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
Patient Centered Medical Homes (PCMH): payments

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

Date: June 18, 2019

Rule Type:

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X Amended	**Rescinded**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

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 rules maintain requirements for the Ohio Department of Medicaid's Comprehensive Primary Care (CPC) program and the CPC for Kids program. 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.

Previous versions of these rules were submitted to CSIO to implement the first program year 2017 and again in subsequent years to incorporate any yearly program updates. These rules are being proposed for amendment to reflect changes to the CPC program for the upcoming 2020 program year.

Proposed for amendment: rule 5160-1-71, "Patient centered medical homes (PCMH): Eligible providers," is being proposed for amendment to reflect proposed changes for the 2020 CPC program year . This rule provides definitional information, identifies eligible entities and requirements for enrollment as a CPC practice, and describes the activity, efficiency, and quality measures including the performance thresholds that must be met. It provides requirements for group practices who participate as a partnership and informs the CPC practice that it may utilize reconsideration rights to challenge a decision of ODM concerning CPC enrollment or eligibility.

Upon enrollment and on an annual basis, this rule requires that each participating CPC practice attest that it will meet the activity requirements set forth in the rule. The CPC practice 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 CPC practice.

This rule will create an additional set of optional requirements, payments, and bonuses for practices that are eligible for and choose to enroll in a pediatric-focused addition to CPC called CPC for Kids. This rule adds a definition for the CPC for Kids program and sets forth the additional requirements participating CPC practices must meet in order to enroll under the CPC for Kids program.

This proposed rule includes two additional activity requirements, removes the generic dispensing rate efficiency metric, and replaces a quality metric. It provides clinical quality requirements specific to the CPC for Kids program and the threshold of metrics that must be passed annually to continue participation in the CPC for Kids program. In addition,

Proposed for amendment: rule 5160-1-72, "Patient Centered Medical Homes (PCMH): payments," is being proposed for amendment to reflect proposed changes for the 2020 program year. This rule provides eligibility criteria to qualify for PCMH payments, including per-member per-month payments, as well as shared savings payments and bonus payments. This rule provides that to be eligible for a bonus payment, the CPC practice must meet all clinical quality, efficiency, and financial outcomes, and must achieve savings on its total cost of care performance. Details regarding payment calculations are included in the rule. Penalties are also stipulated should a CPC practice neglect to meet outcome requirements.

The amendment of this rule will create a payment structure specific to the CPC for Kids program established through the proposed amendments to rule 5160-1-71. This rule defines two new payment types for the CPC for Kids program participants, describes the new payments, how they will be calculated and when payment to the participating CPC practice will begin. The amendments to this rule identify specific requirements that CPC for Kids program participants must meet. It includes a provision in the penalties section of the rule indicating that a CPC practice participating in the CPC for Kids program must continue to meet clinical quality requirements. If those requirements are not met, a warning will be issued and after two consecutive warnings, CPC for Kids participant may be terminated from receiving payment.

CPC for Kids practices will be eligible to qualify for a bonus payment, to be assessed annually, based on their performance on pediatric bonus activities, including supports for children in foster care, behavioral health care linkages, school based health care linkages, transitions of care for children aging out of pediatric care, and select wellness activities including lead testing capabilities, community services and supports screening, tobacco cessation, fluoride varnish, and breastfeeding support. CPC for Kids practices will be scored for performance in each of these categories and top scorers will receive a retrospective bonus payment.

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) under the CPC program 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)?**

ODM believes that promulgating rules related to the optional Ohio CPC program is necessary to inform Ohio Medicaid providers of the Ohio CPC program and clearly communicate requirements of participation.

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 2.8 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. In 2019, the third year of the program, Ohio CPC currently has 163 enrolled practices and practice partnerships, representing 1.1 million Medicaid covered individuals who were attributed to a CPC practice, including 680,000 children age 20 and under.

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

ODM provides quarterly reports to participating practices detailing how well they are meeting the objectives of the Ohio CPC program. ODM will continue measuring the success of this regulation through reporting and monitoring.

Currently, in 2019, the third year of the program, Ohio CPC has 163 enrolled practices and practice partnerships, representing 1.1 million Medicaid covered individuals who were attributed to a CPC practice, including 680,000 children age 20 and under. 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 has been demonstrated through a number of metrics. During the first year of the program, 2017, CPC-enrolled practices experienced cost growth at rate 2.1% less than similar practices not enrolled in CPC, producing an estimated $89 million in cost savings. During the program year, quality metric performance for CPC practices improved by an average of 4.4%. Participating practices are evaluated continually and receive quarterly reports on cost and measure performance. 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.

- 1/17/2019: Provider practice webinar: CPC attribution and payment files
- 1/24/2019: Monthly payment innovation MCP call - discussed 2017 shared savings and program updates
- 1/25/2019: Final Friday best practices webinar: managed care plan and CPC partnering opportunities
- 2/14/2019: Provider practice webinar: Ohio's Comprehensive Primary Care 2017 program outcomes
- 2/22/2019: Final Friday best practices webinar: Using your payment and attribution file
- 3/15-19/2019: One-on-one calls with each MCP - discussed end of SIM period, future directions in CPC, and 2017 program outcomes
- 3/29/2019: Final Friday best practices webinar: integrating non-traditional providers into primary care
- 4/19-23/2019: One-on-one calls with each MCP - discussed upcoming stakeholder engagement and program updates
- 4/25/2019: Monthly payment innovation MCP meeting (discussed CPC for Kids program)
- 4/26/2019: Provider practice webinar: CPC practice and partnership reports

- 4/29/2019: Provider focus group - discussed changes for program year 2020 including updates to Ohio CPC and CPC for Kids vision, practice participation, activity requirements, quality metrics, efficiency metrics, and payment streams
- 5/9/2019: Provider practice webinar: CPC referral reports
- 5/10/2019: Provider focus group - discussed changes for program year 2020 including updates to Ohio CPC and CPC for Kids vision, practice participation, activity requirements, quality metrics, efficiency metrics, and payment streams
- 5/13/2019: Clinical design listening session - discussed changes for program year 2020 including updates to Ohio CPC and CPC for Kids vision, practice participation, activity requirements, quality metrics, efficiency metrics, and payment streams
- 5/21/2019: Listening session - discussed program updates including the inclusion of foster children in Ohio CPC and CPC for Kids
- 5/23/2019: SIM Core Team call (MCPs and other payers) - discussed program changes for 2019
- 5/31/2019: Provider practice webinar: Member attribution

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 amended rules were developed in partnership with stakeholders, including current CPC providers and administrators, health care related associations, and managed care plans. ODM listened to the provider community and incorporated many of their suggested changes in the rules for program year 2020. For example, the "generic dispensing rate" efficiency metric was removed due to negative stakeholder feedback.

Overall, stakeholders were supportive of the revisions proposed for the next program year for the CPC program, and were especially pleased that PCMH practices and partnerships that focus on children will have the option to receive additional incentives to provide high quality, low cost care specifically for their patients.

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. These rules have been in effect since 10/1/2016 and serve the purpose intended, to maintain requirements of the Ohio CPC program. They continue to be applicable to the Ohio CPC program. CPC for Kids builds upon the CPC

program and therefore serves the same purpose but is more directed towards pediatric providers.

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 activity requirements, clinical quality metrics, and efficiency metrics described in the 5160-1-71. CPC for Kids will function in the same way as the original CPC program.

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. CPC for Kids performance data will be added to the existing report formats so that providers participating in CPC for Kids will have one set of consistent, streamlined reports to review and reference.

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

These amended rules will have a minimal adverse impact to the business community. While there are additional requirements for practices voluntarily enrolling in CPC and CPC for Kids, the additional financial incentives offered for participation are expected to offset any additional costs.

Proposed rule 5160-1-71: To be eligible for participation and payment for CPC for Kids beginning in January 2020, a practice must be enrolled as a PCMH, and have at least 150 attributed Medicaid individuals under age 21 as determined through claims-only data.

In this amended rule, a practice that is newly enrolling as a PCMH in 2020 or is re-attesting to continuing as a PCMH in 2020 that meets the criteria to enroll in CPC for Kids as described above may opt-in to enroll in CPC for Kids, in addition to PCMH. All practices participating in CPC for Kids must be enrolled as a PCMH for the 2020 program year and are subject to all the requirements of a PCMH in addition to the requirements of CPC for Kids. PCMH partnerships meeting the criteria for CPC for Kids may opt-in to CPC for Kids at the partnership level, meaning all practices within the partnership will be enrolled at the partnership level and will be assessed for meeting outcomes and requirements at the partnership level.

Two new activity requirements for program year 2020 have been added to the existing eight requirements from program year 2019. Upon enrollment and on an annual basis, each PCMH must attest that it will meet all activity requirements. The two new activity requirements are "community services and supports integration" and "behavioral health integration". The "community services and supports integration" activity requires the PCMH to use screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services. The "behavioral health integration" activity requires the PCMH to identify, refer, and track follow-up care for patients in need of behavioral health services, and has a planned improvement strategy for behavioral health outcomes.

All PCMHs will be required to attest to meeting all ten activity requirements at the beginning of program year 2020, including PCMHs that are re-attesting to meeting activity requirements based on their program year 2019 enrollment.

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.

In addition, practices opting-in to CPC for Kids will need to pass at least 50% of the applicable pediatric metrics, as evaluated at the end of the performance period. There are seven pediatric metrics: the four existing metrics that apply to all PCMHs, including well child visits in the first fifteen months of life, well child visits in the third, fourth, fifth and

sixth years of life, adolescent well care visit, and weight assessment and counseling for nutrition and physical activity for children and adolescents including body mass index assessment for children and adolescents; and three new metrics that will only be calculated for practices opting-in to CPC for Kids, including lead screening in children under age 2, childhood immunization status, and immunizations for adolescents. In addition to passing at least 50% of the applicable pediatric metrics, a CPC for Kids participant must pass at least one of the three new pediatric metrics as long as at least one of the three metrics is applicable (i.e., the practice has at least 30 members that meet the denominator criteria for the metric).

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.

Practices newly enrolling in the Ohio CPC program may incur some costs should they need to perform additional activities to meet those required to become an effective CPC practice. 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, providing attestations to ODM, and building relationships with other providers or networks.

Because the CPC for Kids program builds on the existing requirements of the CPC program, and the additional quality metrics being evaluated for CPC for Kids practices are typically already performed as part of the pediatric standard of care, no additional costs beyond those stated for all CPC practices in the paragraph above are expected. CPC for Kids practices may choose to perform additional activities as described in 5160-1-72 to position themselves to be more likely to receive a bonus payment; however, these changes are not required to participate in the CPC for Kids program.

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. CPC for Kids ongoing participation will be assessed separately from the requirements for CPC practices, as described in the Penalties section of 5160-1-72.

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 cost savings through the consistent and widespread implementation of evidence-based population health activities. It is intended to support practices in their transformation implement these activities by focusing on and linking individuals to primary and preventive care. The implementation of these rules is part of ODM's effort to pay for value by incentivizing and rewarding high quality, low cost care. The Ohio CPC program is performance based, and the incentives afford Medicaid providers the opportunity and flexibility to find the best and most appropriate ways to deliver quality care more efficiently and economically to their patients.

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. With the addition of CPC for Kids, small, often rural, pediatric practices that meet the minimum requirements for the CPC and CPC for Kids programs will receive additional per-member per-month payments as well as the opportunity to earn bonus payments, which under the current CPC program are limited only to larger practices and practice partnerships.

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 rules do 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

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. A PCMH may be a single practice or a practice partnership.

(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 under the PCMH and PCMH for kids program:

(a) The recipient's choice of provider.~~;~~

(b) Claims data concerning the recipient~~; or~~

(c) Other data concerning the recipient.

(3) "Convener" is the practice responsible for acting as the point of contact for ODM and the practices who form a practice partnership.

(4) "PCMH for kids" program is a voluntary enhancement to the PCMH program focused on pediatric members under twenty-one years of age.

~~(4)~~(5) "Practice Partnership" is a group of practices participating as a PCMH whose

performance will be evaluated as a whole. The practice partnership must meet the following requirements:

(a) Each member practice must have an active medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code;

(b) Each member practice must have a minimum of one-hundred-fifty attributed medicaid individuals determined using claims-only data;

(c) Member practices must have a combined total of five-hundred or more attributed individuals determined using claims-only data at each attribution period;

(d) Member practices must have a single designated convener that has participated as a PCMH for at least one year;

(e) Each member practice must acknowledge to ODM its participation in the partnership; and

(f) Each member practice must agree that summary-level practice information will be shared by ODM among practices within the partnership.

(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 for payment beginning in ~~2019~~2020, the PCMH must:

(1) Have at least five-hundred attributed medicaid individuals determined using claims-only data, attest that it will participate in learning activities as determined by ODM or its designee, and share data with ODM and

contracted MCPs; or

(2) Be a practice who participated in the PCMH 2017 program year.

(F) To be eligible for enrollment in the PCMH for kids program for payment beginning in 2020, the PCMH must:

(1) Be a PCMH that participates in ODM's PCMH program for the 2020 program year; and

(2) Have at least one-hundred and fifty attributed medicaid pediatric individuals determined using claims-only data.

~~(F)~~(G) An enrolled PCMH must meet activity requirements within the timeframes below and have written policies where specified. Further descriptions of these activities can be found on the ODM website, www.medicaid.ohio.gov.

(1) Upon enrollment and on an annual basis, the PCMH must attest that it will:

(a) Meet the "twenty-four-seven and same-day access to care" activity requirements in which the PCMH must:

(i) Offer at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include, but is not limited to, e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends.

(ii) Within twenty-four hours of initial request, provide access to a primary care practitioner with access to the patient's medical record; and

(iii) 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.

(b) 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.

(c) 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.

(d) Meet the "team-based care delivery" activity requirements in which the PCMH must define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM, and other providers as applicable for patients in specific patient segments identified by the PCMH.

(e) Meet the "care management plans" activity requirements in which the PCMH must create care plans that include necessary elements for all high-risk patients as identified by the PCMH's risk stratification process.

(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.

(i) Meet the "community services and supports integration" activity requirements in which the practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.

(j) Meet the "behavioral health integration" activity requirements in which the PCMH identifies, refers, and tracks follow-ups for patients in need of behavioral health services, and has a planned improvement strategy for behavioral health outcomes.

~~(G)~~(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. Further details regarding these requirements can be found on the ODM website, www.medicaid.ohio.gov.

~~(1) Generic dispensing rate;~~

~~(2)~~(1) Inpatient admission for ambulatory care sensitive conditions (ACSCs);

~~(3)~~(2) Emergency room visits per one thousand;

~~(4)~~(3) Behavioral health related inpatient admissions per one thousand; and

~~(5)~~(4) Referral patterns to episode principle accountable providers (PAPs) as defined in rule 5160-1-70 of the Administrative Code.

~~(H)~~(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. Further details regarding these metrics 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; HbA1c 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 participating in PCMH for kids must also 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. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Lead screening in children;

(2) Childhood immunization status;

(3) Immunizations for adolescents;

(4) Well-child visits in the first fifteen months of life;

(5) Well-child visits in the third, fourth, fifth, and sixth years of life;

(6) Adolescent well-care visit; and

(7) Weight assessment and counseling for nutrition and physical activity for children and adolescents. Body mass index (BMI) assessment for children and adolescents.

(K) A PCMH participating in PCMH for kids must also pass at least one of the following clinical quality requirements when applicable, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Lead screening in children;

(2) Childhood immunization status;

(3) Immunizations for adolescents;

~~(I)~~(L) 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 or PCMH for kids enrollment or eligibility.

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 paragraphs (C) to (E) and paragraphs (G) to (I) of rule 5160-1-71 of the Administrative Code to be eligible for PCMH payments.

(B) A PCMH participating in the PCMH for kids program must be enrolled as a PCMH and meet all requirements set forth in rule 5160-1-71 of the Administrative Code to be eligible for PCMH for kids payments.

~~(B)~~(C) An eligible PCMH may qualify ~~to access~~for 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 for kids enhanced per-member-per-month (PMPM)" is a payment to support the PCMHs participating in the PCMH for kids program.

(a) Payment is in the form of a prospective flat PMPM payment per attributed medicaid pediatric individual;

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

~~(2)~~(3) The "PCMH shared savings payment" is a payment for a PCMH that meets

quality, efficiency, 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 paragraph (B)(1) of rule 5160-1-71 of the Administrative Code; 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.

(4) The "PCMH for kids bonus payment" is an annual retrospective payment for the highest performing PCMHs participating in the PCMH for kids program that meet quality and efficiency outcomes and perform additional bonus activities focused on improving pediatric care. Specific information regarding the PCMH for kids bonus payment can be found on the ODM website, www.medicaid.ohio.gov.

(a) To be eligible for the PCMH for kids bonus payment, the PCMH must be a high performing PCMH relative to other PCMHs participating in the PCMH for kids program based on performance of risk-adjusted scoring of the following pediatric bonus activities, which will be determined by ODM and evaluated annually during each performance period. Specific information can be found on the ODM website, www.medicaid.ohio.gov.

(i) Additional supports for children in foster care;

(ii) Behavioral health care linkages:

(iii) School-based health care linkages;

(iv) Transitions of care; and

(v) Select wellness activities, including lead testing capabilities, community services and supports screening, tobacco cessation, fluoride varnish, and breastfeeding support.

(b) In the event of a tied score on the pediatric bonus activities, the PCMH will be ranked for bonus payment based upon the percent of applicable quality and efficiency metrics passed. If there is a tie, then the following will be applied:

(i) The PCMHs are ranked based upon the highest average point performance over threshold across all applicable quality and efficiency metrics, rounded to the nearest percent. If additional ties persist then;

(ii) Bonus payment will be split equally among each PCMH in the tie group.

~~(C)~~(D) Penalties.

(1) The PCMH must continue to meet activity requirements annually as defined in paragraph (G) of rule 5160-1-71 of the Administrative Code. 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 rule 5160-1-71 of the Administrative Code. If any of these requirements are not met, a warning will be issued. After two consecutive warnings, payment under this rule will be terminated.

(3) A PCMH participating in PCMH for kids must continue to meet clinical quality requirements defined in paragraphs (J) and (K) of rule 5160-1-71 of the Administrative Code. If any of these requirements are not met, a warning will be issued. After two consecutive warnings, PCMH for kids payments under this rule will be terminated.

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