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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 23-0043

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

February 28, 2024

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 (SPA) Transmittal Number 23-0043

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 23-0043. This SPA makes changes to the Comprehensive Primary Care (CPC) and CPC for Kids programs including simplified descriptions of program goals, total cost of care calculations, per-member per-month payments, and updated risk tier definitions.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Ohio Medicaid SPA 23-0043 was approved on February 28, 2024, with an effective date of January 1, 2024.

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

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tamara Edwards, ODM
Deborah Benson, CMCS
Angela Cimino, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0043

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, 2024

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 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, Item 25b, pages 1, 3, and 4.
Attachment 4.19-B, Item 25b, pages 1, 4, 5, 6, and 9.

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A, Item 25b, page 1, 3 and 4 (TN 22-037)
Attachment 4.19-B, Item 25b, page 1, 4, 5, 6, 9 (TN 22-037)

9. SUBJECT OF AMENDMENT

Comprehensive Primary Care (CPC) and CPC for Kids program year 2024 updates

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]

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
December 7, 2023

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
December 7, 2023

17. DATE APPROVED **02/28/2024**

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGN [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

Comprehensive Primary Care (CPC). The Ohio Comprehensive Primary Care (CPC) program is Ohio's patient-centered medical home (PCMH) program.

Key definitions:

- A **Patient Centered Medical Home (PCMH)** is a team-based care delivery model led by primary care practitioners (PCPs) who comprehensively manage the health needs of individuals. Provider enrollment in the Ohio Department of Medicaid (ODM) PCMH program, known as the Comprehensive Primary Care (CPC) Program is voluntary. A CPC entity may be a single practice or a practice partnership.
- The **CPC for Kids** program is a voluntary enhancement to the CPC program focused on pediatric members under twenty-one years of age.
- A **Practice Partnership** is a group of practices participating as a CPC entity 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; b) each member practice must have a minimum of 150 attributed Medicaid individuals determined using claims-only data; c) member practices must have a combined total of 500 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 CPC entity 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 entities within the partnership.
- A **Convener** is the practice responsible for acting as the point of contact for ODM and the entities that form a practice partnership.
- A **Member Practice** is any practice participating in a practice partnership.

CPC entities that have enrolled in the CPC program provide primary care case management services under authorities of §1905(t) and 1905(a)(25) of the Social Security Act, which includes location, coordination, and monitoring of health care services. The State assures that it will comply with the applicable beneficiary protections in §1905(t)(3) as described below, including providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies. CPC entities enroll in the CPC program to receive per-member-per-month payments (PMPM) for meeting the CPC entity characteristics and to share savings in the total cost of care for certain services.

Program Goals

The CPC model emphasizes primary care and is intended to improve healthcare outcomes and reduce growth in total cost of care over time. An enrolled CPC entity will receive PMPM payments and may have access to shared savings; the payment of savings is contingent upon meeting efficiency metrics and clinical quality of care thresholds. The measures being used to assess performance include activity requirements, efficiency metrics and clinical quality measures.

An enrolled CPC entity that is participating in the CPC for Kids program will receive additional PMPM payments for attributed members under the age of 21 and may have access to shared savings; the payment of savings is contingent upon meeting additional efficiency metrics and clinical quality of care thresholds. Eight additional clinical quality requirements will be used to assess performance

CPC Entity Characteristics

An enrolled CPC Entity 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. Upon enrollment and on an annual basis, the CPC entity must attest that it will:

- Meet the "twenty-four-seven and same-day access to care" activity requirements in which the CPC entity 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 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 entity when the office is closed;

- Meet the "risk stratification" activity requirements in which the CPC entity 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 CPC entity 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 CPC entity 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 CPC entity;

- Meet 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 managed care organizations (MCOs) or community resources as appropriate;

- Meet the "follow-up after hospital discharge" activity requirements in which the CPC entity 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 CPC entity 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 CPC entity focuses on patient preference, access to care, communication, coordination, and whole person care and self-management support to improve attributed Medicaid individual experience and reduce cultural disparities. The CPC entity will report patient experience findings and opportunities to attributed Medicaid individuals, the patient family advisory council (PFAC), payers and ODM.

- Meet the "community services and supports integration" activity requirements in which the CPC entity will identify Medicaid-covered individuals in need of community services and supports, and maintains a process to connect patients to necessary services.

- Meet the "behavioral health integration" activity requirements in which the CPC entity 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 CPC 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 CPC entity.

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

Comprehensive Primary Care (CPC) Program, Payment Adjustment.

Payment for CPC services can include two types of payments for enrolled CPC entities: (1) per-member-per-month (PMPM) payments; and (2) shared savings payments. All enrolled CPC entities are eligible for PMPM payments, and some may be eligible for shared savings payments. PMPM payments and shared savings payments are distributed to enrolled CPC entities 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) CPC program is voluntary. A CPC entity may be a single practice or a practice partnership.
- The **CPC for Kids** program is a voluntary enhancement to the CPC program focused on pediatric members under twenty-one years of age.
- A **Practice Partnership** is a group of practices participating as a CPC entity 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 CPC entity 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 CPC program by an enrolled CPC entity. An enrolled CPC entity'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 CPC program and therefore included in the attribution process. 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. Dual-eligible beneficiaries (i.e., MyCare Ohio);
b. Beneficiaries with limited benefits;
c. Other beneficiaries with third-party liability medical coverage except for those with exclusively third-party dental or vision coverage;
d. Beneficiaries enrolled in a prepaid inpatient health plan under contract with ODM (i.e, OhioRISE).
e. Beneficiaries attributed to other population health alternative payment models administered by ODM (i.e., comprehensive maternal care(CMC)).

Risk tiers: Risk tiers utilize a robust set of data including co-morbidities, acuity, and how well controlled the medical conditions are, to assign a risk tier to an individual. Members attributed to enrolled CPC entities are placed in the following risk tiers with associated PMPMs for each tier:

i Tier I – Low – (e.g., hypertension, panic disorders, migraines) ($1.80 PMPM);
ii Tier II – Medium – (e.g., congestive heart failure, bipolar affective disorder, paraplegia) ($6.33 PMPM);
iii Tier III – High – (e.g., heart transplant status or complications, schizophrenia, quadriplegia) ($10.20 PMPM)

All members under the age of 21 who are attributed to a CPC entity 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 CPC entity is calculated as follows: The final multiplication is to accommodate the three months in the quarter.

$$\textbf{\textit{Quarterly PMPM payment for an enrolled CPC entity}} = [(number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 1 * PMPM\ amount\ for\ tier\ 1) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 2 * PMPM\ amount\ for\ tier\ 2) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 3 * PMPM\ amount\ for\ tier\ 3)] * 3$$

Quarterly PMPM payment for an enrolled CPC entity 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 CPC attributed members)] * 3*

Shared savings payments

Total cost of care (TCOC).

i Definition: Total cost of care for an enrolled CPC entity is defined as the sum of all non-excluded payments made by ODM for the Medicaid members attributed to that enrolled CPC entity. Baseline total cost of care calculations will be adjusted mid-performance year as necessary to reflect factors such as population acuity shifts. 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 CPC entity'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 CPC entity, in addition to PMPM payments made as part of the Ohio CPC 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 CPC entity is calculated by dividing the enrolled CPC entity's TCOC by the average risk score of the members attributed to the enrolled CPC entity, 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 CPC entities must meet the effective activity requirements, clinical quality and efficiency metrics described above and in Attachment 3.1-A in order for the enrolled CPC entity to be eligible for any type of shared savings payment. Enrolled CPC entities may receive shared savings payments based on either self-improvement or on having the lowest TCOC, or both. CPC entities that participate in the CPC for Kids program are eligible for an additional bonus payment if the prescribed requirements are met.

Enrolled CPC entities 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 prepaid inpatient health plans under contract with ODM (i.e., OhioRISE).
   e. Beneficiaries attributed to other population health alternative payment models administered by ODM (e.g., CMC).

(2) Attributed members who receive specific services, including:
   a. All expenditures for waiver services;
   b. All expenditures for dental, vision, and transportation services;
   c. All expenditures in the first year of life for attributed medicaid individuals with a neonatal intensive care unit (NICU) level three or four stay;
   d. All expenditures for outliers within each risk band in the top and bottom one per cent; and
   e. All expenditures for individuals with more than ninety consecutive days in a long-term care facility

i Payment based on self-improvement

a. Definition: Shared savings payments are annual retrospective payments that may be made to an enrolled CPC entity for saving on the TCOC of their attributed members. The components of this calculation are outlined below.

b. Calculation of savings percentage: The savings percentage for an enrolled CPC entity is as follows:

$$Savings\ percentage = \frac{\left(\begin{array}{c}average\ risk\text{-}adjusted\ TCOC\\ for\ the\ members\\ attributed\ to\ the\ enrolled\ CPC\ entity\\ in\ the\ baseline\ year, with\\ adjustments\ for\ programmatic\ changes\\ and\ drug\ price\ increases\end{array}\right) - \left(\begin{array}{c}average\ risk\text{-}adjusted\ TCOC\ for\ the\\ members\ attributed\ to\ the\ enrolled\ CPC\ entity\\ in\ the\ performance\ period\end{array}\right)}{\begin{array}{c}average\ risk\text{-}adjusted\ TCOC\ for\ the\ members\\ attributed\ to\ the\ enrolled\ CPC\ entity\ in\ the\ baseline\ year,\ with\ adjustments\ for\ programmatic\ changes\\ and\ drug\ price\ increases\end{array}}$$

If the savings percentage is less than 1%, no payment based on self-improvement will be made.

c. Calculation of savings amount:

i. The savings amount is calculated as follows for enrolled CPC entities composed of one practice participating individually:

$$Savings\ amount = [savings\ percentage] * [enrolled\ CPC\ entity's\ non\ risk\text{-}adjusted\ TCOC\ in\ the\ baseline\ year]$$

ii. The savings amount is calculated as follows for each member practice participating in a practice partnership:

Monitoring and Reporting

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

To be eligible for the CPC for Kids bonus payment, the CPC entity must be a high-performing CPC entity relative to other CPC entities 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 oral evaluation, dental services.
Specific information can be found on the ODM website at https://medicaid.ohio.gov/.

In addition, ODM will provide enrolled CPC entities 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.