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**State/Territory Name: Ohio**

**State Plan Amendment (SPA) #: 21-0035**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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February 8, 2022

Maureen M. Corcoran, Director  
Ohio Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

Re: Ohio State Plan Amendment Transmittal Number 21-0035

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 21-0035. This amendment updates Ohio's Comprehensive Primary Care (CPC) and CPC for Kids programs for the 2022 program year.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 CFR 440.168. This letter is to inform you that Ohio Medicaid SPA 21-0035 was approved on February 7, 2022 with an effective date of January 1, 2022.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at [christine.davidson@cms.hhs.gov](mailto:christine.davidson@cms.hhs.gov).

Sincerely,

A solid black rectangular box redacting the signature of James G. Scott.

James G. Scott, Director  
Division of Program Operations

cc: Rebecca Jackson, ODM  
Gregory Niehoff, ODM  
Deborah Benson, CMCS  
Justin Myrowitz, CMCS  
Angela Cimino, CMCS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 1 — 0 3 5

2. STATE

OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX  XXI

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION

Sections 1905(a)(25) and 1905(t) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2022 \$ 0  
b. FFY 2023 \$ 1,300,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, Item 25b, pages 3 and 4  
Attachment 4.19-B, Item 25b, pages 1-3, 5, 7, and 9

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Attachment 3.1-A, Item 25b, page 3 (TN-19-025)  
Attachment 3.1-A, Item 25b, page 4 (TN 21-007)  
Attachment 4.19-B, Item 25b, pages 1-3, 5 (TN 21-007)  
Attachment 4.19-B, Item 25b, pages 7 and 9 (TN 19-025)

9. SUBJECT OF AMENDMENT

Comprehensive Primary Care (CPC) program updates for program year 2022

10. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:  
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL

[Redacted Signature]

12. TYPED NAME

MAUREEN M. CORCORAN

13. TITLE

STATE MEDICAID DIRECTOR

14. DATE SUBMITTED

December 20, 2021

15. RETURN TO

Carolyn Humphrey  
Ohio Department of Medicaid  
P.O. BOX 182709  
Columbus, Ohio 43218

**FOR CMS USE ONLY**

16. DATE RECEIVED

December 20, 2021

17. DATE APPROVED

02/07/2022

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

January 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL

[Redacted Signature]

20. TYPED NAME OF APPROVING OFFICIAL

James G. Scott

21. TITLE OF APPROVING OFFICIAL

Director, Division of Program Operations

22. REMARKS

## PCMH Characteristics

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](http://www.medicaid.ohio.gov). Upon enrollment and on an annual basis, the PCMH must attest that it will:

- Meet the “twenty-four-seven and same-day access to care” activity requirements in which the PCMH must: 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; within 24 hours of initial request, provide access to a primary care practitioner with access to the patient’s medical record; and 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;
- 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;
- 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;
- 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;
- Meet the “care coordination” activities in which the PCMH will identify and close gaps in care and refer attributed Medicaid individuals for further intervention as needed, including referrals to managed care organizations or community resources as appropriate;
- Meet the “follow-up after hospital discharge” activity requirements in which the PCMH must have established relationships with emergency departments and hospitals from which it frequently receives referrals and establish a process to ensure a reliable flow of information;
- Meet the “tests and specialist referrals” activity requirements in which the PCMH must have established bi-directional communication with specialists, pharmacist, laboratories and imaging facilities necessary for tracking referrals; and
- 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.

- Meet the “community services and supports integration” activity requirements in which the PCMH will identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
- Meet the “behavioral health integration” activity requirements in which the PCMH will use screening tools to identify and refer patients in need of behavioral health services, track and follow up on behavioral health service referrals, and have a planned improvement strategy for behavioral health outcomes.
- Cooperate with and grant access to ODM or its designee for the purpose of conducting activity requirement evaluations.

### Assurances

The following beneficiary protections in §1905(t) apply to this program:

- Services are provided according to the provisions of 1905(t) of the Social Security Act (the Act);
- §1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment;
- §1905(t)(3)(B), which restricts enrollment to nearby providers, does not apply to this program because there is no enrollment of new Medicaid beneficiaries as part of this program;
- §1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner;
- §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment;
- §1903(d)(1) provides for protections against fraud and abuse;
- Any marketing and/or other activities will not result in selective recruitment and enrollment of individuals with more favorable health status, pursuant to Section 1905(t)(3)(D) of the Act, prohibiting discrimination based on health status, marketing activities included; and
- The state will notify Medicaid beneficiaries of the PCMH program. The notification will include a description of the attribution process, calculation of payments, how personal information will be used and of payment incentives, and will be made publicly available, including to those beneficiaries who are attributed to an enrolled PCMH.

Enrolled PCMHs are those that meet all eligibility criteria outlined above, have applied via the ODM website, and have had their application accepted by ODM. At the end of each performance year, in order to continue participation in Ohio’s PCMH program, an enrolled PCMH must re-attest to meeting all activity requirements, data sharing with ODM and MCPs, and participation in learning activities, and must be meeting other program requirements.

## Comprehensive Primary Care (CPC) Program, Payment Adjustment.

Payment for PCMH services can include two types of payments for enrolled PCMHs: (1) per-member-per-month (PMPM) payments; and (2) shared savings payments. All enrolled PCMHs are eligible for PMPM payments, and some may be eligible for shared savings payments. PMPM payments and shared savings payments are distributed to enrolled PCMHs by ODM.

### Definitions and key calculations applicable to all payment

- 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.
- The **CPC for Kids** program is a voluntary enhancement to the PCMH program focused on pediatric members under twenty-one years of age.
- A **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; (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.
- A **Convener** is the practice responsible for acting as the point of contact for ODM and the practices that form a practice partnership.
- A **Member practice** is a practice participating in a practice partnership.
- The **Performance period** is the 12-month calendar year period of participation in the PCMH program by an enrolled PCMH. An enrolled PCMH's first performance period begins January 1st after their enrollment in the program.
- A **Baseline year** is the twelve-month calendar year two years preceding the performance period.

### Attribution:

- i **Member exclusions:** All Medicaid beneficiaries are included in the Ohio PCMH program and therefore included in the attribution process, except for the following excluded populations:
  - a. Dual-eligible beneficiaries (i.e., MyCare Ohio);
  - b. Beneficiaries with limited benefits;
  - c. All other beneficiaries with third-party liability medical coverage except for those with exclusively third-party dental or vision coverage;
  - d. Beneficiaries enrolled in OhioRISE.

- ii **Methodology:** ODM will attribute all non-excluded fee-for-service and managed care members to a PCMH that meets the provider type and specialty requirements. Attribution of PCMH members occurs quarterly using retrospective data. PCMH members will only be attributed to one PCMH at a time, and only one enrolled PCMH will receive PMPM payments for PCMH services per attributed beneficiary. Attribution will be done using a hierarchical process as follows:
  - a. PCMH member choice when expressed directly (i.e., communicated explicitly via contact with ODM or an MCP);
  - b. Individuals who do not express member choice explicitly will be attributed to a practice based on their claims history;
  - c. For individuals who do not express member choice and do not have any claims history, non-claims factors including but not limited to geographic proximity will be used for attribution.

**Risk scoring:**

- i **Methodology:** ODM will score all members attributed to a PCMH (or attributed to a member practice for practice partnerships) based on health status using an evidence-based proprietary risk scoring methodology. Risk scoring will be done using 24 months of available Medicaid data plus at least six months of run-out. Members without Medicaid history will be assigned to the healthiest risk status, and will be reassigned once there is sufficient claims data to update the risk status.
- ii **Relationship to payment:** The risk score is used both to determine PCMH PMPM payment amounts on a quarterly basis, and as an adjustment in the calculation of shared savings payments on an annual basis. The relationship to both payment streams is described in more detail below.

***Clinical quality and efficiency metrics required for PMPM and shared savings payments***

An enrolled PCMH must meet all of the effective activity requirements described above and in Attachment 3.1-A, in addition to clinical quality metrics and efficiency metrics described below, in order to receive any PMPM or shared savings payments. Enrolled PCMHs must meet the required clinical quality and efficiency metric thresholds for each program year (calendar year) in which they participate.

PCMHs that participate in the CPC for Kids program described above and in Attachment 3.1-A must meet additional clinical quality of care metric for each participating program year to receive additional PMPM or shared savings or bonus payments.

An enrolled PCMH must meet specific numerical thresholds on their performance on clinical quality and efficiency metrics. Enrolled PCMHs either pass or fail each clinical quality and efficiency metric, depending where their performance on the calculated metric falls relative to the specific metric threshold value. It is not possible to partially pass a metric. The state will notify an enrolled PCMH of the full set of metrics and thresholds by publishing them on the ODM website.

Effective January 1<sup>st</sup> of each program year, the clinical quality and efficiency measures and thresholds are in effect for that performance year and can be found at the following link: <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care>.

Clinical quality metrics are only applicable to an enrolled PCMH if the patient volume in the metric denominator is sufficient for the measured metric to be statistically valid. Clinical quality and efficiency metrics will be evaluated for each enrolled PCMH at the end of each performance period using claims from the performance period across Medicaid FFS for all members attributed to the enrolled PCMH.

**Clinical quality metrics:** The set of clinical quality metrics includes adult health measures, behavioral health measures, pediatric measures, and women's health measures. Specific information regarding these requirements can be found at the link to the Payment Innovation website referenced in the paragraph above. An enrolled PCMH must pass at least 50% of applicable metrics. Clinical quality metrics are evaluated annually based on performance through the performance period plus at least six months of claims run-out.

In addition to the above clinical quality metrics, a PCMH participating in the CPC for Kids program must pass at least 50% of applicable metrics specific to members under the age of twenty-one. In addition, the participating PCMH must pass at least one of the following measures: lead screening in children, childhood immunization status, or immunizations for adolescents.

**Efficiency metrics:** Efficiency metrics are measures of health system utilization and efficiency. The full set of efficiency metrics can be found at the link to the Payment Innovation website referenced in the paragraph above. An enrolled PCMH must pass at least 50% of efficiency metrics. Efficiency metrics are evaluated annually based on performance through the performance period plus at least six months of claims run-out.

#### Per-member-per-month (PMPM) payments

**Definition:** The PMPM payment is a prospective payment that is both paid and risk-adjusted quarterly, and that supports the activities required by the PCMH and CPC for Kids programs. The unit of service is quarterly. PMPM payments begin in the first month of an enrolled PCMH's first performance period. Payment for PCMH services under Ohio's PCMH program will not duplicate payments made for the same services under other program authorities or under the Medicare CPC+ program for this same purpose. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that PCMH participants are not receiving similar services through other Medicaid-funded programs. Enrolled PCMHs must meet the effective program requirements described above in order to receive PMPM payments. Failing an activity requirement results in PMPM payment suspension. Failing to pass 50% of either clinical quality metrics or efficiency metrics as described above results in a warning; two consecutive warnings result in PMPM payment suspension. A payment suspension will be lifted once an enrolled PCMH passes all activity requirements and 50% of both clinical quality and efficiency metrics.



baseline year or performance period). The total cost of care in the baseline year and performance period will include the accountable expenditures defined below for the members attributed to the enrolled PCMH, in addition to PMPM payments made as part of the Ohio PCMH program. The types of services included in the TCOC measurement for the baseline year and performance period will be identical.

- iii Calculation of risk-adjusted TCOC: Risk-adjusted TCOC for an enrolled PCMH is calculated by dividing the enrolled PCMH's TCOC by the average risk score of the members attributed to the enrolled PCMH, as determined by the evidence-based proprietary risk scoring methodology described above in Risk Scoring: Methodology.
- iv Excluded expenditures: Expenditures not included in the base year or performance period TCOC are:
  - a. Waiver services;
  - b. Currently underutilized services as determined by the state (initially to include dental, vision, and transportation);
  - c. All expenditures for the first year of life for members with a Neonatal Intensive Care Unit (NICU) day (Nursery 3 and 4);
  - d. All expenditures for member outliers within each risk band (top and bottom 1%); and
  - e. All expenditures for members with at least 90 consecutive days of LTC claims.
- v Accountable expenditures: All Medicaid-covered medical, prescription, and other expenditures that are not explicitly excluded above are considered accountable expenditures and are included in calculation of total cost of care.

### **Shared savings payments.**

There are three types of shared savings payments: payment based on self-improvement, payment for practices with the lowest TCOC, and bonus payment under the CPC for Kids program. All enrolled PCMHs must meet the effective activity requirements, clinical quality and efficiency metrics described above and in Attachment 3.1-A in order for the enrolled PCMH to be eligible for any type of shared savings payment. Enrolled PCMHs may receive shared savings payments based on either self-improvement or on having the lowest TCOC, or both. PCMHs that participate in the CPC for Kids program are eligible for an additional bonus payment if the prescribed requirements are met.

Enrolled PCMHs must have at least 60,000 Medicaid member months over the performance period to be eligible for either type of shared savings payment, counting only members who were attributed to the practice for at least six months during the performance year and who were not excluded during those months due to Ohio CPC exclusion criteria. Full exclusion criteria are:

- (1) Members excluded from Ohio CPC attribution:
  - a. Dual-eligible beneficiaries (i.e., MyCare Ohio);
  - b. Beneficiaries with limited benefits;
  - c. All other beneficiaries with third-party liability medical coverage except for those with exclusively third-party dental or vision coverage;
  - d. Beneficiaries enrolled in OhioRISE.

*Savings amount*

$$= [\textit{savings percentage}]$$

$$* [\textit{enrolled PCMH's non risk-adjusted TCOC in the baseline year}]$$

$$* [\textit{member practice's proportional share of risk – adjusted member months}]$$

d. Calculation of gainsharing percentage: If the savings amount, as calculated above, is positive, the enrolled PCMH receives a percentage of this savings amount as a lump-sum payment. This percentage is called the gainsharing percentage, and is determined as follows:

i. The individually-enrolled PCMH: The enrolled PCMH receives 65% of the savings amount for their practice (as calculated above) if they either have an average risk-adjusted TCOC below a specific threshold set to identify the lowest-cost PCMHs, and/or if the PCMH is a participant in CPC+ Track 2 (through program end in 2021). Practices will be notified of qualification for 65% shared savings when final TCOC calculations are completed. Thresholds for 65% shared savings will be set utilizing data from the baseline year, identifying those that represent 10% of enrolled PCMHs with the lowest total cost of care. Thresholds will be effective for each performance year. This information will be shared with all enrolled PCMHs no later than July 31<sup>st</sup> of the performance year.

ii. Practice Partnerships enrolled as a PCMH: A member practice receives 65% of the savings amount for their enrolled PCMH (as calculated above) if the enrolled PCMH has an average risk-adjusted TCOC below a specific threshold set to identify the lowest-cost enrolled PCMHs, and/or if the member practice is a participant in CPC+ Track 2 (through program end in 2021). Practices will be notified of qualification for 65% shared savings when final TCOC calculations are completed. Thresholds for 65% shared savings will be set utilizing data from the baseline year, identifying those that represent 10% of enrolled PCMHs with the lowest total cost of care. Thresholds will be effective for each performance year. This information will be shared with all enrolled PCMHs no later than July 31<sup>st</sup> of the performance year.

iii. All other individually-enrolled PCMHs and member practices in partnerships receive 50% of the total savings amount for their practice (as calculated above).

e. Overall calculation of shared savings amount paid to enrolled PCMHs: The shared savings payment is calculated as follows:

*Shared savings payment*

$$= [\textit{enrolled PCMH's savings amount}] * [\textit{gainsharing percentage}]$$

This calculation is conducted annually for each enrolled PCMH's performance over the performance period. One payment is then made to the enrolled PCMH for each year-long performance period. For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the

## Monitoring and Reporting

ODM will collect data from and monitor enrolled PCMHs in the following ways: 1) Upon enrollment, enrolled PCMHs will attest to activity requirements as specified in the “Practice Characteristics” section. The PCMH activity requirements will be confirmed one year after enrollment and annually thereafter; 2) the state, or its designee, will monitor enrolled PCMHs to verify and document that activity requirements are being met.

To be eligible for the CPC for Kids bonus payment, the PCMH must be a high-performing PCMH relative to other PCMHs participating in the CPC for Kids program based on performance of risk-adjusted scoring of specific pediatric bonus activities, which will be determined by ODM and evaluated annually during each performance period. These activities include: additional supports for children in the custody of a title IV-E agency; behavioral health linkages; school-based health care linkages; transitions of care; and select wellness activities including lead testing capabilities, community services and supports screening, tobacco cessation, fluoride varnish, and breastfeeding support. Specific information can be found on the ODM website at <https://medicaid.ohio.gov/>.

In addition, ODM will provide enrolled PCMHs with quarterly progress reports which include efficiency and clinical quality metrics.

Further, ODM, or its designee, will evaluate the program to demonstrate improvement against past performance using cost and clinical quality data to determine whether the payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs. With regard to methodological changes and continued movement toward value-based purchasing, ODM will reflect in its annual updates any changes to the measures being used to assess program performance and/or determine payment eligibility and distribution.

Ohio will:

- Review the payment methodology as part of the evaluation; and,
- Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment updates.