



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): 5160-19-01 (amend), 5160-19-02 (amend)

Date of Submission for CSI Review: 8/19/2025

Public Comment Period End Date: 8/25/2025

Rule Type/Number of Rules:

New/___ rules

No Change/___ rules (FYR? ___)

Amended/ 2 rules (FYR? N)

Rescinded/___ rules (FYR?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.

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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 three million Ohioans covered by Medicaid.

CPC is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs with the goal of improving quality of care and lowering costs by empowering practices to deliver the best care possible.

The rules contained in this package are being proposed for amendment to reflect changes to the CPC program for the upcoming 2026 program year.

OAC rule 5160-19-01: "Comprehensive primary care (CPC) program: eligible providers" is being amended to adjust the following provisions:

- 5160-19-01(A)(1): ODM will update the attribution definition to clarify that those not able to participate in accordance with rule 5160-1-17.2 of the Administrative Code at the

time of attribution or during the prospective payment period are not eligible for payment.

- 5160-19-01(A)(3)(e): ODM will remove “Recipients attributed to other population health alternative payment models administered by ODM under Chapter 5160-19 of the Administrative Code” and add it to paragraph (C)(1)(a) of rule 5160-19-02 under per-member-per-month (PMPM) payments to clarify that there are not dual payments being paid for one member.
- 5160-19-01(A)(5): ODM will add the definition for “CPC entity” which may be a single practice or a practice partnership participating in CPC for clarity.
- 5160-19-01(A)(10): ODM will add the definition for “population health management” which is an approach to maintain and improve physical and psychosocial well-being and address differences in health outcomes among communities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.
- 5160-19-01(D): ODM will add that CPC entities will continue to meet all of the provisions described in paragraph (F) of this rule as of January 1 of the program year to align with the required Provider Network Management module (PNM) attestation statement that providers currently attest to and removing “participate in learning activities as determined by ODM or its designee” and “attest that it will share all requested data with ODM and contracted MCOs” and moving them to paragraph (F)(12) and (F)(13) respectively for clarity.
- 5160-19-01(F): ODM will add “population health” to “activities” to reinforce the intent of the activities.
- 5160-19-01(F)(3): ODM will update the definition of “population health management” activities to clarify the intent of the activity which is to identify attributed Medicaid individuals in groups or segments by using practice-defined common characteristics that are in need of preventative or chronic services and outreach to schedule applicable appointments or identify additional services needed to meet the needs and improve the health of the identified group or segment of attributed Medicaid individuals.
- 5160-19-01(F)(4): ODM will remove “team-based care delivery” to reduce duplicity in the program and upon recommendation from the ODM clinical team, replacing it with “continuous quality improvement” activities in which the CPC entity will demonstrate regular and ongoing quality improvement through the use of quality improvement projects, quality goals for outcome metrics, quality improvement education for staff, quality improvement committees, or other quality improvement activities that also includes the voice of the patient and the provider to continuously improve the quality of care for attributed Medicaid individuals.

- 5160-19-01(F)(8): ODM will add “CPC entity staff and provider” to the patient experience activity upon recommendation from the ODM clinical team so CPC entities take internal staff and provider satisfaction into account in addition to their patients’ experience.
- 5160-19-01(F)(8)(f): ODM will replace references to “cultural disparities” with “differences in health outcomes among communities” to align with the Medicaid Managed Care Provider Agreement effective 07/01/2025.
- 5160-19-01(F)(8)(g): ODM will add guidance for the CPC entity upon recommendation from the ODM clinical team on gathering internal staff and provider experience feedback by using resources such as meeting minutes, surveys, or a comment box.
- 5160-19-01(F)(12) and (F)(13): ODM will add due to moving “will participate in learning activities as determined by ODM or its designee” and “share all requested data with ODM and contracted MCOs” from paragraph (D).
- 5160-19-01(F)(14): ODM will add this to align with the required Provider Network Management module (PNM) attestation statement that providers currently annually attest to that CPC entities are to conduct outreach and deliver primary care services to attributed Medicaid individuals who are not current patients.
- 5160-19-01(F)(15): ODM will add the use of electronic health records to align with the Comprehensive Maternal Care (CMC) program.
- 5160-19-01(H)(13): ODM will remove “Comprehensive diabetes care; HbA1c poor control (greater than nine per cent)” and replace it with “Glycemic status assessment for patients with diabetes” to align with measure year (MY) 2025 Healthcare Effectiveness Data and Information Set (HEDIS) updates.
- 5160-19-01(H)(16): ODM will remove “Antidepressant medication management” and replacing it with “Follow up after emergency department (ED) visit for mental illness” to align with MY2025 HEDIS updates.
- 5160-19-01(H)(22): ODM will add “Follow up after ED visit for substance use” upon recommendation from the ODM clinical team to align with MY2025 HEDIS updates.

OAC rule 5160-19-02: “Comprehensive primary care (CPC) program: payments” is being proposed for amendment to reflect updates for the upcoming 2026 program year including:

- 5160-19-02(C)(1)(a): ODM will add an exception to CPC PMPM payments for individuals attributed to other population health alternative payment models

administered by ODM under Chapter 5160-19 of the Administrative Code to align with system functionality and to prevent dual payments for one Medicaid individual.

- 5160-19-02(C)(3)(a)(iii)(d): ODM will update the expenditure outlier determination definition to align with the Chronic Illness and Disability Payment System plus prescriptions (CDPS+Rx) risk scoring system that is currently being used to determine patient health risk in the program.
- 5160-19-02(D)(4): ODM will add that ODM can take payments back from a CPC entity if it is discovered that the CPC entity has failed to meet other program provisions defined in rule 5160-19-01 of the Administrative Code.

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 rule updates 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. Ohio implemented its state CPC program in alignment with federal goals to shift primary care from fee-for-service care to value-based health care and has agreed in its Medicaid State Plan with CMS to continue to support the Patient Centered Medical Home (PCMH) model to achieve better health, better care and cost savings through improvement.

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

These regulations do not include provisions specifically required by the federal government. These regulations are a part of a state plan amendment that has been authorized by the federal government for ODM to implement the CPC program. 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)?

Promulgating these regulations related to the optional CPC program is necessary to inform Medicaid providers of the program, 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 public purpose for these regulations is to ensure the CPC program is implemented consistently across all participating provider types. Since the regulations require certain activities be performed and contain specific clinical quality and efficiency metrics to be met, ODM believes codifying these rules is necessary to achieve the desired outcomes.

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 these regulations through reporting and monitoring. ODM provides quarterly reports to participating entities detailing how well they are meeting the objectives of the CPC program.

The success of this program has been demonstrated through a number of metrics. Quality metric performance for CPC entities improved by an average of 8.21% from program year 2017 to program year 2021. Participating entities are evaluated continually and receive quarterly reports on cost and metric performance. Metrics and data related to CPC entity operation are derived from claims data submitted by the Medicaid managed care organizations 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.

ODM meets regularly with CPC entities to discuss program updates. The CPC program rule updates were sent to all of the internal ODM policy teams for review on 5/21/2025 and was also sent to all Managed Care Organizations on 5/22/2025 through email for feedback.

ODM posted the rules to clearance for comment on 7/22/2025 until 7/29/2025.

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 the managed care organizations and ODM policy teams. Overall, stakeholders have been supportive of the revisions proposed for the next CPC program year.

Stakeholders provided input and responded with questions related to shared savings distribution, the outlier determination calculation, the continuous quality improvement activity, and recoupments. Stakeholders were uncertain of the other situations where CPC entities could get a recoupment and how to find more details on the outlier determination calculation. So, ODM clarified that payments to CPC entities can be recouped in circumstances such as enrolling in the program as an entity that primarily provides primary healthcare services when the entity is not primarily providing primary care services (i.e., an Urgent Care facility) and that more details on outlier determinations is located on the CPC website at <https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care>. ODM also clarified that shared savings distribution is to be determined between the Medicaid managed care organizations and the CPC entities through a mutually agreed upon contractual agreement. Stakeholders asked for examples of which activities can meet the “continuous quality improvement” and ODM responded with examples recommended from our External Quality Review Organization that monitors the entities.

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 rules.

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? *Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.*

ODM did not consider regulatory alternatives as the regulations in these rules need to be codified so that they can be enforced. The CPC program rules have been in effect since 10/01/2016 and serve the purpose intended, to maintain requirements of the CPC program. They continue to be applicable to the CPC program and CPC for Kids program and are necessary to clearly delineate responsibilities of participation, maintain program integrity, and to remain in alignment with the Centers for Medicare and Medicaid Services (CMS) program expectations.

The CPC and CPC for Kids programs are performance-based. Primary care entities that volunteer to participate in the CPC and CPC for Kids programs must meet the requirements

including activity requirements, clinical quality metrics, and efficiency metrics described in rule 5160-19-01 of the Administrative Code.

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

In the development of these regulations, ODM conducted an internal review and worked with other related entities to ensure these rules do not duplicate existing Ohio regulations or programs.

14. 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 entities on a quarterly basis. CPC entities serve Medicaid fee-for-service and Medicaid managed care organization members.

These reports improve consistency, lessen administrative burden for CPC and CPC for Kids entities, 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. Rule updates for program year 2026 will be communicated to those affected prior to the rules going into effect.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

Business communities impacted include providers enrolled in the Medicaid fee-for service program, Medicaid managed care organizations, and providers who contract with Medicaid managed care organizations that have chosen to participate in these programs. The CPC program and CPC for Kids program are voluntary; only entities that choose to enroll and participate will be impacted by these rules.

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

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.

The revisions made for CPC program year 2026 are expected to have little adverse impact to the overall business community. The requirements of these rules require entities to comply

with the requirements outlined in the rules to remain in the CPC program. Not complying with the rules' provisions can put an entity's program payments and participation at risk for termination. Entities incur some costs through participation; however additional financial incentives are expected to offset any additional costs. CPC entities are required to report specific information as outlined below. Entities that fail to comply with program requirements may be at risk of losing payment as outlined below. Entities newly enrolling in the CPC program may incur some costs to meet the requirements described in rule 5160-19-01 of the Administrative Code. Costs 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.

Rule 5160-19-01 to be amended: To meet the provisions of this rule, it is likely that expenses will increase for newly participating entities. Expenses for participating entities may also increase or decrease based on changes in their attribution which impacts an entity's per member per month payment. To be eligible to enroll for participation in the 2026 program year, an entity must report specific information as a condition of compliance. Each participating entity must enroll as a CPC entity by completing the online application and have at least 150 attributed Medicaid individuals to be considered for participation as a practice partnership or 500 attributed Medicaid individuals to be considered as an individual entity. To be eligible for participation in the CPC for Kids program, the CPC entity must enroll as a CPC for Kids entity by completing the online application and have at least 150 attributed Medicaid individuals under age 21 as determined through claims-only data.

Entities newly enrolling as a CPC entity in the 2026 program year must report specific information by completing an application during the designated enrollment period and attesting that it will conduct certain activities throughout its participation. The CPC program requires entities that participated in the CPC program for the previous performance year to re-attest their desire to continue as a CPC and/or CPC for Kids entity in 2026 by completing the enrollment application during the designated enrollment period.

Entities newly enrolling in the CPC program may incur some costs to meet the requirements described in rule 5160-19-01 of the Administrative Code. Costs 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 entities are typically already performed as part of the pediatric standard of care, no additional costs beyond those stated for all CPC entities are expected. CPC for Kids entities may choose to perform

additional activities as described in rule 5160-19-02 of the Administrative Code to position themselves to be more likely to receive a bonus payment.

Upon enrollment and on an annual basis, this rule requires each participating CPC entity to attest to meet certain requirements set forth in the rule including population health activity requirements, participating in learning activities as determined by ODM or its designee, sharing all requested data with ODM and its contracted Medicaid managed care organizations, conducting outreach and delivering primary care services to attributed Medicaid individuals who are not current patients, and actively using an electronic health record in its clinical services.

Participating CPC entities have to pass a number of efficiency and clinical quality measures that represent at least 50% of applicable metrics on a yearly basis. Entities 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 to maintain enrollment and avoid disenrollment.

There are ten pediatric metrics including six existing metrics that apply to all CPC entities and four metrics that will only be calculated for entities who participate in the CPC for Kids program. In addition to passing at least 50% of the applicable pediatric metrics, a CPC for Kids entity has to pass at least one of the three other pediatric metrics as long as at least one of the three metrics is applicable (i.e., the entity has at least 30 members that meet the denominator criteria for the metric).

The estimated cost for a CPC entity to complete all of these requirements and meet clinical quality measures in the voluntary CPC program vary widely. Many entities that choose to participate may already have the required practitioners on staff. Entities who also participate in the Comprehensive Maternal Care (CMC) program may incur fewer costs as they have already established many of the same activities also required under the CPC program. Practices who form a partnership to participate as a CPC entity may combine resources and share in any costs that are incurred. Entities who are already participating in value-based care models with ODM or other payers may experience fewer costs as they are likely already conducting many of the activities required in this rule. This is largely dependent on provider size, current baseline operations, and available resources. Most CPC entities are expected to have many of these costs already incorporated into their entity infrastructure, and the per-member per-month payments provided prospectively through the CPC program are expected to offset most or all of the costs of meeting program requirements.

Rule 5160-19-02 to be amended: This rule identifies specific activities that CPC entities have to meet to qualify for bonus payments and maintain enrollment in the CPC program. To meet the provisions of this rule, it is likely that expenses will increase for entities newly enrolling in the program. Expenses for participating entities may also increase or decrease based on changes in their attribution which impacts an entity's per member per month payment.

This rule identifies specific activities that CPC and CPC for Kids program participants are expected to meet to qualify for bonus payments and maintain enrollment in the CPC and CPC for Kids programs. To receive bonus payments as identified in this rule, the participating provider must be enrolled in the CPC program. Providers who enroll or re-attest their participation in the CPC program complete this process through an online application portal. There is no cost to submit the application or re-attestation that takes less than 20 minutes to complete. Any costs would be minimal and administrative in nature. There are no additional expected adverse impacts in terms of dollars as a result of this rule. Participation in the CPC program is voluntary, and this rule would impose no additional costs on primary care providers that deliver services under the authorities of §1905(t), §1905(a)(25) and §1905(t)(3) of the Social Security Act.

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

This rule provides that to be eligible for a shared savings payment in calendar year 2026 and beyond, the CPC entity must meet all requirements found in rule 5160-19-01 of the Administrative Code. Details regarding payment calculations are included in the rule. In this rule, penalties are also stipulated should a CPC entity neglect to meet outcome metric requirements. If these metrics are not met, a warning letter will be issued and after two consecutive years of this not being met, the CPC entity may no longer receive payment under this rule.

This rule specifies that a CPC entity participating in the CPC for Kids program must 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 years of this not being met, CPC for Kids entity may no longer receive payment under this rule.

CPC for Kids entities 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 oral evaluation, dental services. CPC for Kids entities will be scored for performance in each of these categories and top scorers will receive a retrospective bonus payment.

- 16. Are there any proposed changes to the rules that will reduce a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability,***

eliminating requirements, reducing compliance time or fees, or other related factors).

There are no proposed changes to the rules that will reduce a regulatory burden.

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

The regulatory intent justifies the adverse impact of these regulations 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 purpose of the CPC and CPC for Kids programs is to achieve better health outcomes and cost savings through improvement. It is intended to support CPC entities 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 advances the shift to value-based care. 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 CPC entity, there are no alternative means of compliance; however, informational resources are available on the ODM website to support the CPC entity.

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?

These rules do not include an administrative fine or civil penalty as contemplated by Ohio Revised Code section 119.14. A CPC entity must meet all requirements found in rule 5160-19-01 of the Administrative Code. In these rules, should a CPC entity neglect to meet outcome metrics a warning letter will be issued and after two consecutive years of this not being met, the CPC entity may no longer receive payment under this rule.

These rules specify that a CPC entity participating in the CPC for Kids program must 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 years of this not being met, the CPC for Kids entity may no longer receive payment under this rule. ODM does not impose other monetary fines.

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, <https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care>, includes additional information for participating entities on the CPC and CPC for Kids programs including frequently asked questions, training, and educational materials. The ODM website, www.medicareid.ohio.gov, also houses additional information and resources for providers to assist with a variety of topics. Providers may also contact the Integrated Help Desk by calling 1-800-686-1516. Provider representatives are available on weekdays from 8:00 a.m. through 4:30 p.m. EST.

5160-19-01 **Comprehensive primary care (CPC) program: eligible providers.**

(A) For ~~the purpose~~**purposes** of rules 5160-19-01 and 5160-19-02 of the Administrative Code, the following definitions apply:

(1) "Attribution" is the process through which medicaid recipients are assigned to specific primary care practitioners (PCPs) who are able to participate in the medicaid program in accordance with rule 5160-1-17.2 of the Administrative Code. The Ohio department of medicaid (ODM) is responsible for attributing fee-for-service recipients; medicaid managed care organizations (MCOs) are responsible for attributing their enrolled recipients. CPC entities who are not able to participate in accordance with rule 5160-1-17.2 of the Administrative Code at the time of attribution or during the prospective payment period ~~may are~~ **not be attributed members or be** eligible for payment until the next attribution period following the provider's reinstatement. The following hierarchy will be used in assigning recipients to PCPs under the CPC and CPC for kids program:

(a) The recipient's choice of provider.

(b) Claims data concerning the recipient.

(c) Other data concerning the recipient.

(2) "Baseline year" is a twelve month calendar year, typically two years preceding the performance period unless otherwise specified by ODM. More information about baseline years can be found at www.medicaid.ohio.gov."

(3) "CPC attributed medicaid individuals" are Ohio medicaid recipients for whom PCPs have accountability under a CPC entity. A PCP's attributed medicaid individuals are determined by ODM or the MCOs. All medicaid recipients are attributed. The following attributed individuals are excluded from CPC program quality and efficiency metrics, total cost of care calculations, and per member per month payments:

(a) Recipients dually enrolled in both medicare and Ohio medicaid.

(b) Recipients not eligible for the full range of medicaid benefits.

(c) Recipients with third party benefits as defined in rule 5160-1-08 of the Administrative Code except for recipients with exclusively third party dental or third party vision coverage.

(d) Recipients enrolled in a prepaid inpatient health plan, as defined in 42 C.F.R. 438.2 (as in effect on ~~October 1, 2023~~)[May 10, 2024](#), under contract with ODM.

~~(e) Recipients attributed to other population health alternative payment models administered by ODM under Chapter 5160-19 of the Administrative Code.~~

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

(5) "CPC entity" is a single practice or a practice partnership participating in CPC.

~~(5)~~(6) "CPC for kids" program is a voluntary enhancement to the CPC program focused on attributed pediatric medicaid covered individuals under twenty-one years of age.

~~(6)~~(7) "Eligible provider" is as defined in rule 5160-1-17 of the Administrative Code.

~~(7)~~(8) "A Patient-centered medical home (PCMH)" is a team-based care delivery model led by PCPs who comprehensively manage the health needs of individuals. Provider enrollment in ODM's PCMH program, known as the CPC program is voluntary. A CPC entity may be a single practice or a practice partnership.

~~(8)~~(9) "Performance period" is the twelve month calendar year period of participation in the CPC program by an enrolled CPC entity. An enrolled CPC entity's first performance period begins the first of January after their enrollment in the program.

(10) "Population health management" is an approach to maintain and improve physical and psychosocial well-being and address differences in health outcomes among communities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

~~(9)~~(11) "Practice Partnership" is a group of practices participating as a CPC entity 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 CPC entity for at least one year.
 - (d) Each member practice will acknowledge to ODM its participation in the partnership.
 - (e) Each member practice will agree that summary-level practice information will be shared by ODM among practices within the partnership.
- (B) The following eligible providers may participate in ODM's CPC program through their contracts with MCOs or provider agreements for participation in medicaid fee-for-service in accordance with rule 5160-1-17.2 of the Administrative Code:
- (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.
- (C) The following eligible providers may participate in the delivery of primary care activities or services in the CPC 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.
 - (g) Geriatric.
- (2) Clinical nurse specialist, certified nurse midwife, 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.
 - (d) Family practice.
- (3) Physician assistant as defined in section 4730.11 of the Revised Code.
- (D) To be eligible for enrollment in the CPC program, the CPC will have at least five hundred attributed medicaid individuals determined using claims-only data, and attest that it will ~~participate in learning activities as determined by ODM or its designee, and attest that it will share all requested data with ODM and contracted MCOs;~~ continue to meet all of the provisions described in paragraph (F) of this rule as of the first day of January in the program year.
- (E) To be eligible for enrollment in the CPC for kids program, the CPC entity will:
- (1) Be a CPC entity that participates in ODM's CPC program for the same performance period.

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

(F) It is the responsibility of an enrolled CPC entity to complete [population health](#) 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 CPC entity is expected to attest that it will:

(1) Complete the "twenty-four-seven and same-day access to care" activities in which the CPC entity 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) Provide twenty-four-seven and same-day access to a PCP with access to the attributed medicaid individual's medical record.

(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 CPC entity 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 CPC entity will identify attributed medicaid individuals, [in groups or segments by using practice-defined common characteristics](#), in need of preventive or chronic services and ~~begin~~ outreach to schedule applicable appointments or identify additional services needed to meet the needs [and improve the health](#) of the [identified group or segment of](#) attributed medicaid ~~individual~~[individuals](#).

[\(4\) Complete the "continuous quality improvement" activities in which the CPC entity will demonstrate regular and ongoing quality improvement through the use of quality improvement projects, quality goals for outcome metrics.](#)

quality improvement education for staff, quality improvement committees, or other quality improvement activities that also includes the voice of the patient and the provider to continuously improve the quality of care for attributed medicaid individuals.

- ~~(4) Complete the "team-based care delivery" activities in which the CPC entity 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 CPC entity.~~
- (5) Complete the "care coordination" activities in which the CPC entity will identify and close gaps in care and refer attributed medicaid individuals for further intervention as needed, including referrals to MCOs or community resources as appropriate.
- (6) Complete the "follow-up after hospital discharge" activities in which the CPC entity 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 CPC entity will have established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.
- (8) Complete the "patient, CPC entity staff, and provider experience" activities in which the CPC entity will:
- (a) Orient all attributed medicaid individuals to the practice and incorporate patient preferences in the selection of a PCP to build continuity of attributed medicaid individual relationships throughout the entire care process.
 - (b) Ensure all staff who ~~provides~~provide direct care or otherwise ~~interacts~~interact with attributed medicaid individuals ~~completes~~complete cultural competency training, as deemed acceptable by ODM, within six 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 thirty 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.
- (f) Use the information collected pursuant to paragraph ~~(G)(8)(e)~~(F)(8)(e) of this rule to identify and act on opportunities to improve attributed medicaid individual experience and reduce ~~cultural disparities~~differences in health outcomes among communities, including ~~disparities~~differences in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. The CPC entity will report findings and opportunities to attributed medicaid individuals, the PFAC, payers, and ODM.
- (g) Demonstrate a means of assessing staff and provider satisfaction at least once annually by using resources such as meeting minutes, surveys, or a comment box.
- (9) Complete the "community services and supports integration" activities in which the CPC entity will identify medicaid covered individuals in need of community services and supports and ~~maintains~~maintain a process to connect attributed medicaid individuals to necessary services.
- (10) Complete the "behavioral health integration" activities in which the CPC entity will use screening tools to identify attributed medicaid individuals in need of behavioral health services, ~~track~~track and follow up on behavioral health service referrals, and ~~has~~have a planned improvement strategy for behavioral health outcomes.
- (11) Cooperate with and grant access to ODM or its designee for the purpose of conducting activity requirement evaluations.
- (12) Participate in learning activities as determined by ODM or its designee.
- (13) Share all requested data with ODM and its contracted MCOs.
- (14) Conduct outreach and deliver primary care services to attributed medicaid

individuals who are not current patients.

(15) Actively use an electronic health record (EHR) in clinical services.

(G) It is the responsibility of a CPC entity to pass 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.

(4) Adherence to the single preferred drug list.

(H) It is the responsibility of a CPC entity 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) Child and adolescent well-child visits for members who are three to eleven years of age.

(3) Child and adolescent well-child visits for members who are twelve to seventeen years of age.

(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) Chlamydia screening for women.

- (9) Cervical cancer screening.
 - (10) Controlling high blood pressure.
 - (11) Asthma medication ratio.
 - (12) Statin therapy for attributed medicaid individuals with cardiovascular disease.
 - (13) ~~Comprehensive diabetes care; HbA1c poor control (greater than nine per cent)~~[Glycemic status assessment for patients with diabetes.](#)
 - (14) Comprehensive diabetes care: blood pressure control.
 - (15) Comprehensive diabetes care: eye exam.
 - (16) ~~Antidepressant medication management~~[Follow up after emergency department \(ED\) visit for mental illness.](#)
 - (17) Follow-up after hospitalization for mental illness.
 - (18) Preventive care and screening: tobacco use, screening and cessation intervention.
 - (19) Initiation and engagement of alcohol and other drug dependence treatment.
 - (20) Well visits for members who are eighteen to twenty-one years of age.
 - (21) Well visits for members who are fifteen to thirty months of age.
 - [\(22\) Follow up after ED visit for substance use.](#)
- (I) It is the responsibility of a CPC entity participating in CPC 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.medicareid.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) Child and adolescent well-child visits for members who are three to eleven years of age.
 - (6) Child and adolescent well-child visits for members who are twelve to seventeen years of age.
 - (7) Weight assessment and counseling for nutrition and physical activity for children and adolescents. BMI assessment for children and adolescents.
 - (8) Well visits for members who are eighteen to twenty-one years of age.
 - (9) Well visits for members who are fifteen to thirty months of age.
 - (10) Oral evaluation, dental services.
- (J) It is the responsibility of a CPC entity participating in CPC 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.
 - (3) Immunizations for adolescents.
- (K) A CPC entity 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 CPC or CPC for kids program enrollment or eligibility.

5160-19-02

Comprehensive primary care (CPC) program: payments.

- (A) A comprehensive primary care (CPC) entity has to be enrolled and meet the provisions set forth in rule 5160-19-01 of the Administrative Code to be eligible for patient centered medical home (PCMH) payments.
- (B) A CPC entity participating in the CPC for kids program has to be enrolled as a CPC entity and meet all provisions set forth in rule 5160-19-01 of the Administrative Code to be eligible for CPC for kids payments.
- (C) An eligible CPC entity may qualify for the following payments:
- (1) The "CPC per-member-per-month (PMPM)" is a payment to support the CPC entity.
 - (a) Payment is in the form of a prospective risk-adjusted PMPM payment that is calculated for each attributed medicaid individual except for individuals attributed to other population health alternative payment models administered by the Ohio department of medicaid (ODM) under Chapter 5160-19 of the Administrative Code. Further detail regarding risk-adjustment can be found on the ~~Ohio department of medicaid (ODM)~~ website, www.medicaid.ohio.gov.
 - (b) Payment begins following enrollment and in accordance with the payment schedule determined by the Ohio department of medicaid (ODM).
 - (2) The "CPC for kids enhanced PMPM" is a payment to support the CPC entities participating in the CPC for kids program.
 - (a) Payment is in the form of a prospective flat PMPM payment per attributed medicaid pediatric individual except for those excluded in rule 5160-19-01 of the Administrative Code.
 - (b) Payment begins following CPC entity enrollment in CPC for kids and in accordance with the payment schedule determined by ODM.
 - (3) The "CPC shared savings payment" is a payment for a CPC entity to reward total cost of care savings.
 - (a) To be eligible for the CPC shared savings payment, the CPC entity has to meet the following:

- (i) The CPC entity has to meet quality, efficiency, and financial outcomes outlined in rule 5160-19-01 of the Administrative Code;
 - (ii) The CPC entity has at least sixty thousand member months in the performance period;
 - (iii) The CPC entity achieves savings on its total cost of care during the performance period compared to its own baseline total cost of care performance by performing in the top decile of all CPC entities based on total cost of care performance. The total cost of care for a CPC entity is calculated by summing all claims for a given patient, plus any PMPM payment that the CPC entity has received through the CPC program, minus the following exclusions and taking into account the overall risk status of the population. Baseline total cost of care calculations may be adjusted mid-performance year as necessary to reflect factors such as population acuity shifts. 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~~tier as determined by statistical methods described on the ODM website, www.medicaid.ohio.gov.
 - (e) All expenditures for individuals with more than ninety consecutive days in a long-term care facility.
- (b) The CPC 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 is determined by the CPC entity's total

cost of care for its attributed medicaid individuals as defined in rule 5160-19-01 of the Administrative Code.

- (ii) An annual retrospective bonus payment based on total cost of care for CPC entities in the top-performing decile, to be determined annually by ODM and not to exceed one million dollars.
- (4) The "CPC for kids bonus payment" is an annual retrospective payment for the highest performing CPC entities participating in the CPC for kids program that meet quality and efficiency outcomes and perform additional bonus activities focused on improving pediatric care.
- (a) To be eligible for the CPC for kids bonus payment, the CPC entity has to be a high performing CPC relative to other CPC entities participating in the CPC 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. More information on the CPC for kids program can be found on the ODM website, www.medicaid.ohio.gov.
 - (i) Additional supports for children in the custody of a title IV-E agency.
 - (ii) Integration of behavioral health services.
 - (iii) School-based health care linkages.
 - (iv) Transitions of care.
 - (v) Oral evaluation, dental services.
 - (b) In the event of a tied score on the pediatric bonus activities, the CPC entity 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 CPC entities 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 CPC entity in the tie group.

(D) Payment and program participation conditions.

- (1) A CPC entity has to continue completing activities annually as defined in rule 5160-19-01 of the Administrative Code. If activities are not completed upon evaluation, program participation and payment under this rule terminates.
 - (2) A CPC entity has to continue to meet efficiency and clinical quality metrics defined in rule 5160-19-01 of the Administrative Code. If any of these metrics are not met in a program year, a warning will be issued. After two consecutive program years of a metric not being met, entity participation in the program and payment under this rule will be terminated.
 - (3) A CPC entity participating in CPC for kids has to continue to meet clinical quality metrics defined in rule 5160-19-01 of the Administrative Code. If any of these provisions are not met, a warning will be issued. After two consecutive program years of a metric not being met, the CPC for kids entity participation in the program and payments under this rule will be terminated.
 - (4) ODM may recoup payments if it is discovered that the CPC entity has failed to meet other program provisions defined in rule 5160-19-01 of the Administrative Code.
- (E) A CPC entity 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.