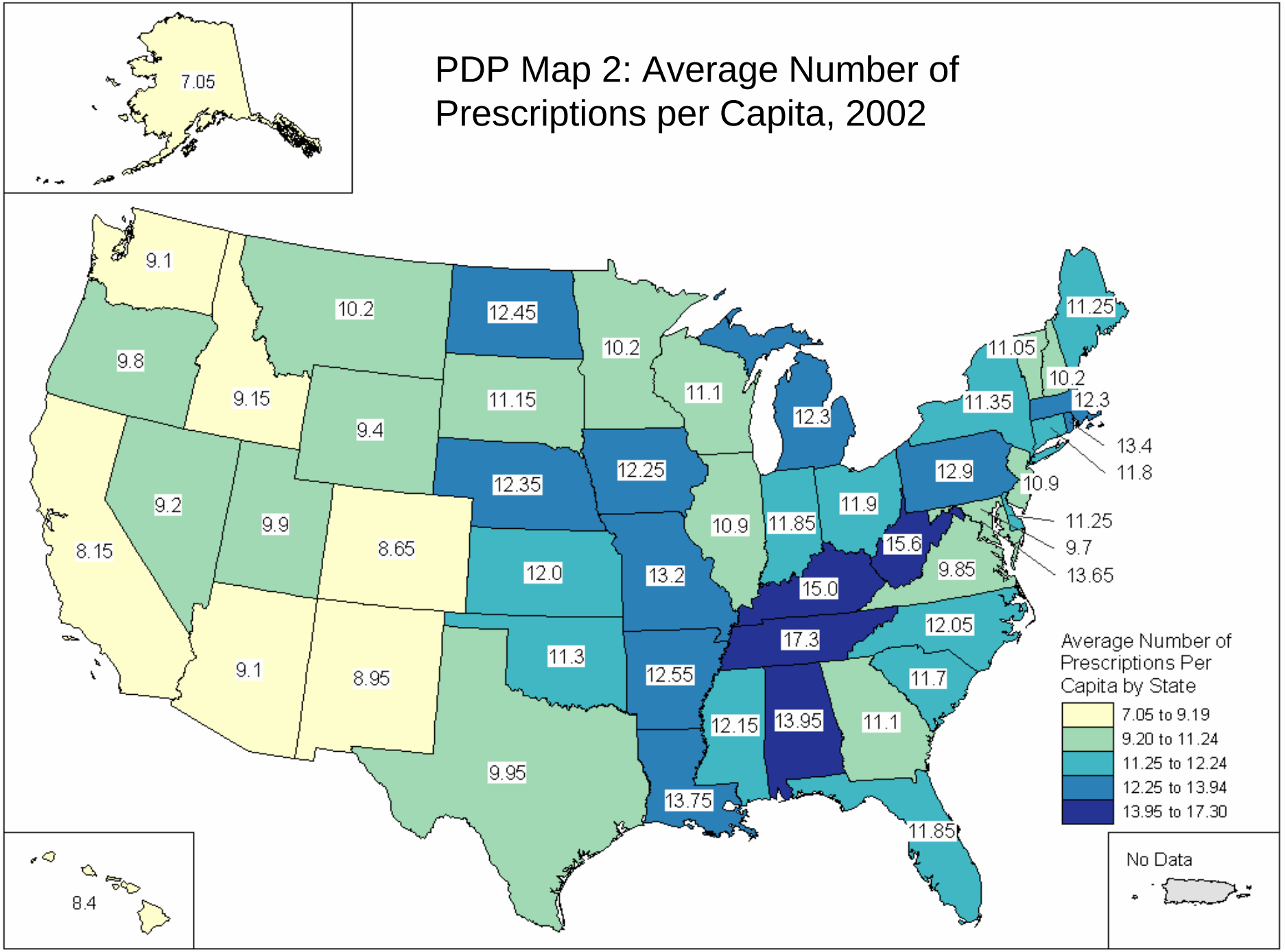
PDP Map 2: Average Number of Prescriptions per Capita, 2002
7.05
9.1
10.2
12.45
10.2
11.25
11.05
9.8
9.15
11.15
11.1
10.2
12.3
11.35
9.4
12.3
12.35
12.25
12.9
13.4
11.8
9.2
9.9
8.65
10.9
11.85
11.9
10.9
11.25
9.7
13.65
8.15
12.0
13.2
15.6
9.85
15.0
17.3
12.05
11.3
12.55
11.7
9.1
8.95
12.15
13.95
11.1
9.95
13.75
11.85
8.4
Average Number of Prescriptions Per Capita by State
7.05 to 9.19
9.20 to 11.24
11.25 to 12.24
12.25 to 13.94
13.95 to 17.30
No Data

Average Prescription Drug Price Per Capita (PDP Map 3)

- State average prescription drug price per capita ranges from $47.6 to $70.3.
- Six states (NY, NJ, MD, CT, MA, and AK) and the District of Columbia have the highest average prescription drug price per capita.
- Eight states (WY, SD, IA, AR, LA, MS, HI, and AL) have the lowest average prescription drug price per capita.

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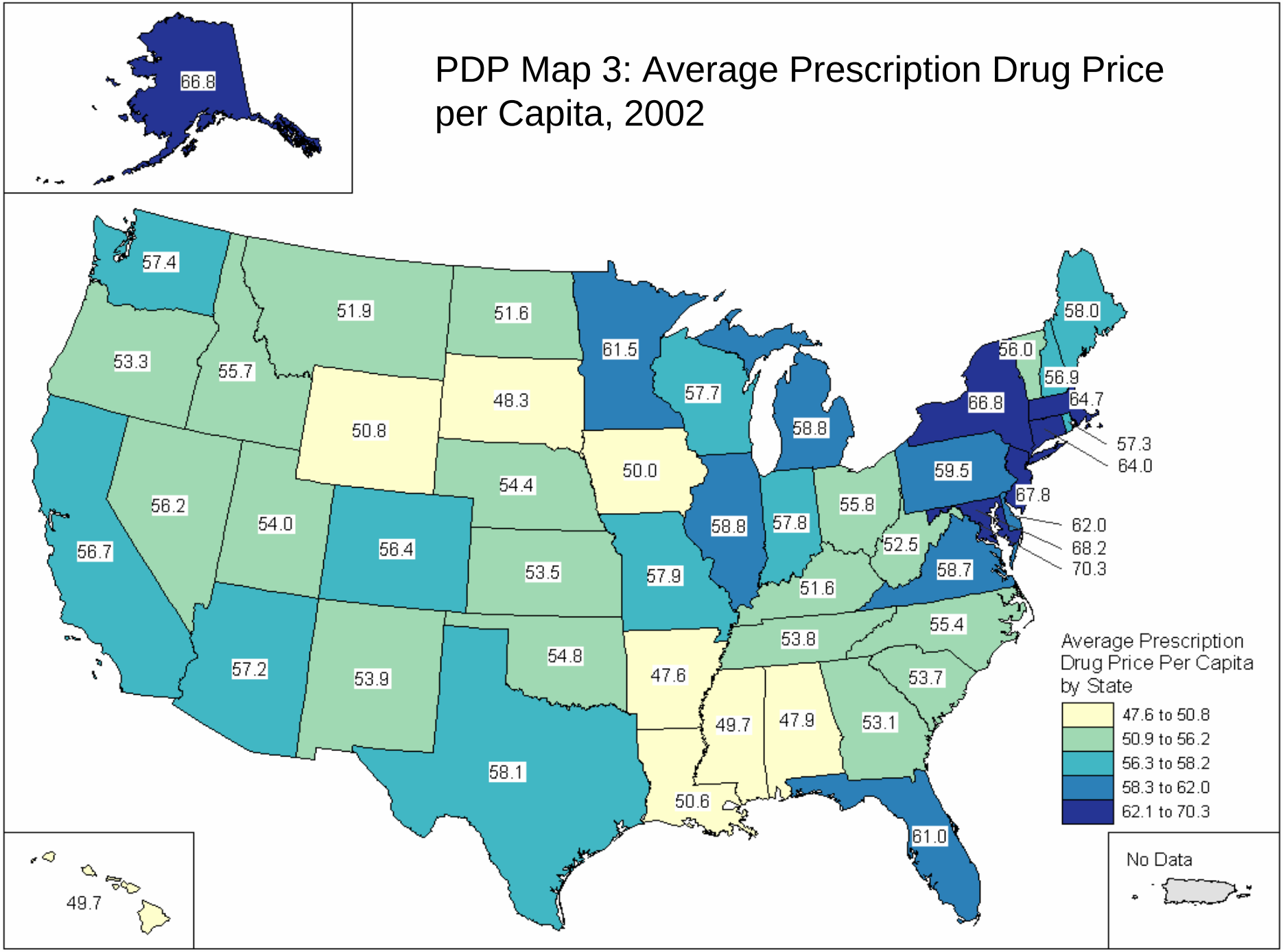
PDP Map 3: Average Prescription Drug Price per Capita, 2002



Option 2: 10 CMS Administrative Regions by Number of Medicare Eligibles

- All CMS regions have minimum eligible populations of between about 1.2 million and 8.7 million.

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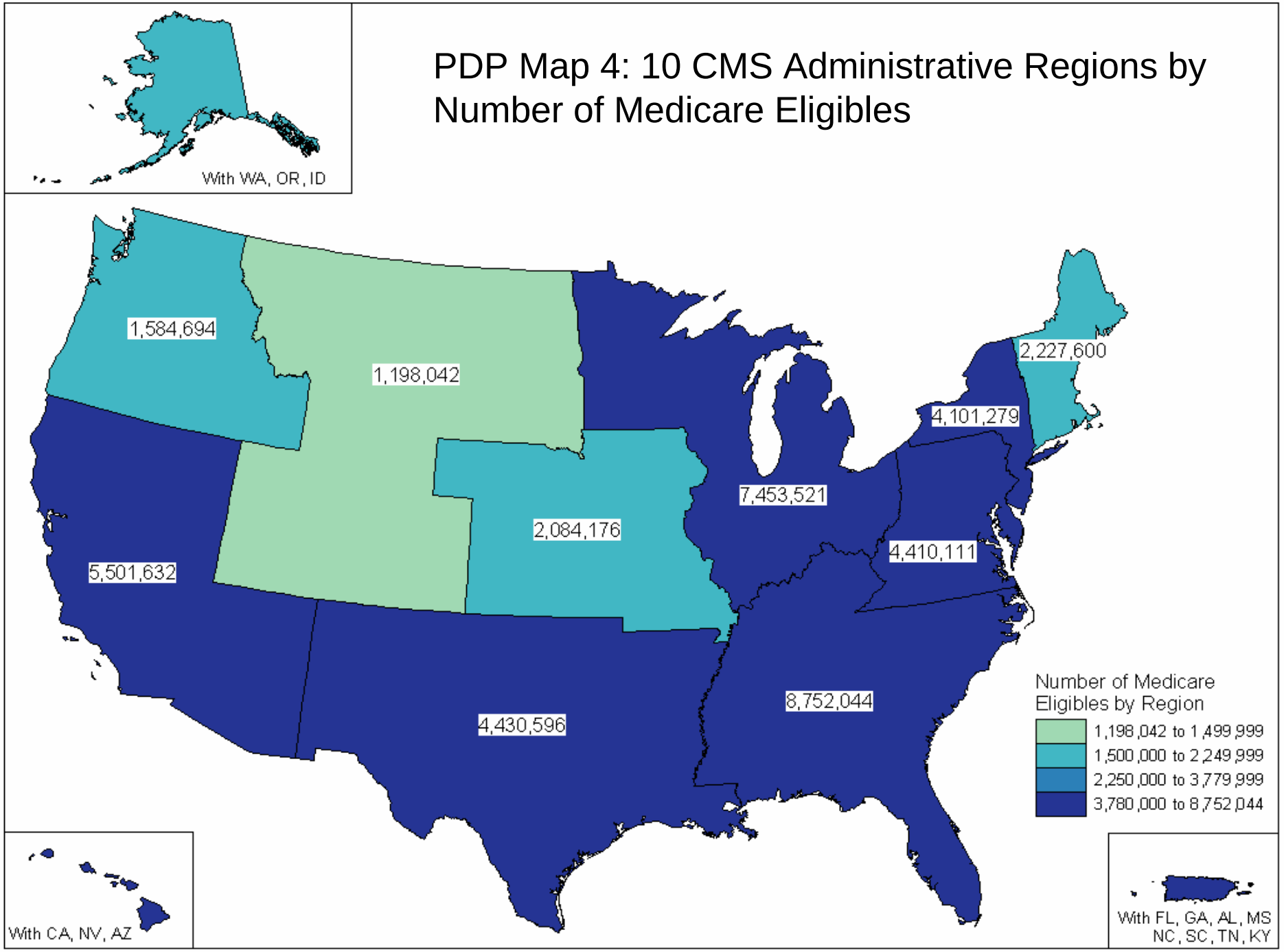
PDP Map 4: 10 CMS Administrative Regions by Number of Medicare Eligibles
With WA, OR, ID
1,584,694
1,198,042
2,084,176
5,501,632
4,430,596
7,453,521
4,101,279
2,227,600
4,410,111
8,752,044
Number of Medicare Eligibles by Region
1,198,042 to 1,499,999
1,500,000 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 8,752,044
With CA, NV, AZ
With FL, GA, AL, MS NC, SC, TN, KY

Option 3: 11 Regions with Approximately Equal Medicare Population Size by Number of Medicare Eligibles

- PDP Map 5 shows more equal distribution of the eligible population and closer range in eligible population size than the 10 CMS regions (ranges between 2.2 and 4.8 million).

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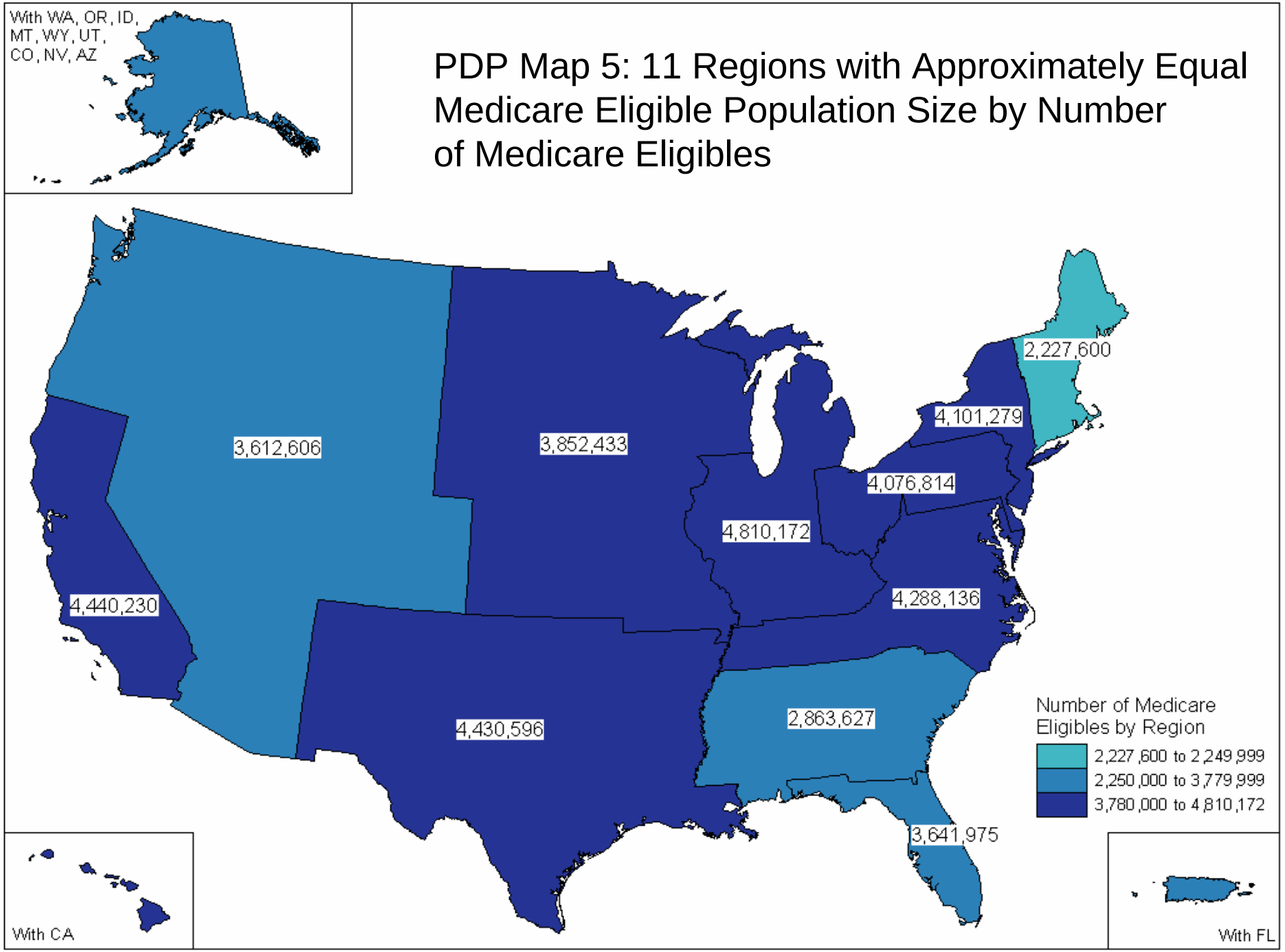
With WA, OR, ID, MT, WY, UT, CO, NV, AZ
PDP Map 5: 11 Regions with Approximately Equal Medicare Eligible Population Size by Number of Medicare Eligibles
3,612,606
3,852,433
2,227,600
4,101,279
4,076,814
4,810,172
4,440,230
4,288,136
4,430,596
2,863,627
3,641,975
Number of Medicare Eligibles by Region
2,227,600 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 4,810,172
With CA
With FL

Option 4: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million

- This option adds to the minimum population an additional factor: drug utilization.
- The goal is to balance between the regions in terms of population and expected possible drug utilization (and therefore, expected risk).

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Option 4: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million

- Minimizing the variation in drug utilization within a region was cited as one evaluation factor for PDP regions.
- Combined states to create regions with a target population of 1.1 million Medicare eligibles (but at least 400,000) AND states that have similar utilization are combined.

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Option 4: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million -- Methods

- Approach used a statistical method that "builds up" regions from individual states, rather than "breaking down" large regions to form smaller, more numerous regions.
- At each stage, all pairs of adjacent states are investigated for possible combining.

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Option 4: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million -- Methods

- For each combination, a measure of variation in drug utilization between two states was computed.
- States were combined into regions based on minimizing variation in drug utilization in the resulting multi-state region.
- Added condition of a target population of 1.1 million eligibles.

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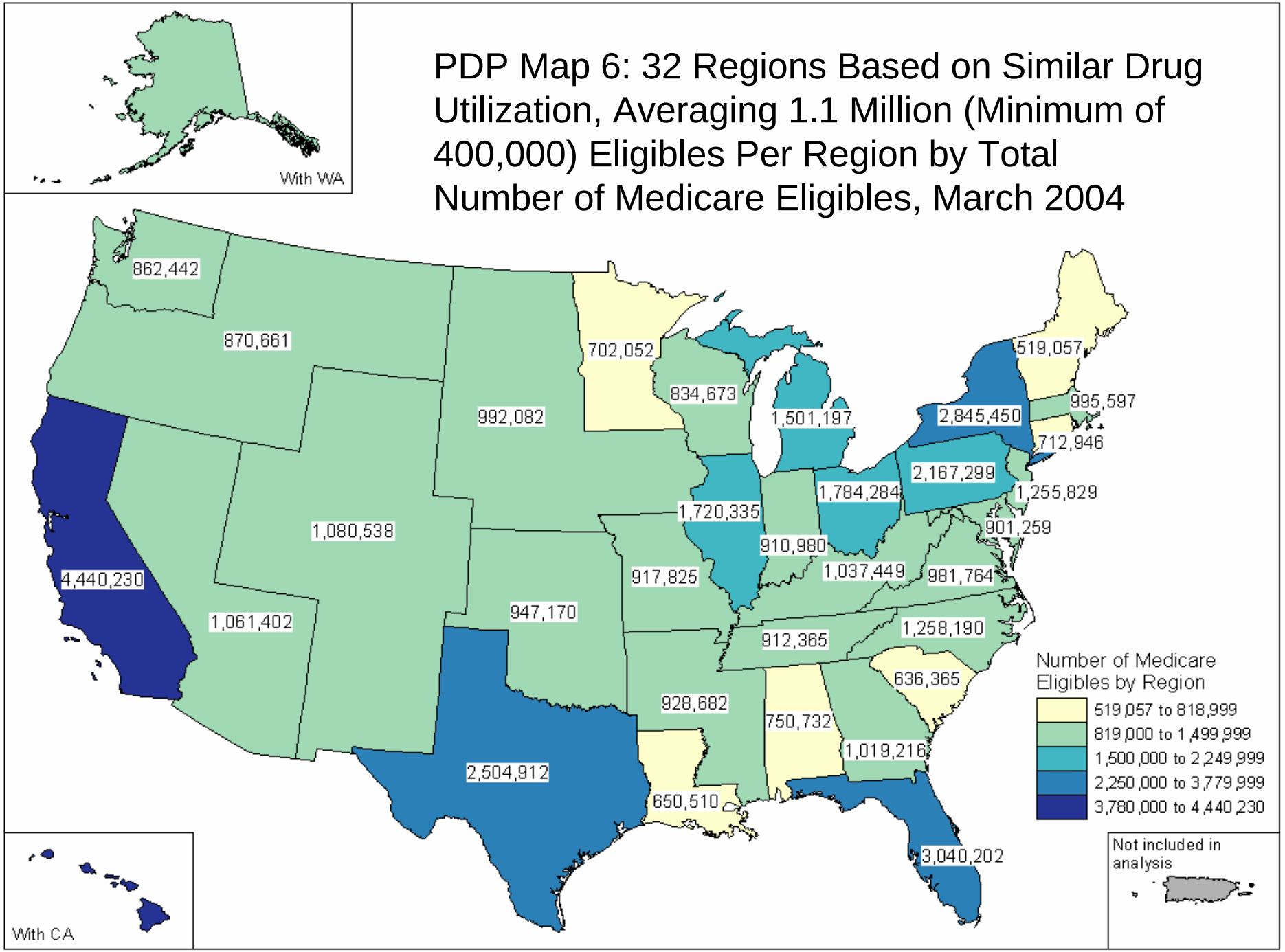
PDP Map 6: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million (Minimum of 400,000) Eligibles Per Region by Total Number of Medicare Eligibles, March 2004



Option 4: 32 Regions Based on Similar Drug Utilization, Averaging 1.1 Million -- Summary

- Option creates regions of between 519,057 and 4,440,230 Medicare eligibles.
- Six regions have between 519,057 and 818,999 eligibles.
- Four regions have more than 2,250,000 eligibles.
- Stakeholder concerns were raised regarding very large, multi-state regions.
- Therefore, we attempted to preserve the basic approach of minimizing variation in drug utilization lowering the eligible population target.

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Option 5: 34 Regions Based on Similar Drug Utilization, Combining Only Regions With Less than 400,000 Eligibles

- This option is similar to the 32 region PDP option.
- But in this option, only states with less than 400,000 Medicare eligible beneficiaries were combined.
- The result is slightly smaller regions with fewer Medicare eligibles.

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Option 5: 34 Regions Based on Similar Drug Utilization, Combining Only Regions With Less than 400,000 Eligibles

- As in the 32 region approach, used a statistical method that "builds up" regions from individual states.
- At each stage, all pairs of adjacent states are investigated for possible combining.
- But different from the 32 region approach, only states with less than 400,000 eligibles are combined.

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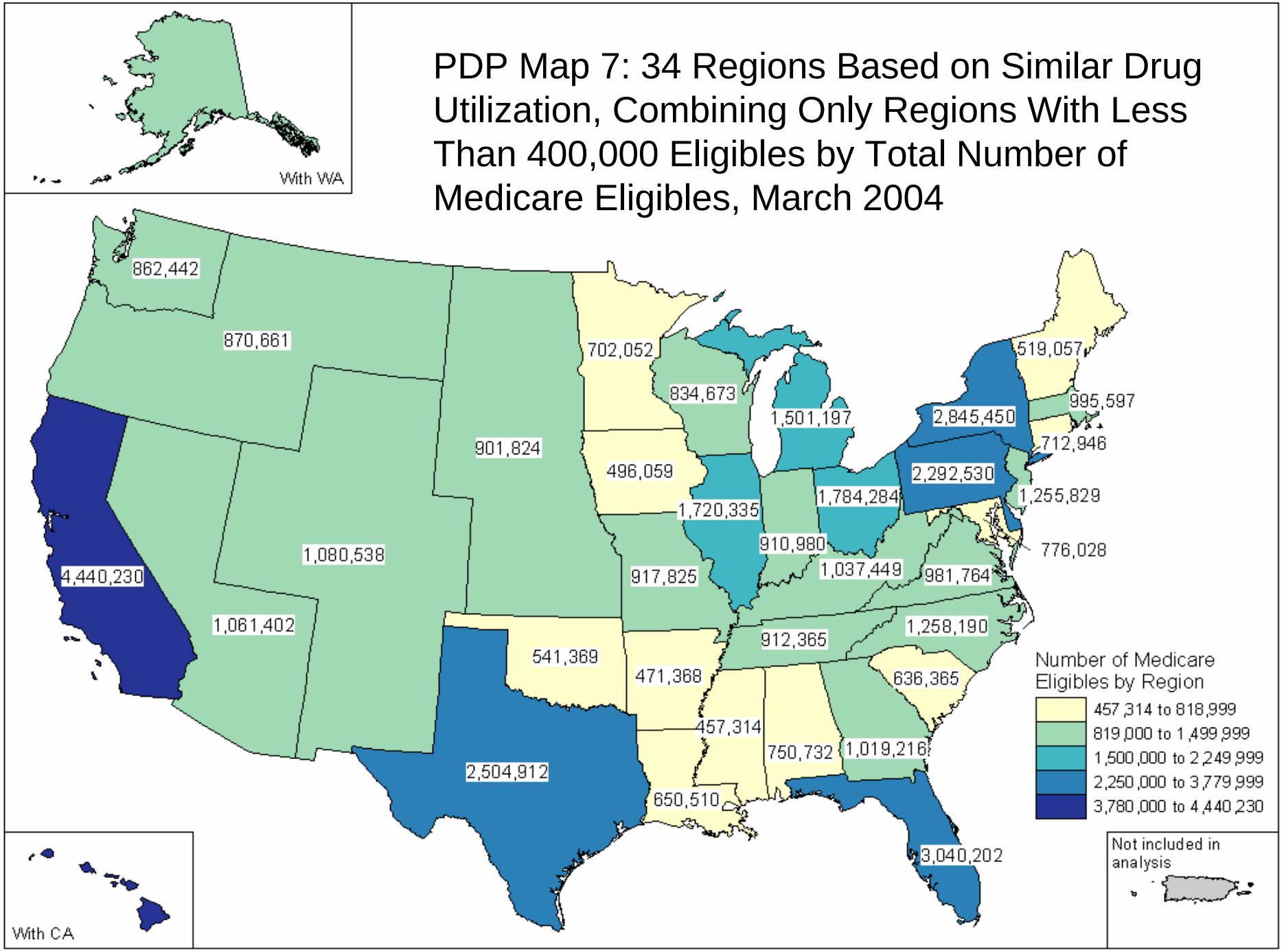
PDP Map 7: 34 Regions Based on Similar Drug Utilization, Combining Only Regions With Less Than 400,000 Eligibles by Total Number of Medicare Eligibles, March 2004



Option 5: 34 Regions Based on Similar Drug Utilization, Combining Only Regions With Less than 400,000 Eligibles -- Summary

- Option creates regions of between 457,314 and 4,440,230 Medicare eligibles.
- Eleven regions have between 457,314 and 818,999 eligibles.
- Five regions have more than 2,250,000 eligibles.
- Option does result in more regions (relative to the 32 region option) with less than 818,999 eligibles.
- Option also adds one more region with more than 2,250,000 eligibles.
- Therefore, we developed an option that used only the minimum PDP eligible population of 400,000 as a criteria.

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Option 6: 37 Regions Based on Medicare Eligible Population

- This option is based only on the minimum eligible population required to support two PDPs in a region (>400,000).
- Goal in this option was to develop regions with smaller numbers of eligibles
  - Based on feedback advocating for smaller regions.
- Similarly, an option with 37 regions meets the PPO minimum standards, as well as standards for population.

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Option 4: 37 Regions Based on Medicare Eligible Population -- Methods

- Criterion is that all regions must have more than 400,000 Medicare eligible beneficiaries and be created from adjacent states.
- There are few multi-state regions east of the Mississippi. The exceptions are:
  - Northern New England
  - RI, because of its size, combined with MA
  - DE and DC combined with MD
  - WV combined with VA

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Option 4: 37 Regions Based on Medicare Eligible Population -- Methods

- In the western U.S., some very large states are in multi-state combinations because of low-eligible population adjacent states:
  - TX combined with NM.
  - CA combined with HI.
  - AK combined with WA.
- In addition, there are several low-population states that have been combined to reach the 400,000 threshold:
  - Northern Great Plains (NE, ND, SD).
  - Northern Mountain states (ID, MT, WY).

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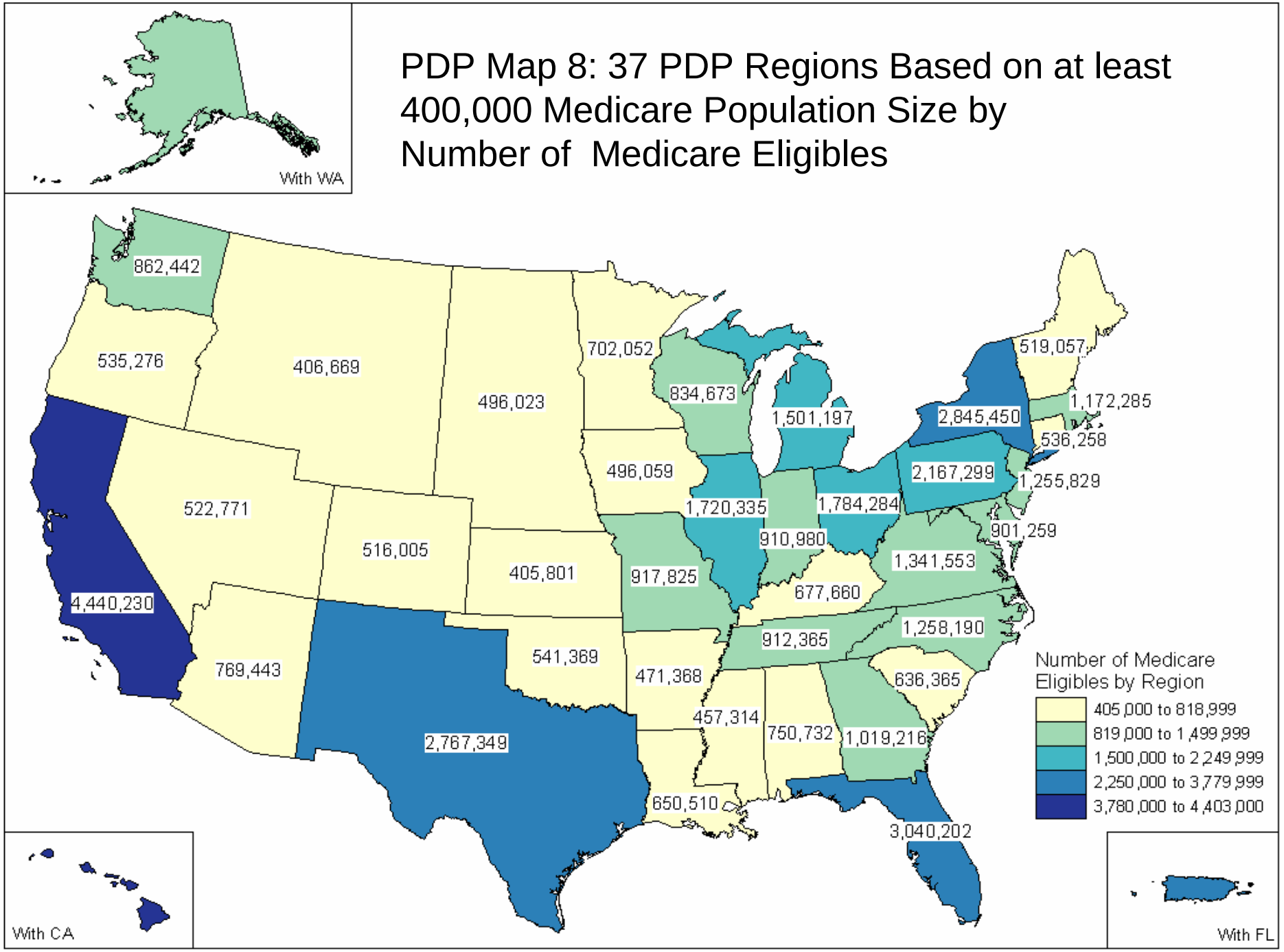
PDP Map 8: 37 PDP Regions Based on at least 400,000 Medicare Population Size by Number of Medicare Eligibles
With WA
862,442
535,276
406,669
496,023
702,052
834,673
1,501,197
519,057
1,172,285
2,845,450
536,258
496,059
2,167,299
1,255,829
522,771
1,720,335
1,784,284
901,259
516,005
910,980
405,801
1,341,553
917,825
677,660
4,440,230
912,365
1,258,190
541,369
769,443
471,368
636,365
457,314
750,732
1,019,216
2,767,349
650,510
3,040,202
Number of Medicare Eligibles by Region
405,000 to 818,999
819,000 to 1,499,999
1,500,000 to 2,249,999
2,250,000 to 3,779,999
3,780,000 to 4,403,000
With CA
With FL

Option 4: 37 Regions Based on Medicare Eligible Population -- Summary

- Option results in 37 regions.
- Some regions with large eligible populations still remain based on large single states (CA, TX, FL, NY).

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Summary of PDP Regional Options Presented

- Six possible PDP Regional Options have been presented:
  - 50 state-based regions.
  - 10 multi-state regions based on CMS Administrative regions.
  - 11 multi-state regions based on equal Medicare eligible population.
  - 32 multi-state regions based on drug utilization and Medicare eligible population of 1.1 million.
  - 34 multi-state regions based on drug utilization and minimum Medicare eligible population of 400,000.
  - 37 multi-state regions based on minimum Medicare eligible population of 400,000.

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Additional Issues to be Considered: Multi-State MSAs

- All of the 6 PDP regional options presented include multi-state MSAs that would be split:
  - 50 regions: 44 split MSAs
  - 10 CMS regions: 21 split MSAs
  - 11 regions: 15 split MSAs
  - 32 regions: 42 split MSAs
  - 34 regions: 44 split MSAs
  - 37 regions: 41 split MSAs

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Additional Issues to be Considered: U.S. Territories

- As with MA regions, territories could be assigned to regions on the basis of Medicare patient flows.
- Of the territories, Puerto Rico might have enough Medicare eligibles to stand alone, if population is the only criteria, with about 600,000 eligibles.

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Additional Issues to be Considered: Overlap of PDP and MA Regions

- MA regions must be consistent with PDP regions for bidding purposes.
- MA regions may collapse into larger PDP regions.
- Overlap of PDP and MA regions will be discussed in detail in next session.

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OVERLAP BETWEEN MA AND PDP REGIONS

Presented by
Ed Drozd

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Review of MMA Legislation

- MA regional plans and PDPs must serve the entire region.
- Beneficiary premiums for MA regional plans and PDPs cannot vary within region.
- In establishing the Medicare Prescription Drug Plan Regions, the HHS Secretary is required to:
  - Establish PDP regions consistent with the requirements for the establishment of MA regions; and,
  - To the extent practicable, make the PDP regions the same as MA regions unless it is determined that different regions would improve access to prescription drug benefits.

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Review of MMA Legislation

- Congressional intent was to define the PDP regions to be consistent with MA regions.
- PDP regions are to be the same as MA regions “to the extent practicable.”
- However, the PDP regions do not necessarily need to be identical to the MA regions if it can be shown that a different configuration of regions for PDPs improves beneficiaries’ access to prescription drugs.

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Combining MA and PDP Regions

- As part of this discussion, remember the bidding components of the MA regional and PDP programs.
- For example, when combining 2 states in a region, recall that the PDP premium must be uniform throughout the region.
- If the MA regions cannot be combined to "fit" (geographically) into the PDP regions, then a single bid (and premium) for the region is not possible.

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Combining MA and PDP Regions

- Based on the MA and PDP regional options presented:
  - 50 PPO (MA) regions can be “fit “ into 10 PDP regions (or any number of PDP regions), which are based on groupings of states.
  - But 10 PPO (MA) regions cannot “fit” into 50 PDP regions.

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Combining MA and PDP Regions

- Therefore, considering all the options presented, the following types of combinations are possible:
  - 50 MA and 10 /11/ 32/ 34 or 37 PDP, regions.
  - Any option, but applied to both MA and PDP.

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Some Things to Think About

- The next two maps show what some PDP regional options might look like if used as MA regions.
- Map 1 shows the average estimated 2005 MA payment rates for the 37 PDP region option.
  - In this case, we see considerable variation in payment rates.
- Map 2 shows the number of commercial risk bearing PPOs in each of 11 regions
  - This option could be used for both MA and PDP regions.

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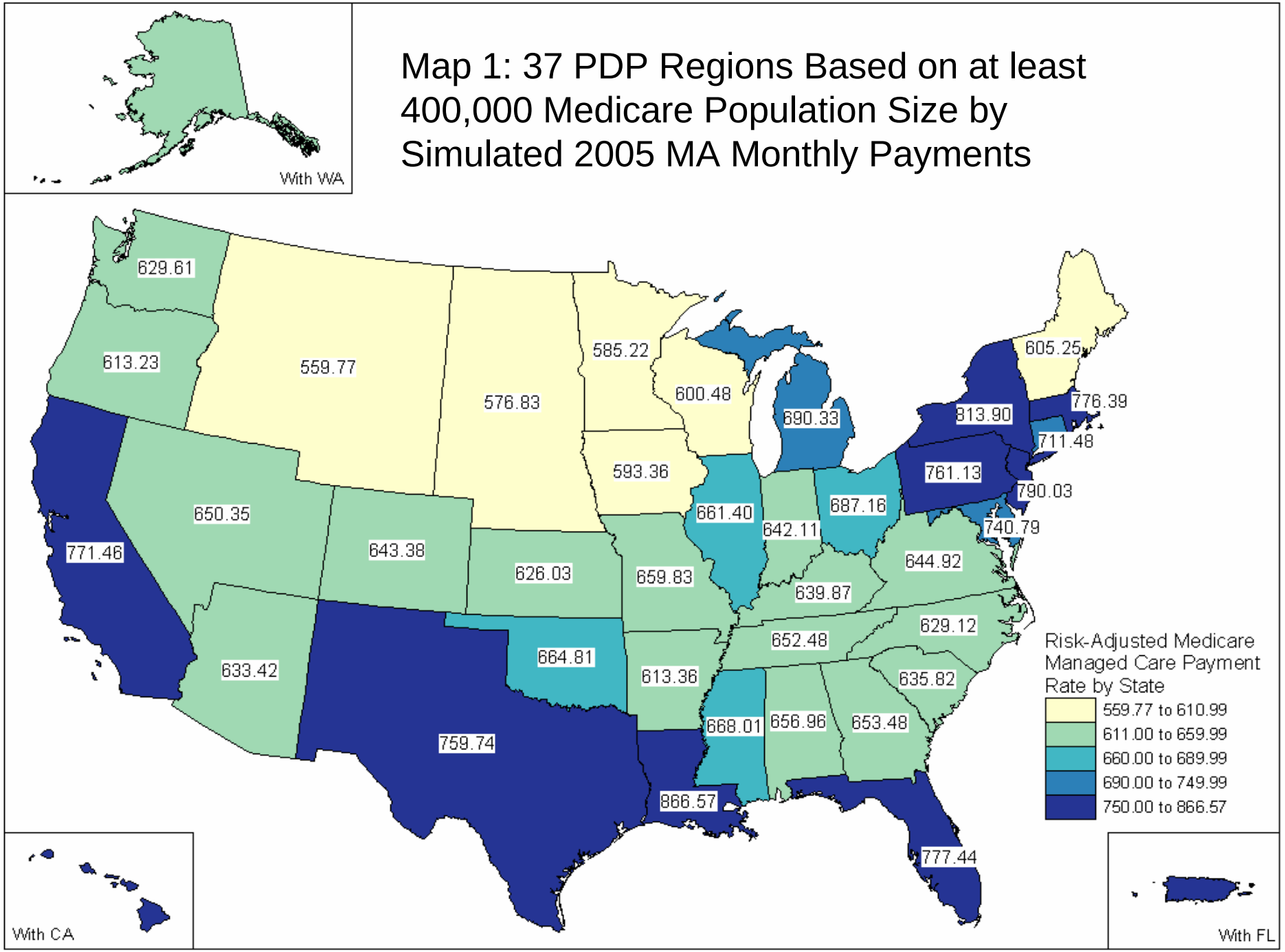
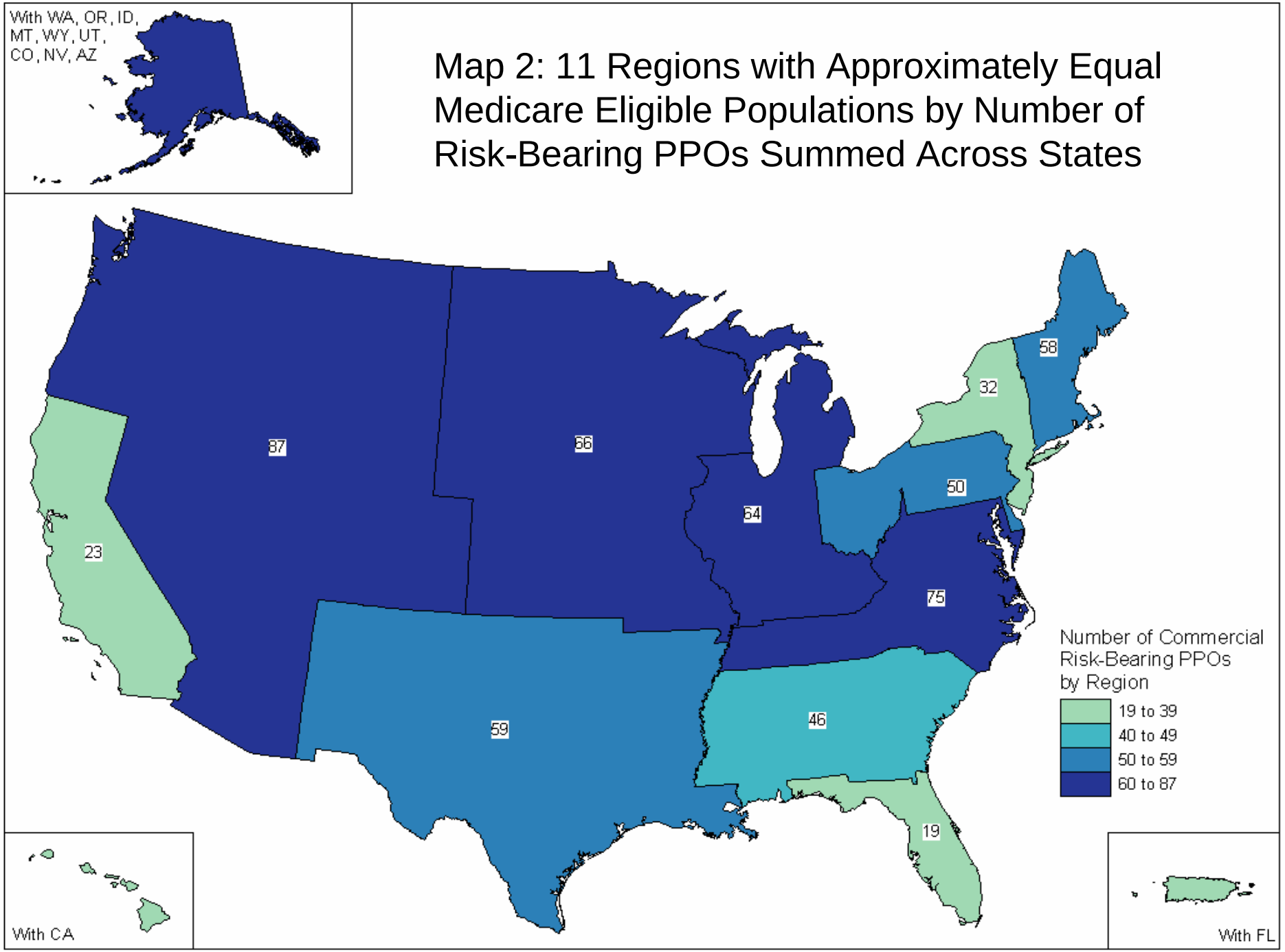

Map 1: 37 PDP Regions Based on at least 400,000 Medicare Population Size by Simulated 2005 MA Monthly Payments
With WA
629.61
613.23
559.77
576.83
585.22
600.48
690.33
605.25
776.39
813.90
711.48
761.13
790.03
593.36
661.40
642.11
687.16
740.79
650.35
643.38
626.03
659.83
644.92
771.46
639.87
629.12
652.48
664.81
633.42
613.36
635.82
668.01
656.96
653.48
759.74
866.57
777.44
Risk-Adjusted Medicare Managed Care Payment Rate by State
559.77 to 610.99
611.00 to 659.99
660.00 to 689.99
690.00 to 749.99
750.00 to 866.57
With CA
With FL


With WA, OR, ID, MT, WY, UT, CO, NV, AZ
Map 2: 11 Regions with Approximately Equal Medicare Eligible Populations by Number of Risk-Bearing PPOs Summed Across States
87
66
23
64
58
32
50
75
59
46
19
Number of Commercial Risk-Bearing PPOs by Region
19 to 39
40 to 49
50 to 59
60 to 87
With CA
With FL

Discussion

- There are no obvious answers on the importance of overlap between MA and PDP regions.
- Input and feedback will be particularly important.

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Questions for Discussion

- What are the advantages and disadvantages of using the same regions for MA and PDP plans?
- Under what circumstances should there be differences between MA and PDP regions?
- If different MA and PDP regions are defined, how would access be impacted?

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The call-in line phone number for the CMS public meeting on PPO and PDP regions, set up for Wednesday, July 21 2004 beginning at 9:00 a.m. central time and going through 4:00 p.m. central time, is below. Please note that while this line is available (in listen-only mode), we cannot be assured of the quality of the audio due to the size of the room or other technological limitations. Therefore, we are encouraging people to attend in person, or alternatively, watch a web-cast of the entire meeting that will available via the Kaiser Family Foundation web-cast site after 5:00 p.m. on Wednesday, July 28, 2004 at http://www.kaisernetwork.org/healthcast/cms/21jul04.

AT&T TELECONFERENCE SERVICE

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Start Time: 09:00A (TZ: Central) 450 Mins.

If a problem, call 800 932-1100 for conference operator

Host: Leslie Greenwald
Confirmation Number: 739535
CMS Public Meeting