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**CMS Demonstration
Initiative, Phase Two:
Findings from Interviews
with Health Plan
Executives**

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Executive Summary

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CMS Demonstration Initiative, Phase Two: Findings from Interviews with Health Plan Executives

EXECUTIVE SUMMARY

CMS has undertaken a two-phase process to encourage Medicare + Choice (M+C) plans to remain in the market and to develop new products for Medicare beneficiaries. In Phase One (summer of 2001), CMS accepted unsolicited proposals from M+C plans that otherwise intended to leave the market the following January. In Phase Two (spring of 2002), CMS will solicit proposals from health plans to demonstrate new Medicare products. To support Phase Two, CMS directed two of its research contractors – Abt Associates and the University of Minnesota (UMN) – to interview a sample of health plans by telephone, to identify the most promising options for Medicare to consider and the most important barriers to those options.

Product types

Five types of *new* models or “products” seemed to be receiving the most serious consideration by the 19 health plans we interviewed:

1. Preferred provider organizations (PPOs) or point-of-service (POS) plans – PPO and POS products were distinguished by the fact that the beneficiary’s point-of-purchase cost sharing varies, depending on which provider provides the service and, in some models, on the circumstances under which the services are provided. The POS/PPO model was mentioned much more frequently than any other innovative model, although plans were by no means unanimous in their endorsement of the PPO/POS model.
2. Fee-for-service (FFS) based administrative services only (ASO) models – Interest in ASOs generally came from plans that believed they could manage care, and could not obtain discounts from providers who in recent years have been “pushing back” in negotiations. These plans were satisfied to pay health care providers at FFS Medicare rates, and to receive an administrative fee for managing care.
3. High-deductible models – A few plans are exploring the idea of a high-deductible option for the Medicare market. Some plans feel that this model is bad social policy and likely to exacerbate selection problems in the M+C program. Interest in this model for Medicare may depend on its acceptance in the commercial market.
4. Care-system models – The care system model represents is a hybrid of M+C capitation and FFS Medicare, based on the Buyers Health Care Action Group (BHCAG) model in the Twin Cities. There was some tentative interest in this model among plans.
5. Plans for populations with special health needs – Several plans were interested in setting up and marketing delivery systems within their existing M+C plans to care for

enrollees with particular medical conditions. The most important prerequisite for such systems: adequate payment for the risks of care of the special populations.

Barriers to product innovation

The interviews identified barriers to the introduction of the innovative products outlined above, focusing on barriers deriving from Medicare itself and from CMS practices. This is an incomplete perspective on innovation, but one useful for considering possible Phase Two demonstrations.

Payment barriers. All plans emphasized in interviews that eroding M+C payments under the 1997 Balanced Budget Act (BBA) and successor legislation were a major barrier to innovation. Almost all plans suggested various forms of tying M+C payments to the trend in medical costs, as measured by local FFS payments.

Knowledge barriers. The absence of information makes it more difficult for plans to design and price new M+C options. One area of particular concern is *risk sharing*. The 100 percent risk that plans assume for medical care is difficult to sustain in M+C today, given the much tighter payment levels under BBA and the uncertainties of doing business with CMS. Demonstration options import special unknowns, such as the absence of actuarial data – thus increasing the need for explicit risk sharing by CMS. Second, plans want better *risk adjustment* in Medicare. They unanimously opposed collection of outpatient encounter data in the manner CMS originally required, suggesting instead that CMS take a more statistical approach to data collection. Otherwise, respondents did not have many suggestions to accomplish the goals of risk adjustment.

Regulatory barriers. A third general group of barriers are the obstacles that M+C regulations present to new product innovation.

1. *Suspend the lock-in requirement* – All plans that mentioned the imminent lock-in requirement argued that it should be cancelled. Lock-in would eliminate a safety valve that is important in an unstable market – and in any demonstration of new, untested products.

2. *Revise quality monitoring requirements to fit new models* – Some plans suggested that out-of-network and similar care be exempt from the M+C quality monitoring requirements in a demonstration. Others made a more fundamental argument: CMS should get out of the business of setting separate quality monitoring standards, and instead rely on the same standards that private payers use.

3. *Change requirements to give plans more benefit flexibility* – The development of innovative products for Medicare requires the configuration of benefits in flexible ways that sometimes run afoul of Medicare regulations – often, with regulations concerning “actuarial equivalence.” Some plans urged modification of certain regulations related to the Adjusted Community Rate (ACR) process; others urged elimination of the ACR requirement entirely, to rely more on the market.

4. *Reduce the burden of doing business with CMS more generally* – Many criticisms went beyond specific regulations to a more fundamental critique of how CMS does business. Many plans suggested that CMS should (a) rely to a greater extent on standards used in the private, commercial insurance industry, rather than establishing new, separate, government standards; and (b) make information about choices available to beneficiaries and let them choose, rather than constraining options to meet certain requirements.

5. *Change CMS’ requirements on marketing materials* – These requirements were widely disliked. Some plans urged that the approval period be shortened, while others suggested that the review requirements be eliminated entirely – i.e., that beneficiaries’ best remedy was to “vote with their feet” if they did not get what marketing materials led them to expect. One suggested compromise: a “file and use” process for plans in good standing.

6. *Inappropriate application of FFS regulations to M+C plans* – As noted in one interview, “everything gets compared to the FFS program, and that leads to bad choices for the program.” When FFS is the baseline for judging managed care practices, M+C plans have to spend frustrating and unproductive time explaining or justifying the differences (e.g., in relation to FFS’ three-day hospitalization requirement for SNF coverage).

7. *Make service areas more flexible* – Plans generally wanted to see market-driven definitions of service areas, rather than arbitrary, county-based definitions.

8. *Mid-year changes in coverage requirements* – When CMS changes coverage guidelines for M+C plans mid-year, it should phase-in the implementation of the new guidelines, or compensate plans more fully to cover the costs of the change (e.g., to compensate for unexpected systems and other administrative costs).

9. *Need for a more level playing field with FFS* – Another area of concern for the plans was the need for a more level playing field with FFS.

10. *“Whiplash” among CMS’ Central and Regional Offices* – One plan used the term “whiplash” to describe the lack of regulatory coordination between CMS’ central and regional offices, which undermined Central Office initiatives.

Regulatory Uncertainty. A final set of barriers discussed in the interviews concerned problems that were not associated with existing regulations, but uncertainties about the regulatory environment that CMS or Congress might consider. New models will bring regulatory uncertainties that will have to be resolved for plans to offer the models.

Steps leading to Phase Two Demonstrations

How can a demonstration ease the barriers outlined above, to encourage more innovation and to create a more cooperative relationship between Medicare and M+C plans? CMS’

objective in further discussions with health plans and the policy community will be to answer that question, in order to formulate a solicitation in 2002 to begin the Phase Two Demonstrations.