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.

(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) "Comprehensive Primary Care Plus" (CPC+) is a national demonstration run by the center for medicare and medicaid innovation (CMMI) within the centers for medicare and medicaid services (CMS) designed to improve quality and lower costs in primary care.

(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, the entity must have at least 500 attributed medicaid individuals and attest that it will participate in learning activities as determined by ODM or its designee, and share data with ODM and contracted MCPs.

(F) For an entity to enroll as a PCMH for payment beginning in 2017, one of the following must be met:

(1) A minimum of five thousand attributed medicaid individuals and accreditation by one of the following:

(a) Accreditation association for ambulatory health care (AAAHC);

(b) The joint commission;

(c) National committee for quality assurance (NCQA);

(d) Utilization review accreditation commission (URAC); or

(2) An Ohio CPC+ practice with five hundred or more attributed medicaid individuals at each attribution period; or

(3) A practice with five hundred or more attributed medicaid individuals determined through claims-only data at each attribution period and NCQA III accreditation.

(G) An enrolled PCMH must meet activity requirements within the timeframes below and have written policies where specified. Specific information regarding these requirements can be found on the ODM website, www.medicaid.ohio.gov.

(1) Within six months of initial enrollment, the PCMH must attest that it will:

(a) Meet the "same-day appointments" activity requirements in which the PCMH must provide same day appointments, within twenty-four hours of initial request, including some weekend hours to sufficiently meet patient demand. The PCMH can arrange this with other proximate providers who have access to the patient's records.

(b) Meet the "twenty-four-seven access to care" activity requirements in which:

(i) The PCMH must provide interactive clinical advice to patients by telephone or secure electronic video conferencing or messaging. A primary care physician, primary care physician assistant or primary care nurse practitioner who has access to the patient's medical record must ensure a response is provided to patients seeking clinical advice when the office is both open and closed;

(ii) The PCMH must 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;

(iii) The PCMH must document all clinical advice provided in the patient records within one business day, in accordance with written policy of the PCMH; and

(iv) The PCMH must provide a response to requests for clinical advice received after hours within a reasonable time frame in accordance with written policy of the PCMH.

(c) 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.

(d) 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.

(e) Meet the "team-based care management" activity requirements in which the PCMH must designate and begin training staff to fill care manager roles to overcome barriers to the patient receiving needed evidence-based treatment.

(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.

(2) After the first year of enrollment and annually thereafter, the PCMH must attest to, and meet the following:

(a) The "same-day appointments" activity requirements as defined in paragraph (G)(1)(a) of this rule;

(b) The "twenty-four seven access to care" activity requirements as defined in paragraph (G)(1)(b) of this rule:

(c) The "risk stratification" activity requirements as defined in paragraph (G)(1)(c) of this rule and:

(i) The PCMH must use risk stratification from ODM and contracted MCPs in addition to all available clinical and other relevant information such as cost data or screening results, tobacco use, and health risk behaviors to risk stratify all patients and communicate the information to ODM and contracted MCPs as requested;

(ii) The PCMH must fully integrate patient risk status into patient records and utilize the information to drive decisions around patient treatment, including the development of individualized care management plans; and

(iii) The PCMH must update risk stratification periodically and correspondingly update care plans to reflect changes in patient risk status.

(d) The "population health management" activity requirements as defined in paragraph (G)(1)(d) and:

(i) The PCMH must identify patients with gaps in care and implement ongoing multifaceted outreach efforts to schedule appointments;

(ii) The PCMH must have a planned improvement strategy for health outcomes and business processes including appropriate detailed coding for health risk factors;

(iii) The PCMH must devote staff resources and time to quality improvement activities with the goal of improving health outcomes for the entire patient population.

(e) The "team-based care management" activity requirements as defined in paragraph (G)(1)(e) of this rule and:

(i) The PCMH must designate a quality improvement lead (as appropriate), define care team members and their qualifications, define the functional relationship of team members to other providers, ODM and/or contracted MCPs outside the care team, provide orientation and ongoing education and training to staff, and hold scheduled patient care team meetings;

(ii) The PCMH must provide various care management strategies in partnership with ODM and/or contracted MCPs including coordination with practitioners and external care agencies, integration of behavioral health, self-management support for patients with at least three high risk conditions, medication management, and linkage to community-based resources;

(iii) The PCMH must create and provide written care plans for high-risk patients in an understandable format incorporating patient preferences, functional and lifestyle goals, treatment goals, self-management plan, and potential barriers; and

(iv) The PCMH must identify activities that require additional action or follow-up by ODM and/or the contracted MCP.

(f) The "follow-up after hospital discharge" activity requirements as defined in paragraph (G)(1)(f) of this rule and:

(i) The PCMH must proactively and consistently obtain patient discharge summaries from hospitals and other facilities; and

(ii) The PCMH must track patients receiving care at hospitals and emergency departments, and proactively contact patients and families for appropriate follow-up care within an appropriate period following hospital admission or emergency department visit. Follow-up care may include an in-person visit, physician counseling, referrals to community resources, and disease, case management or self-management support programs.

(g) The "tests and specialist referrals" activity requirements as defined in paragraph (G)(1)(g) of this rule and:

(i) The PCMH must have a documented process for inquiring about self-referrals and requesting reports from clinicians, tracking lab tests and imaging tests until results are available, tracking referrals until reports are available, and tracking the fulfillment of pharmacy prescriptions where data is available; and

(ii) The PCMH must have a documented process for tracking referrals and reports.

(h) The "patient experience" activity requirements as defined in paragraph (G)(1)(h) of this rule and:

(i) The PCMH must assess the approach to patient experience and cultural competence at least once annually through quantitative or

qualitative means, and integrate additional data sources into its assessment where available;

(ii) The information collected by the PCMH must cover access, communication, coordination, and whole person care and self-management support; and

(iii) The PCMH must use the collected information to identify improvement opportunities, and take action using concrete initiatives with dedicated staff time to improve overall patient experience and reduce disparities.

(H) 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. Specific information 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 Administrative Code rule 5160-1-70.

(I) 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. Specific information regarding these requirements 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; HgA1c 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.

(J) 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.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

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