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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0007

This file contains the following documents in the order listed:

- 1) Approval Letter
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TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 21-007 Revised	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2021	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> : <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT </div>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate Transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1905(a)(25) of the Social Security Act Section 1905(t) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 21 \$0 b. FFY 22 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 29, pages 2, 4 Attachment 4.19-B, Item 29, 1-5, 8		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 3.1-A, Item 29, pages 2, 4 (TN 19-025) Attachment 4.19-B, Item 29, pages 1-5, 8 (TN 19-025)	
10. SUBJECT OF AMENDMENT: Patient Centered Medical Homes: Suspension of Shared Savings Payments for the 2020 Performance Year			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee </div> </div>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Carolyn Humphrey Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: MAUREEN M. CORCORAN		14. TITLE: STATE MEDICAID DIRECTOR	
15. DATE SUBMITTED: Feb. 8, 2021		17. DATE RECEIVED: February 8, 2021	
FOR REGIONAL OFFICE USE ONLY			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2021		20. SIGNATURE: 	
21. TYPED NAME: James G. Scott		22. TITLE: Director, Division of Program Operations	
23. REMARKS:			

for CPC for Kids. A PCMH participating in CPC for Kids must also pass at least one of three additional clinical quality requirements when applicable.

Additionally, the program will be monitored and evaluated as described in Attachment 4.19-B, Item 29, in the section entitled “Monitoring and Reporting.” Evaluation includes process and outcome measures based on a combination of qualitative and quantitative factors, including but not limited to claims, PCMH reporting and survey data. PCMHs may participate in the PCMH program via a provider agreement for participation in Medicaid fee-for-service (FFS). Medicaid FFS beneficiaries are free to choose from any qualified provider. Practices that enroll in the PCMH program continue to provide services and submit claims in accordance with fee-for-service requirements.

Provider Qualifications

Enrolled PCMHs participating in the PCMH program serve as primary care case managers and must meet all of the qualifications set forth in this section.

The following types of entities may participate in the Ohio PCMH program as a primary care case manager:

- i. Individual physicians and practices;
- ii. Professional medical groups;
- iii. Rural health clinics;
- iv. Federally qualified health centers;
- v. Primary care or public health clinics; or
- vi. Professional medical groups billing under hospital provider types.

Members will be attributed only to PCMH practices with providers of the following types:

- i. Medical doctor (MD) or doctor of osteopathy (DO) with primary care-related specialties or sub-specialties;
- ii. Clinical nurse specialist or certified nurse practitioner within the State’s scope of practice, with primary care-related specialties or sub-specialties;
- iii. Physician assistant within the State’s scope of practice.

To be eligible for enrollment in the PCMH program for payment beginning January 1st of each program year, the PCMH must have at least 500 attributed Medicaid individuals determined using claims-only data, attest that it will participate in learning activities as determined by ODM or its designee, and share data with ODM and contracted MCPs.

To be eligible for enrollment in the CPC for Kids program for payment beginning January 1st of each program year, the PCMH must:

- 1. Be a PCMH that participates in the PCMH program; and
- 2. Have at least 150 attributed Medicaid pediatric individuals determined using claims-only data.

- 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.

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. Beneficiaries in transition;
 - d. All other beneficiaries with third-party liability medical coverage except for those with exclusively dental or vision coverage.

- 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

Except for the 2020 calendar year, 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.

Except for the 2020 calendar year, 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.

Except for the 2020 calendar year, 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 1st 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: <http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx>. 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.

Risk tiers: Members attributed to enrolled PCMHs are placed in the following risk tiers with associated PMPMs for each tier:

- i Healthy members including those with history of disease (\$1.80 PMPM);
- ii Members with minor or significant chronic diseases (\$8.55 PMPM);
- iii Members with severe chronic conditions across multiple organ systems (\$22 PMPM)

All members under the age of 21 who are attributed to a PCMH participating in CPC for Kids will have an additional associated PMPM of \$1.

PMPM amounts may be updated no more frequently than annually.

Calculation: The quarterly PMPM payment for an enrolled PCMH is calculated as follows: The final multiplication is to accommodate the three months in the quarter.

Quarterly PMPM payment for an enrolled PCMH

$$= [(number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 1 \\ * PMPM\ amount\ for\ tier\ 1) \\ + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 2 \\ * PMPM\ amount\ for\ tier\ 2) \\ + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 3 \\ * PMPM\ amount\ for\ tier\ 3)] * 3$$

Quarterly PMPM payment for an enrolled PCMH also participating in the CPC for Kids program

$$= [(number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 1 * PMPM\ amount\ for\ tier\ 1) \\ + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 2 * PMPM\ amount\ for\ tier\ 2) \\ + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 3 * PMPM\ amount\ for\ tier\ 3) \\ + (number\ of\ patients\ under\ the\ age\ of\ twenty-one\ on\ the\ practice's\ panel\ attributed\ under\ CPC\ for\ Kids * PMPM\ amount\ for\ PCMH\ attributed\ members)] * 3$$

Shared savings payments

Total cost of care (TCOC).

- i Definition: Total cost of care for an enrolled PCMH is defined as the sum of all non-excluded payments made by ODM for the Medicaid members attributed to that enrolled PCMH. Details of the calculation are below.
- ii Calculation of non-risk-adjusted TCOC: The TCOC for the baseline year and the performance period will be calculated by ODM retrospectively, using fee-for-service claims data. Total cost of care is calculated by summing the total Medicaid fee-for-service claims for the enrolled PCMH's attributed members during the relevant period (i.e.,

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.

PCMH practices are not eligible to earn any type of shared savings payment for the 2020 calendar year, as they are not subject to the quality and efficiency metric thresholds during that time.

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. Beneficiaries in transition; and
 - d. All other beneficiaries with third-party liability medical coverage except for those with exclusively dental or vision coverage.

member practice's attributed members that made up the patient panel used in the TCOC calculation. This means that if the average risk-adjusted TCOC in the performance period is lower than the average risk-adjusted TCOC in the baseline year, and the savings percentage is greater than or equal to 1%, an enrolled PCMH may receive a lump-sum payment based on this difference.

- f. Timing of payments: Shared savings payments will be made no more than 12 months after the end of the performance period when all necessary data is received in final form.
- g. Payments made by ODM: While the determination of the shared savings amount paid to enrolled PCMHs includes fee-for-service members, the payment that ODM makes to enrolled PCMHs for its fee-for-service patients will be the share of the shared savings payment described above, pro-rated based on risk-adjusted member months for FFS members.

Payment for enrolled PCMHs with the lowest TCOC: The 10% of enrolled PCMHs with the lowest average risk-adjusted TCOC will receive a bonus payment from ODM. This payment will be a lump sum amount calculated and paid annually, no more than 12 months after the end of the performance period when all necessary data is received in final form. Payment amounts to practices will be based on a \$5 per member per year bonus, with a practice's member count calculated as the total annualized attributed member months that made up the patient panel used in the TCOC calculation.

For payments for PCMHs with the lowest TCOC, the performance pool for each performance year is capped at \$1,000,000. If the sum of all calculated payments for enrolled PCMHs with the lowest TCOC across all Ohio CPC practices during a performance year exceeds \$1,000,000, each practice's payment is scaled down proportionally until total outlays equal \$1,000,000.

For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the member practice's annualized attributed member months that made up the patient panel used in the TCOC calculation.

- ii Bonus payment under CPC for Kids: The highest-performing PCMHs participating in the CPC for Kids program that meet quality and efficiency outcomes and perform additional bonus activities focused on improving pediatric care will be eligible for an annual retrospective bonus payment. This annual lump-sum payment will be contingent upon risk-adjusted entity performance on the bonus payment scorecard for CPC for Kids.

The performance pool for each performance year is capped at a total of \$2,000,000. The bonus pool will be awarded to the thirteen highest-performing CPC for Kids entities: the top performer will receive \$500,000; two entities will each be awarded \$250,000; and ten entities will each be awarded \$100,000. For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the member practice's annualized attributed member months that made up the quality metric panel.