CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Patient Centered Medical Homes (PCMH): eligible providers

Rule Number(s): 5160-1-71

SUBJECT TO BUSINESS IMPACT ANALYSIS:

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

Date: 9/22/2017

Rule Type:

New
X **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☐ **Rescinded**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.

   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.

   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 under the Ohio CPC program. It was submitted to CSIO for review when it was proposed as a new rule in 2017.

   The amendments proposed for 5160-1-71 are technical in nature and do not create new requirements for providers who participated in the first year of the program. Some language has been streamlined to simplify the requirements for practices participating in the CPC program. To accommodate a new accreditation option under the National Committee for Quality Assurance (NCQA) and the ultimate phase-out of the existing NCQA III accreditation, the rule has been amended to allow providers newly enrolling for program year 2018 to have either NCQA III accreditation or accreditation under NCQA PCMH standards as in effect March 31, 2017. The rule has been clarified to state that practices must have the PCMH specific accreditation from one of the listed accrediting bodies. This rule includes a provision which allows practices who participated in the 2017 program year to continue participation in the Ohio CPC program.

   This amended rule removes references to specific program years and simplifies language addressing the time period in which a participating practice must attest to or complete program requirements. The activity requirements in the amended rule have been consolidated into one section instead of distinguishing different time periods as in the existing rule. This section has been clarified to state the activity requirements must be attested to upon enrollment and on an annual basis. The efficiency requirement concerning referral patterns to episode principle accountable providers has been removed as it is no longer a requirement.

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 the Ohio CPC program, which is a step in its goal to shift to value based purchasing.

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

   This rule does 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)?**

   The Ohio CPC program was implemented by ODM in 2017 as a method to further the Department's initiative to shift from volume-based purchasing to value-based purchasing of medical services. As a performance based model, the Ohio CPC program encourages Medicaid providers to deliver services more efficiently and economically through a PCMH model while continuing to emphasize quality of care.

   In the long term and at full implementation, the Ohio CPC 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 this program. At full implementation, ODM hopes to realize greater savings by growing the CPC program to include 100% of eligible practices. Actual savings will be shared between Medicaid, the Medicaid managed care plans, and Medicaid providers participating in the Ohio CPC program.

   These figures were projected based on savings from similarly structured PCMH-modeled 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 Ohio CPC program (2017), ODM anticipated that approximately 350,000 to 525,000 Medicaid individuals would be attributed to a participating practice for linkage to primary care and care coordination. In the first program year, ODM enrolled 111 practices in the CPC program, representing over 830,000 Medicaid covered individuals who were attributed to a CPC practice. ODM anticipates this number to grow in the second year of the program (2018) to approximately 840,000 to 1,260,000 Medicaid covered individuals who will be attributed to a participating CPC practice 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 this rule that implements the CPC program, Ohio initially projected to reach 350,000 to 525,000 Ohio Medicaid members in 2017 and 840,000 to 1,260,000 members in 2018. In 2017, the Ohio CPC program exceeded this goal and reached more than 830,000 Medicaid covered individuals through the 111 participating practices. Considering Ohio Medicaid covers more than 3 million individuals throughout the state, the positive impact on this population is expected to be significant.

The success of this rule 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 an Ohio CPC practice. Participating practices will be evaluated continually and will receive quarterly reports on progress toward measures. Metrics and data related to Ohio CPC practice operation are derived from claims data submitted by Managed Care Plans and providers to ODM for traditional reimbursement. The full list of metrics is 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.

A copy of the draft rule was sent to current Ohio CPC practices, all Ohio Medicaid Managed Care Plans, other payer partners, and provider associations.

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

   No concerns were raised in response to the draft rules that were distributed.

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?**

   Scientific data was not used to develop this rule or the measurable outcomes of the rule.

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?**

    ODM did not consider regulatory alternatives. This rule has been in effect since 10/1/2016 and serves the purpose it was intended for to implement the Ohio CPC program. It continues to be applicable to the Ohio CPC program.

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.***

    The Ohio CPC program is performance-based. Primary care practices that volunteer to participate in the Ohio CPC program must meet the required activity requirements, quality and efficiency metrics described in the rule.

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 practices participating in the CPC program.

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 creates and delivers reports to participating practices on a quarterly basis. These Ohio CPC practices serve Medicaid fee-for-service and Medicaid managed care plan members. These reports improve consistency, lessen administrative burden for CPC 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 CPC program is voluntary; practices that choose to enroll and participate will be impacted by this rule.

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

The proposed amendments to this rule are technical in nature, and do not change the adverse impact for practices participating in the program.

Rule 5160-1-71 requires that to be eligible for participation, practices must have a minimum number of attributed Medicaid individuals as determined by ODM, be accredited by a nationally recognized certifying organization or be a participating practice in the CPC+ program through the Centers for Medicare and Medicaid Services (CMS). Each CPC practice must also attest, upon enrollment and on an annual basis, that it will meet a set of activity requirements in order to continue participating in the program. This rule requires an enrolled Ohio CPC practice 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.

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 newly enrolling in the Ohio CPC program will incur some costs as they undergo the transitions required to become an effective CPC practice, meeting the program requirements. For participation in the Ohio CPC program, national accreditation is required unless the practice is a CPC+ participant. The estimated cost for a practice to receive and maintain its national accreditation is $3,000. This estimate is based on existing NCQA accreditation standards, which is the most costly of the accreditations recognized

under the Ohio CPC program rules.

Under the NCQA PCMH accreditation standards released in 2017, accreditation pricing varies between single-sites and multi-sites. Both options require initial recognition fees and annual reporting fees based on the number of sites and covered clinicians. For single-site accreditation, initial recognition fees are $50 per clinician for practices with 13 or more clinicians or $400 per clinician for practices with 1-12 clinicians. Annual reporting fees are $12 per clinician for practices with 13 or more clinicians or $120 per clinician for practices with 1-12 clinicians. For multi-site accreditation, initial recognition fees are $25 per clinician for practices with 13 or more clinicians or $250 per clinician for practices with 1-12 clinicians. Annual reporting fees are $12 per clinician for practices with 13 or more clinicians or $120 per clinician for practices with 1-12 clinicians.

The Accreditation Association for Ambulatory Health Care (AAAHC) requires a standard application fee of $775. Survey fees for accreditation vary based on the type, size, and range of services offered by the organization seeking accreditation. The length and cost of the survey is determined based on the organization's Application for Survey and supporting documents. For this reason, exact fees were not available on the AAAHC website.

Practices seeking accreditation from the Joint Commission are required to pay a $1,700 deposit at the time of application which is applied toward accreditation fees. Accreditation fees are spread over a 3-year period and most practices can expect to pay 60% of the accreditation fees for the first year, 20% due the second year, and 20% due the third year.

The Utilization Review Accreditation Commission (URAC) offers various types of accreditation, all of which are valid for a three year period with no yearly fees during the period of accreditation. Fees related to each accreditation vary and are not published. All application fees include desktop review, validation review, and access to the URAC application guide, interpretations guide, and educational tutorials for organizations to learn more about the accreditation process.

The estimated cost for an Ohio CPC 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 Ohio CPC program. This estimate also takes into consideration the resources needed to effectively comply with the activity, clinical quality, and efficiency metrics.

If a CPC practice does not meet the requirements for the Ohio CPC program, participation in the program may be terminated. A participating CPC 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 Ohio CPC 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 this rule is a step toward shifting to value based purchasing and implementing one of the objectives of the State Innovation Model grant. The Ohio CPC 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 CPC program is not mandatory but it is highly encouraged for primary care practices that meet the criteria defined in the rule. For small businesses that choose to participate in the Ohio CPC program, there are no alternate means of compliance; however, informational resources are available on the ODM website to support participating practices.

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 has developed a web page for the Ohio CPC program which includes documentation about the 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.

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 PCMH 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 determined through claims-only data 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 or accreditation under NCQA PCMH standards as in effect March 31, 2017, www.ncqa.org~~.~~; or

(4) The practice participated in the 2017 program year.

(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~~Upon 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 rule 5160-1-70 of the Administrative Code.~~

(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.