

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](http://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 individual.
- (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](http://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](http://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](http://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](http://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.

Effective:

Five Year Review (FYR) Dates:

---

Certification

---

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02