maryland
health services
cost review commission

EQIP Primary Care (EQIP PC) Subgroup Meeting

June 26, 2024

EQIP PC Request for Applications (RFA) Overview

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.

Funding Announcement

- The State is seeking applications from interested organizations for the new EQIP Primary Care Pilot Program
  - Funding program is intended to provide organizations with start-up infrastructure funding in return for adding advanced primary care capacity in designated areas under a multi-year commitment.
  - Focus of the Program is to increase access to advanced primary care in areas of Maryland that are currently underserved for primary care
- Total Funding of up to $19 million
- Funding Period: CY 2025 – CY 2029
- Proposed January 1, 2025 Program Measurement Start Date

Administrative Structure and Program Support

- EQIP PC will be organized under the banner of the existing EQIP program to leverage the structure and resources already established.
  - EQIP-PC is organized under EQIP for administrative purposes. It is not a bundled payment program and will have unique characteristics that are distinct from the existing EQIP program.
- The State will provide program support through existing tools established by CRISP, the MDPCP PMO, and the HSCRC EQIP.

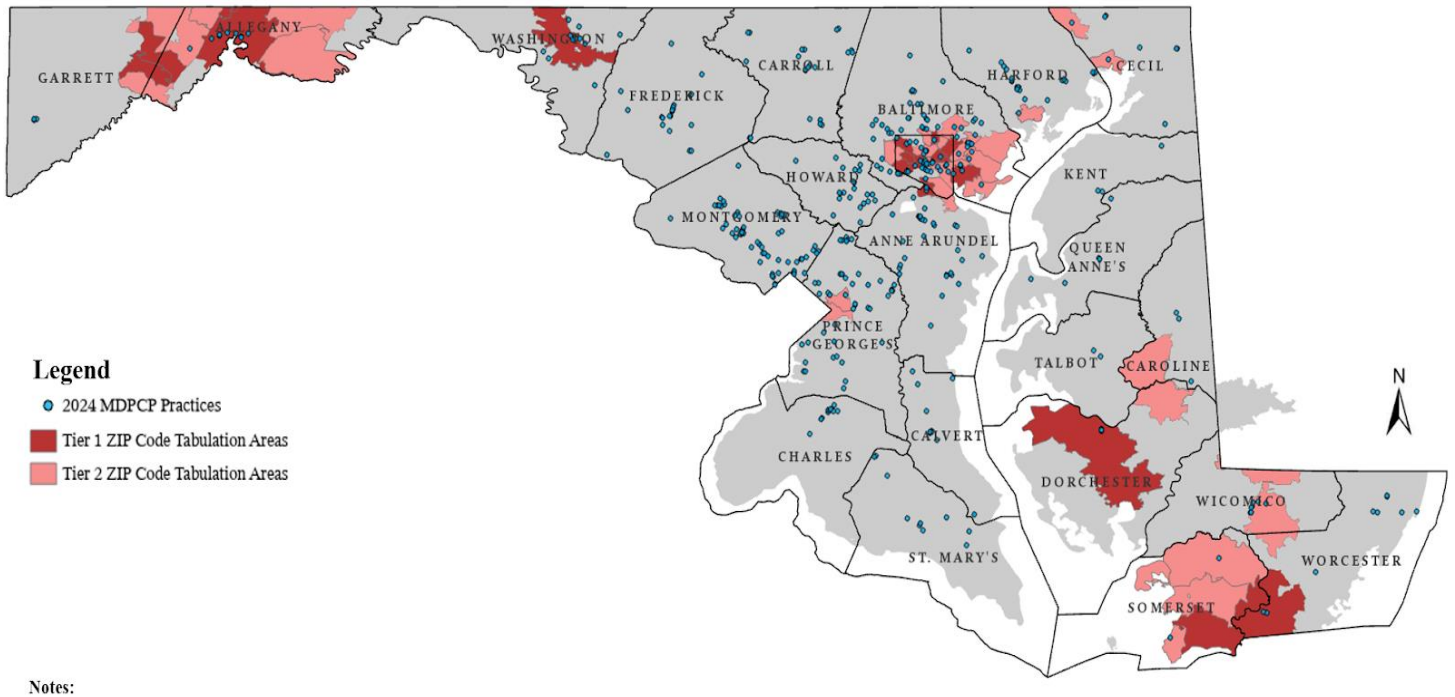
Eligibility

- The State seeks organizations for a multi-year commitment under which the organization will receive start-up infrastructure funding in return for adding advanced primary care capacity in the designated areas.
- Eligible organizations include existing practices who commit to adding new providers in the designated areas, completely new practices, and organizations (such as a large employer or local government) who would sponsor an advanced primary care practice.
  - These organizations may include MDPCP and non-MDPCP practices.
    - EQIP PC seeks to supplement MDPCP in two ways:
      - (1) this new program will be focused on the expansion and creation of new access to advanced primary care (whereas MDPCP focuses on strengthening existing primary care access)
      - (2) the additional resources will be focused in currently underserved areas.
    - The state envisions EQIP PC as “on ramp” or pathway to MDPCP participation in order to build capacity for providing comprehensive, advanced primary care.

Focus Area Selection

- The State has designated geographic areas in the State, that are a mix of rural and urban areas, and will select the best applications that address the needs of these focus area populations.
- By identifying zip codes where there is a low supply of primary care and poorer health and social outcomes, the State determined the geographic areas of the state where the program will be focused. (see Figure on next slide):
- Specific focus areas were determined based on:
  1. Health Professional Shortage Area (HPSA)
  2. Prevention Quality Indicators (PQI)
  3. Area Deprivation Index (ADI)

Focus Area Selection continued



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.

Utilizing the combination of HPSA (supply) and ADI/PQI (need), Tier 1 areas (displayed as red on the map) are those with low primary care supply (HPSA) and very high primary care need (combination of high ADI and PQI values). Tier 2 areas (displayed as pink on the map) would be those with low supply (HPSA) and high need (moderate ADI and/or PQI).

Model of Care

- This program will provide a pathway for access to new, high quality care delivery. In the application, practices will describe their model of care and how it aligns with the advanced primary care framework outlined below:
  - Care Management
    - Build care management and chronic condition self-management support services.
    - Emphasize 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. Community Health Workers 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 Behavioral Health 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.

Financial Goals & Funding

- All EQIP-PC proposed start-up funding is supplemental to normal revenues. Providers are expected to bill all payers, including Medicare FFS, as appropriate, under standard reimbursement practices.
- The specific nature and amount of funding available to each organization will be determined based on what applicants submit in the funding proposal worksheet.
- There will be no restriction on practices' ability to participate with other payers or serve non-Medicare FFS beneficiaries.
- Practices may use the funds from this program on activities related to infrastructure development and for the care of all patients in the practice.

Funding Streams

- The funding streams are outlined below:
  - 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 the last quarter prior to each program year
  - Beneficiary payment (BP)
    - Available years 3 through 5
    - Incentive structure to align with Medicaid Advanced Primary Care Program and MDPCP
    - The specific amounts have not been finalized. Practices are asked to include their assumptions about per beneficiary amounts in establishing their request for the Infrastructure Payment.
    - Practices can look to payment levels under MDPCP currently as guidance
  - Shared savings (SS)
    - Available years 4 and 5
    - Upside only
    - Further details available later to align with Medicaid Primary Care Program and MDPCP design

Attribution

- Beneficiaries will be attributed 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.
- There are no restrictions based on prior eligibility.
- There is no minimum attribution requirement at this time.

Participation Requirements

- New sites and providers will be required to participate in Medicaid and/or contract with at least two Managed Care Organizations (MCOs)
- Practices must be in one of the Tier 1 or Tier 2 focus areas to participate 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 will not have to participate in EQIP PC
  - The Lead Care Partner will need to meet CMS vetting and certification requirements as outlined in this document.

MDPCP Interaction

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

Program Compliance

- To ensure ongoing compliance the State will develop program monitoring controls, including, but not limited to, items such as the following:
  - Meet all CMS vetting and certification requirements (see next section).
  - Monitoring of net increase in primary care capacity in the geographic focus areas.
  - Audits to ensure program integrity (ex. Review of Annual Wellness Visits for upcoding).
  - Quality monitoring utilizing a framework similar to MDPCP starting in Year 2.
  - Demonstration of fidelity to the model of care (see Model of Care section) as well as certain operating requirements Items will be assessed using an annual progress report
  - Failure to comply with program controls, after allowing for a reasonable corrective action period, will result in either a reduction of funding or practices being eliminated from the program.
- The State will work with EQIP PC practices to develop a quality framework similar to MDPCP.

CMS Vetting & Certification of Care Partners

- Each Care Partner that is operating within an EQIP PC practice must meet, at a minimum, the following requirements:
  - A clinician must have a National Provider Identifier (NPI);
  - The provider must participate in the Medicare program;
  - The provider must be licensed;
  - The provider must use at least 2015 CEHRT and CRISP, Maryland's health information exchange; and
  - The provider will be subject to a federal program integrity screening process; while participants can opt to engage Care Partners at the physician group practice level, all members of the group must be screened individually.
- Vetting and certification must occur on a quarterly basis

QPP Eligibility Participation Requirements

- Through the federal vetting and certification process required for CRP, Care Partners may be eligible to become Qualifying APM Participants (QPs).
- They can opt out of the Merit-based Incentive Payment System (MIPS). Care Partners who are in one QP snapshot are eligible for the year and certified as QPs.
- The HSCRC will update methodologies to ensure alignment with the QP thresholds policy in the Advanced APM track of QPP

Application & Evaluation

- Interested organizations will apply for participation in EQIP PC.
- The application will include:
  - Narrative template
  - Funding proposal worksheet
  - Work plan (short- and long-term milestones) including timeline and staffing model
- An Evaluation Committee formed by the HSCRC will review and score the Program applications.
- The State will make awards based on applications received and will determine how funds are disbursed.

Evaluation Criteria

- Applications will be reviewed, and funding awarded based on the following criteria
  - Background and qualifications for deliver high quality primary care
  - Knowledge, presence, and experience in the geographic focus area
  - Woman/Minority Status
  - Model of care
  - Staffing Model and Recruitment Strategy
  - Location Desirability
  - Care Coordination and Practice Support Function

EQIP PC Program Timeline

- The HSCRC is planning on the following timeline:

June 28, 2024	HSCRC releases EQIP PC Program Application
June 28 – July 15, 2024	Opportunity for potential participants to ask questions regarding the application
August 11, 2024	Deadline for EQIP PC Program Application
August 12 – September 15, 2024	Review Panel evaluates applications
September 20, 2024	Successful applicants are notified
September 21 – October 31, 2024	Selected organization(s) complete program enrollment (it will not be required to identify participating providers to enroll the organization)
November 1, 2024 – June 30, 2025	Participating providers are identified and vetted by CMS and initial subsidy payments are made based on agreed upon schedule (it is anticipated organizations would have until half-way through the first year of the program to meet provider recruitment goals to earn payments for that year.)
January 1, 2025	EQIP-PC Program measurement start date
January 1, 2026	Practices begin transition from infrastructure subsidy to per beneficiary reimbursement. At least 1 year of activity would be required to establish attribution. Therefore, the HSCRC anticipates transitioning the payments during Year 2.

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, MI	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