CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Patient Centered Medical Home

Rule Number(s): 5160-1-71 and 5160-1-72

SUBJECT TO BUSINESS IMPACT ANALYSIS:

New 5160-1-71 Patient Centered Medical Homes (PCMH): Eligible Providers.

New 5160-1-72 Patient Centered Medical Homes (PCMH): Payments.

Date: 6/23/2016

Rule Type:

- X **New**
- ☐ **Amended**
- ☐ **5-Year Review**
- ☐ **Rescinded**

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   These new rules implement a component of 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 Patient Centered Medical Home (PCMH) program emphasizes primary care and encourages providers to deliver medical services more efficiently and economically to achieve better health outcomes for the more than 3 million Ohioans covered by Medicaid.

   New rule 5160-1-71, "Patient centered medical homes (PCMH): Eligible providers," sets forth the eligibility requirements that primary care practices must meet in order to enroll as a PCMH. PCMH is a team-based care delivery model led by a primary care practitioner who comprehensively manages the health needs of individuals.

   New rule 5160-1-72, "Patient centered medical homes (PCMH): Payments," describes payment available for practices enrolled as a PCMH and sets forth additional criteria for payment. These payments were created to support practices for the activities described in new Administrative Code rule 5160-1-71.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   The Ohio Department of Medicaid (ODM) is promulgating this rule under section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. In 2014, Ohio received a federal State Innovation Model (SIM) test grant, a cooperative agreement between the federal government and the state of Ohio, from the Centers for Medicare and Medicaid Services (CMS), to implement new healthcare delivery payment systems to reward the value of services, not volume. Specifically, these payment models increase access to primary care through patient centered medical homes (PCMH) and support episode-based payments for high-cost medical events. The purpose of both models is to achieve better health, better care and cost savings through improvement. ODM's rules implement PCMH, which is a step in its goal to shift to value based purchasing. The implementation of PCMH is one of the stated objectives of this federal SIM grant.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

PCMH is being implemented by ODM as it shifts to becoming a value-based purchaser of medical services. As a performance based model, PCMH encourages Medicaid providers to deliver services more efficiently and economically while continuing to emphasize quality of care.

In the long term and at full implementation, the Ohio PCMH program is designed to produce savings for the healthcare system and taxpayers, and achieve greater health outcomes for the more than 3 million Ohioans covered by Medicaid. Savings are expected to average 2% or $500 million over the next five years assuming 80% of eligible practices participate in the PCMH program. At full implementation, ODM hopes to realize greater savings by growing the PCMH program to include 100% of eligible practices. Actual savings will be shared between Medicaid, the Medicaid managed care plans, and Medicaid providers serving as a PCMH with at least half of the savings shared back with participating PCMHs who have achieved savings on total cost of care.

These figures were projected based on savings from similarly structured PCMH programs in other states. The state of Minnesota implemented a medical home program which reached 54% of primary care clinics in the state. Over a five-year period, costs improved by an estimated $1 billion and the state saw higher patient satisfaction, and better provider performance on quality measures in asthma, diabetes, vascular disease, and depression.

In the first year of the PCMH program (2017), ODM anticipates that approximately 350,000 to 525,000 Medicaid individuals will be attributed to a participating PCMH for linkage to primary care and care coordination. ODM anticipates this number to grow in the second year of the program (2018) to approximately 840,000 to 1,260,000 Medicaid individuals who will be attributed to a participating PCMH for linkage to primary care services and care coordination.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

Through these rules that implement PCMH, Ohio is projecting to reach 350,000 to 525,000 Ohio Medicaid members in 2017 and 840,000 to 1,260,000 members in 2018. Considering Ohio Medicaid covers more than 3 million individuals throughout the state, the impact on this population is expected to be significant.

The success of these rules will be measured through a number of metrics. These metrics include measurements like total number of participating practices and number of Medicaid enrolled individuals receiving health care coordinated through a PCMH. Participating PCMHs will be evaluated continually and will receive quarterly reports on progress toward measures. Metrics and data related to PCMH operation are derived from claims data submitted by Managed Care Plans and providers to ODM for traditional reimbursement. The full list of metrics will be posted on the ODM website.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

ODM, in partnership with OHT, engaged many diverse stakeholders in payment innovation efforts overall and more specifically the design of PCMH. On January 9, 2013, Governor Kasich's Advisory Council on Health Care Payment Innovation, which includes employers, health care providers, payers and consumer advocacy groups, met for the first time. This Advisory Council committed to work together to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. From this Advisory Group, members committed staff time and resources to work on teams to develop PCMH and episode based payments. First, a Payment Innovation Core team was created which included commercial payers Aetna, Anthem, Medical Mutual, and United Healthcare, as well as the five Medicaid managed care plans – Buckeye, CareSource, Molina, Paramount, and United Healthcare (UHC is participating as both commercial and managed care plan). The Core Team met on a monthly basis during PCMH development and continues to meet on this cadence to discuss items on all payment innovation efforts.

A PCMH Design team made up of health care providers, payers, consumer advocates and employers, and the State was convened and met monthly to determine early elements of a PCMH model. This team was reconvened in May 2015 as the PCMH Advisory Group and expanded to include other stakeholders such as behavioral health providers and staff from the Ohio Department of Mental Health and Addiction Services. During these meetings, participants helped create, design, and implement various areas of the PCMH program including communications and provider outreach, attribution of individuals, metrics and payment structure. Since January 2015, the design team has met a total of eight times. Additional specific focus groups working on the model include a primary care provider group, patient advocate group and population health advisory group. Further, in December 2015 we partnered with the Ohio Medical Board to reach out to all primary care providers and clinic managers around the state to garner information related to knowledge and readiness to implement a PCMH model of care. The state received over 760 responses that were analyzed to help inform the vision and of an Ohio PCMH model of care.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   Stakeholders have provided input in the form of comments, requirements, and design suggestions that informed all key decisions for the design of the PCMH model. Input received from stakeholders was incorporated into the draft rules proposed here. For the care delivery model, this included decisions on target patients and scope, clinical quality metrics, efficiency metrics, activity requirements, and care delivery improvements. For the payment model, this included decisions on requirements for PCMH participation, attribution, payment streams/types of incentives, activity requirements, quality metrics, efficiency metrics, inclusions/exclusions in total cost of care, and risk adjustment.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   Medicaid provider claims data was used to inform and develop the definitions for the various metrics and outcomes for the delivery of health care services under the PCMH rules.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    Each Medicaid rule in the Ohio Administrative Code is specific to a particular subject or aspect of a subject. No other rules specifically address patient centered medical homes or the payments that participating practices are eligible to receive.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.**

    PCMH, which is implemented by these rules, is performance-based. Primary care practices that volunteer to participate in the PCMH program are provided an enhanced payment to provide a broader range of comprehensive care meet the required activity requirements, quality and efficiency metrics. Based on a PCMH practice's ability to become comprehensive and efficient, the PCMH may be eligible to receive shared savings payments if certain quality metrics and outcomes are achieved.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, there are currently no other rules or programs that specifically address PCMHs.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

ODM consistently continues to meet with managed care plans, the SIM Core team, PCMH Advisory Group, Primary Care Provider Focus Group, Patient Advocate Group, and other provider and advocacy associations regarding the development and implementation of the PCMH program. Further, ODM is planning to create and deliver PCMH reports to practices on a quarterly basis. These PCMH practices serve Medicaid fee-for-service and Medicaid managed care plan members. This will further improve consistency, lessen administrative burden for PCMH practices, and ensure they have timely and streamlined access to their performance data.

Adverse Impact to Busines

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

Business communities impacted include providers enrolled in Ohio's Medicaid fee-for-service program, Medicaid managed care plans, and providers who contract with Medicaid managed care plans. The Ohio PCMH program is voluntary; practices that choose to enroll and participate as Ohio PCMHs will be impacted by this rule.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

New rule 5160-1-71 requires that to be eligible for participation in 2017, practices must have a minimum number of attributed Medicaid individuals as determined by ODM, be accredited by a nationally recognized certifying organization, and attest that within six months of enrollment as a PCMH, the PCMH will meet a set of activity requirements in order to continue participating as a PCMH. After the first year and annually thereafter, the PCMH must attest to and continually meet additional activity requirements. This rule requires an enrolled PCMH to meet a percentage of applicable efficiency requirements, and a percentage of applicable clinical quality requirements as defined by ODM and detailed within the rule and on the ODM website.

For new practices planning to enroll in the PCMH program for participation in 2018, practices must have a minimum number of attributed Medicaid individuals as determined by ODM and attest that within six months of enrollment as a PCMH, a set of activity requirements will be met in order to continue participating as a PCMH.

After the first year and annually thereafter, the PCMH must attest to and continually meet additional activity requirements. This rule requires an enrolled PCMH to meet a percentage of applicable efficiency requirements, and a percentage of applicable clinical quality requirements as defined by ODM and detailed within the rule and on the ODM website.

New rule 5160-1-72 requires a PCMH to meet all requirements set forth in rule 5160-1-71 to be eligible for PCMH payments. This includes the specified activity requirements, clinical quality and efficiency metrics. This rule defines the types of payments available under PCMH and how they are calculated by ODM. It describes the prospective PCMH per-member per-month (PMPM) payment and the risk tiers used to categorize attributed Medicaid individuals. The rule also describes additional requirements to qualify for the "PCMH Shared Savings Payment" including a minimum of 5,000 attributed Medicaid individuals.

A practice enrolled in the Ohio PCMH program may experience an adverse financial impact in the form of discontinued PCMH PMPM payment and PCMH Shared Savings payment if the Ohio PCMH requirements are not met. For a PCMH practice that fails to meet the activity requirements in 5160-1-71, payment under the rule will be terminated. A PCMH practice that fails to meet efficiency and clinical quality requirements in 5160-1-7 will receive a warning. After two consecutive warnings, PCMH payment under the rule will be terminated. Under these rules, a PCMH will not incur a fine or other monetary penalty.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

In the short term, practices will incur some costs as they undergo the transitions required to become an effective PCMH practice, meeting the program requirements. For participation in the first year of the PMCH program only, national accreditation is required. The estimated cost for a practice to receive and maintain its national accreditation is $3,000. This estimate is based on National Committee for Quality Assurance (NCQA) accreditation, which is the most costly of the accreditations recognized under the Ohio PCMH rules.

The estimated cost for a PCMH practice to meet activity requirements, clinical quality, and efficiency metrics is $180,000. This figure was estimated by considering care coordinator costs, average primary care practitioner salary, and administrative costs for the average practice projected to participate in the PCMH program. This estimate also takes into consideration the resources needed to effectively comply with the activity, clinical quality, and efficiency metrics.

If a PCMH practice does not meet the requirements set forth in 5160-1-71 and 5160-1-72, the PCMH PMPM payment will be terminated. A PCMH practice with more than 5,000 attributed Ohio Medicaid individuals who does not achieve savings on total cost of care may not qualify for the additional payment type. A participating PCMH practice will not be charged a fine for failure to meet these requirements.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The purpose of the PCMH program is to achieve better health outcomes and achieve cost savings through improvement. It is intended to support practices in their transformation to achieve cost savings and improve health outcomes by focusing on and linking individuals to primary and preventive care. The implementation of these rules is a step toward shifting to value based purchasing and implementing one of the objectives of the State Innovation Model grant. The PCMH program is performance-based and the incentives encourage Medicaid providers to deliver quality care more efficiently and economically.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

The Ohio PCMH program is not mandatory but it is highly encouraged for primary care practices that meet the criteria defined in the rules. For small businesses that choose to enroll as a PCMH practice, there are no alternate means of compliance; however, informational resources are available on the ODM website to support the PCMH.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This does not apply as the rule does not impose any fine or penalty for a paperwork violation.

18. What resources are available to assist small businesses with compliance of the regulation?

ODM is developing a web page for the PCMH program which will be in place when practices are eligible to enroll. This web page will include documentation about the PCMH program and additional information for participating practices including frequently asked questions (FAQs), training and educational materials. The ODM website houses additional information and resources for providers.

Providers may contact the Bureau of Provider Services for technical assistance by calling 1-800-686-1516. Providers may also submit policy questions to ODM through the contact page at www.medicaid.ohio.gov

DRAFT - NOT FOR FILING

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 thirty 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.

DRAFT - NOT FOR FILING

5160-1-72 Patient centered medical homes (PCMH): Payments.

(A) A Patient centered medical home (PCMH) must be enrolled and meet the requirements set forth in rule 5160-1-71 of the Administrative Code to be eligible for PCMH payments.

(B) An eligible PCMH may qualify to access the following payments:

(1) The "PCMH per-member-per-month (PMPM)" is a payment to support the PCMH.

(a) Payment is in the form of a prospective risk-adjusted PMPM payment that will be calculated for each attributed medicaid individual using 3M clinical risk grouping (CRG) software to categorize the individual into one of the following risk tiers:

(i) Healthy individuals including those with a history of significant acute diseases or a single minor chronic disease;

(ii) Individual with minor chronic diseases in multiple organ systems, significant chronic disease, or significant chronic diseases in multiple organ systems;

(iii) Individual with dominant chronic diseases in three or more organ systems, metastatic malignancy, or catastrophic condition.

(b) Payment begins following enrollment and in accordance with the payment schedule published on the ODM website, www.medicaid.ohio.gov;

(2) The "PCMH shared savings payment" is a payment for a PCMH that meets quality and financial outcomes. Specific information regarding the PCMH shared savings payment can be found on the ODM website, www.medicaid.ohio.gov.

(a) To be eligible for the PCMH shared savings payment, the PCMH must meet the following requirements:

(i) The PCMH must have at least sixty thousand member months in the performance period;

(ii) The PCMH must achieve savings on its total cost of care during the performance period compared to its own baseline total cost of care performance, and/or perform in the top decile of all PCMH practices based on total cost of care performance. The total cost of care for a PCMH is calculated by summing all claims for a given patient, plus any PMPM payment that the PCMH has received through the PCMH program, minus several exclusions and taking into account the overall risk status of the population. The following categories of expenditures are excluded:

(a) All expenditures for waiver services;

(b) All expenditures for dental, vision, and transportation services;

(c) All expenditures in the first year of life for members with a neonatal intensive care unit (NICU) level three or four stay;

(d) All expenditures for outliers within each risk band in the top and bottom one percent; and

(e) All expenditures for individuals with more than a specified number of consecutive days in a

long-term care facility.

(b) The PCMH shared savings payment consists of the following:

(i) An annual retrospective payment equivalent to a percentage of the savings on total cost of care over the course of the performance period. The percentage will be determined by several factors including but not limited to the PCMH's total cost of care for its attributed medicaid individuals as defined in (B)(1) of Administrative Code rule 5160-1-71; and

(ii) An annual retrospective bonus payment based on total cost of care for PCMHs in the top-performing decile, to be determined annually by ODM.

(C) Penalties.

(1) The PCMH must continue to meet activity requirements annually as defined in paragraph (G) of Administrative Code rule 5160-1-71. If activity requirements are not met upon evaluation, payment under this rule terminates; and

(2) The PCMH must continue to meet efficiency and clinical quality requirements defined in paragraphs (H) and (I) of Administrative Code rule 5160-1-71. If any of these requirements are not met, a warning will be issued. After two consecutive warnings, payment under this rule will be terminated.

(D) A PCMH may utilize reconsideration rights as stated in 5160-70-01 and 5160-70-02 of the Administrative Code to challenge decisions by ODM to terminate payments described in this rule.