maryland
health services
cost review commission

EQIP Primary Care (EQIP PC) Subgroup Meeting

February 2024

Agenda

1. Background
2. RFI responses/themes
3. Next steps
4. Questions

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
  - TBD which relevant metrics 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:
  - Upfront infrastructure subsidy (~years 1-2)
  - A per Medicare FFS beneficiary (previously underserved) subsidy (~years 2-3)
  - Upside shared savings vs. pre-program costs of attributed panel (~years 3-5)

- State will set criteria and share scoring in advance of application
  - 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

RFI Responses

Focus Area Selection

- HPSA
- ADI
- Poor overall health outcomes
- Primary care utilization (low rates)
- Absence of safety net institutions
- Significant adverse social factors that undermine health
- Contribution to inequities in health
- Existence of/absence of safety net institutions (do not limit to FQHCs)
- Avoidable/inappropriate use of hospital/ED
- Areas with significant population density
- Counties without hospitals or low bed availability (ex. somerset county has low bed availability and poorest ratio of primary care)

Funding

- Upfront infrastructure subsidy (UIS) – 1-2 years (or up to 3 yrs)
  - Various amounts suggested to support practice establishment, provider recruitment, program ramp up costs
  - Increase number of years subsidy is provided
  - Maintain if patient volumes aren't achieved
- Per Medicare FFS bene (previously underserved) subsidy – 2-3 years (2-4 yrs)
  - Prospective, capitated payments suggested
  - Hybrid PMPM plus incentive neutral fee for certain primary care services
- Upside shared savings (vs. pre-program costs of attributed panel) – 3-5 years (4-5 yrs)
  - Use to fund APC activities but respondents noted this may not be sufficient funding

Model of Care

- Respondents indicated that the state should not provide a specific model of care but should provide a framework, such as:
  - **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.
    - CHWs and Johns Hopkins nursing program (leveraging existing programs or innovative approaches to care management, in the state)
  - **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 FQHCs and other safety net providers

Quality Metrics

- Majority of respondents agreed with alignment with MDPCP metrics along with others:
  - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
  - Preventive Care and Screening: Screening for Depression and Follow-Up Plan
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Controlling High Blood Pressure
  - Kidney Health Evaluation
  - Screening for fall risk
  - Influenza vaccination
  - Tobacco screening and cessation interevention
  - Statin therapy for prevention and treatment of cardiovascular disease
  - Depression remission at 12 months
  - SDOH screening
  - Advance care planning
  - Decreased ED visits and hospital visits
- In addition, several respondents indicated that funding attached to quality should be low and increase as practice grows

Scoring Criteria

- Criteria are listed in rough order of priority based on RFI responses
  - Organization's background and qualifications for delivering high quality primary care (including experience with other primary care initiatives) including experience with MDPCP, EQIP
  - Organization's knowledge, presence, and experience in the geographic focus area
  - Independent vs. hospital owned practice
  - Woman/minority status
  - Resources organization can commit to start up
  - Proposed model of care

Other themes

- Attribution
  - Suggest being lenient about attribution given time it takes to build a panel of patients
- Recruitment time period/challenges
  - Indicated that it takes between 9-18 months to recruit physicians
  - Need to think of innovative ways to recruit and retain
- Transition to VBP after program ends
  - Mixed responses about requiring transition to another APC model – for sustainability will be important to plan for how the practice will continue to provide these services beyond the 5 year period

Other themes

- Medicaid and duals
  - Working/contracting with Medicaid MCOs critical
  - These populations are higher need so building that capacity in the practice is critical – model of care should address the needs
- Definition of primary care
  - How we think about primary care and what it is conceptually – many different suggestions offered including NASEM and WHO definition
  - How we define for methodology purposes – respondents agree that it should be similar to other VBP programs in the state including MDPCP and CTIs.
- Shared savings methodology
  - Consider methodological approaches similar to ACO Reach and other ACO programs
  - Early access to data to be used in the shared savings phase
  - Is shared savings the best approach?
- Telehealth
  - Should be a service offering – part of basic functionality
  - Important to understand the limitations of telehealth

Next Steps

Next Steps

- Next subgroup meeting ending of March – date and time TBD
- Submit program document to CMS beginning of April 2024
- Application will open mid-May through end of June followed by 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