maryland
health services
cost review commission

EQIP Primary Care (EQIP PC) Subgroup Meeting

March 27, 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.

Policy Updates

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**
- Critical priority areas – **Bonus 5 points for area 1**

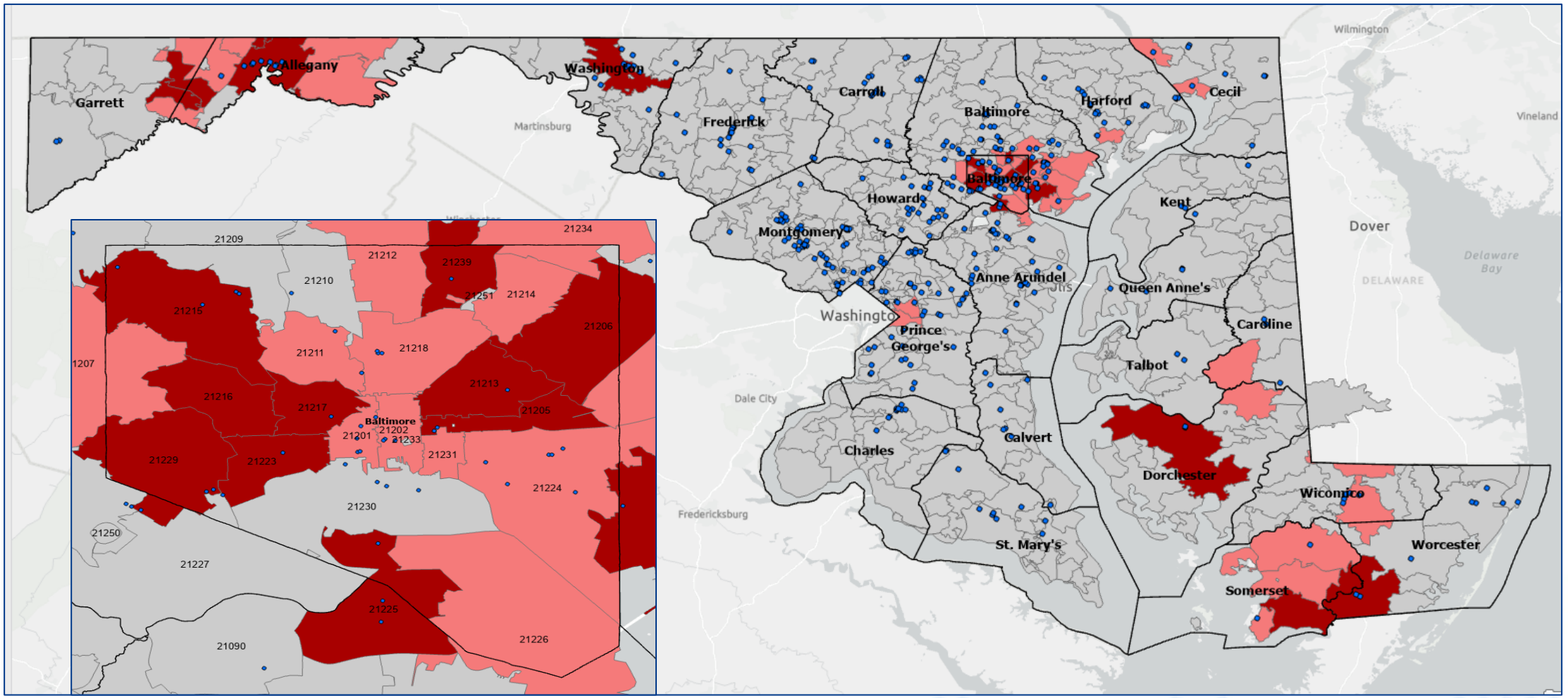
Funding Streams

- Infrastructure Payment (IP)
  - Available the first 2 years
  - 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 the criteria for “lacking primary care”
- Shared savings (SS)
  - Available years 4 and 5
  - Payment amounts set by HSCRC
  - Upside only

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).

Potential Focus Areas



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

Attribution strategy

- Tentative 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.
  - Lacking primary care = Zero or one primary care visit in the year preceding attribution to a primary care provider.
    - No restrictions based on prior eligibility
  - Organizations much establish a new TIN for NPIs operating at that practice.

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 reporting suite will be made available through CRISP.

Next Steps

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- Next subgroup meeting – April 17 from 11-12pm
- 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

More info at:

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