Medicare Advantage Partnership Grant Program

March 13, 2020

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Funding Announcement

The Health Services Cost Review Commission (HSCRC) is seeking proposals for the new Medicare Advantage Partnership (MAP) Grant Program. This funding program is intended to foster collaboration between hospitals and Medicare Advantage Plans, increase access to 4+ Star Rating Medicare Advantage plans in the State, and develop strategies that improve care coordination, quality, and lead to long term health improvement of Medicare Advantage Plan beneficiaries. Under the MAP Grant Program, hospitals and their Medicare Advantage Plan partners will collaborate to implement or expand strategies that will help improve the quality and sustainability of Medicare Advantage Plans in Maryland. The MAP Grant Program is a temporary funding mechanism for the following two year period:

- Round One Funding: FY2020 (July 1, 2019– June 30, 2020)
- Round Two Funding: FY2021 (July 1, 2020– June 30, 2021)

All grant funding will end on June 30, 2021.

Proposal Requirements and Timeline

Proposals must be single-spaced, single sided, Calibri style and 11 point font size and submitted using the requirements described herein by the date below to hscrc.rfp-implement@maryland.gov in order to be considered. **Separate proposals must be submitted for each funding round.** An HSCRC review committee will review the proposals and, as authorized by the HSCRC, will make award decisions.

- **RFP Release Date:** March 13, 2020

- **Round One Proposal Deadline: March 27, 2020, Noon EST**
  - Preliminary Proposal Disposition Notifications – April 1, 2020
  - Amended Rate Orders Issued – May 2020 (Effective July 1, 2019)
  - Hospitals that apply by the deadline and are awarded Round One funding will receive funding for FY2020 and may also apply for funding in Round 2.

- **Round Two Proposal Deadline: November 13, 2020, Noon EST**
  - Preliminary Proposal Disposition Notifications – December 15
  - Mid-Year Rate Orders Issued – January 2021 (Effective July 1, 2020)
  - Hospitals that apply by the deadline and are awarded Round Two funding will be eligible to receive grant funding for FY2021 only.

Background

The Maryland All-Payer Model, which launched in 2014, established global budgets for Maryland hospitals to reduce Medicare hospital expenditures and improve quality of care. Global budgets provide hospitals with a fixed amount of revenue for the upcoming year. A global budget encourages hospitals to eliminate unnecessary hospitalizations, among other benefits. Under the All-Payer Model, Maryland achieved significant savings for Medicare and improved quality. However, the Maryland All-Payer Model historically focused primarily on the hospital setting, constraining the State's ability to sustain its rate of Medicare savings and quality improvements.

In 2019, the Centers for Medicare & Medicaid Services (CMS) and the State of Maryland initiated the Maryland Total Cost of Care (TCOC) Model, which seeks to broaden transformation of Maryland's healthcare system by setting a per capita savings target on Medicare total cost of care in the State. The TCOC Model builds on the success of Maryland's All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries. The TCOC Model and the hospital global budget revenue (GBR) also create a unique opportunity to extend transformation efforts to related parts of Maryland's healthcare system including the Medicare Advantage market.

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 penetration levels in Maryland at 11 percent are well below national levels (approximately 38 percent and growing). This lack of penetration means that eligible Maryland Medicare beneficiaries do not have the same level of access to Medicare Advantage benefits as do Medicare beneficiaries nationally; there are also indications that several current Medicare Advantage Plans may be considering pulling out of the Maryland market. Low Medicare Advantage penetration has been a historic problem for Maryland. The market continues to disappoint expectations, leaving 70,000 current enrollees at risk of plan withdrawal and denying widespread penetration to the several hundred thousand potential enrollees who should have this option. While many plans have exited the State or certain jurisdictions in the State, there are some bright spots where plans are growing, or local companies are considering entering certain markets.

The Medicare Advantage Plans, both provider-based and payer-based, have identified certain barriers created by the Maryland all-payer rate setting system that make investing in Medicare Advantage more challenging in Maryland than in other states. Conversely, there are also features of the global budget revenue (GBR) system and the hospital all-payer rate setting system that are complementary to Medicare Advantage, and thus Maryland should expect a more robust Medicare Advantage market over time as health care transformation continues.

The MAP Grant Program is intended to provide temporary action to foster engagement of hospitals in the efforts to support the Medicare Advantage market. In parallel with the grant program, the HSCRC intends to engage CMS in a discussion on how best to align the Medicare Advantage payment system with the unique features of Maryland's all-payer rate setting system so that Maryland will be more competitive for Medicare Advantage plans. Thus, the MAP Grant Program is intended to support the market in a manner consistent with TCOC objectives while HSCRC engages with CMS on potential long-term solutions that can result in a stronger Medicare Advantage market for consumers.

In order to stabilize the Medicare Advantage market and promote the further expansion of Medicare Advantage services in Maryland in the short term, the HSCRC intends to make grants available to hospitals that either operate a Medicare Advantage Plan or partner with an existing Medicare Advantage Plan. Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC and meet the additional requirements identified in this announcement are eligible to apply for the MAP Grants. *Awards will only be available to the most promising and competitive hospital applicants.*

Medicare Advantage Partnership Grants

The Medicare Advantage Partnership Grant Program is designed to support, promote competition, and enhance access to Medicare Advantage benefits for Medicare beneficiaries in a defined period. The Grant Program will help to ensure access to Medicare Advantage services for populations and will mitigate possible negative impacts to the State's total cost of care financial targets by helping to prevent Medicare Advantage Plans from exiting the market.

The MAP Grants will be narrowly focused to support activities that lead to increased stability, expansion, more robust plan design, and/or improved quality of Medicare Advantage Plans. The intent of the Medicare Advantage Partnership Grant Program is to achieve the following:

- Encourage partnerships and strategies that result in long term health improvement of Medicare Advantage Partnership beneficiaries
- Improve Medicare Advantage penetration and/or improved services to high cost and high risk populations
- Preserve and/or expand access to the number of 4+ Star Rating Medicare Advantage plans in the State to promote competition and access for seniors
- Develop strategies that improve care coordination and quality of services offered in Medicare Advantage Plans
- Extend healthcare transformation efforts to the Medicare Advantage market.

Hospitals interested in applying will be required to submit proposals describing how they will use the MAP Grant Program funds to work in collaboration with Medicare Advantage Plans to design and initiate strategies that will support improvement in population health in the long run. Successful hospital proposals will articulate detailed plans for achieving the aforementioned goals.

The aggregate amount available for Medicare Advantage Partnership Grant Program is a maximum of $50 million in FY2020 and $50 million in FY2021.

Hospital Rate Implications

Hospitals that apply in Round One will be eligible to apply for either one or two year funding. Round One grant awards will be incorporated into successful hospital applicant rates effective FY2020. Amended rate orders are expected to be issued in May 2020. Round Two grant awards for FY2021 will be incorporated into successful hospital applicant mid-year rate orders issued in January 2021. Hospitals that apply by the deadline and are awarded Round Two funding will be able to receive grants for FY2021 only.

Limitation on Award Amounts

The maximum amount a hospital may receive for the Medicare Advantage Partnership grant is 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.

Funding will only be awarded to the most competitive proposals. Proposals must provide justification for the requested funding amount and demonstrate the appropriateness and reasonableness of the request associated with the planned activities under the program. Applicants may be required to alter the scope or amount of a proposal during the evaluation process to come into compliance with award limitations and the total statewide funding allocation.

Measuring Impact

All grantees must demonstrate the impact being made as a condition of funding. If impact targets are not achieved, the HSCRC may discontinue and retract funds. The impact will be assessed based on the following four areas:

1. *Star Rating Measure Improvement*

Medicare Advantage contracts are rated on up to 45 unique quality and performance measures. Grant funds should be used to design and implement strategies that will result in improvement in the 2020 Part C/Part D measures established by CMS for the Medicare Advantage Program. Appendix A includes a listing of the 2020 measures. In particular, it is expected that the MAP Grant Program can leverage hospital expertise on quality in an effort to improve star rating measures of Medicare Advantage plans. By doing this, the Medicare Advantage Plans will be eligible for higher reimbursement from CMS. This additional funding can then be returned to enrollees in the form of enhanced benefits and reduced cost-sharing. MAP grantees will be required to define the specific star rating measures they will target for improvement efforts and provide baseline performance data so that improvement can be measured. Proposals that focus on improvements in measures associated with managing long-term chronic conditions, in particular diabetes measures, will be considered most favorably.

2. *Increase in Annual Wellness Visits*

The Annual Wellness Visit provides an annual opportunity for Medicare Advantage beneficiaries to work with their providers to create or update their personalized prevention plan. This visit can be particularly important for beneficiaries who are high cost or who have high healthcare needs. The Annual Wellness Visit creates an opportunity to proactively assess changes in beneficiary health by performing a health risk assessment at 12 month intervals. Grant funds should be used to design and implement strategies that result in an increase in the number of annual wellness visits per year. MAP grantees will be required to create strategies that will lead to an increase in the number of visits and provide baseline performance data so that improvement can be measured.

3. *Expansion of Coverage*

Maryland's current Medicare Advantage Plan penetration and distribution of services do not provide adequate coverage and choice for all eligible Marylanders. Appendices B-C provide information on Medicare Advantage penetration in the State. Plans are concentrated in urban counties while rural counties have far fewer choices without the extra benefits Medicare Advantage plans can provide, such as vision or dental services. Grant funds should be used to design and implement strategies that result in the expansion of coverage and access to these services. MAP grantees will be required to create strategies that can expand services to new areas for the 2022 Medicare Advantage plan year.

4. *High Cost Beneficiary Penetration*

It has been well documented that a small portion of Medicare patients account for more than half the program's spending in any given year. This is true of Medicare Advantage Plans as well. According to a 2019 study by the Commonwealth Fund, "37 percent of Medicare Advantage enrollees have chronic conditions and functional limitations requiring a range of medical and social services; many also contend with low income, low education, and isolation."[1] Because of this, hospitals are encouraged to collaborate with Medicare Advantage Plans to identify and address the high cost/high need beneficiaries as part of the MAP Grant Program. Grant funds should be used to design and implement outreach, education, enrollment, prevention, and management strategies that identify and target these beneficiaries with appropriate coverage and services.

Across these four impact measurement areas, hospitals and their Medicare Advantage Plan partners will be required to define areas they intend to address and then self-report on the progress in these areas. The HSCRC may also independently verify performance. Hospitals and Medicare Advantage Plans will *not* be accountable for a specific total cost of care savings goal during the grant period, but will instead be held accountable to achieve improvement in these four areas.

Eligibility Criteria

Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC are eligible to apply for the MAP Grants. Additionally, applicants must meet the following criteria:

- A single hospital may submit a proposal, or multiple hospitals affiliated with a health system may jointly apply under a single proposal.
- Hospitals may partner with only **one** Medicare Advantage Plan in a single proposal.
- As of the application date, hospitals must have a collaboration arrangement with a Medicare Advantage Plan currently operating in Maryland to be eligible for grant funding. A letter of intent signed by both the hospital and the Medicare Advantage Plan confirming the intent to collaborate must be included with the proposal. Hospitals are only eligible to partner with Medicare Advantage Plans that have a minimum of 3.5 stars as their overall CMS star rating.
- Proposals must include a list of strategies that will be implemented to improve Medicare Advantage Plan performance in one or more of the four impact areas (star rating measure

[1] DuGoff, Eva H., et al. *Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs.* The Commonwealth Fund, 11 Feb. 2019, www.commonwealthfund.org/publications/issue-briefs/2019/feb/targeting-high-need-beneficiaries-medicare-advantage.

improvement, annual wellness visits, expansion of services, and/or high cost beneficiary penetration).

To be eligible for consideration, all proposals must include details about the hospital plan to collaborate with Medicare Advantage organizations. Details about arrangements for resource sharing, financial payments, and/or in-kind support must be disclosed in the proposals. Specifically, the proposal should clearly detail how resources, funds, or in kind support will flow from hospitals to Medicare Advantage organizations.

Competitive Medicare Advantage Partnership Grant Program awards are intended as a one-time adjustment to approved hospital rates. If awarded, enhanced reporting will be expected. Activities will be monitored and measured to demonstrate how funds have been used and to show the impact that the related activities have on Medicare Advantage metrics.

Proposal Requirements

Proposals must be submitted before the deadline. Proposals that are late, incomplete, or in a format that does not adhere to requirements specified will not be considered. Proposals must be formatted as follows:

- Section I: "Scope of Work" – this section of the proposal should describe in detail the proposed activities for the hospital/Medicare Advantage Plan partnership.
- Section II: "Financial Projections" – this section of the proposal should describe in detail the proposed budget.

Section I: Scope of Work

The scope of work section must include the seven sections listed below.

- Sections 1-6 of the proposal must be submitted as a PDF of Microsoft Word or similar formats and may not exceed 25 pages.
- Section 7 (Implementation Work Plan) must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project.

1. Summary of Proposal (no more than 3 pages)

Hospitals are required to summarize their proposal using the standard template in Appendix D for the required summary format table.

2. Impact Area

This section must define the impact area that will be addressed with grant funding. Hospitals

should specify whether star rating measure improvement, annual wellness visits, expansion of services, and/or high cost beneficiary penetration will be the focus of their efforts. Additionally, the geographic scope of the efforts should be included with a county, incorporated city, and/or list of the ZIP codes that will be targeted. Additionally, data and a corresponding narrative should be used to describe the health needs that the proposed activities will address within the proposed geographic area.

3. Proposed Activities

This section must include a description of the proposed strategies to be implemented or expanded. The description should include information on the beneficiary population(s), the services and/or interventions the beneficiaries will receive, and the role of the hospital and/or the Medicare Advantage organization in the activity. This section should also describe the planning, foundation building (e.g., technology, workforce, delivery model, etc.), and outreach strategies that will be included in the proposed activities. The discussion of the proposed model should be very specific and describe the planning, implementation, and monitoring of all elements of the proposed model.

4. Measurement and Outcomes

This section of proposals should describe tools the hospitals and Medicare Advantage organizations will use to coordinate and measure their progress in the selected impact areas. This section also should describe the expected results and include baseline data and measures. In addition to high level goals that the applicants are pursuing, program-specific measures should be proposed by applicants. Applicants should provide the evidence basis for their approach.

5. Scalability and Sustainability

This section should detail how the intervention/program is sustainable after the grant period expires and funding is discontinued. Plans for funding an expansion of the program/intervention if it proves successful should also be described. The partners should demonstrate a commitment to sharing resources and addressing alignment of payment models on an ongoing basis.

6. Partnership Definition and Decision-Making Process

This section should include a list of the participating entities and the roles they will play in the hospital/Medicare Advantage Plan partnership using the template in Appendix D. Additionally, this section should also include a description of a shared decision making process that incorporates the perspectives of all partners. If a formalized governance structure will be used, it should be described in this section. This section should describe the roles and responsibilities for partnering organizations and the proposed funding for each.

7. Implementation Work Plan (no page limit to this non-narrative section, must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project)

This section should clearly describe how different initiatives will move from a planning to implementation phase, including when intervention(s) will begin.

Section II: Financial Projections

1. Budget

Proposals must include a complete and comprehensive line item projected budget using the format in Appendix E to specify expected expenses and how funds, resources, and/or in-kind support will be distributed and flow from hospitals to Medicare Advantage collaborating organizations.

For Round One (FY2020) funding, awarded funds are expected to be issued to hospitals through amended rate orders in May 2020 (effective July 1, 2019). Round Two funding (FY2021) will be issued to hospitals in January 2021 mid-year rate orders (effective July 1, 2020). The proposed budget is expected to demonstrate the applicant's ability to execute the described scope of work to the extent practicable, within the grant period. For each year awards are made, it is expected that funds will be expended within twelve months of fund issuance. Funds can only be used for planning, capital expenditures, implementation, service delivery and operating expenses related to Medicare Advantage impact areas. Examples of ineligible expenses are described in Appendix F. The HSCRC reserves the right to terminate an award at any time for what it considers to be material lack of performance, or for its determination that a participating hospital and/or its partner Medicare Advantage Plan is not meeting the letter or intent of an application as approved. If the HSCRC determines that a hospital has used award funds in a manner inconsistent with the approved proposal, the Commission may require repayment of those funds. Additionally, at the end of the two-year grant period, the HSCRC will report on the impact of the Medicare Advantage Partnership grants. At the discretion of the HSCRC, partnerships that did not demonstrate improvement in performance by the end of the grant program may be required to pay back some or all of awarded grant amounts from hospital rates.

2. Budget and Expenditures Narrative (no more than 3 pages)

Proposals must include a brief narrative justifying the expenses included in the line item budget. This section of the proposal should also include the percentage of the total investment of the program covered by the award and the source of any other funding that may apply to support the proposed activities. Investments included in the budget should have the potential to impact the population health priority areas within the communities that each partnership serves. Additionally, investments included in the budget are expected to be data driven and able to be evaluated using measurable outcomes.

Evaluation Process

An evaluation committee formed by the HSCRC will review and score the grant proposals. Additionally, the HSCRC may engage subject matter experts with Medicare Advantage expertise to assist in the review and evaluation of grant applications. The HSCRC or its designee will make awards based on applications received and will determine how funds are disbursed. This means that:

- Determinations by the evaluation committee are not subject to appeal;
- The evaluation committee may require alterations to the scope or amount of a proposal during the process; and
- The evaluation committee may require an applicant to alter a proposal(s) to come into compliance with the award limitation described above.

Evaluation Criteria

Applications will be reviewed and funding awarded based on the following criteria:

1. **Impact Potential –** The potential for the proposed activities to achieve improvement in star rating measure improvement, annual wellness visits, expansion of services, and/or high cost beneficiary penetration.

2. **Collaboration Plan** – The extent to which proposals articulate plans to establish collaboration with hospitals, physicians, Medicare Advantage organizations, and other downstream providers to support TCOC and care transformation aims through meaningful engagement (financial arrangements, resource sharing, and/or in-kind support).

3. **Evidence-Based Approaches** - Whether the proposed activities are well-conceived, evidence-based/evidence-informed, and appropriately propose how to implement the investments in an efficient and effective manner to address the impact areas.

4. **Strategies to Engage High Needs Population –** The degree to which the proposed activities identify and target high cost and/or high risk beneficiaries with activities that reduce risk and lead to improved health outcomes in the long term.

5. **Novel Outreach and Enrollment Approaches –** The extent to which effective healthcare consumer engagement strategies have been incorporated into the proposal with targets and measures for how the strategies will lead to increased enrollment. Approaches that will integrate input and feedback from diverse consumers and lead to their improved

understanding of Medicare Advantage Plan availability, benefits, and disease prevention/health promotion opportunities.

6. **Expansion of Access –** The extent to which the proposal describes an approach that will result in preserved or expanded coverage and/or increased services for areas with limited Medicare Advantage plan choices.

7. **Sustainability Plan** - The extent to which the proposal has identified criteria to determine the effectiveness of proposed activities, long term costs, and alternative funding strategies in order to be successful beyond the two-year grant period.

8. **Governance & Operational Planning -** Level of detail and feasibility of implementation plans including governance model to enable partners to work together effectively. The reasonableness and adequacy of the proposed budget. A clear description of how awarded funds will be disbursed to organizations included in the proposal consistent with existing law.

Resources Available to All Hospitals

In an effort to support hospitals during the process of establishing their partnerships with Medicare Advantage Plans, HSCRC will post RFP information including answers to frequently asked questions on the HSCRC website at: https://hscrc.maryland.gov/Pages/MedicareAdvantagePartnershipGrantProgram.aspx.

Questions about the Medicare Advantage Partnership Grant Program may be **submitted via email to hscrc.rfp-implement@maryland.gov.**

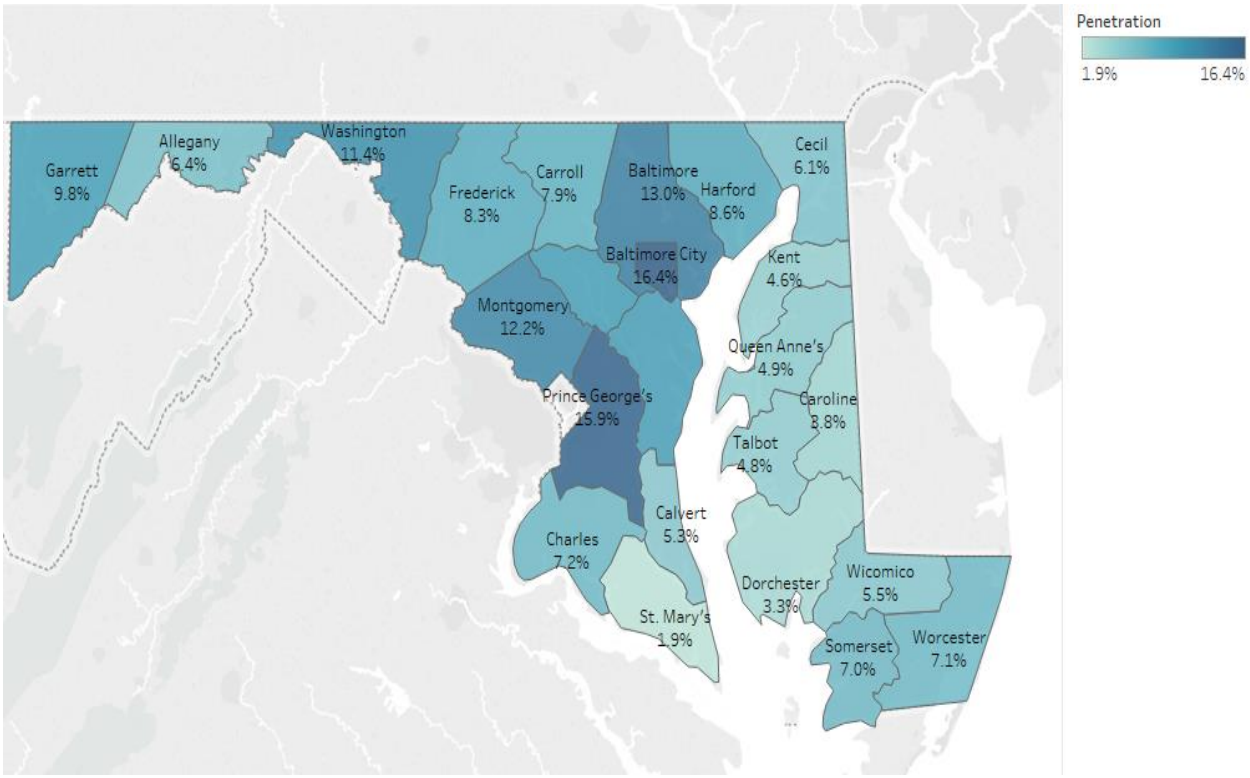
Appendix A – CMS Star Ratings for 2020

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[2]	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[3]	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
D13	MTM Program Completion Rate for CMR	Process	1	2018
D14	Statin Use in Persons with Diabetes	Intermediate Outcome	1[4]	2018

[2] 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.
[3] Measures that are applicable for both Part C and Part D plans are only counted once for MA-PD plans.
[4] New measures are given a weight of 1 regardless of category.

Appendix B – Maryland's Current Medicare Advantage Penetration



Source: CMS Medicare Advantage/Part D Contract and Enrollment Data. Accessed October 10, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

Appendix C – 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.

Appendix D – Proposal Summary Template

As such, the applicants should provide short summaries with the most relevant points. Reviewers will rely on the more detailed Project Narrative for a more complete understanding of the proposal.

Hospital Applicant:	
Medicare Advantage Plan:	
Health System Affiliations:	
Total Budget Request:	

Plan Coverage Area
Impact Area

Proposed Activities
Measurement and Outcomes
Scalability and Sustainability

Partnership and Decision-making Process
Implementation Plan
Budget & Expenditures

Appendix E - Budget Template

Hospital Applicant:	
Medicare Advantage Plan:	
Total Budget Request:	

Workforce/Type of Staff	**Description**	**Amount**
IT/Technologies	**Description**	**Amount**
Other Indirect Costs	**Description**	**Amount**
Total Expenses & Investments		

Appendix F – Beneficiary Counts by County Template

Hospital Applicant:	
Medicare Advantage Plan:	

County Service Area	**Average Monthly Enrollment** (January 2020 – March 2020)	**Average HCC Score** (January 2020 – March 2020)
1.		
2.		
3. More as needed		

Appendix G – Examples of Expense Not Covered

Examples of expenses that will not be covered under the Medicare Advantage Partnership Grant Program include:

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for Medicare Advantage beneficiaries.
- Investments to improve coding or documentation, including upgrades to systems to be compliant with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- CRISP participation fees other than specific projects not otherwise available to all CRISP users.
- Any expenses for physicians that do not clearly relate to Medicare Advantage Partnership goals (i.e., expenses for acquiring existing physicians that do not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes unless these are specifically related to Medicare Advantage Partnership goals.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives). Programs however may use ROI for provider gain sharing and pay-for-performance incentives that are consistent with legal requirements.
- All other expenses that do not fall under the intent of the grant program.