Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Comprehensive Primary Care (CPC) Program

Rule Number(s): 5160-1-71 (rescind), 5160-1-72 (rescind), 5160-19-01 (new), 5160-19-02 (new)

For information only: 5160-1-71 (new) and 5160-1-72 (new)

Date of Submission for CSI Review: 6/23/2020

Public Comment Period End Date: 6/30/2020

Rule Type/Number of Rules:

New/ 4 rules — No Change/____ rules (FYR? ___)

Amended/____ rules (FYR? ___) — Rescinded/ 2 rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing

regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **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 implement the Ohio Department of Medicaid's Comprehensive Primary Care Program (CPC) and the CPC for Kids program. These programs utilize 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.

   These rules were initially submitted to CSIO to implement the first program year 2017 and again in subsequent years to incorporate any yearly program updates. The rules contained in this package are being proposed for rescission and adoption to reflect changes to the CPC program for the upcoming 2021 program year.

As Ohio Medicaid continues to streamline operations and implement value-based incentive programs, ODM determined that rules related to these and other alternative payment models should be included together in a separate chapter under agency 5160 of the Administrative Code. For this reason, rules governing this program are being moved from Chapter 5160-1 of the Administrative Code to Chapter 5160-19 of the Administrative Code.

The new proposed rules under Chapter 19 modify language found in rules 5160-1-71 and 5160-1-72 of the Administrative Code to remove regulatory restrictions and comply with Section 121.95 of the Ohio Revised Code.

Proposed for rescission: Rule 5160-1-71, "Patient centered medical homes (PCMH): Eligible providers," is being proposed for rescission because its content will be replaced with new proposed rule 5160-19-01 under the same title. 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.

For CPC practices who choose to participate in the optional CPC for Kids program, they will be subject to additional requirements and be eligible for additional payments and bonuses under the CPC for Kids program. This rule defines 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 rule 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.

Proposed for adoption: Rule 5160-19-01, "Patient centered medical homes (PCMH): eligible providers," is a new rule that will contain the content from existing OAC rule 5160-1-71 of the same title that is being proposed for rescission in this package.

This new proposed rule contains the same content from rule 5160-1-71 that is being proposed for rescission with the following exceptions:

- This new proposed rule modifies language to remove regulatory restrictions and comply with Section 121.95 of the Ohio Revised Code.
- This new proposed rule no longer allows practices to enroll as a PCMH if they participated in the PCMH 2017 program year but do not meet the minimum attributed member threshold identified in the rule. Since the program is no longer new and for purposes of program integrity, this provision for early adopters is no longer needed.
- This new proposed rule modifies the "community service and supports integration" activity to remove the provision that the PCMH practice use screening tools to identify patients in need of community services and supports. The participating practice should continue to identify patients in need but screening tools are not specifically necessary to complete this activity.
- This new proposed rule modifies the "behavioral health integration" activity to include the provision that the PCMH practice should use screening tools to identify patients in need of behavioral health services. In the proposed rule to be rescinded, there is no provision that screening tools be used.
- For the 2020 calendar year, this new proposed rule removes the provision that PCMH practices must pass a number of efficiency and clinical quality measures to qualify for shared savings payments under the PCMH and PCMH for Kids programs. Due to challenges presented by COVID-19 and the state of emergency declared in response, it is unlikely that PCMH practices would be able to meet these thresholds therefore these requirements are being suspended and shared savings payments will not be available for the 2020 calendar year.

Proposed for rescission: Rule 5160-1-72, "Patient Centered Medical Homes (PCMH): Payments," is being proposed for rescission as the content of 5160-1-72 is being moved to the new proposed rule 5160-19-02 under the same title. This rule provides eligibility criteria to qualify for CPC program payments, including per-member per-month payments (PMPMs), shared savings payments and bonus payments.

This rule outlines the payment structure and defines payment types specific to the CPC and CPC for Kids programs, describes payments, how they will be calculated and when payment to the participating CPC practice occurs. This rule identifies specific activities that CPC and CPC for Kids program participants must meet to qualify for bonus payments.

This rule sets forth the eligibility requirements to receive a CPC shared savings payment. The CPC practice must meet all requirements found in rule 5160-1-71 of the Administrative Code

that is being rescinded and replaced with 5160-19-01. Details regarding payment calculations are included in the rule.

This rule outlines the eligibility requirements for the CPC for Kids program and states that a CPC practice must be enrolled and meet all requirements set forth in rule 5160-1-71 of the Administrative Code. If those requirements are not met, a warning will be issued and after two consecutive warnings, CPC for Kids practices may no longer receive payment under this rule.

CPC for Kids practices are eligible under this rule 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. CPC for Kids practices will be scored for performance in wellness activities and top scorers will receive a retrospective bonus payment.

Proposed for adoption: Rule 5160-19-02, "Patient Centered Medical Homes (PCMH): payments," is a new rule which will replace existing OAC rule 5160-1-72 of the same title that is being proposed for rescission in this package. As Ohio Medicaid continues to streamline operations, ODM determined that rules related to alternative payment models should be included in a separate chapter under agency 5160 of the Administrative Code.

This new proposed rule contains the same content from rule 5160-1-72 that is being proposed for rescission with the following exceptions:

- This new proposed rule modifies language to remove regulatory restrictions and comply with Section 121.95 of the Revised Code.
- For the 2020 calendar year, this new proposed rule modifies the definitions of "PCMH shared saving payment" and "PCMH for kids bonus payment" to indicate that PCMH practices are not eligible to earn these payments because they are not subject to meeting the required quality and efficiency metrics. Due to challenges presented by COVID-19 and the state of emergency declared in response, it is unlikely that PCMH practices would be able to meet these thresholds therefore they are being suspended and the shared savings payment will not be available for the 2020 calendar year.
- For the 2020 calendar year, this new proposed rule removes the potential for disenrollment associated with not meeting the efficiency and clinical quality measures under the PCMH and PCMH for Kids programs.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   ODM is promulgating these rules under section 5164.02 of the Revised Code.

4. **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.***

   In 2017, CMS implemented a new health care delivery payment system known as Comprehensive Primary Care Plus (CPC+). This model increases access to primary care using patient centered medical homes (PCMH). Ohio implemented its state Comprehensive Primary Care (CPC) program in alignment with the federal CPC+ program and has agreed in its Medicaid State Plan with CMS to continue to support the PCMH model 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.

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

   This regulation does not include provisions specifically required by the federal government. The provisions that are not a federal requirement are still consistent with federal expectations for this type of program.

6. **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 program, to clearly communicate responsibilities of participation, maintain program integrity, and meet expectations of the Centers for Medicare and Medicaid Services (CMS) who provide federal financial participation to support this program.

   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. in the first two years of the CPC program, Ohio is estimated to have saved 2% per year on the total cost of care for members attributed to a CPC practice. Ohio has paid out a total of $54 million dollars in shared savings to

practices participating in the CPC program for 2017 and 2018, based on their estimated reductions to total cost of care for their Medicaid patients

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 dollars 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 2020, the fourth year of the program, Ohio CPC has 197 CPC practices, representing 1.2 million Medicaid covered individuals who were attributed to a CPC practice, including 800,000 children age 20 and under.

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

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

   In 2020, the fourth year of the program, Ohio CPC has 197 CPC practices, representing 1.2 million Medicaid covered individuals who were attributed to a CPC practice, including 800,000 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 program has been demonstrated through a number of metrics. During the first year of the program in 2017, CPC-enrolled practices experienced cost growth at a 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.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. 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.

- 3/4/2020: Representatives from the Medicaid Managed Care Plans listed below attended an onsite meeting to discuss CPC Updates for 2021
  - CareSource
  - Buckeye Health Plan
  - Paramount Advantage
  - United Health Care Community Plan of Ohio and
  - Molina Healthcare of Ohio

- 3/16/2020: One-on-one calls with each MCP - Discussed 2021 CPC updates
- 3/26/2020: Webinar: Emergency Telehealth Rules and CPC Rules -An Overview for CPC Practices
- 4/15/2020: 2021 Program Improvement Survey was sent to all CPC provider practices and Medicaid Managed Care Plans to obtain feedback for rule and program improvements for the 2021 CPC program year
- 4/17/2020: One-on-one calls with each MCP - Discussed 2021 CPC updates and COVID -19 possible impacts to 2021 CPC program changes
- 4/23/2020: Provider practice CPC webinar: Communication Updates Specific to COVID-19

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

These rules were developed in partnership with stakeholders, including current CPC providers and administrators, health care related associations, and managed care plans. Overall, stakeholders have been supportive of the minor revisions proposed for the next program year.

11. 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.

12. **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. The CPC program 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 and CPC for Kids program and are necessary to clearly communicate responsibilities of participation, maintain program integrity and to remain in alignment with the Centers for Medicare and Medicaid Services (CMS) program expectations.
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13. **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.***

    Ohio CPC and CPC for Kidsare performance-based programs. Primary care practices that volunteer to participate in the Ohio CPC and CPC for Kids programs must meet the activity requirements, clinical quality metrics, and efficiency metrics described in the new proposed rule 5160-19-01.

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

    ODM consulted with representatives from the Medicaid Managed Care Plans and with ODM legal staff to ensure that respective rules and processes set forth therein are well coordinated and are not duplicative.

15. **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 and CPC for Kids practices, and ensure they have timely and streamlined access to their performance data. All providers participating in the CPC program will receive a set of consistent and streamlined reports to review and reference.

Adverse Impact to Business

16. **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; and**

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 that have chosen to participate in these programs. The Ohio CPC program and CPC for Kids program is voluntary; only practices that choose to enroll and participate will be impacted by these rules.

Under proposed rule 5160-19-01, practices who participated in 2017 are no longer eligible to participate in the CPC program if they do not meet the minimum member attribution threshold. While most participating practices meet the minimum thresholds, a small number of practices do not meet the threshold and will be unable to participate in the 2021 program year. This does not prevent such practices from participating in a practice partnership or in future years beyond 2021 of the CPC program if the attribution thresholds are met.

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

The revisions made for CPC program year 2021 are minimal and are expected to have little adverse impact to the overall business community. Practices incur some costs through participation however additional financial incentives are expected to offset any additional costs. Some adverse impacts are being removed for program year 2021 and no new adverse impacts are being added.

Rule 5160-1-71 to be rescinded: The content of this rule will be moving to the new proposed rule 5160-1-01 therefore**,** there will be no adverse impact as a result of the rescission of this rule.

Rule 5160-19-01 to be adopted: To meet the provisions of this rule, it is likely that expenses will increase. To be eligible to enroll for participation in January 2021, a practice has to report specific information as a condition of compliance. Each participating practice has to enroll as a CPC practice by completing the online application and have at least 150 attributed Medicaid individuals. To be eligible for participation in the CPC for Kids program, the CPC practice has to enroll as a CPC for Kids practice by completing the online application and have at least 150 attributed Medicaid individuals under age 21 as determined through claims-only data. Practices newly enrolling as a CPC practice in the 2021 program year have to report specific information by completing an application during the designated enrollment period. The CPC program requires practices that participated in the CPC program for the previous performance year to re-attest their desire continue as a CPC and/or CPC for Kids practice in 2021 by completing the enrollment application during the designated enrollment period.

Upon enrollment and on an annual basis, each CPC practice has to report specific information and attest that it will meet all activity requirements. All CPC practices will be required to attest to completing all activities at the beginning of program year 2021, including CPC practices that are re-attesting to meeting activity requirements based on their current program year enrollment.

Except for the 2020 calendar year, participating CPC practices have to pass a number of efficiency and clinical quality measures that represent at least 50% of applicable metrics on a yearly basis. Except for the 2020 calendar year, practices who choose to participate in the CPC for Kids program 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 including four existing metrics that apply to all CPC practices and three metrics that will only be calculated for practices who participate in the CPC for Kids program. Except for the 2020 calendar year, in addition to passing at least 50% of the applicable pediatric metrics, a CPC for Kids practice has to pass at least one of the three 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).

Rule 5160-1-72 to be rescinded: The content of this rule is being moved to the new proposed rule 5160-19-02, therefore there will be no adverse impacts as a result of the rescission of this rule.

Rule 5160-19-02 to be adopted: This rule identifies specific activities that CPC practices have to meet to qualify for bonus payments. To meet the provisions of this rule, it is likely that expenses will increase.

This rule provides that to be eligible for a shared savings payment in calendar year 2021 and beyond, the CPC practice has to meet all requirements found in rule 5160-19-01 of the Administrative Code. Details regarding payment calculations are included in the rule. Except for the 2020 calendar year, penalties are also stipulated should a CPC practice neglect to meet outcome measures. If these measures are not met, a warning letter will be issued and after two consecutive warnings, the CPC practice may no longer receive payment under this rule.

This rule specifies that a CPC practice participating in the CPC for Kids program has to be enrolled and meet all requirements set forth in rule 5160-19-01 of the Administrative Code. If those requirements are not met, a warning will be issued and after two consecutive warnings, CPC for Kids practice may no longer receive payment under this rule.

Except for the 2020 calendar year, CPC for Kids practices are eligible under this rule 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. Except for the 2020 calendar year, CPC for Kids practices will be scored for performance in each of these categories and top scorers will receive a retrospective bonus payment.

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.

Rule 5160-1-71 to be rescinded: The content of this rule is being moved to the new proposed rule 5160-19-01, therefore there will be no adverse impacts as a result of the rescission of this rule.

Rule 5160-19-01 to be adopted: To meet the provisions of this rule, it is likely that expenses will increase. To be eligible for participation in January 2021, an eligible practice has to be enrolled as a CPC practice and have at least 150 attributed Medicaid individuals. To be eligible for participation in the CPC for Kids program, the CPC practice has to enroll as a CPC for Kids practice and have at least 150 attributed Medicaid individuals under age 21 as determined through claims-only data. Practices newly enrolling as a CPC practice in the 2021 program year are expected to complete an application during the designated enrollment period. Existing CPC practices will re-attest for the next year if they desire to continue as a CPC and/or CPC for Kids practice by completing an enrollment application during the designated enrollment period.

Practices newly enrolling in the Ohio CPC program may incur some costs to meet the requirements described in 5160-19-01.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 are expected. CPC for Kids practices may

choose to perform additional activities as described in 5160-19-02 to position themselves to be more likely to receive a bonus payment.

Upon enrollment and on an annual basis, each CPC practice must attest that it will meet all activity requirements. All CPC practices have to attest to meeting all ten activity requirements at the beginning of program year 2021, including CPC practices that are re-attesting to meeting activity requirements based on their current program year enrollment.

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 are incurred. This is largely dependent on provider size, current baseline operations, and available resources.

Rule 5160-1-72 to be rescinded: The content of this rule is being moved to the new proposed rule 5160-19-02, therefore there will be no adverse impacts as a result of the rescission of this rule.

Rule 5160-19-02 to be adopted: This rule identifies specific activities that CPC and CPC for Kids program participants are expected to meet to qualify for bonus payments. There are no expected adverse impacts in terms of dollars as the participation in the CPC program is voluntary and would impose no additional costs on primary care providers that provide such services under authorities the of §1905(t), §1905(a)(25) and §1905(t)(3) of the Social Security Act.

CPC enrolled providers receive per-member-per month payments to support the CPC practice in comprehensively managing a patient's health needs and provides the CPC enrolled providers with the opportunity to share savings in the total cost of care if they meet the requirements described in 5160-19-01.

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

The regulatory intent justifies the slight adverse impact to the regulated business community as it provides regulated business with incentives in the form of per-member-per-month payments and the opportunity to receive shared savings bonus payments for providing services in the form of comprehensive care that they are currently and expected to provide under §1905 of the Social Security Act. Furthermore, the CPC and CPC for Kids program is to achieve better health outcomes and cost savings through improvement. It is intended to support practices in their transformation to achieve cost savings and improve health outcomes by focusing on and linking individuals to primary and preventive care. The implementation of these rules is a step toward shifting to value-based purchasing. The CPC program is performance-based and the incentives encourage Medicaid providers to deliver quality care more efficiently and economically.

Regulatory Flexibility

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

For small businesses that choose to enroll as a PCMH practice, there are no alternate means of compliance; however, informational resources are available on the ODM website to support the PCMH.

19. 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.

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

Since implementation of the CPC program in 2017, ODM has developed a web page for the program and conducts periodic learning sessions and webinars. The ODM web page includes additional information for participating practices on the CPC and CPC for Kids programs including frequently asked questions, training, and educational materials. The ODM website also houses additional information and resources for providers to assist with a variety of topics.

Providers may contact Provider Assistance by calling 1-800-686-1516.

TO BE RESCINDED

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.

(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.

(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 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 fifty attributed medicaid pediatric individuals determined using claims-only data.

(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.

(H) An enrolled PCMH must pass a number of the following efficiency requirements representing at least fifty per cent 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) Inpatient admission for ambulatory care sensitive conditions (ACSCs);

(2) Emergency room visits per one thousand;

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

(4) 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 per cent 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 per cent);

(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 at least fifty per cent of the applicable metrics from the following list of clinical quality requirements, 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;

(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.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	null
Rule Amplifies:	null

TO BE RESCINDED

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.

(C) An eligible PCMH may qualify 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.

(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 per cent; 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 per cent 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 per cent. If additional ties persist then;

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

(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.

(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.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	null
Rule Amplifies:	null

DRAFT - NOT FOR FILING

5160-1-71 Relocated provisions concerning patient centered medical homes (PCMH) and eligible providers.

Provisions concerning patient centered medical homes (PCMH) and eligible providers are set forth in rule 5160-19-01 of the Administrative Code. The PCMH rules implement the Ohio department of Medicaid's comprehensive primary care (CPC) program and CPC for Kids programs.

DRAFT - NOT FOR FILING

5160-1-72 Relocated provisions concerning patient centered medical homes (PCMH) and payments.

Provisions concerning patient centered medical homes (PCMH) and payments are set forth in rule 5160-19-02 of the Administrative Code. The PCMH rules implement the Ohio department of medicaid's comprehensive primary care (CPC) program and CPC for Kids programs.

DRAFT - NOT FOR FILING

5160-19-01 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, known as the comprehensive primary care (CPC) program is voluntary. A PCMH may be a single practice or a practice partnership.

(B) For purposes of Chapter 5160-19 of the Administrative Code, the following definitions apply:

(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 organizations (MCOs). 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 recipients 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; MCOs 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.

(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) "Eligible provider" is as defined in rule 5160-1-17 of the Administrative Code.

(5) "PCMH for kids" program is a voluntary enhancement to the PCMH program focused on attributed pediatric medicaid covered individuals under twenty-one years of age.

(6) "Practice Partnership" is a group of practices participating as a PCMH whose performance will be evaluated as a whole. The practice partnership has to meet the following provisions:

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

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

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

(d) Each member practice will acknowledge to ODM its participation in the partnership; and

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

(C) The following eligible providers may participate in ODM's PCMH program through their contracts with MCOs 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 clinics.

(6) Public health department clinics.

(7) Professional medical groups billing under hospital provider types.

(D) The following eligible providers may participate in the delivery of primary care activities or services in the PCMH program:

(1) Medical doctor (MD) or doctor of osteopathy (DO) as defined in 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 as defined in 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 as defined in section 4730.11 of the Revised Code.

(E) To be eligible for enrollment in the PCMH program for payment beginning in 2021, the PCMH will 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 MCOs;

(F) To be eligible for enrollment in the PCMH for kids program for payment beginning in 2021, the PCMH will:

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

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

(G) It is the responsibility of an enrolled PCMH to complete activities within the time frames stated in this rule and have written policies where specified. Further descriptions of these activities can be found on the ODM website, www.medicaid.ohio.gov. Upon enrollment and on an annual basis, the PCMH is expected to attest that it will:

(1) Complete the "twenty-four-seven and same-day access to care" activities in which the PCMH will:

(a) 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.

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

(c) Make clinical information of the attributed medicaid individual 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.

(2) Complete the "risk stratification" activities in which the PCMH will have a developed method for documenting patient risk level that is integrated within the attributed medicaid individual's record and has a clear approach to implement this across the practice's entire patient panel.

(3) Complete the "population health management" activities in which the PCMH will identify attributed medicaid individuals 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 attributed medicaid indivudual.

(4) Complete the "team-based care delivery" activities in which the PCMH will define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM, and other providers as applicable for attributed medicaid individuals in specific segments identified by the PCMH.

(5) Complete the "care management plans" activities in which the PCMH will create care plans that include necessary elements for all high-risk attributed medicaid individuals as identified by the PCMH's risk stratification process.

(6) Complete the "follow-up after hospital discharge" activities in which the PCMH will 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.

(7) Complete the "tests and specialist referrals" activities in which the PCMH will have established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.

(8) Complete the "patient experience" activities in which the PCMH will:

(a) Orient all attributed medicaid individuals to the practice and incorporate patient preferences in the selection of a primary care provider to build continuity of attributed medicaid individual relationships throughout the entire care process;

(b) Ensure all staff who provides direct care or otherwise interacts with attributed medicaid individuals completes cultural competency training, as deemed acceptable by ODM, within twelve months of program enrollment and annually thereafter;

(c) Ensure that new staff who will provide direct care or otherwise interact with attributed medicaid individuals complete cultural competency training within ninety days of their start date;

(d) Routinely assess demographics and adapt training needs based on demographics;

(e) Assess its approach to attributed medicaid individual experience and cultural competency at least once annually through the use of the Patient and Family Advisory Council (PFAC) or other quantitative and qualitative means, such as focus groups or a patient survey, that covers access to care, communication, coordination, and whole person care and self-management support; and

(f) Use the information collected pursuant to paragraph (G)(8)(e) of this rule to identify and act on opportunities to improve attributed medicaid individual experience and reduce cultural disparities, including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. The PCMH will report findings and opportunities to attributed medicaid individuals, the PFAC, payers, and ODM.

(9) Complete the "community services and supports integration" activities in which the PCMH practice will identify medicaid covered individuals in need of community services and supports and maintains a process to connect attributed medicaid individuals to necessary services.

(10) Complete the "behavioral health integration" activities in which the PCMH practice will use screening tools to identify attributed medicaid individuals in need of behavioral health services, tracks and follow up on behavioral health service referrals, and has a planned improvement strategy for behavioral health outcomes.

(H) Except for the 2020 calendar year, it is the responsibility of a PCMH practice to pass a number of the following efficiency metrics representing at least fifty per cent 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) Inpatient admission for ambulatory care sensitive conditions (ACSCs);

(2) Emergency room visits per one thousand;

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

(4) Referral patterns to episode principle accountable providers (PAPs) as defined in Agency 5160 of the

Administrative Code.

(I) Except for the 2020 calendar year, it is the responsibility of a PCMH practice to pass a number of the following clinical quality metrics representing at least fifty per cent 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 attributed medicaid individuals with asthma;

(13) Statin therapy for attributed medicaid individuals with cardiovascular disease;

(14) Comprehensive diabetes care; HbA1c poor control (greater than nine per cent);

(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; and

(20) Initiation and engagement of alcohol and other drug dependence treatment.

(J) Except for the 2020 calendar year, it is the responsibility of a PCMH practice participating in PCMH for kids to also pass at least fifty per cent of the applicable metrics from the following list of clinical quality 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. BMI assessment for children and adolescents.

(K) Except for the 2020 calendar year, it is the responsibility of a PCMH practice participating in PCMH for kids to also pass at least one of the following clinical quality metrics 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; and

(3) Immunizations for adolescents.

(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.

5160-19-02 **Patient centered medical homes (PCMH): payments.**

(A) A patient centered medical home (PCMH) has to be enrolled and meet the provisions set forth in rule 5160-19-01 of the Administrative Code to be eligible for PCMH payments.

(B) A PCMH participating in the PCMH for kids program has to be enrolled as a PCMH and meet all provisions set forth in rule 5160-19-01 of the Administrative Code to be eligible for PCMH for kids payments.

(C) An eligible PCMH may qualify 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 is calculated for each attributed medicaid individual by 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 determined by ODM;

(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 determined by ODM.

(3) The "PCMH shared savings payment" is a payment for a PCMH that meets quality, efficiency, and financial outcomes. PCMH practices are not eligible to earn this payment for the 2020 calendar year as they are not subject to the quality and efficiency metric thresholds.

(a) To be eligible for the PCMH shared savings payment, the PCMH has to

meet the following:

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

(ii) The PCMH can achieve savings on its total cost of care during the performance period compared to its own baseline total cost of care performance, or by performing 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 the following 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 attributed medicaid individuals 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 per cent; and

(e) All expenditures for individuals with more than ninety 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 the PCMH's total cost of care for its attributed medicaid individuals as defined in paragraph (B)(1) of rule 5160-19-01 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 and not to exceed one million dollars.

(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. PCMH practices are not eligible to earn

this payment for the 2020 calendar year as they are not subject to the quality and efficiency metric thresholds identified in rule 5160-19-01 of the Administrative Code.

(a) To be eligible for the PCMH for kids bonus payment other than for calendar year 2020, the PCMH has to 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) Integration of behavioral health services:

(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 per cent 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 per cent. If additional ties persist then;

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

(D) Payment conditions.

(1) A PCMH has to continue completing activities annually as defined in paragraph (G) of rule 5160-19-01 of the Administrative Code. If activities are not completed upon evaluation, payment under this rule terminates; and

(2) Except for the 2020 calendar year, t PCMH has to continue to meet efficiency and clinical quality metrics defined in paragraphs (H) and (I) of rule 5160-19-01 of the Administrative Code. If any of these metrics are not met, a

warning will be issued. After two consecutive warnings, payment under this rule will be terminated.

(3) Except for the 2020 calendar year, a PCMH participating in PCMH for kids has to continue to meet clinical quality metrics defined in paragraphs (J) and (K) of rule 5160-19-01 of the Administrative Code. If any of these provisions are not met, a warning will be issued. After two consecutive warnings, PCMH for kids payments under this rule will be terminated.

(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.