EQIP Primary Care (EQIP PC) Questions and Answers

Based on questions received via email through 8/23
New questions received from 8/20-23 are highlighted in yellow

*Note: The Q&A period for EQIP PC closed on **Friday 8/23**. We will not be able to answer questions sent in after that date.*

General

Q: What are the infrastructure payments intended to cover? A provider's salary? An entire clinic's costs? Subsidizing losses typically incurred when taking care of a rural population?
A: *Infrastructure payments are intended to support practice start-up costs, and may cover any of the above costs listed including providers, staff, equipment, space, and other operational costs. Applicants are expected to specify intended uses of infrastructure payments in their application. Final approval of infrastructure costs will be determined during the month of September in the application review and negotiations process.*

Q: How should we estimate per beneficiary payments? What are the payment amounts? Do they vary by risk tier? Are they equal to MDPCP?
A: *Applicants are encouraged to submit a proposal for estimated costs to include establishing care management and other advanced primary care capabilities which might normally be covered via beneficiary payments. Applicants may use MDPCP and other primary care value-based payment models, like PCMH programs, as guidance on payments and attribution. Here is a link to the 2024 MDPCP payment table.*

Q: How will shared savings be determined?
A: *The availability of shared savings, as well as details and methodology, will be determined at a future time. Any shared savings design will be aligned with the advanced primary care models for Medicaid and MDPCP under AHEAD.*

Q: What is the timeline for getting a new practice actually set up? Is there a time table from the start of the program to when an awarded applicant has to be providing services?
A: *The timeline to set up a new practice will likely vary based on numerous factors including geography. There is no prescribed time table, and each organization should provide their best assessment of the timeline in their application taking into account these factors for the applicant's particular proposal. Awarded organizations should treat infrastructure payments as an infrastructure grant and not a planning grant. We anticipate this process may take as little as one year but should not exceed three years. Additionally, we will ask participants to report on progress throughout participation.*

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Q: What advice is given regarding developing an operating model estimate if an exact location and costs of operation are still being researched during the time of the application?
A: *Your application should include your best estimate of costs, noting the limitations and current unknowns. We understand that costs in your application are not exact given that you will not start building practice capacity until funding is received, however your application should justify how you came to your stated costs.*

Q: When do you anticipate hearing back from CMS about program approval?
A: *We do not have a specific timeline from CMS, though anticipate hearing back in the coming months. Until the State receives final approval for EQIP PC, acceptance into this program for 2025 will be contingent.*

Q: What advice exists if the model of care is being designed as primary care with the potential for specialized services related to primary care (behavioral health)?
A: *The model of care is an advanced primary care practice demonstrating the ability to address behavioral health needs of the community. We understand that behavioral health may not be integrated into primary care services on day one, however you should demonstrate a clear plan for integrating behavioral health services into your primary care model.*

Q: Would you entertain an application that collaborates with FQHCs?
A: *Yes. As the RFA states, FQHCs are eligible to apply. We encourage applicants to collaborate across organizations, which can include FQHC collaboration.*

Q: Is there any additional information on program oversight? Will MDH set up a portal that includes attribution and practice performance?
A: *Much of this detail is yet to be determined. We expect practices will be able to view attribution and certain performance data via CRISP. Any data reports will aim to align with reports for Medicaid and MDPCP under AHEAD, to prepare practices for participation in these programs.*

Q: Is $19 million the total funding for all years of the program or just for year 1?
A: *$19 million is currently the total funding for all years of the program.*

Q: Is there an approximation of how many practices will be approved?
A: *The number of selections made will be based on successful applications received that show the ability to boost primary care access in underserved areas in perpetuity, and total funding available for the program. There is no stated minimum or maximum for funding for an individual organization.*

Q: What will the reporting requirements consist of?
A: *Exact reporting requirements are still to be determined. At a minimum, participants will need to complete an annual progress report. Additional reporting requirements will be determined at a later date, and HSCRC and MDH will consider administrative burden when designing reporting.*

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Q: Will annual financial reporting be required on how dollars are being or have been spent?
A: *Tentatively yes. Financial reporting will likely be at a high level to indicate in which broad categories practices have spent funds, such as providers, staff, equipment, space, and other operational costs.*

Q: Can you define CRP?
A: *The CMMI Maryland Model website explains what CRP is and how it fits into the larger model context: https://www.cms.gov/priorities/innovation/innovation-models/md-tccm. Additional information can be found on the HSCRC website: https://hscrc.maryland.gov/Pages/CareRedesign.aspx.*

Q: Can you provide clarity around the beneficiary payment? Is it separate from the infrastructure cost or should it be included in the infrastructure cost on an assumption of a panel size and then broken out?
A: *Applicants are encouraged to submit a proposal for estimated costs to include establishing care management and other advanced primary care capabilities which might normally be covered via beneficiary payments. In your funding proposal worksheet, you may explain any assumptions made (such as panel size) in developing your funding targets.*

Q: Is the beneficiary payment intent to act as a supplement to the CMS fee-for-service payments until the practice is stabilized and operating on its own independent of any additional beneficiary payments?
A: *The intent of the beneficiary payment is to cover ongoing costs related to establishing an advanced primary care model of care. The availability of beneficiary payments will be determined during negotiations with selected applicants.*

Q: Can our milestones include a staffing model that matches patient demand? Meaning, can we plan to open with 2 or 3 providers in a space that can accommodate more and then grow providers as patient demand requires? Or if our proposed space can handle six providers, is it better to ask for funds for those six providers upfront?
A: *Your application should reflect your expectations for how your proposed practice will start up its operations. For example, if you expect your proposed practice to start with 2-3 providers and then grow, your application should reflect these costs accordingly. Your application is expected to detail a cost model that reflects your business plan for the practice.*

Q: Is EQIP PC open to funding health education consulting organizations or other community organizations, or is the program only considering clinical primary care practices?
A: *The goal of EQIP PC is to increase access to primary care in underserved areas of Maryland. As such, EQIP PC will only fund the establishment or expansion of clinical primary care practices. As the RFA states "eligible organizations include existing practices, including Federally Qualified Health Centers ("FQHCs") 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." We encourage applicants to collaborate across organizations, which can include health education and other community organizations.

Q: Can you confirm if a particular city is eligible for adding primary care supply through EQIP PC?
A: *Any geographic area in the Zip Code Tabulation Areas (ZCTA) listed in Appendix A on the EQIP PC website is eligible as part of the selected geographic focus areas for EQIP PC.*

Q: If a practice is not physically located in the red/pink geographic focus areas, does this mean they are disqualified from participating?
A: *Yes. Only practices located in the Zip Code Tabulation Areas (ZCTA) listed in Appendix A on the EQIP PC website will be considered.*

Q: Is this program open to larger health systems?
A: *As the RFA states "eligible organizations include existing practices, including Federally Qualified Health Centers ("FQHCs"), 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." All organizations falling into these categories, including organizations under health systems, are eligible to apply.*

Q: If a practice applies and is accepted for participation are there any penalties for backing out during the negotiations stage or before the start date?
A: *We expect only organizations with serious interest in joining EQIP PC to apply. After applicants are accepted into EQIP PC, there will be an official enrollment process to begin participation. Before that time, there will not be a penalty if an organization is no longer able to participate.*

Q: If an organization is submitting more than one application for different areas in the State, can the same Lead Care Partner be used?
A: *If an organization is submitting more than one application for different areas in the State, yes, the same Lead Care Partner can be used.*

Q: What is the process if a practice needs to withdraw from EQIP-PC?
A: *The EQIP-PC RFA is intended to select practices for a multi-year agreement. Specific details for participation withdrawals are still being determined.*

Q: Are participating practices required to contract with multiple MCOs by year 1 or is there flexibility in this deadline?
A: *Specific details on how and when participating practices will contract with MCOs and meet other participation requirements are still being determined.*

Application

Q: Do you recommend including letters of support from community organizations in the application?
A: *Letters of support may be included in your application but are not required.*

Q: Is there a suggested word count? Is it better to include detail or exercise brevity?
A: *No. Concise descriptions with supporting detail are appreciated.*

Q: Is there a suggested template for the workplan?
A: *No. We will accept whatever format you submit in your application for the workplan.*

Q: Is the application non-binding until a contract is signed?
A: *Though responses to the EQIP-PC RFA are non-binding, your application should reflect your best effort to describe expectations for how your proposed practice will start up its operations. Selected participants will be invited to participate and sign a participation agreement after the Selection Committee determines the selected participants.*

(NEW) Q: What is the process for submitting an application?
A: *To respond to the EQIP PC Request for Applications, please consult the full Request for Applications document which outlines information on the program, as well as the application process. Details on the application process begin on page 9. Please note that a complete submission should include the EQIP Primary Care Application, the EQIP Primary Care Funding Proposal Worksheet, and work plan, timeline, and staffing model. All of these items including the RFA can be found on the EQIP PC website.* ***Completed applications must be submitted to EQIP.PrimaryCare@maryland.gov by Friday, August 30th****.*

(NEW): Q: In reference to the Tier 1 and Tier 2 ZCTA list, are the population numbers shown representative of MD HSCRC estimates on the population or the total population requiring medical service?
A: *The population numbers shown in Tier 1 and Tier 2 of May Subgroup Meeting Slide Deck represent HSCRC estimates of the total population in that ZCTA, but are not population numbers requiring medical services. Applicants should use the final Appendix A of the RFA as opposed to previous versions in Subgroup slide decks.*

MDPCP Overlap

Q: How will the program co-exist with primary care programs in the AHEAD model?
A: *EQIP PC is a startup program to build primary care capacity and increase access to primary care in areas of the state that are underserved. We see EQIP PC as a glidepath to participation in Medicaid and Medicare value-based payment programs in AHEAD. Applicants should clearly demonstrate their plan to transition to Medicaid and Medicare value-based payment programs in AHEAD.*

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Q: Can a practice participate in both EQIP PC and MDPCP (with different NPIs)?
A: *Existing MDPCP practices that commit to adding new providers in the designated areas and/or completely new practices are eligible to apply for EQIP PC. Your application should clearly lay out how dual participation would work for the delivery model and how the organization will provide net new access to primary care in the specified zip codes for both Medicare and Medicaid beneficiaries.*

Q: Will MDPCP practices qualify for the EQIP PC beneficiary payments, including for EQIP PC beneficiaries not attributed to MDPCP?
A: *The final RFA guidance states that the availability of beneficiary payments will be determined during negotiations with selected applicants. All payment needs and associated justifications should be built into your proposal. Duplicate payments for the same beneficiary will not be allowed.*

Q: If an EQIP PC practice exits MDPCP at some point (or never enters to begin with), what would the implications be? Would they need to pay back EQIP funds?
A: *The application review panel will be looking for applicants to clearly demonstrate their plan to transition to Medicaid and MDPCP participation in AHEAD. The State may require EQIP PC awardees to sign an agreement stating their intention to transition.*

Q: Will practice coaches be part of this program, as they are with MDPCP?
A: *Tentatively yes. However, those operational details have not yet been finalized. Applicants should clearly articulate any supports, both in-kind and those with a cost, that will be required to implement the care model.*

Q: One question we have is about the MDPCP Track that our proposed practice would enter. Will our new practice enter MDPCP Track 3? Or should we anticipate a stepped introduction to MDPCP for this practice and a move from Track 1 to Track 2 then Track 3?
A: *The details of MDPCP Track options under the AHEAD Model for 2026 and beyond are still to be determined. A new practice entering the EQIP PC program will be expected to transition to MDPCP and the Medicaid primary care program under the AHEAD model, but the Track transition details are still to be determined.*