Staff Report on Maryland's Medicare Advantage Landscape and Options for Medicare Advantage-Hospital Partnership Grant Program

February 12, 2020

Health Services Cost Review Commission

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This document contains request for comments by February 20, 2020 on Maryland's Medicare Advantage landscape, the factors affecting Maryland's low penetration rate, and options for a Medicare Advantage-Hospital Partnership Grant Program. Comments should be submitted to hscrc.rfp-implement@maryland.gov.

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Request for Comments on Analysis and Options

Commissioners have expressed concerns about the low levels of enrollment in Maryland by Medicare beneficiaries into Medicare Advantage plans. This is of potential concern because Medicare Advantage plans can help manage the care of their enrollees and are sometimes able to offer enrollees reduced cost sharing and enhanced benefits. While all Maryland counties have access to a Medicare Advantage plan, less than half of Maryland Medicare beneficiaries have access to a $0-premium Medicare Advantage plan.[1,2]

The Commission seeks to understand why the penetration rate of Medicare Advantage plans is so low in Maryland and what actions the State should consider to spur greater enrollment. The potential actions may differ for what the State does in the short run versus the longer run. In response to the Commission's request to develop options for short-run interventions, staff have compiled various Commissioners' insights to produce potential options that appear in this report.

The initial HSCRC staff analysis included in this report finds that the enrollment rates of Medicare Advantage plans nationally, as well as in Maryland, are most strongly correlated with the quality of the Medicare Advantage plans in an area. No correlation appears between the average Medicare fee-for-service (FFS) total cost of care (TCOC) in an area and the resulting benchmark that Medicare Advantage plans receive on their payments from the Centers for Medicare & Medicaid Services (CMS). In addition, although Maryland's all-payer hospital rate-setting prohibits Medicare Advantage and other payers from negotiating rates below those set by the Commission, research indicates that nationally Medicare Advantage plans generally pay hospitals the FFS rate[3].

On the other hand, Maryland has some Medicare Advantage plans that are relatively new to the market, and it generally takes several years for new plans to attain the quality rankings that are most attractive to prospective enrollees and that provide the plan with quality-related bonus payments from CMS. Multiple Medicare Advantage plans in Maryland have increased their quality scores and are on the cusp of attaining that 4-star rating.

Moreover, hospital global budgets in Maryland mean that hospitals are better aligned with payers and consumers to avoid potentially avoidable hospital utilization. For hospitals to receive their Global Budget Revenue (GBR), as hospital volumes decline, hospital prices on individual may services rise. Overall, payers and consumers should benefit as the Commission sets an Annual Update Factor that produces greater savings than would otherwise have occurred, balancing

[1] Jacobson, et al. (2020). "Medicare Advantage 2020 Spotlight: First Look." *Data Note,* Kaiser Family Foundation. October 24, 2019: https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/

[2] Medicare Advantage can provide extra benefits if beneficiaries pay for those benefits (similar to a standalone supplemental plan) but beneficiaries incur those additional costs unless the plan earns a rebate by bidding below the Medicare Advantage benchmark.

[3] Berenson et al. (2015). "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." *Health Affairs,* 34(8): 1289-1295. healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1427

sustainable levels of payments to hospitals with adequate savings to payers. However, this also means that if Medicare Advantage plans cannot reduce hospitalizations faster than other payers, the mechanics of the GBR can result in their hospital spending being higher than in the absence of the GBR.

This staff report seeks comments on:

A. The state of the Medicare Advantage market in Maryland and the factors affecting it, including the findings in this staff report;
B. the roles of Medicare Advantage plans versus hospitals in Maryland under the TCOC Model;
C. Long-term and short-term options and issues to increase Medicare Advantage enrollment in Maryland and how such options could be implemented in a way that is budget neutral to the federal government; and
D. A specific short-term option for the Commission to implement a Medicare Advantage-Hospital Partnership Grant Program that awards selected hospitals with funding through rates. The primary purpose of this program would be to improve partner plans' quality performance as measured by the Medicare Advantage Star Ratings program and to improve health outcomes for the members they serve. Specifically, the grant program could be structured as follows:
    1. Provide funding to hospitals partnering with a Medicare Advantage plan for no more than two years (CY2021 and CY2022);
    2. Provide an amount of up to 5 percent of the county-level FFS costs included in the Medicare Advantage Ratebook multiplied by the number of enrollees in the plan;
    3. Recapture grant funding from the hospital if the Commission-specified targets for the partner plan are not attained regarding:
        a) Improvement in quality scores;
        b) Improvement in enrollees' use of Annual Wellness Visits; and
        c) Maintenance of enrollment levels; and
    4. Ensure budget neutrality by reducing the RY 2021 and RY 2022 Update Factors by an amount necessary to offset the aggregate amount of the Medicare Advantage-Hospital Partnership Grants issued — but increasing future Update Factors by any amounts recaptured if targets are not attained.

Background on Medicare Advantage

Medicare Advantage is a program that allows Medicare beneficiaries to receive health insurance coverage provided by a private insurer, rather than traditional fee-for-service (FFS) Medicare. Under Medicare Advantage, private health plans are paid a per person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. The plan is at risk for financial losses if aggregate costs exceed the aggregate capitated payments. Conversely, the plan can retain profits if its costs are less than the payments it receives from CMS.

The Medicare Advantage capitation rate is determined by a plan's benchmark and the plan's bid. The benchmark represents the maximum amount that CMS will pay the Medicare Advantage plan. The plan's bid represents the amount that the plan believes it requires to cover its enrollees. If the plan's bid is less than the benchmark, a portion of the difference between the plan's benchmark and the plan's bid is returned to CMS as additional savings and a portion is rebated to the Medicare Advantage plan's enrollees. The rebate must be returned to the Medicare Advantage plan's enrollees in the form of either reduced cost sharing or in the form of supplemental benefits.

CMS makes adjustments to the Medicare Advantage capitation rate based on the quality of the Medicare Advantage plan. Each Medicare Advantage plan receives from 1 to 5 stars. Higher stars (4 or higher) earn the Medicare Advantage plan a positive adjustment to its benchmark and also higher rebates for its enrollees.

Medicare Advantage Payment System

The Medicare Advantage benchmark is set separately by county based on the FFS spending in that county. To determine per capita spending for each county, the national estimated level of FFS per capita cost is multiplied by a county-level geographic index, which is calculated using a five-year rolling average (2013 to 2017 for the 2020 benchmarks) of claims data for beneficiaries in original Medicare in the county and includes risk adjustment. To project the FFS spending in the county during the upcoming year, CMS calculates the growth in fee-for-service costs. The estimated county-level FFS costs are equal 2019 FFS costs times the geographic index times the projected FFS growth trend.

Two adjustments are made to the county-level estimates FFS costs to derive the Medicare Advantage benchmarks. First, counties are broken into quartiles of FFS costs, with the benchmark equal to FFS costs multiplied by a percentage (115, 107.5, 100, and 95 percent) based on which quartile the county is in. In other words, a plan in a county in the first (lowest) quartile will receive 115 percent of the estimated FFS costs; a county in the fourth (highest) quartile will receive 95 percent of the estimated FFS costs. Second, each plan that has receive 4+

stars will receive a quality adjustment to their Medicare Advantage benchmark.[4] For example, a plan that would have otherwise received 95 percent of the estimated FFS costs for a county could instead receive 100 of the estimated FFS costs for a county. Additionally, a plan with 4+ stars receives additional rebates that are passed on to the plan's enrollees. A 4 or 4.5 star plan receives 65 percent of the difference between its bid and the benchmark while a 5 star plan receives 70 percent of the difference, all of which are passed on to the plan's enrollees. A plan with less than 4 stars receives 50 percent of the difference between its bid and the benchmark. The combination of a higher benchmark and a greater rebate share means that 4+ star Medicare Advantage plans can offer significantly more rebates than a plan with less than four stars.[5]

The final benchmark for Medicare Advantage plans is the estimated FFS costs in the county with the quartile and quality adjustments applied. The payments a plan receives will be equal to its bid. If the bid exceeds the benchmark, CMS will pay the benchmark and the enrollee will pay a premium equal to the difference. If the bid is less than the benchmark, CMS will pay the plan's bid plus the rebate amount. Plans that bid less than the benchmark are known as 0-premium plans since beneficiaries to not pay a premium to enroll. The plans payments are risk adjusted using the CMS Hierarchical Conditions (HCC) Model.[6]

Medicare Advantage Star Program

The Medicare Advantage star rating is a critical component of the Medicare Advantage reimbursement system. The star ratings are based on nearly 50 different measures[7] that are aggregated into an overall star rating. Each individual measure is given a star rating from 1 to 5. CMS uses a clustering algorithm to identify cut-points in the measure values. These cut-points are designed to minimize variance within each cluster. In other words, the clustering algorithm identifies where the cut points should be so that plans within the same star rating have measure results that are relatively close to each other. Based on the cut-points identified by CMS, each

[4] The ACA also requires that benchmarks (including any quality adjustment) be capped at the level they would have been in the absence of the ACA. In 2018, in half of U.S. counties, the MA benchmark adjusted by a 5 percentage point quality bonus is constrained by the pre-ACA benchmark cap. However, in 2020 no Maryland counties are subject to this cap.

[5] For example, in general, a 4+ star plan that had the exact same bid as a less-than-4 star plan would receive the same capitation payment from CMS. But the plan would be able to offer an additional rebate equal to 3.125 percent of premium as supplemental benefits to enrollees because the 4+ star plan would receive a 5 percentage point quality adjustment to the benchmark and 65 percent of the difference between its bid and the benchmark as a rebate to pass on to enrollees.

[6] Because plan payments depend on the number and severity of conditions for Medicare Advantage enrollees, Medicare Advantage plans are highly incentivized to code more accurately/intensely than providers in FFS Medicare. This has resulted in an upward trend in Medicare Advantage risk scores relative to the FFS population. In order to avoid overpaying Medicare Advantage plans due to the coding intensity, CMS reduces the plan's average risk score by a coding intensity factor.

[7] Not every plan will be evaluated on all 47 measures. For instance, plans that do not offer a Part D component will not be measured on the Part D specific measures. See the Medicare 2019 Parts C and D Star Ratings Technical Notes: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf

individual measure receives a star rating. A list of star measures, their CMS assigned weights, and the time period that the measure is based on is shown in Appendix 1.

The overall star ratings are based on the weighted average of the individual ratings on each of the measures. The weights are set by CMS with the highest weight given to the improvement measures, followed by the outcomes and intermediate outcomes measures, then by patient experience/complaints and access measures, and finally process measures. Two adjustments are made. First, to reward consistently high performance, contracts that have both high and stable relative performance earn a reward factor. Second, a technical adjustment based on the percentage of Low Income Subsidy and Dually Eligible beneficiaries is made while CMS completes a comprehensive review of the Medicare Advantage star program as mandated by the IMPACT Act.

Medicare Advantage and the Total Cost of Care Model

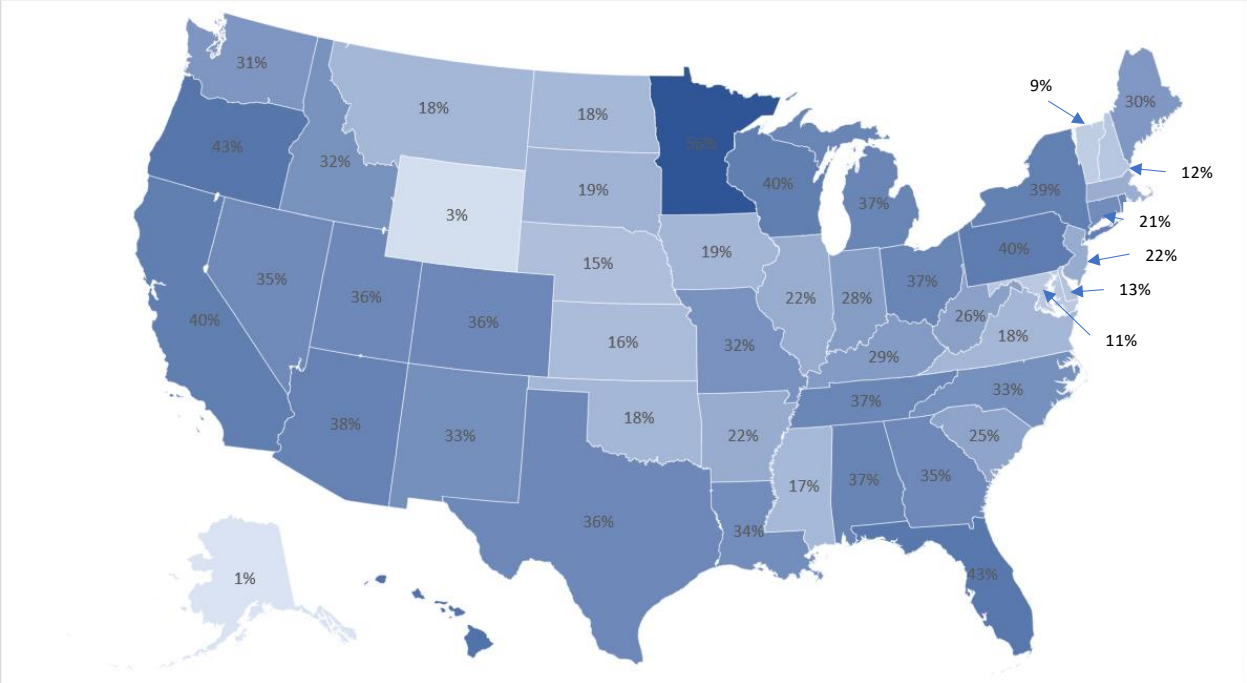
Maryland is unique in that both the Medicare FFS population and the Medicare Advantage population is capped by a benchmark. Under the Maryland Model, the State must ensure that Medicare FFS total cost of care grows less than the national average growth rate relative to a 2013 baseline. The State's performance under the Maryland Model is calculated based on beneficiaries who have Medicare Parts A or B and are not enrolled in Medicare Advantage. Thus increased enrollment is potentially complementary to the State's success under the Maryland Model.

If high cost beneficiaries enroll in Medicare Advantage, then the total cost of care measured across the FFS population will decline and appear as savings under the waiver test. Conversely, if low cost beneficiaries enroll in Medicare Advantage, then the total cost of care in FFS will increase and appear as a dissaving under the waiver test. Due to data limitations, staff were not able to analyze the costs of beneficiaries leaving FFS to enroll in Medicare Advantage. The plan's HCC scores could be a proxy for their expected FFS costs but staff suspects that risk scores in Maryland may be unreliable and Medicare Advantage coding intensity would need to be taken into account. In general, staff expects that special needs plans, and particularly duals plans, would be a net benefit to the Maryland Model waiver tests.

Medicare Advantage Penetration in Maryland

Medicare Advantage penetration in Maryland is low relative to the nation. Nationally, 34 percent of all Medicare beneficiaries have enrolled in a Medicare Advantage plan, while only 11 percent of Medicare beneficiaries in Maryland enrolled in a Medicare Advantage plan. There are few obvious patterns associated with low Medicare Advantage penetration, with the exception of the Plain States, which are rural states with few large metropolitan areas that tend to have Medicare Advantage penetration. The two concentrations of low Medicare Advantage penetration in Maryland, Delaware, and Virginia, and in Vermont and New Hampshire, appear to be outliers.

Figure 1: Medicare Advantage Penetration in the US as of 2018



Source: HSCRC analysis of CMS' State and County Enrollment Files

Growth in Medicare Advantage in Maryland has been higher than the national average. In 2014, the national penetration in Medicare Advantage was 30 percent while it was only 9 percent in Maryland. By 2018, the penetration rate in Medicare Advantage had grown to 34 percent nationally (13 percent increase) and grew to 11 percent in Maryland (22 percent increase). The growth in Medicare Advantage reflects a changing market. In 2015, only 5 organizations (Aetna, Cigna, Humana, Erickson, and MedStar) offered Medicare Advantage plans in the state. In 2017, Johns Hopkins and the University of Maryland entered the market. Simultaneously, United entered the market by acquiring the Erickson plans. In 2018, Kaiser Permanente entered the Medicare Advantage market.[8] In 2019, MedStar exited the market and the University of Maryland closed their Medicare Advantage plans except for a duals plan.

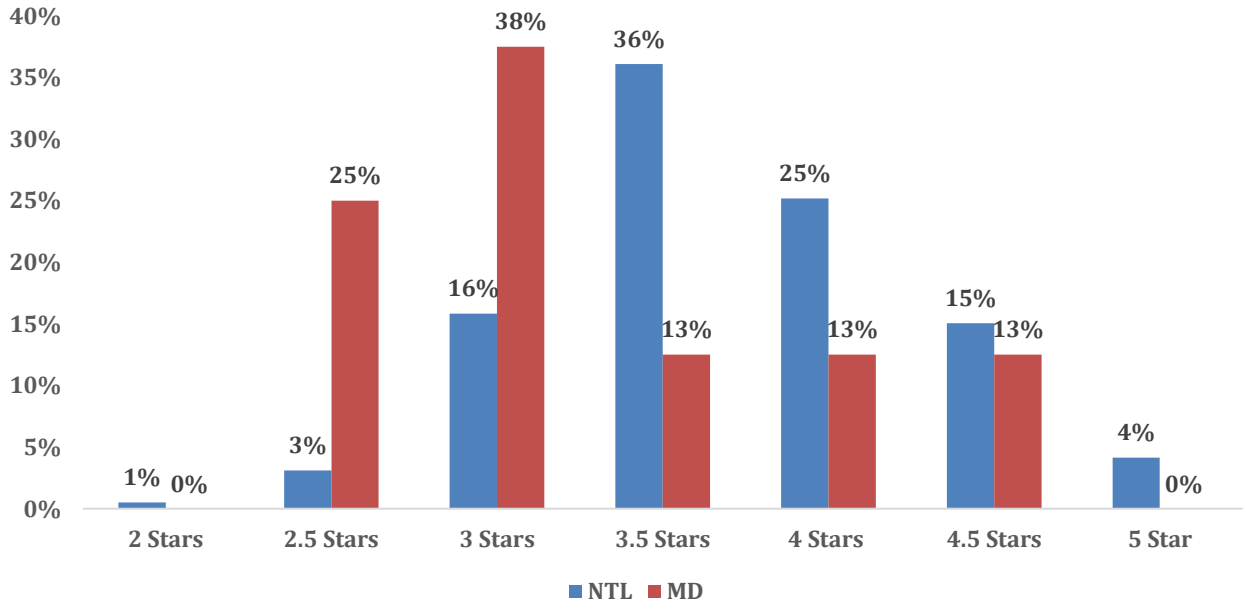
Appendix 2 shows the availability of plans by county since 2015. There are a relatively large number of Medicare Advantage plans available in the urban counties. But in some rural areas there are no traditional Medicare Advantage plans, only special needs plans. As a result, Medicare Advantage penetration is concentrated the urban counties. The highest penetration rates in Maryland are 18 percent in Baltimore City, 16 percent in Prince George's County, 13 percent in Baltimore County, and 12 percent in Montgomery County. Conversely, the lowest penetration rates are 2 percent in Saint Mary's, and 5 percent in Allegheny, Calvert, and Kent

[8] Kaiser Permanente offered Section 1876 Cost Contract Plans in Maryland. CMS terminated their cost based contracts on December 31, 2018 as required by the 2015 Medicare Access and CHIP Reauthorization Act.

Counties. This follows a national pattern where rural counties have about 10 percentage points less penetration (24 percent) than the national average (34 percent).

The availability of highly rated Medicare Advantage plans was limited prior to Kaiser's entry to the market. In 2018, United and Humana both offered plans with 4+ stars (26 percent) of the plans offered on the market.[9] The presence of United and Humana overstates the quality of plans that are general available to Maryland beneficiaries because those plans were only offered to a limited segment of the market. The United plan was available to residents of Erickson Living, and the Humana plan was available only in Carroll, Fredrick, Garrett, and Washington Counties. Overall, the enrollment-weighted average star rating was 3.1 in Maryland.[10] Nationally, there is more access to 4+ star plans; 44 percent of all plans earned more than 4 stars, 4 percent of plans earned 5 stars, and the enrollment-weighted average was 4.1 stars—one star above Maryland.[11]

Figure 2: Percent of Plans by Star Ratings in Maryland and the Nation, 2018



Source: HSCRC analysis of CMS Landscape Files and CMS Star Rating Fact Sheet 2018.
Note: This analysis excludes employer-based (group) Medicare Advantage plans, Special Needs Plans (SNPs), other plans not available for general enrollment, and new market entrants and does not include Kaiser, which was converting from a cost plan to an HMO.

[9] This excludes new entrants since they typically do not have enough data to assign a star rating or are in the process of converting from a cost plan.
[10] HSCRC Analysis of the CMS Landscape & Enrollment Files
[11] See CMS Star Rating Fact Sheet: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-Star-Ratings-Fact-Sheet-.pdf

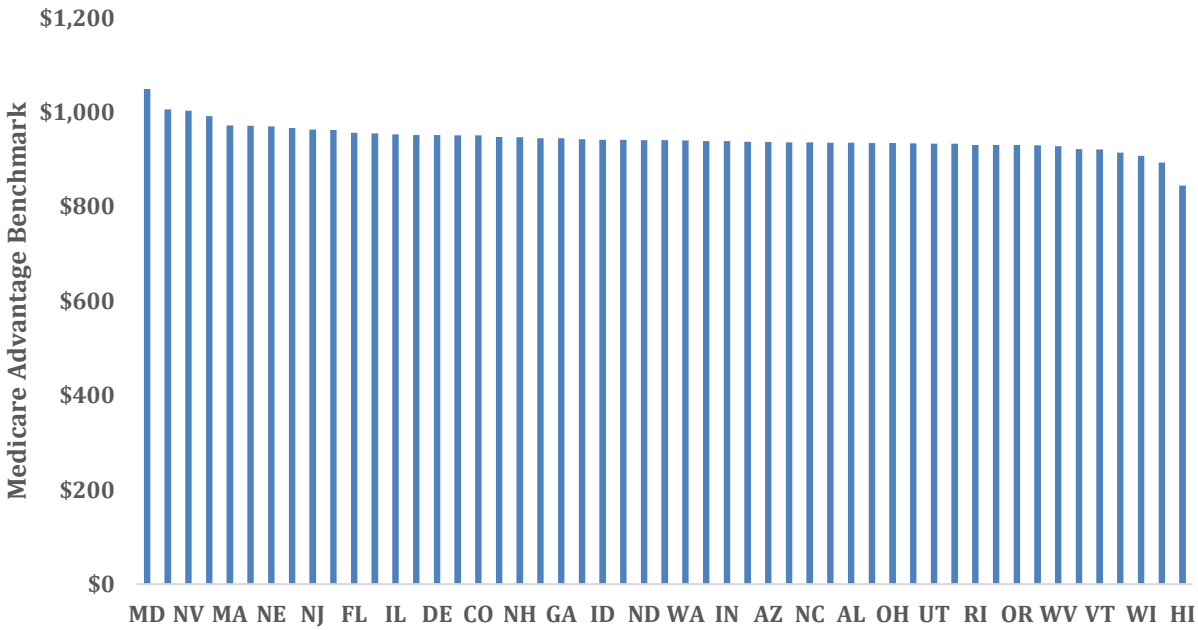
The availability of high-quality health plans is a significant issue for consumers. Medicare Advantage can offer a richer benefit package and lower cost sharing than traditional FFS Medicare. However, the benefits offered by the Medicare Advantage plans is dependent on their star ratings for two reasons: First, highly rated Medicare Advantage plans have a significant marketing advantage; and second, the plans with 4+ stars receive a higher benchmark and can provide additional supplemental benefits or lower cost-sharing to enrollees. In Maryland, more than half of beneficiaries lack access to a 0-premium plan (e.g., a plan that offers either supplemental benefits or lower cost sharing). This indicates that enrolling in a Medicare Advantage plan costs beneficiaries more than enrolling in Medicare FFS. Additionally, beneficiaries cannot get extra benefits – such as vision or dental – without paying an additional premium for the benefits.

Impact of the Benchmark for High-Cost Counties

One hypothesis is that Medicare Advantage penetration in Maryland is relatively low because the majority of Maryland counties are in the top quartile of all counties in terms of FFS costs. As a result, the Medicare Advantage payment benchmark for those counties is equal to 95 percent of the FFS costs. Figure 3 shows the Medicare Advantage benchmark by state, which reflects the quartile adjustments.[12] Even with the 5 percent reduction for being in the highest quartile in most counties, Maryland has the highest Medicare Advantage benchmark in the nation.

[12] Each county is weighted by the number of Medicare Advantage eligible beneficiaries to create a weighted benchmark by State.

Figure 3: Weighted Medicare Advantage Benchmarks by State

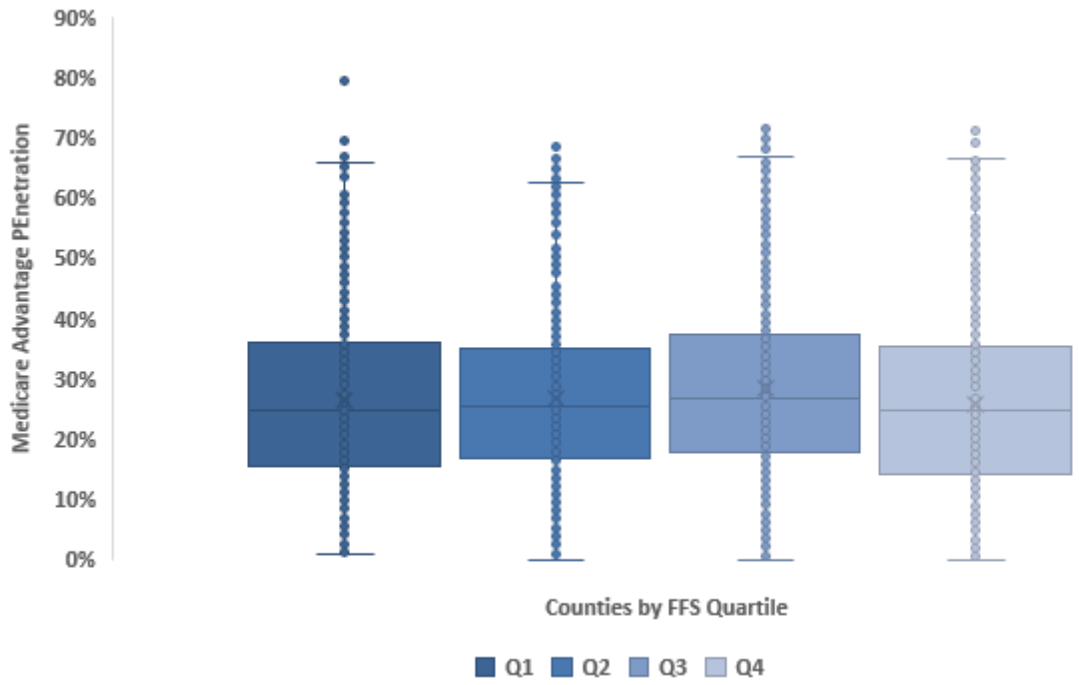


Source: HSCRC analysis of CMS 2020 Ratebook.

Medicare Advantage penetration may be lower in the 95 percent benchmark counties if plans are unable to make up the 5 percent reduction relative to FFS costs. However, as shown in Figure 4, there is no statistical relationship between the FFS quartile and the Medicare Advantage penetration. This implies that Medicare Advantage plans can operate effectively – and likely profitably[13] – in counties that receive a 95 percent benchmark. In fact, some of the states with the highest Medicare Advantage penetration are also are paid at the 95 percent benchmark across the majority of their counties. For instance, the weighted average benchmark in California is 95.13 percent while the Medicare Advantage penetration is 48 percent; the weighted average benchmark in Florida is 95.60 percent while the Medicare Advantage penetration is 46 percent; and the weighted average benchmark in New York is 97.02 percent while the Medicare Advantage penetration is 45 percent.

[13] Nationally, the return on book equity is about 20 percent. The return on equity is not available by state or county because the data is only available at the firm level. Whether the benchmark drives plan profitability is not known.

Figure 4: Medicare Advantage Penetration Nationally by FFS Quartile



Source: HSCRC analysis of CMS State/County Market Penetration Files and the CMS Star Summary Files.
Note: This analysis excludes employer-based (group) Medicare Advantage plans, Special Needs Plans (SNPs) and other plans not available for general enrollment. Q4 represents the counties in the highest-cost quartile, subject to the 5% Medicare Advantage reduction in the benchmark. All but two Maryland counties (Garrett and Montgomery) are in this quartile.

Given that there is no clear relationship between the Medicare Advantage benchmark and Medicare Advantage penetration, staff does not consider the FFS costs or the benchmark in Maryland to be the primary cause of low Medicare Advantage penetration in Maryland.

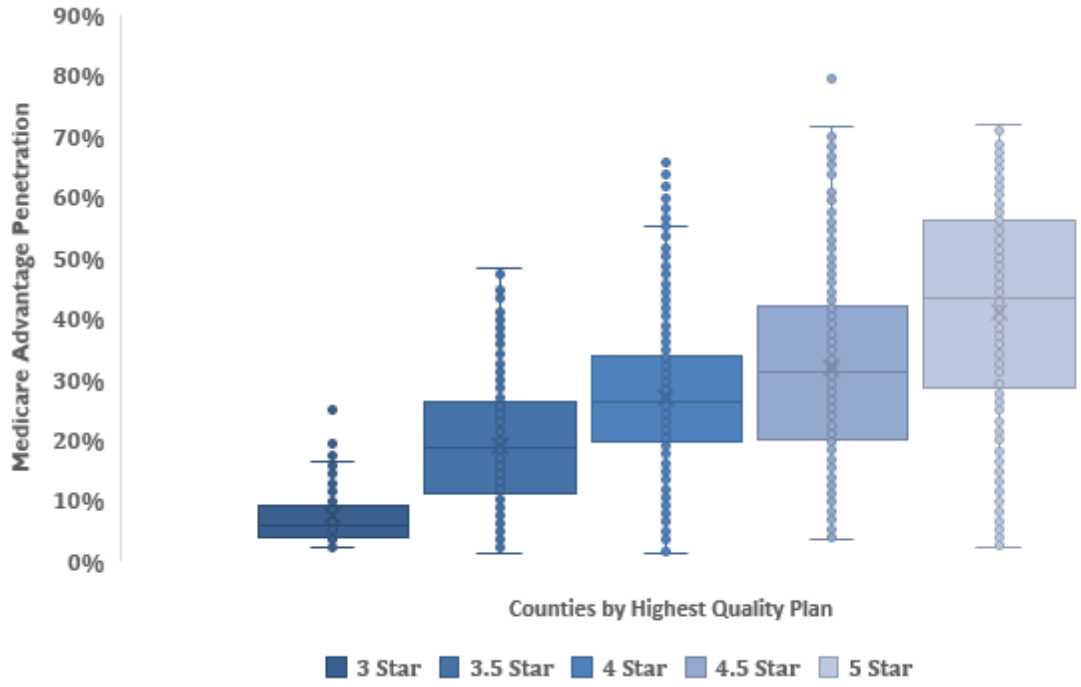
Impact of High-Quality Plans on Medicare Advantage Enrollment

Another hypothesis is that Medicare Advantage penetration varies according to the highest star-rated plan available in the county. Figure 5 shows a clear correlation between Medicare Advantage penetration and the highest quality star rating offered in the county.[14] Generally, counties with higher star ratings have greater Medicare Advantage penetration than counties that have lower quality plans available. As discussed above, the availability of 4+ star plans was

[14] This analysis excludes employer-based (group) Medicare Advantage plans, Special Needs Plans (SNPs) and other plans not available for general enrollment.

limited until Kaiser entered the market. Medicare Advantage penetration in Maryland appears to be similar to areas with similar quality plans. Thus, Maryland does not appear to be an outlier.

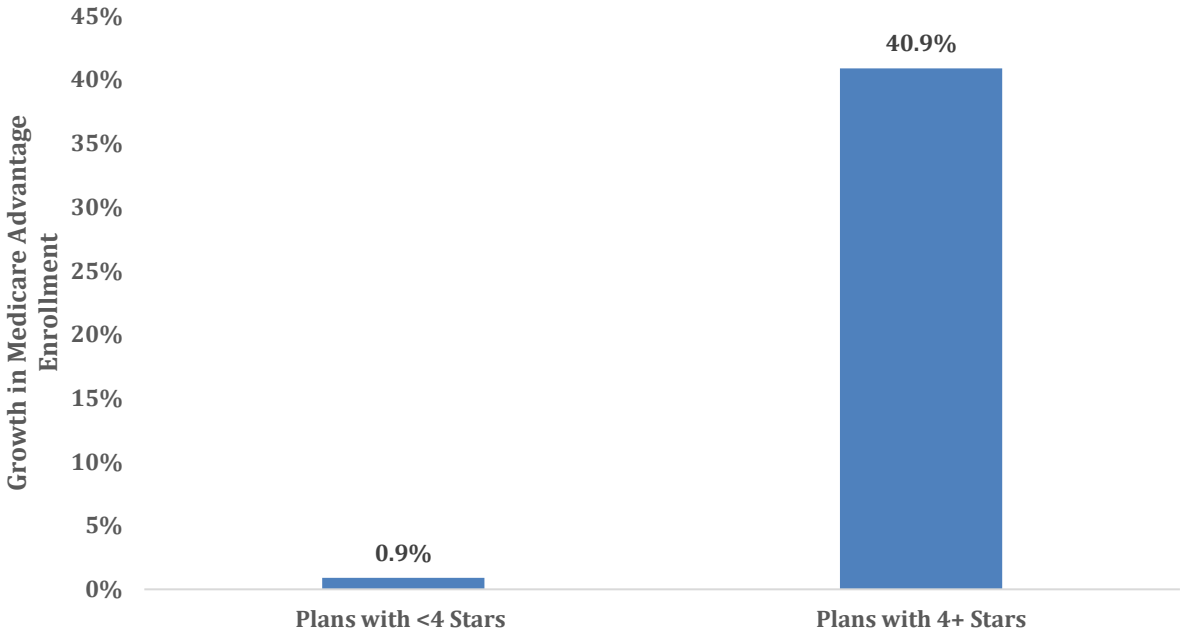
Figure 5: Medicare Advantage Penetration Nationally by Plan Star Rating



Source: HSCRC staff analysis of HSCRC analysis of CMS State/County Market Penetration Files, the 2017 Geographic Variation Public Use Files, and the CMS Star Summary Files.
Note: This analysis excludes employer-based (group) Medicare Advantage plans, Special Needs Plans (SNPs) and other plans not available for general enrollment.

Figure 4 shows enrollment growth in plans with 4+ stars and plans with fewer than 4 stars. Between 2014 and 2016, plans that had and maintained 4+ stars grew by 40 percent. On the other hand, plans that were consistently less than 4 stars grew by only 0.9 percent. Consequently, areas that lack access to plans with 4+ stars are unlikely to have significant Medicare Advantage penetration.

Figure 4: Medicare Advantage Enrollment Growth Nationally by Star Rating

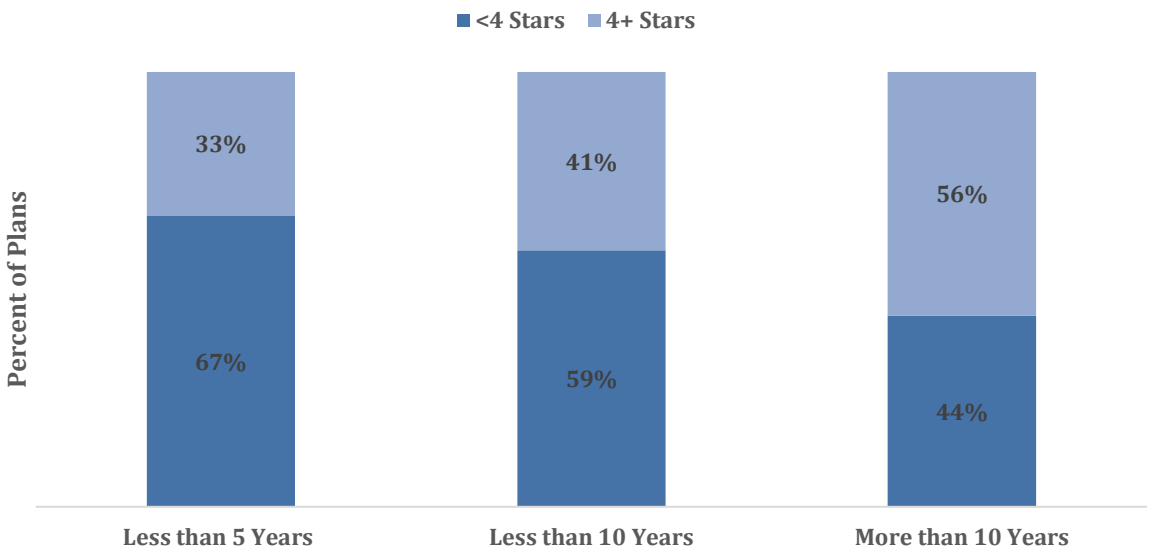


Source: McKinsey & Company. 2017. *Against the odds: How payors can succeed under persistent uncertainty.*

In Maryland, low enrollment in Medicare Advantage is at least partially driven by the lack of high-quality health plans. In turn, Medicare Advantage plans' star ratings are partially driven by the plans' maturity. New entrants into the market had an average score of 3.4 stars. Only 33 percent of Medicare Advantage plans earned 4+ stars within five years of entering the market and on average it took new plans more than 10 years to earn 4+ stars.[15] Thus, current Medicare Advantage penetration is driven by the decision of Medicare Advantage plans to enter the market 5-15 years ago and their willingness to persist in the market with low enrollment for a prolonged period of time.

[15] Based on CMS' Medicare Advantage Star Summary Report.

Figure 5: Plan Star Ratings Nationally by Maturity



Source: CMS Star Rating Fact Sheet.

Large and mature (and often multi-state) Medicare Advantage plans are unique in many respects. These plans can expand their markets to include adjacent counties, and their star ratings are averaged across their entire market area. Thus, established plans can immediately enter the market as a 4+ star plan with the corresponding advantages in reimbursement, marketing, and benefits offering. Medicare Advantage enrollment growth can thus be jumpstarted. The Maryland market may see increased Medicare Advantage penetration from a similar situation, because Kaiser Permanente recently began to offer a 5 star plan in Maryland.[16] Based on national patterns, Medicare Advantage enrollment in Maryland is likely to increase quickly as a result.

Given the relationship of Medicare Advantage enrollment with the availability of 4+ star rated plans, staff believes that low Medicare Advantage enrollment in Maryland is primarily driven by the relatively low quality plans in Maryland. However, existing plans have experienced increases in the stars rating and may soon qualify for the 4+ star bonus. In addition, CareFirst is also looking at entering the Medicare Advantage market in Maryland, although the average star rating for new Blues plans is 3.4 and increasing star ratings will likely take time.[17]

Impact of Hospital Rate-Setting on Medicare Advantage

[16] Kaiser previously offered a cost plan in the Maryland Market. Plans are allowed to carry over their quality ratings from their cost plans. This potentially offers a faster route towards the availability of a 4+ star plan for areas that had a preexisting cost plan in their area.

[17] https://www.modernhealthcare.com/mergers-acquisitions/blues-insurer-carefirst-enter-medicaid-market-two-acquisitions

Unlike other states, Maryland hospitals are waived from the FFS payment systems, which has been raised as one possible barrier to Medicare Advantage penetration. In particular, there are two features of the Maryland Model that could disadvantage Medicare Advantage in the State:

1. *Hospital All-Payer Rate Setting*

   In Maryland, Medicare Advantage plans must pay hospitals the same rate as other payers, based on rates set by HSCRC. Medicare FFS unit rates are higher for hospital services in Maryland than in IPPS and OPPS, but those unit costs are passed dollar-for-dollar into the Medicare Advantage benchmark. Thus Medicare Advantage plans are – for the most part – held harmless for the higher unit rates paid by FFS Medicare. However, because most Maryland counties are high cost on the basis of total cost of care, only 95 cents on the dollar are generally passed into the benchmark. Thus, 5 percent of the higher unit costs are not passed into the Medicare Advantage benchmark.

   Even though higher unit rates are built into the Medicare Advantage benchmark, requiring Medicare Advantage plans to pay the same rate as Medicare FFS may disadvantage Medicare Advantage plans by depriving them of the ability to negotiate lower rates. However, an analysis by the Congressional Budget Office concluded that "the hospital prices paid by MA plans are nearly identical, on average, to Medicare FFS prices."[18] Other studies[19] confirm this analysis noting that: "Currently, 110 percent of traditional Medicare seems to be the rate ceiling in markets with powerful hospitals that use "more of their muscle" to get the higher payments, while 100 percent of traditional Medicare is generally the floor, with the majority reporting in the 100–105 percent range."

   Given that nationally Medicare Advantage plans do not make margin by negotiating lower hospital payment rates, the unit rate that they pay hospitals does not appear critical to their success. Plans in the highest quartile have to reduce utilization by 5 percent to offset the benchmark. Higher unit rates means that the Medicare Advantage plan receives a higher benchmark and means that the Medicare Advantage plan pays more per hospitalization. But the Medicare Advantage plan also retains more revenue when a hospitalization is avoided. Nationally, Medicare Advantage plans are clearly successful, as indicated by high Medicare Advantage penetration in areas with a 95 percent benchmark. Maryland Medicare Advantage plans have the same opportunity to reduce utilization. Therefore, staff does not consider the all-payer rate setting system to be a barrier to the success of Medicare Advantage plans in Maryland.

2. *Global Budget Revenue*

[18] Maeda and Nelson (2017). "An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans." Presentation to Academy Health. https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/52819-presentation.pdf

[19] Berenson et al. (2015). "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." *Health Affairs*, 34(8): 1289-1295. healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1427

One method for Medicare Advantage plans to reduce costs is by reducing utilization, particularly in hospitals. The Maryland Model also incentivizes hospitals to reduce their utilization under their global budget revenue (GBR). Theoretically, this aligns the incentives between the hospital and Medicare Advantage plans, while nationally, Medicare Advantage plans are trying to reduce utilization while hospitals are trying to increase utilization.

Under the GBR, the savings from reduced hospitalization are not always captured by payers on a dollar-for-dollar basis. If utilization declines across all payers, the unit rates of hospitalization services increase. Thus, the GBR potentially diminishes the financial rewards of the Medicare Advantage plans' hospital utilization management as a strategy to reduce the total cost of care.

However, the unit rates changes are spread across all payers. When the Medicare Advantage plan avoids a hospitalization, their unit rates and everyone else's increase by a small amount. The Medicare Advantage plan's utilization savings are offset by an amount equal to their share of the hospital's overall utilization. For example, if the Medicare Advantage plan avoids a $20,000 hospitalization and has a 10 percent share of the hospital's volume, then the increase in unit rates would offset the Medicare Advantage plan's utilization savings by $2,000.

Theoretically, the Medicare Advantage plan can still create savings by reducing the hospital utilization of their enrollees – albeit their savings are partially offset. But if all other payers are reducing hospital utilization faster than the Medicare Advantage plans, the increase in hospital unit rates will be a headwind to the Medicare Advantage plans. Hospital utilization in Medicare FFS has decreased significantly under the Maryland Model, as hospitals have been incentivized to reduce unnecessary hospitalizations. It is possible that Maryland hospitals have been more effective at managing the utilization of their patients than Medicare Advantage plans, in which case the Maryland Model would be a disadvantage to those Medicare Advantage plans.

The interaction between the Maryland Model and Medicare Advantage is complex. Staff is uncertain whether the GBR incentives for hospitals to reduce unnecessary utilization — and allowing them to keep the savings — is a headwind or tailwind to Medicare Advantage plans in the State. The global budgets would be a headwind if Maryland hospitals under the Model are more effective at reducing utilization than Medicare Advantage plans.

Grant Program for Medicare Advantage

If the Commission wanted to increase Medicare Advantage penetration in Maryland, the availability of Medicare Advantage plans with 4+ stars appears necessary. Even if the Maryland Model were removed and Medicare Advantage plans allowed to negotiate rates with hospitals and negotiate lower rates, Medicare Advantage penetration would be unlikely to grow without the availability of 4+ star plans.

However, many of the quality measures used to set the Medicare Advantage stars are also population health and quality of care measures that are closely aligned with the Commission's other policies under the Maryland Model. It is possible that the Commission could assist Medicare Advantage plans to improve their star ratings through a grant program for hospitals that partner with Medicare Advantage plans.

The intent of the Medicare Advantage Partnership Grant Program would be to achieve the following:

- Create partnerships and strategies that result in long-term improvement in the population health of Medicare Advantage beneficiaries; and
- Increase the Medicare Advantage star ratings, which makes the plan more attractive to prospective enrollees and earns the plan higher reimbursements from the Centers for Medicare & Medicaid Services (CMS), some of which can be returned to enrollees in the form of enhanced benefits and reducing cost-sharing, making the plan even more attractive to prospective enrollees.

This grant funding could support the hospitals' work with physicians and other health care providers to improve quality and care coordination. The Commission could add to the hospital rates an amount up to 5 percent of the county-level FFS costs included in the Medicare Advantage Ratebook multiplied by the number of enrollees in the Medicare Advantage partner plan. The Medicare Advantage Partnership Grant would be a temporary funding mechanism, for the following two-year period:

- Year 1: CY2021 (January 1 – December 31, 2021)
- Year 2: CY2022 (January 1 – December 31, 2022)

Hospitals would apply to participate in the grant program by submitting a proposed list of activities that will result in increased quality measures for the Medicare Advantage plan. The hospital would also be required to submit a letter of support from their Medicare Advantage partner(s) in order to be eligible to participate.

Terms and Conditions of the Medicare Advantage Grant Program

The Medicare Advantage Partnership Grants would be narrowly focused to improve quality for Medicare Advantage beneficiaries, while ensuring enrollment does not decrease. Hospitals may spend grant funds on any activity that they deem is necessary to improve the Part C quality measures in the following domains, as well as to increase enrollees' Annual Wellness Visits:

- Domain 1 – Staying Healthy: Screenings, Tests, and Vaccines;[20] and

[20] Domain 1 measures are C01 – C07 in Appendix 1.

- Domain 2 – Managing Chronic (Long Term) Conditions.[21]

As a condition of the Medicare Advantage Grant, the hospital would be required to ensure that the Medicare Advantage Plan meets the following three conditions:

- First, any quality measure in Domains 1 and 2 that is less than a 3 star rating on the plan's 2020 star ratings must improve by at least 1 star rating per year;
- Second, the health plan must increase its rates of Annual Wellness Visits by 5 percentage points per year (and make auditable data available to HSCRC for the baseline year and the two performance years);[22] and
- Third, the health plan must maintain or increase their Medicare Advantage enrollment.

In July of each year, the Commission would assess the Medicare Advantage Plan's star ratings and enrollment. The Commission would only assess those measures that are based on data after the approval of the Medicare Advantage grant program.[23]

If none of the conditions are met, the Commission would end the grant program and additionally make a temporary reduction in the hospital's rates to recapture the grant funding. This would also occur if enrollment fell by more than 10 percent, including if the Medicare Advantage plan ceased operations. Because this money would be recaptured from the hospitals that were the original recipients, it is critical that hospitals understand their partner plan's commitment to participation.

If some of the conditions are not met, the amount of the repayment would be dependent on the share of star ratings that have not improved, along with Annual Wellness Visits and enrollment decline between 0 and 10 percent as two additional measures. If the hospital had 5 measures with less than 4 stars and only improved 2 of them, while meeting the targets for Annual Wellness Visits and enrollment, then the hospital would repay 43 percent (failing 3 out of 7 measures = 43 percent) of the initial grant. This would hold hospitals accountable to ensure that their Medicare Advantage partners are successful.

Funding for the Medicare Advantage Grant Program

The grant funds will be provided in the form of increased hospital rates to award recipients, and thus paid by all payers in the State. In order to ensure that these grant funds do not result in a net increased cost to payers, the Commission would reduce the inflation portion of the RY 2021

[21] Domain 2 measures are C08 – C21 in Appendix 1.
[22] The average increase in Annual Wellness Visits among Medicare Advantage plans nationally was from 13.5 percent in 2013 to 25.2 percent in 2015 (https://www.aarp.org/content/dam/aarp/ppi/2019/05/annual-wellness-visits-among-medicare-advantage-enrollees.pdf).
[23] In July of 2021, the Commission would assess the following measures: Annual Flue Vaccines, Getting Needed Care, Getting Appointment and Care Quickly, Customer Service, Rating of Health Care Quality, Rating of Health Plan, Care Coordination, Call Center Rating, Rating of Drug Plan, Getting Need Prescription Drugs, and MPF Accuracy. In July of 2022, the Commission would assess all measures.

update factor to hospitals by an amount necessary to offset the aggregate amount of Medicare Advantage grants issued. If the Medicare Advantage Plan failed to meet the conditions of the grant or ceased operations or in any way deemed itself not responsible for performance under this program, the grant amount would be terminated and repaid from that hospital's global budget, with a corresponding increase the update factor in order to return that money to other hospitals.

Appendix 1: CMS Star Ratings for 2020

ID	Measure Name	Category	Weight	Date
C01	Breast Cancer Screening	Process	1	2018
C02	Colorectal Cancer Screening	Process	1	2018
C03	Annual Flu Vaccine	Process	1	03/2019-05/2019
C04	Improving or Maintaining Physical Health	Outcome	3	04/2018-07/2018
C05	Improving or Maintaining Mental Health	Outcome	3	04/2018-07/2018
C06	Monitoring Physical Activity	Process	1	04/2018-07/2018
C07	Adult BMI Assessment	Process	1	2018
C08	Special Needs Plan (SNP) Care Management	Process	1	2018
C09	Care for Older Adults – Medication Review	Process	1	2018
C10	Care for Older Adults – Functional Status Assessment	Process	1	2018
C11	Care for Older Adults – Pain Assessment	Process	1	2018
C12	Osteoporosis Management in Women with Fracture	Process	1	2018
C13	Diabetes Care – Eye Exam	Process	1	2018
C14	Diabetes Care – Kidney Disease Monitoring	Process	1	2018
C15	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome	3	2018
C16	Rheumatoid Arthritis Management	Process	1	2018
C17	Reducing the Risk of Falling	Process	1	2018
C18	Improving Bladder Control	Process	1	2018
C19	Medication Reconciliation Post-Discharge	Process	1	2018
C20	Plan All-Cause Readmissions	Outcome	3	2018
C21	Statin Therapy for those with Cardiovascular Disease	Process	1	2018
C22	Getting Needed Care	Patient Experience	1.5	03/2019-05/2019
C23	Getting Appointments and Care Quickly	Patient Experience	1.5	03/2019-05/2019
C24	Customer Service	Patient Experience	1.5	03/2019-05/2019
C25	Rating of Health Care Quality	Patient Experience	1.5	03/2019-05/2019
C26	Rating of Health Plan	Patient Experience	1.5	03/2019-05/2019
C27	Care Coordination	Patient Experience	1.5	03/2019-05/2019
C28	Complaints about the Health Plan	Patient Experience	1.5	2018
C29	Members Choosing to Leave the Plan	Patient Experience	1.5	2018
C30	Health Plan Quality Improvement[24]	Improvement	5	NA
C31	Plan Makes Timely Decisions about Appeals	Access	1.5	2018
C32	Reviewing Appeals Decisions	Access	1.5	2018
C33	Call Center – Foreign Language Interpreter	Access	1.5	02/2019-06/2019
D01	Call Center – Foreign Language Interpreter[25]	Access	1.5	02/2019-06/2019
D02	Appeals Auto–Forward	Access	1.5	2018
D03	Appeals Upheld	Access	1.5	2018
D04	Complaints about the Drug Plan	Patient Experience	1.5	2018
D05	Members Choosing to Leave the Plan	Patient Experience	1.5	2018
D06	Drug Plan Quality Improvement	Improvement	5	NA
D07	Rating of Drug Plan	Patient Experience	1.5	03/2019-05/2019
D08	Getting Needed Prescription Drugs	Patient Experience	1.5	03/2019-05/2019
D09	MPF Price Accuracy	Process	1	01/2018-09/2018
D10	Medication Adherence for Diabetes Medications	Intermediate Outcome	3	2018
D11	Medication Adherence for Hypertension	Intermediate Outcome	3	2018
D12	Medication Adherence for Cholesterol	Intermediate Outcome	3	2018

[24] The value of the improvement measure is equal to the number of measures the change in the measure score from 2019 to 2020 divided by the standard error of the measure score exceeds 1.96.
[25] Measures that are applicable for both Part C and Part D plans are only counted once for MA-PD plans.

D13	MTM Program Completion Rate for CMR	Process	1	2018
D14	Statin Use in Persons with Diabetes	Intermediate Outcome	1[26]	2018

[26] New measures are given a weight of 1 regardless of category.

Appendix 2: Number of Medicare Advantage Plans by County

County	2015	2016	2017	2018	2019	2020
Allegany	1	1			1	
Anne Arundel	2	3	3	4	3	3
Baltimore	3	4	4	5	4	4
Baltimore City	2	3	3	5	3	3
Calvert		1	2	1	1	2
Caroline		1	1	1		
Carroll		2	2	3	2	3
Cecil		1	1	1		
Charles	1	1	1	1	1	1
Dorchester		1	1	1		
Frederick	1	1	1	3	3	4
Garrett	1	1	1	1	1	1
Harford	1	2	2	4	2	2
Howard	3	4	4	5	3	3
Kent		1	1	1		
Montgomery	3	4	4	6	5	5
Prince George's	4	3	3	6	4	4
Queen Anne's		1	1	1		
Saint Mary's County	1	1	1			
Somerset		1	1	1	1	1
Talbot		1	1	1		
Washington	1	2	2	2	2	1
Wicomico		1	1	1	1	1
Worcester		1	1	1	1	1

Note: This analysis excludes employer-based (group) Medicare Advantage plans, Special Needs Plans (SNPs), other plans not available for general enrollment, and new market entrants.