maryland
health services
cost review commission

EQIP Primary Care (EQIP PC) Subgroup Meeting

April 17, 2024

Background on EQIP PC

Background

- CMS approved a one-time reversal of the MPA Savings Component implemented January 1, 2023, for Calendar Year 2023.
- The State set aside the majority of this amount to fund targeted investments to improve the reach and effectiveness of primary care in Maryland.
  - $19 million for an EQIP Primary Care Program
  - Expands EQIP to address primary care availability in underserved areas of the state.
  - Funding available to organizations to subsidize expansion of primary care access.
  - State expects that over the long term the program will reduce the total cost of care for patients who currently lack access to adequate primary care.
  - Start date January 1, 2025

Background cont'd

- Seeks to supplement MDPCP in two ways:
  - It will focus on *expansion* of primary care access whereas MDPCP focuses on *strengthening and transforming* existing practices.
  - EQIP-PC funding will be focused in currently underserved areas
    - MDPCP is encouraging more safety net providers to enter but does not currently set program requirements on participation in underserved areas of the state.
- State plans to implement in certain geographics areas that are underserved.
  - Specific metrics will be used to determine what "underserved" is
  - Would be a mix of urban and rural

Background cont'd

- A small number of organizations will be chosen to receive funding
  - Infrastructure, per bene, and shared savings payments for up to 5 years.
- State will set criteria and share scoring in advance of application, including:
  - Background and qualifications for delivering high quality primary care
  - Knowledge and experience in the geographic focus area
  - Resources the organization can commit providing
  - Proposed model of care
- HSCRC strongly encourages multi-payer alignment with this program to allow practices to serve more patients under an aligned approach, in turn affording them the ability to transform care across their entire patient panel.

Program Updates

Focus Area Selection

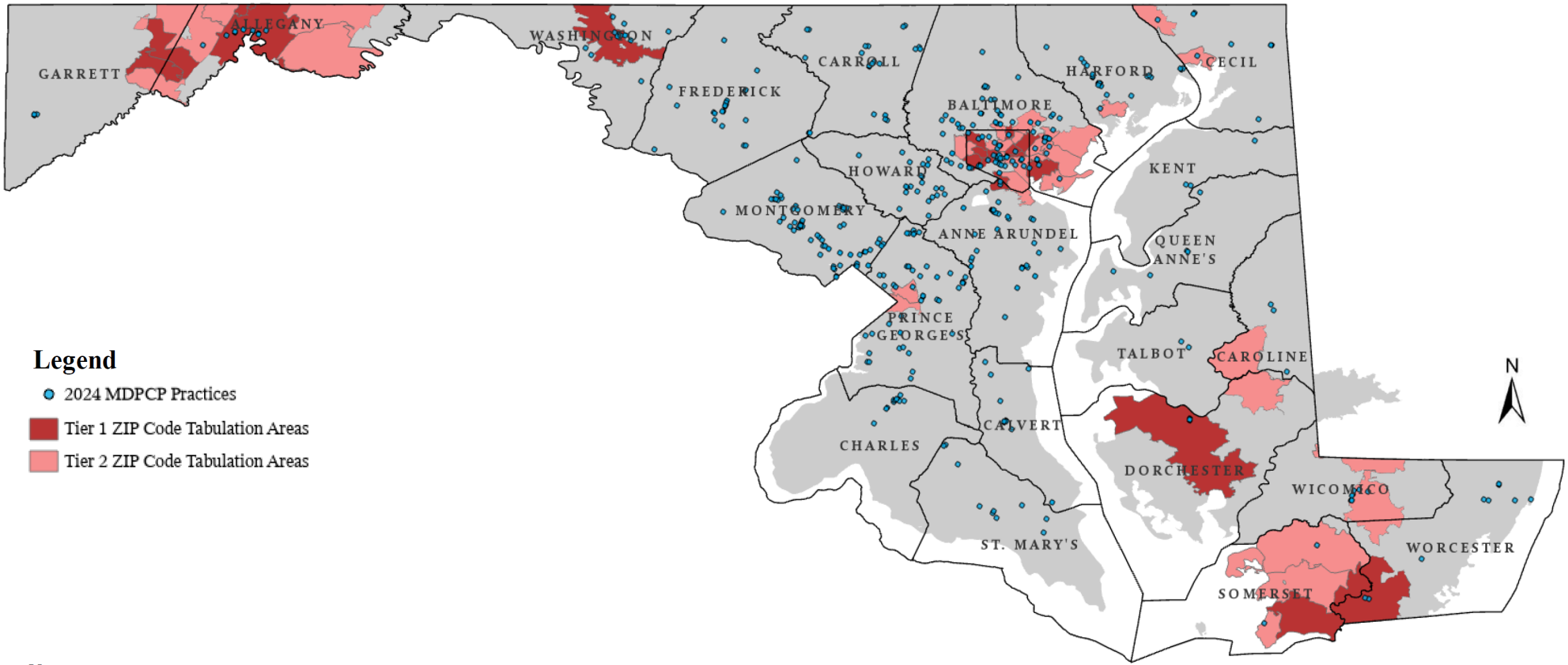
- Identifying zip codes where primary care capacity should be increased could be conceptualized as areas with high potential need for primary care and low supply of primary care.
- HPSA is a measure of primary care supply.
  - Comprised of provider-to-population ratio, travel time to nearest source of care, and proportion of the population in poverty.
- PQI and ADI are measures of primary care need; however, each captures different aspects of need.
  - PQI captures information about ambulatory care sensitive conditions.
  - ADI captures information about social determinants of health.
- Using a combination of HPSA (supply) and ADI/PQI (need) may be the fairest way to identify target areas.
  - Top priority areas could be those with low primary care supply (HPSA) and high primary care need (combination of high ADI and PQI values).
  - Moderate priority areas would be those with low supply (HPSA) and moderate need (moderate ADI and/or PQI).

Tier 1 and Tier 2 ZCTA - PQI and ADI Data Compared to All Maryland

	Maryland	Tier 1	Tier 2
Population	**6,177,216**	**527,004**	**695,423**
ADI National Rank	**32.8**	**69.6**	**51.2**
ADI Decile	**4**	**7**	**6**
PQI per K	**9.2**	**21.4**	**14.9**

- 20 ZCTAs in Tier 1
- 34 ZCTAs in Tier 2
- Tier 1 and Tier 2 represent close to 20% of the population of Maryland

Maryland Episode Quality Improvement Program-Primary Care (EQIP-PC)
Geographic Focus Areas



Notes:

1. ZIP Code Tabulation Areas (ZCTAs) are geographic areas defined by the U.S. Census Bureau that correspond to United States Postal Service ZIP Codes.
2. Tier 1 and Tier 2 designations are a function of the Area Deprivation Index (ADI), Prevention Quality Indicators (PQI), and whether the ZCTA contains any Primary Care Health Professional Shortage Areas (PC-HPSAs). Tier 1 indicates a higher need than Tier 2.

Scoring Criteria with points

- Organization's background and qualifications for delivering high quality primary care – **25 points**
- Model of care – **25 points**
- Organization's knowledge, presence, and experience in the geographic focus area – **20 points**
- Workplan, staffing model, and recruitment strategy – **15 points**
- Care coordination and practice support activities – **15 points**
- Woman/minority status – **Bonus 5 points for yes**
- Tier 1 area – **Bonus 5 points**

Funding Streams

- Infrastructure Payment (IP)
  - Available the first 2 years with potential for expansion to years 3 to 5 depending on the applicant
  - Annual payments made to practices in last quarter prior to each program year
- Beneficiary Payment (BP)
  - Available years 3 through 5
  - Payment amounts set by HSCRC
  - Per Medicare beneficiary amounts calculated on a per month basis but paid in the first month of each quarter
    - Based on the latest available beneficiary counts with true-up to final beneficiary counts in future quarters
  - Per beneficiary amounts set separately for dual and non-dual beneficiaries
  - Add-on payment will be available for beneficiaries who meet certain criteria
    - Potentially LPC and high risk
- Shared savings (SS)
  - Available years 4 and 5
  - Payment amounts set by HSCRC
  - Upside only

Attribution

- Proposed methodology
  - Attribute beneficiaries to a primary care provider when that beneficiary has their first claim for an Annual Wellness visit or Welcome to Medicare visit during the performance year.
  - Similar to MDPCP and Making Care Primary attribution methodologies.
  - Would participating practices be interested in an estimate of beneficiaries for their practice?

Model of Care

- Proposed framework
  - **Care Management**
    - Build care management and chronic condition self-management support services
    - Emphasis on managing chronic diseases prevalent in the community with the goal of reducing unnecessary emergency department (ED) use and total cost of care
    - Leverage existing programs or innovative approaches to care management, in the state. (Ex. CHWs and Johns Hopkins nursing program)
  - **Integrated care**
    - Strengthen connections with specialty care clinicians (CMS' Specialty Integration Strategy)
    - Utilize evidence-based behavioral health screening and evaluation to improve patient care and coordination.
    - Demonstrate ability to address behavioral health needs of the community – co location of BH providers, in house providers, direct scheduling, etc.
  - **Community Linkages**
    - Identify and address health-related social needs (HRSNs) and connect patients to community supports and services.
    - Build sustainable community partnerships to support the underserved population (transportation, housing, food banks, churches, schools, emergency medical, etc) as well as partner with FQHCs and other safety net providers

Participation Requirements

- Participating practices are required to identify a Lead Care Partner who will sign an agreement with the CRP entity and comply with all applicable requirements.
  - Lead Care Partner won't have to participate in EQIP PC.
  - Lead Care Partner will need to meet CMS quarterly vetting and certification requirements.
- New sites and providers will be required to participate in Medicaid and register their sites.
- As with other similar CMS programs, the use of CMS secured CEHRT is required.
- Discussion around TIN requirement is ongoing.
- Practices must be in one of the Tier 1 or Tier 2 focus areas to participate.

Reporting

- Annual progress report
  - Attest to and report on certain requirements such as:
    - Minimum number of patients
    - Is the practice open?
    - Has your practice hired at least one physician and staff?
    - Has your practice put care coordination and practice support functions in place?
    - Does the practice plan to stay open?
  - Future funding may be withheld depending on practice's responses in the progress report.
- Quality reporting
  - No reporting required in first year.
  - Will work with practices to develop quality framework similar to MDPCP.
  - MDPCP- like reporting suite will be made available through CRISP.

MDPCP Interaction

- MDPCP practices will not be eligible to receive the per bene payments.
  - Eligible for Infrastructure Payment and Shared Savings
- Transition to MDPCP required at the end of the pilot, as appropriate.
  - Practices can transition sooner, as appropriate.
- Existing MDPCP practices will be expected to continue in MDPCP.

Next Steps

Next Steps

- Next subgroup meeting – May 15 from 11-12pm
- Application now open through end of June
- Next meeting on June 5th will be an opportunity for Q&A with interested organizations
- Review of applications in July
- Applicants notified end of July
- Enrollment in the EQIP portal through end of August

Questions

Please submit any questions to our TCOC mailbox:

hscrc.tcoc@maryland.gov

More info at:

https://www.crisphealth.org/learning-system/eqip-pc/

Appendix

Tier 1 and Tier 2 ZCTA List with PQI and ADI Data Compared to All Maryland

Tier 1						
ZCTA	ZCTA Name	Primary County Name	Population	ADI National Rank	ADI National Decile	PQI per K
Tier 1 Subtotal			527,004	69.6	7	21.4
21502	Cumberland, MI	Allegany	41,153	75.1	8	16.6
21524	Corriganville, M	Allegany	500	75.0	8	15.2
21529	Ellerslie, MD	Allegany	651	75.0	8	15.2
21539	Lonaconing, MD	Allegany	2,536	89.8	9	16.2
21521	Barton, MD	Allegany	1,171	89.9	9	18.0
21225	Baltimore, MD	Baltimore city	34,138	70.9	8	21.1
21229	Baltimore, MD	Baltimore city	43,464	70.0	8	19.1
21215	Baltimore, MD	Baltimore city	54,198	70.7	8	23.3
21222	Dundalk, MD	Baltimore	59,062	64.7	7	19.3
21206	Baltimore, MD	Baltimore city	49,470	63.5	7	19.6
21239	Baltimore, MD	Baltimore city	26,605	61.0	7	21.0
21613	Cambridge, MD	Dorchester	17,967	61.2	7	14.6
21838	Marion Station,	Somerset	1,717	71.1	8	14.8
21851	Pocomoke City,	Worcester	7,229	71.0	8	16.5
21740	Hagerstown, MI	Washington	65,619	60.5	7	14.8
21205	Baltimore, MD	Baltimore city	14,691	87.0	9	29.9
21213	Baltimore, MD	Baltimore city	28,217	81.7	9	32.0
21217	Baltimore, MD	Baltimore city	30,448	65.8	7	28.8
21216	Baltimore, MD	Baltimore city	27,729	82.2	9	28.7
21223	Baltimore, MD	Baltimore city	20,438	83.2	9	30.0

Tier 2						
ZCTA	ZCTA Name	Primary County Name	Population	ADI National Rank	ADI National Decile	PQI per K
Tier 2 Subtotal			695,423	51.2	6	14.9
21530	Flintstone, MD	Allegany	1,520	60.4	7	13.3
21555	Oldtown, MD	Allegany	1,619	62.8	7	12.4
21545	Mount Savage, M	Allegany	1,719	83.8	9	11.7
21532	Frostburg, MD	Allegany	13,328	76.0	8	10.2
21562	Westernport, M	Allegany	2,857	83.7	9	12.5
21226	Riviera Beach, M	Anne Arundel	7,368	53.1	6	14.1
21207	Lochearn, MD	Baltimore	46,595	53.0	6	16.9
21237	Rosedale, MD	Baltimore	31,477	42.3	5	18.1
21234	Parkville, MD	Baltimore	67,309	46.0	5	13.6
21224	Baltimore, MD	Baltimore city	54,266	51.4	6	13.3
21221	Essex, MD	Baltimore	43,381	55.2	6	20.1
21220	Middle River, MI	Baltimore	44,568	49.2	5	16.9
21219	Edgemere, MD	Baltimore	9,594	34.2	4	22.0
21212	Baltimore, MD	Baltimore city	32,317	39.7	4	13.7
21655	Preston, MD	Caroline	4,798	66.2	7	6.5
21903	Perryville, MD	Cecil	5,835	43.1	5	12.8
21918	Conowingo, MD	Cecil	4,269	40.6	5	13.7
21643	Hurlock, MD	Dorchester	5,820	65.2	7	5.1
21040	Edgewood, MD	Harford	25,138	54.6	6	12.9
20743	Coral Hills, MD	Prince Georges	40,709	44.4	5	13.9
20785	Landover, MD	Prince Georges	41,636	39.6	4	12.1
21853	Princess Anne,	Somerset	10,179	73.7	8	11.9
21821	Deal Island, MD	Somerset	847	70.1	8	8.9
21817	Crisfield, MD	Somerset	4,825	80.2	9	12.8
21871	Westover, MD	Somerset	1,918	69.0	7	9.0
21890	Easton Correcti	Somerset	3,258	68.4	7	7.3
21804	Salisbury, MD	Wicomico	40,049	62.3	7	10.1
21875	Delmar, MD	Wicomico	7,231	61.0	7	9.7
21231	Baltimore, MD	Baltimore city	17,062	38.1	4	14.1
21202	Baltimore, MD	Baltimore city	22,247	57.1	6	16.1
21201	Baltimore, MD	Baltimore city	18,382	45.7	5	17.5
21218	Baltimore, MD	Baltimore city	46,238	58.9	6	19.5
21211	Baltimore, MD	Baltimore city	17,721	45.9	5	13.1
21214	Baltimore, MD	Baltimore city	19,344	52.8	6	19.7

All Maryland					
	Population	ADI National Rank	ADI National Decile	PQI per K
All Maryland	6,177,216	32.8	4	9.2

Primary Care Definition – HCPCS codes

Primary Care Service Claims	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99201*-99205 99211-99215
Home Care	99324-99328 99334-99337 99339-99345 99347-99350
Welcome to Medicare (WTM)	G0402
Annual Wellness Visit (AWV)	G0438, G0439
Advance care planning	99497, 99498
Collaborative care model	G0502-G0504
Cognition and functional assessment for patient with cognitive impairment	G0505
Transitional care management services	99495-99496
CCM services	99490, 99491, G0511
Complex CCM services	99487, 99489
Assessment/care planning for patients requiring CCM services	G0506
Non-complex CCM clinical staff time	G2058, 99439**
CCM services for a single high-risk disease (Principal Care Management or PCM)	G2064, G2065
CCM Services for PCM	99424 - 99427
Care management services for behavioral health conditions (CCM)	G0507
Cervical/vaginal cancer screening; pelvic and clinical breast exam	G0101
Relating to Influenza virus vaccine	90630, 90653 - 90658, 90660 - 90662, 90672 - 90674 90682, 90685 – 90689, 90694, 90756, G0008, G8482 Q2034 – Q2039
Detection tests relating to Influenza	87804, 87275, 87276
Relating to Pneumococcal Vaccine	G0009, 90670 - 90671, 90677, 90732
Relating to Hepatitis-B virus vaccine	90739, 90740, 90743, 90744, 90746, 90747, 90759, G0010
Relating to COVID-19 virus vaccine	90480, 91300 -91309, 91311 - 91322, 0001A -0004A, 0011A -0013A, 0031A, 0034A, 0041A, 0042A , 0044A, 0051A -0054A, 0064A, 0071A - 0074A, 0081A - 0083A, 0091A - 094A, 0111A - 0113A, 0121A, 0124A, 0134A, 0141A, 0142A, 0144A, 0151A, 0154A, 0164A, 0171A - 0174A, M0201
Established patient periodic preventive medicine examination, age 65 years and	99397
Preventive medicine services	99385-99387, 99401-99402, 99420
Established patient periodic preventive medicine examination age 18-39 years	99395
Established patient periodic preventive medicine examination age 40-64 years	99396
Adult preventive medicine	90750
Hemoglobin; glycosylated	83036
Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use	83037
Glucose, blood, by glucose monitoring device(s) cleared by	82962
Prolonged non-face-to-face evaluation and management (E&M) services	99358-99359
Prolonged Service with Direct Patient Contact	99354-99355
Federally qualified health center (FQHC) visit, new patient	G0466
Federally qualified health center (FQHC) visit, established patient	G0467
Federally qualified health center (FQHC) visit, initial preventive physical examination (IPPE) or annual wellness visit (AWV)	G0468
Distant site telehealth services Rural Health Clinics or Federally Qualified Health Centers (RHC/FQHC)	G2025

continued

Telephone Evaluation and Management Service Provided by A Physician	99441-99443
Digital E&M: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days	99421-99423
FQHC Virtual Communication Services	G0071
Virtual Check-in	G2012
Remote evaluation of video or images	G2010
Complex E&M visit add on	G2211
Prolonged E&M visit for visits that required an additional 15 minutes, including face-to-face or non-face-to-face	G2212
Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate)	99453-99454
Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data	99457-99458
Management of behavioral health conditions(s), timed, per month	99484, 99492-99494, G2214, G0323
Interprofessional Consultation	99446-99449, 99451-99452
Assessment of and care planning for a patient with cognitive impairment	99483
Chronic Pain Management	G3002, G3003