maryland health services cost review commission

EQIP Advanced Primary Care Pilot

Request for Information

December 2023

Responses Requested by January 26, 2024

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A. Introduction

The Maryland Health Services Cost Review Commission ("HSCRC") is seeking information from interested parties to inform the creation of a pilot program focused on increasing access to advanced primary care in areas of Maryland that are currently underserved for primary care. Funding of up to $19 Million has been approved for this pilot program which will focus on a small number of geographic areas within the State of Maryland ("State")[1]. The State is proposing a January 1, 2025, start date (see section C3 for a full timeline). This document includes a high-level description of the proposed program and relevant current programs as well as a set of questions upon which the State is interested in receiving comment. This is not an official document or program announcement from the State of Maryland ("State") or the Center for Medicare and Medicaid Services ("CMS") and, as such, details included are subject to change and the program may not be implemented.

Comments should be submitted to christa.speicher@maryland.gov by ***January 26, 2024***. The HSCRC requests respondents organize their comments in line with the questions outlined within this Request for Information ("RFI").

B. Background

The goals of the Maryland model include improved health, better patient experience, lower costs, and greater equity. Under its agreement with CMS, the State is at risk for the total cost of care ("TCOC") for Maryland Medicare fee-for-service ("Medicare FFS") Beneficiaries under the Maryland Total Cost of Care Model State Agreement ("TCOC Model"). Further information on the TCOC Model can be found on the HSCRC's website (TCOC Model). Currently, the TCOC Model has three Maryland-specific programs that are components of the Model test. These include the Hospital Payment Program, under which hospitals are paid based on a global budget; the Care Redesign Program ("CRP") to align care transformation efforts across providers; and the Maryland Primary Care Program ("MDPCP").

B1. Background on the Episode Quality Improvement Program

Maryland providers and suppliers are excluded from federal Center for Medicare and Medicaid Innovation ("CMMI") episode payment models that include hospital costs in episode prices. As a result, the HSCRC has implemented the Episode Quality Improvement Program ("EQIP") as a vehicle within CRP, to allow

[1] This program is in accordance with the recommendation adopted by the HSCRC on November 8, 2023, found here in the section titled "Final Recommendation On Adjusting the MPA Savings Component for Calendar Year 2023")

providers to participate in care transformation and earn shared savings where they are able to reduce total cost of care.

EQIP is a voluntary program that engages non-hospital Medicare providers and suppliers in care transformation and value-based payment. Currently EQIP holds participants accountable for achieving cost and quality targets for one or more clinical episodes, each of which will incorporate a specified alternative payment arrangement. To date EQIP has covered a wide range of specialty providers. Specifics on the current EQIP program can be found on the website of the Chesapeake Regional Information System for our Patients, Inc. ("CRISP"), the State Designated Health Information Exchange (HIE) for Maryland and the program administrator of EQIP. Further information on EQIP can be found on CRISP's website (EQIP).

In establishing the EQIP program the HSCRC has focused on minimizing provider administrative burden and developing structures that incent provider participation. The HSCRC anticipates carrying these principles into this pilot primary care program.

B2. Background on the Maryland Primary Care Program

MDPCP is a voluntary program for qualifying physician and non-physician Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization. Enrollment in the MDPCP is currently closed. MDPCP is jointly managed by MDH's MDPCP Management Office ("PMO") and CMMI. Further information on MDPCP can be found on their website. (MDPCP).

C. EQIP Primary Care Pilot Program

As described in the introduction the State is evaluating expanding EQIP to address primary care availability in underserved areas of the state as a complement to MDPCP. Under this proposed EQIP Primary Care Program ("EQIP-PC") organizations would be able to access additional funding to subsidize efforts to increase access to advanced primary care in currently underserved areas.

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) and (2) the additional resources will be focused in currently underserved areas.

EQIP-PC is organized under EQIP for administrative purposes. It will not be a bundled payment program and will have unique characteristics that are distinct from the existing EQIP program.

The following sections describe the State's initial concept for this program. These sections are intended to provide a framework for respondents to this RFI. They do not reflect firm commitments and revisions will be considered based on input received.

C1. EQIP-PC Pilot Program Outline

Under the proposed program the State would seek a small number of organizations for a multi-year commitment under which the organization would receive start-up infrastructure funding in return for adding advanced primary care capacity in the designated areas. The State anticipates funding would help meet start-up challenges such as provider recruitment as well as provide financial security during program ramp-up. Both existing practices who commit to adding new providers and completely new practices would be considered as well as organizations who might then sponsor an advanced primary care practice (such as a large employer or local government).

C1a. Focus Area Selection

The State anticipates focusing the pilot program in a small number of areas in the State. Factors to be considered will include:

- Levels of ambulatory care sensitive emergency department visits and hospitalizations
- Poor overall health outcomes
- Contribution to inequities in health
- Significant adverse social factors that undermine health
- Existence of/absence of safety net institutions
- Primary care utilization
- HPSA designation (as defined by the Federal Health Professional Shortage Area designation (HPSA)

C1b. Financial Goals and Funding

Over the long term, participating practices will be expected to reduce the total cost of care and improve access and quality. The assumption is that the practices would be reaching patients who have poor access to primary care. Therefore, delivering additional, high value advanced primary care services should reduce future unplanned inpatient and ED visits as well as improve the management of chronic conditions.

All EQIP-PC proposed start-up funding would be supplemental to normal revenues. Providers should bill all payers, including Medicare FFS, as appropriate, under standard reimbursement practices. The specific nature and amount of funding available is to be determined. The start-up funding will gradually migrate participants along the following proposed continuum:

(1) an upfront infrastructure subsidy (years 1-2)

(2) a per Medicare FFS beneficiary (previously underserved) subsidy (years 2-3)[2]

(3) upside shared savings vs. pre-program costs of attributed panel (years 3-5).

The State anticipates continuing the EQIP approach, which does not include downside financial risk but rather substitutes that with risk of losing qualification for participation in the program. A key goal of this RFI is to gather information on appropriate funding levels to achieve the State's goal of expanding access to primary care.

As the proposed program is organized under the TCOC Model which focuses on Medicare FFS total cost of care, most program elements including aspects such as provider eligibility, payment amounts and quality measurement, will be based on Medicare FFS results. The subsidies under this program would only be based on Medicare FFS participation. However, there will be no restriction on practices ability to participate with other payers or serve non-Medicare FFS beneficiaries. The State is interested in hearing from interested parties on whether various payers, across the State, are interested in offering a similar or aligned payment program (specifically as it relates to the per beneficiary payment in C1.b.) and on what timeline.

C1c. Model of Care

This program will provide a pathway for access to new, high-quality care, at the outset, for care delivery that practices will need to meet to qualify (e.g. expanded hours, 24/7 case manager). However, the State does not want to create barriers to program entry by setting standards that are not achievable for de novo practices. The State is interested in gathering information in this RFI on what elements should be required of practices, over what timeline, and what transition to a primary care value-based program looks like for these practices at the end of the pilot program.

C1d. Program Support

The State would provide program support through existing tools established by CRISP, the PMO and the HSCRC for MDPCP and EQIP. The HSCRC and PMO would partner and work across all state agencies to ensure any regulatory barriers to program participation are addressed. Practices would also be potentially eligible for other funding such as practice transformation grants or participation in MDPCP. Although it is anticipated that, where applicable, compensation would be reconciled with MDPCP for both Medicare and Medicaid to avoid duplicate payments or funding gaps.

[2] As it is a critical outcome measure the State would establish attribution metrics to track whether new Medicare fee-for-service patients are being served over time.

C1e. Administrative Structure

EQIP-PC will be organized under the banner of the HSCRC's existing EQIP program and will be administered by the HSCRC to leverage the structure and resources already established.

C2. EQIP-PC Participation Requirements

EQIP-PC will have two stages for qualification. In Stage 1, the State will use an application process to evaluate interested organizations. Applications would be open to organizations capable of operating an effective advanced primary care practice. The application would require information such as:

- the organization's background and qualification for delivering high quality primary care (to include experience with other primary care initiatives and/or programs),
- their proposed care model of care,
- their knowledge of/presence in the geographic focus area,
- the nature of the organization (independent practice vs hospital-owned vs private equity),
- whether they qualify for woman/minority ownership status, and
- the resources that the organization will commit to start up and ongoing funding.

The applications would be scored, and participants selected based on the reported information. As part of the application process the HSCRC would disclose scoring criteria to be used in weighing the various application requirements.

In Stage 2, selected sponsoring organizations would propose the staffing and a plan for the use of the upfront infrastructure funding. Each provider participant would be required to meet CMS vetting as with the current EQIP program[3]. It is anticipated that Maryland qualified physician and non-physician primary care providers would be eligible for the program.

To ensure ongoing compliance the HSCRC will develop program compliance and ongoing monitoring controls, including, but not limited to, items such as the following:

- A net increase in primary care capacity in the focus areas.
- Quality monitoring utilizing a framework similar to MDPCP.
- Fidelity to the model of care, including key issues that relate to equity.

[3] Prior to participating in EQIP, providers must be vetted by CMS to determine they are eligible to participate in Medicare. This includes ensuring providers are active in the PECOS Medicare provider enrollment system, and that they have no program integrity issues.

The HSCRC and CRISP will work closely with participating organizations to minimize the administrative burden created by these controls. Failure to comply with program controls, after allowing for a reasonable correction period, will result in practices being eliminated from the program.

C3. EQIP-PC Tentative Program Timeline

The HSCRC is currently planning on the following timeline, this timeline is provided as a reference for respondents, all dates are tentative and are likely to change.

January 26, 2024	Deadline for RFI Responses
January 1 – March 31, 2024	State refines program design and shares with stakeholders
By April 30, 2024	State finalizes focus areas and program design and obtains CMMI approval
By May 15, 2024	HSCRC releases EQIP-PC program application to potential participants including designating focus areas
May 15 - June 1, 2024	Opportunity for potential participants to ask questions regarding the application
June 30, 2024	Deadline for program application
July 1, 2024 - July 31, 2024	State reviews and evaluates applications
By July 31, 2024	HSCRC notifies successful applicants
August 1, 2024 – August 31, 2024	Selected organization(s) complete program enrollment (it will not be required to identify participating providers to enroll the organization)
September 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	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.

D. Request for Information - Questions

The State is interested in obtaining feedback on the topics below, respondents should feel free to address some or all questions in their response. Respondents are asked to submit responses as an attachment rather than the body of the email. Responses should identify specific questions to which they are being

addressed. If potential respondents have questions about this RFI please reach out to christa.speicher@maryland.gov.

D1. Focus Areas

The questions in this section relate to how the State should choose focus areas of the State:

1. Please review the list of factors to be considered for program geographic area in Section C1a and provide suggested additions or deletions. Of these (and other factors), which are most important? Based on these factors, should the state designate one or two focus areas, or should the state designate up to 5 focus areas and choose one or two based on the quality of the applications received?
2. What other aspects related to program geographic focus should the State consider?

D2. Funding and Timeline

The questions in this section relate to expected funding levels and structure and the implementation timelines:

1. Section C1b outlines a five-year funding migration. Please comment on the feasibility of this approach and on alternatives that might be preferable.
2. What level of start-up costs would be required at each stage to build a sustainable advanced primary care practice?
3. What provisions would make sense for the shared savings phase of the program? For example, degree of sharing, method of calculation, exclusions, risk adjustment etc.?
4. The tentative timeline in section C3 provides nine months for an organization to recruit and onboard providers to meet their commitment under the program. Is this appropriate?
5. How should start-up payments be structured between upfront investments versus payments based on the volume of advanced primary care visits?
6. Given the State is trying to balance promoting access in focus areas with ensuring high quality care:
    a. What percent of funding is reasonable to attach to meeting quality and other metrics?
    b. What time windows/mechanisms should be allowed for corrective action plans for practices who fail to meet initial goals?
    c. What type of minimum funding guarantees would need to be in place for organizations to participate?
7. How can this program support the needs of the Medicaid population? What support would be necessary to support a panel of Medicaid patients? Dual-eligible beneficiaries?
8. What other aspects related to funding and timeline should the State consider?

9. What costs should be unallowable under this pilot?

D3. Participation Requirements

The questions in this section relate to standards for participation:

1. As described in section C2 the State anticipates selecting participant organizations for inclusion in the program based on a set of criteria. Please comment on these criteria and their relative importance and suggest others for inclusion if appropriate.
2. Should there be limitations on which types of organizations can sponsor primary care practices? If so, what should these be?
3. The State anticipates requiring practices to monitor and perform on a core set of quality metrics (similar to those used in MDPCP). Which and how many metrics should the State consider? Which, if any, metrics should be critical requirements for continued program participation?
4. Should the State require a specific care delivery model or components as pre-condition for entry or for continued participation? If so what model or what elements should be considered? Over what timeline?
5. As an alternative to requiring a specific model of care the State could focus on monitoring relevant quality metrics and allow the practice to dictate the model of care. Which metrics should be considered?
6. How should the State define “primary care” for the purposes of this program?
7. Should the State consider elements that encourage alignment of participants with primary care providers who may not serve Medicare patients – e.g., pediatrics and obstetrics? If yes, how?
8. How should telemedicine and virtual care be considered under this pilot? Would the start-up payments be different for such an arrangement?
9. At the end of the pilot period, should practices be required to transition to another primary care value-based care program?
10. What other aspects related to program participation should the State consider?

D4. Other Questions

1. Are there legal or regulatory barriers to practice formation that the State could assist in addressing? If so, please identify the challenges and what support would be needed?
2. Are there other non-financial business challenges to practice formation that the State could assist with addressing? If so, please identify the challenges and how the State could assist?
3. What else should the State consider in designing this program that has not already been addressed above?

D5. Questions for payers

1. Are payers interested in offering an aligned payment program and over what timeline?
2. What elements of this pilot are most feasible for payers to implement?