MEMORANDUM

TO: Tommi Potter, Ohio Department of Medicaid

FROM: Christopher Smyke, Regulatory Policy Advocate

DATE: July 17, 2018

RE: **CSI Review – Patient-Centered Medical Homes (OAC 5160-1-71)**

On behalf of Lt. Governor Mary Taylor, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) § 107.54, CSI has reviewed the abovementioned administrative rules and associated Business Impact Analysis (BIA). This memo represents CSI's comments to the Agency as provided for in ORC § 107.54.

Analysis

This rule package consists of one amended[1] rule submitted by the Ohio Department of Medicaid (ODM) pertaining to patient-centered medical homes (PCMH). The rule was submitted on June 21, 2018 and the CSI public comment period closed on June 28, 2018 with three comments received.

Ohio Administrative Code 5160-1-71 was previously reviewed by CSI with recommendations issued July 15, 2016 and October 16, 2017 in order to implement the rule for the 2017 and 2018 program years. The rule specifies PCMH as a voluntary healthcare delivery model which is driven by primary care providers, is team-based, and provides comprehensive care to individuals enrolled in Medicaid. OAC 5160-1-71 outlines definitions, eligible providers, as well as activity, efficiency, and quality requirements.

The rule is being heavily amended for the 2019 program year in order to allow multiple practices to form a partnership as a PCMH, so long as they collectively maintain the Medicaid enrollment requirement. In addition, the amended rule refines and consolidates several activity requirements, adds a "care management plan" requirement, and adds an additional efficiency requirement

[1] OAC 5160-1-71 is being amended to the extent that the Legislative Service Commission requires the Department to rescind the rule and replace it with a new rule of the same rule number.

related to referral patterns.

The BIA includes a timeline of stakeholder engagement activities that ODM undertook prior to filing the proposed rules with CSI. Between February and June, ODM conducted in-person meetings, telephone calls, webinars, and focus groups, engaging providers and each of the managed care plans. In general, stakeholders were pleased that accreditation will no longer be required and that practice partnership will be an option for service. Three comments were received during the CSI public comment period. One commenter expressed support for the changes instituting practice partnerships, but was concerned that the claims-level data furnished by Medicaid is insufficient for providers to effectively meet the activity requirements under OAC 5160-1-71(F)(1)(c), (d), and (e). ODM responded that it cannot release complete claims-level data to providers, as it would be a violation of HIPAA. Another commenter was concerned about removing the accreditation requirement to which ODM explained that removing this requirement will allow incorporation of more primary care practices into the model while maintaining quality through reporting and other safeguards. A third commenter was concerned about removal of some clinical advice and also some metrics. ODM responded to their questions and explained that more guidance will be provided as necessary.

The BIA identifies the affected business community as providers enrolled in Medicaid fee-for-service, managed care plans, and providers that contract with managed care plans. Providers enrolled in the program must have a minimum number of attributed Medicaid individuals, attest annually that they meet certain quality activity requirements, and other reporting requirements. The BIA lists some of the costs, such as approximately $180,000 to meet the efficiency metrics and activity requirements. The $180,000 cost estimate includes primary care practitioner and care coordinator salaries and administrative costs to report necessary information and keep accurate metrics. National accreditation is no longer required and the amended rule permits the flexibility for smaller providers to form partnerships, reducing costs by pooling resources. ODM justifies this impact as PCMH is a voluntary program to provide quality care more efficiently and implement one of the objectives of the State Innovation Model grant.

Recommendations

For the reasons discussed above, the CSI Office does not have any recommendations for this rule package.

Conclusion

Based on the above comments, the CSI Office concludes that the Ohio Department of Medicaid should proceed with the formal filing of this rule package with the Joint Committee on Agency Rule Review.

Cc: Emily Kaylor, Lt. Governor's Office