5160-1-71 Patient-centered medical homes (PCMH): eligible providers.

(A) A Patient-centered medical home (PCMH) is a team-based care delivery model led by primary care practitioners (PCPs) who comprehensively manage the health needs of individuals. Provider enrollment in the Ohio department of medicaid (ODM) PCMH program is voluntary. A PCMH may be a single practice or a practice partnership.

(B) Definitions.

(1) "Attributed medicaid individuals" are Ohio medicaid recipients for whom PCPs have accountability under a PCMH. A PCP's attributed medicaid individuals are determined by ODM or medicaid managed care plans (MCPs). All medicaid recipients are attributed except for:

(a) Recipients dually enrolled in Ohio medicaid and medicare;

(b) Recipients not eligible for the full range of medicaid benefits; and

(c) Recipients with third party benefits as defined in rule 5160-1-08 of the Administrative Code except for members with exclusively dental or vision coverage.

(2) "Attribution" is the process through which medicaid recipients are assigned to specific PCPs. ODM is responsible for attributing fee-for-service recipients, MCPs are responsible for attributing their enrolled recipients. The following hierarchy will be used in assigning recipients to PCPs:

(a) The recipient's choice of provider;

(b) Claims data concerning the recipient; or

(c) Other data concerning the recipient.

(3) "Convener" is the practice responsible for acting as the point of contact for ODM and the practices who form a practice partnership.

(4) "Practice Partnership" is a group of practices participating as a PCMH whose performance will be evaluated as a whole. The practice partnership must meet the following requirements:

(a) Each member practice must have an active medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code;

(b) Each member practice must have a minimum of one-hundred-fifty attributed medicaid individuals determined using claims-only data;

(c) Member practices must have a combined total of five-hundred or more attributed individuals determined using claims-only data at each attribution period;

(d) Member practices must have a single designated convener that has participated as a PCMH for at least one year;

(e) Each member practice must acknowledge to ODM its participation in the partnership; and

(f) Each member practice must agree that summary-level practice information will be shared by ODM among practices within the partnership.

(C) The following entities may participate in ODM's PCMH program through their contracts with MCPs or provider agreements for participation in medicaid fee-for-service:

(1) Individual physicians and practices;

(2) Professional medical groups;

(3) Rural health clinics;

(4) Federally qualified health centers;

(5) Primary care or public health clinics; or

(6) Professional medical groups billing under hospital provider types.

(D) The following medicaid providers are eligible to participate in the delivery of primary care activities or services in the PCMH program:

(1) Medical doctor (MD) or doctor of osteopathy (DO) who has met the requirements of section 4731.14 of the Revised Code with any of the following specialties or sub-specialties:

(a) Family practice;

(b) General practice;

(c) General preventive medicine;

(d) Internal medicine;

(e) Pediatric;

(f) Public health; or

(g) Geriatric.

(2) Clinical nurse specialist or certified nurse practitioner who has met the requirements of section 4723.41 of the Revised Code and has any of the following specialties:

(a) Pediatric;

(b) Adult health;

(c) Geriatric; or

(d) Family practice.

(3) Physician assistant who has met the requirements of section 4730.11 of the Revised Code.

(E) To be eligible for enrollment in the PCMH program for payment beginning in 2019, the PCMH must:

(1) have at least five-hundred attributed medicaid individuals determined using claims-only data, attest that it will participate in learning activities as determined by ODM or its designee, and share data with ODM and contracted MCPs; or

(2) be a practice who participated in the 2017 program year.

(F) An enrolled PCMH must meet activity requirements within the timeframes below and have written policies where specified. Further descriptions of these activities can be found on the ODM website, www.medicaid.ohio.gov.

(1) Upon enrollment and on an annual basis, the PCMH must attest that it will:

(a) Meet the "twenty-four-seven and same-day access to care" activity requirements in which the PCMH must:

(i) offer at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include, but is not limited to, e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends.

(ii) within twenty-four hours of initial request, provide access to a primary care practitioner with access to the patient's medical record; and

(iii) make patient clinical information available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed.

(b) Meet the "risk stratification" activity requirements in which the PCMH must have a developed method for documenting patient risk level that is integrated within the patient record and has a clear approach to implement this across the patient panel.

(c) Meet the "population health management" activity requirements in which the PCMH must identify patients in need of preventive or chronic services and begin outreach to schedule applicable appointments or identify additional services needed to meet the needs of the patient.

(d) Meet the "team-based care delivery" activity requirements in which the PCMH must define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM, and other providers as applicable for patients in specific patient segments identified by the PCMH.

(e) Meet the "care management plans" activity requirements in which the PCMH must create care plans that include necessary elements for all high-risk patients as identified by the PCMH's risk stratification process.

(f) Meet the "follow-up after hospital discharge" activity requirements in which the PCMH must have established relationships with all emergency departments and hospitals from which it frequently receives referrals and has an established process to ensure a reliable flow of information.

(g) Meet the "tests and specialist referrals" activity requirements in which the PCMH must have established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.

(h) Meet the "patient experience" activity requirements in which the PCMH must orient all patients to the practice and incorporate patient preferences in the selection of a primary care provider to build continuity of patient relationships throughout the entire care process.

(G) An enrolled PCMH must pass a number of the following efficiency requirements representing at least fifty percent of applicable metrics, to be evaluated annually at the end of each performance period. Further details regarding these requirements can be found on the ODM website, www.medicaid.ohio.gov.

(1) Generic dispensing rate;

(2) Inpatient admission for ambulatory care sensitive conditions (ACSCs);

(3) Emergency room visits per one thousand;

(4) Behavioral health related inpatient admissions per one thousand; and

(5) Referral patterns to episode principle accountable providers (PAPs) as defined in rule 5160-1-70 of the Administrative Code.

(H) An enrolled PCMH must pass a number of the following clinical quality requirements representing at least fifty percent of applicable metrics, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Well-child visits in the first fifteen months of life;

(2) Well-child visits in the third, fourth, fifth, and sixth years of life;

(3) Adolescent well-care visit;

(4) Weight assessment and counseling for nutrition and physical activity for children and adolescents. Body mass index (BMI) assessment for children and adolescents;

(5) Timeliness of prenatal care;

(6) Live births weighing less than two thousand five hundred grams;

(7) Postpartum care;

(8) Breast cancer screening;

(9) Cervical cancer screening;

(10) Adult BMI;

(11) Controlling high blood pressure;

(12) Medical management of asthma patients;

(13) Statin therapy for patients with cardiovascular disease;

(14) Comprehensive diabetes care; HbA1c poor control (greater than nine percent);

(15) Comprehensive diabetes care: HbA1c testing;

(16) Comprehensive diabetes care: eye exam.

(17) Antidepressant medication management;

(18) Follow-up after hospitalization for mental illness;

(19) Preventive care and screening: tobacco use, screening and cessation intervention;

(20) Initiation and engagement of alcohol and other drug dependence treatment.

(I) A PCMH may utilize reconsideration rights as stated in rules 5160-70-01 and 5160-70-02 of the Administrative Code to challenge a decision of ODM concerning PCMH enrollment or eligibility.

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