LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID
COLUMBUS, OHIO

DATE: **08/17/2018**
TIME: **9:00 A.M.**
LOCATION: **A501 Lazarus Building**
50 W. Town St., Columbus, Ohio 43215

Pursuant to section 5164.02, 5162.03 and Chapter 119 of the Ohio Revised Code, the Director of the Ohio Department of Medicaid (Department) gives notice of the Department's intent to amend the rules identified below and of a public hearing thereon.

This rule implements the Ohio Department of Medicaid's Comprehensive Primary Care Program (CPC) under the State Innovation Model (SIM) grant, the development of which is a joint collaboration between the Ohio Department of Medicaid (ODM) and the Governor's Office of Health Transformation (OHT). The CPC program utilizes a Patient Centered Medical Home (PCMH) model to emphasize primary care and encourage providers to deliver medical services more efficiently and economically to achieve better health outcomes for the more than 3 million Ohioans covered by Medicaid. This is a team-based care delivery model led by a primary care practitioner who comprehensively manages the health needs of individuals.

Existing rule 5160-1-71, "Patient centered medical homes (PCMH): Eligible providers," is being proposed for rescission and will be replaced with a new rule to reflect proposed changes for the 2019 program year. This rule sets forth the eligibility requirements that primary care practices must meet in order to enroll under the Ohio CPC program.

This rule provides definitional information, identifies eligible entities and requirements for enrollment as a PCMH, and describes the activity, efficiency, and quality measures including the performance thresholds that must be met. To be eligible for participation and payment, practices must meet one of the following requirements: have participated in the 2017 program year, have at least five thousand attributed medicaid individuals and PCMH accreditation from a national accrediting body, be a participating Comprehensive Primary Care Plus (CPC+) practice with at least 500 attributed Medicaid individuals, or have at least 500 attributed Medicaid individuals and accreditation under National Committee for Quality Assurance (NCQA) III or NCQA PCMH standards.

Upon enrollment and on an annual basis, this rule requires that each participating PCMH attest that it will meet the activity requirements set forth in the rule. The PCMH must also pass a number of efficiency and clinical quality requirements on an annual basis to continue participation under this rule. This rule allows practices who participated in initial program year 2017 to continue participation as a PCMH.

New rule 5160-1-71, “Patient Centered Medical Homes (PCMH): Eligible Providers” is being proposed for adoption to replace the existing rule of the same title which is being proposed for rescission. This rule is being proposed to reflect program year 2019 changes in which accreditation will no longer be required. Other modifications for program year 2019 include the option of forming a PCMH through a practice partnership led by a convener, and revision of activity requirements for participation as a PCMH.

This rule provides definitional information, identifies eligible entities and requirements for enrollment as a PCMH, and describes the activity, efficiency, and quality measures including the performance thresholds that must be met. This rule informs the PCMH that it may utilize reconsideration rights to challenge a decision of ODM concerning PCMH enrollment or eligibility. To be eligible for participation and payment beginning in January 2019, a PCMH must have at least 500 attributed Medicaid individuals determined through claims-only data. A practice may choose to participate as a PCMH on its own or through a practice partnership which is an option being introduced for the 2019 program year.

In this new proposed rule, a group of practices may participate together as a PCMH by forming a practice partnership. Each member practice in the partnership must have an active medicaid provider agreement and at least 150 attributed Medicaid individuals determined through claims-only data. Each practice partnership must have a combined total of 500 or more attributed individuals using claims-only data at each attribution period and must be led by a single designated convening practice, known as a “convener.” The convener is defined in the rule as being the responsible practice for acting as the point of contact for ODM on behalf of the practice partnership. The convener must have participated as a PCMH for at least one previous program year. Additionally, each member practice of the partnership must acknowledge to ODM its participation in the partnership and agree that summary-level practice information can be shared by ODM among practices within the partnership.

The activity requirements for program year 2019 have been further refined and consolidated from the previous program year. Upon enrollment and on an annual basis, each PCMH must attest that it will meet the activity requirements. The “twenty-four-seven access to care” activity requirements were removed and some components were combined with the “same day appointments” activity requirements. This activity requirement is now referred to as the “twenty-four-seven and same-day access to care” activity requirements. This requires the PCMH to offer at least one alternative to traditional office visits to increase access and best meet the needs of the population. It requires the PCMH to within 24 hours of initial request, provide access to a primary care practitioner with access to the patient’s medical record. Additionally, it requires the PCMH to make patient clinical information available to on-call staff, external facilities, and other clinicians outside the practice when the office is closed.

A “team-based care management” activity requirement is being proposed in the new rule and is similar to previous program years however it is being re-named as “team-based care delivery.” This requires the PCMH to define care team members, roles, and qualifications

and to provide various care management strategies in partnership with payers, ODM, and other providers for attributed members as necessary.

Finally, the "care management plans" activity requirements were added in the new proposed rule. This requires the PCMH to create care plans that include necessary elements for all high-risk patients as identified by the PCMH's risk stratification process. The remaining activity requirements remain the same from the previous program year and are not being proposed for revision in this new proposed rule. The risk stratification, population health management, follow-up after hospital discharge, tests and specialist referrals, and patient experience activity requirements will remain the same as in program year 2018.

Similar to previous program years, this new proposed rule requires the PCMH to pass a number of efficiency and clinical quality requirements that represent at least 50% of applicable metrics on a yearly basis. For program year 2019, an additional efficiency requirement is being proposed to include referral patterns to episode principle accountable providers. This was a requirement in the first program year in 2017 and was subsequently removed for program year 2018. For program year 2019, ODM is proposing it be added as a requirement. The clinical quality requirements will remain and will not change from program year 2018.

A public hearing on the proposed rule will be held at the date, time, and location listed at the top of this notice. Both written and oral testimony will be taken at the public hearing. Additionally, written comments submitted or postmarked no later than the date of the public hearing will be treated as testimony.

A copy of the proposed rule is available, without charge, at the address listed below. The rule is also available on the internet at http://www.registerofohio.state.oh.us/.

Requests for a copy of the proposed rule and testimony on the rule should be submitted by mail to the Ohio Department of Medicaid Rule Administrator, Office of Chief Legal Counsel, 50 W. Town Street, Suite 400, Columbus, Ohio 43215-3414, by fax at (614) 995-1301, or by e-mail at Rules@Medicaid.Ohio.gov. Testimony received may be reviewed at this address.