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:

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

Date: 6/21/2018

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☐ **Rescinded**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.

   This rule was submitted to CSIO for review when it was proposed for the first program year 2017 and again when it was amended for program year 2018. The existing rule is now being proposed for rescission because more than 50% of the text was replaced. It will be replaced with a new proposed rule of the same title.

   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 is 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.

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 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. For program year 2018, an additional 50 practices were enrolled, bringing the total number of attributed Medicaid members to more than one million. 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.

   ODM has worked with stakeholders to gather input on revisions to the policy for the CPC program year 2019. Several in-person meetings, telephone calls, and webinars were conducted:

   - 2/6/2018: Provider practice webinar: Attribution and Payment
   - 3/13/2018: Provider practice webinar: Activity Requirements
   - 4/10/2018: Provider practice webinar: Ohio CPC Practice and Referral Reports
   - 5/11/2018: Call with all MCPs
   - 5/15/2018: Provider practice webinar: Ohio CPC Referral Reports
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   - 5/18/2018 through 5/22/2018: One-on-one calls with each MCP
   - 5/24/2018: SIM Core Team call (Managed Care Plans and other payers) – discussed changes for program year 2019
   - 5/25/2018: Provider focus group – discussed changes for program year 2019 including minimum member threshold, activity requirements, and practice partnerships.
   - 6/15/2018: Provider focus group – discussed efficiency metric related to referral patterns to episode principle accountable providers (PAPs).

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

   Requirements in the new proposed rule were developed in partnership with stakeholders. Stakeholders were overall supportive of the revisions proposed for the next program year,

and were especially pleased to learn that accreditation will no longer be required and that practice partnerships were included as an option for program year 2019.

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 Business

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; only 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

This new proposed rule will eliminate some of the adverse impact to providers compared to requirements in previous program years. To be eligible for participation as a PCMH in program year 2019, national accreditation is no longer required and smaller practices will be able to form a practice partnership to participate as a PCMH.

New proposed 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. 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. Practices newly enrolling will not be subject to the cost of national accreditation since this requirement was removed for those participating in program year 2019. Costs will vary widely based on provider size, current level of staffing, and existing relationships with other providers and networks. Many costs are expected to be administrative and in time spent training existing staff, hiring additional staff, updating

technology, and building relationships with other providers or networks.

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. Practices who form a partnership to participate as a PCMH may combine resources and share in any costs that incur. This is largely dependent on provider size, current baseline operations, and available resources.

Practices who form a partnership may incur additional costs in coordinating, implementing, and aligning CPC program objectives among member practices. The practice who acts as the convener may also incur additional costs in this role.

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.

No. 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, with the option of practice partnerships, a small business may now be eligible to participate. 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. More information about the CPC program may be found at: http://medicaid.ohio.gov/Provider/PaymentInnovation.