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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 26-0004

This file contains the following documents in the order listed:

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



Medicaid and CHIP Operations Group

May 1, 2026

Scott R. Partika, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, OH 43218

Re: Ohio State Plan Amendment (SPA) - 26-0004

Dear Director Partika:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) OH-26-0004. This amendment proposes to update the Comprehensive Primary Care (“CPC”) and CPC for Kids programs for Program Year 2026 as follows: remove the team-based care activity and replace it with continuous quality improvement; add CPC entity staff and provider experience to the patient experience activity, update the risk outlier determination methodology, clarify that recipients attributed to other population health APMs administered by Ohio Medicaid are only excluded from PMPM payment, add that entities must outreach to attributed Medicaid individuals who are not current patients, and actively use EHR in clinical services.

We conducted our review of your submittal according to statutory requirements, sections 1905(a)(25) and 1905(t), in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Ohio’s Medicaid SPA TN 26-0004 was approved on May 1, 2026, with an effective date of January 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Ohio State Plan.

If you have any questions, please contact Keri Rosenbloom Toback at (312) 353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

A solid black rectangular box redacting the signature of Nicole McKnight.

Nicole McKnight
Acting Director, Division of Program Operations

Enclosures

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tamara Edwards, ODM
Robert Bromwell, CMCS
Justin Myrowitz, CMCS
Angela Cimino, CMCS
Christine Davidson, CMCS

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

1. TRANSMITTAL NUMBER

2 6 — 0 0 0 4

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, 2026

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 2026 \$ 0
b. FFY 2027 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, Item 25b, pages 2 and 3
Attachment 4.19-B, Item 25b, pages 1, 3, 5, and 6

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

Attachment 3.1-A, Item 25b, pages 2 and 3 (TN 25-002)
Attachment 4.19-B, Item 25b, page 1 (TN 25-002)
Attachment 4.19-B, Item 25b, page 3 (TN 22-037)
Attachment 4.19-B, Item 25b, pages 5 and 6 (TN 23-043)

9. SUBJECT OF AMENDMENT

Comprehensive Primary Care (CPC) and CPC for Kids program year 2026 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

12. TYPED NAME

SCOTT PARTIKA

13. TITLE

STATE MEDICAID DIRECTOR

14. DATE SUBMITTED

February 6, 2026

15. RETURN TO

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

FOR CMS USE ONLY

16. DATE RECEIVED

February 6, 2026

17. DATE APPROVED

May 1, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

January 1, 2026

20. TYPED NAME OF APPROVING OFFICIAL

Nicole McKnight

21. TITLE OF APPROVING OFFICIAL

Acting Director, Division of Program Operations

22. REMARKS

performance for CPC for Kids. A CPC entity participating in CPC for Kids must also pass additional CPC for Kids clinical quality requirements when applicable.

Additionally, the program will be monitored and evaluated as described in Attachment 4.19-B, Item 25b, 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, CPC reporting and survey data. CPC entities may participate in the CPC program via a provider agreement for participation in Medicaid fee-for-service (FFS). Medicaid FFS beneficiaries are free to choose from any qualified provider. Entities that enroll in the CPC program continue to provide services and submit claims in accordance with fee-for-service requirements.

Provider Qualifications

Enrolled CPC entities participating in the CPC 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 CPC 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 CPC entities 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, certified nurse midwife, 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 CPC program for payment beginning January 1st of each program year, the CPC entity 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, share data with ODM and its designees, conduct outreach to attributed Medicaid individuals who are not current patients, and actively use an electronic health record (EHR) in clinical services. ODM contracts with an external quality review team that goes into the field to evaluate how providers conduct outreach to attributed Medicaid individuals who are not current patients.

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

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

CPC Entity Characteristics

An enrolled CPC Entity must meet activity requirements within the timeframes below and have written policies where specified. ODM contracts with an external quality review team that goes into the field to evaluate how providers are meeting activity requirements. 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; provide 24/7 and same-day 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 “continuous quality improvement” activity requirements in which the CPC entity must 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;
- 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, staff and provider 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 differences in health outcomes. The CPC entity will report patient experience findings and opportunities to attributed Medicaid individuals, the patient family advisory council (PFAC), payers and ODM and 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.

TN: 26-0004

Supersedes:

TN: 25-002

Approved: 05/01/2026

Effective: 01/01/2026

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 be an active Medicaid provider for the Ohio Department of Medicaid (ODM); (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 PMPM payments except (e) which are only excluded from PMPM 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.

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: <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 CPC entity 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 CPC entity at the end of each performance period using claims from the performance period across Medicaid FFS for all members attributed to the enrolled CPC entity.

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 CPC entity 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 CPC entity 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 CPC entity 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 CPC entity 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 CPC and CPC for Kids programs. The unit of service is quarterly. PMPM payments begin in the first month of an enrolled CPC entity's first performance period. Payment for CPC services under Ohio's CPC program will not duplicate payments made for the same services under other program authorities or under Ohio's CMC program for this same purpose. ODM offers guidance to providers on this restriction, and throughout the development of this program, ODM carefully reviews existing and new services to ensure that CPC participants are not receiving similar services through other Medicaid funded programs. Enrolled CPC entities 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 program years of a metric not being met result in PMPM payment suspension. A payment suspension will be lifted once an enrolled CPC entity 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 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 members with a Z-score of 4 or greater (the Z-score method compares the risk score of each member to the mean of the population and assigns a score. The calculation used is: $[(\text{Observed Value}) - (\text{Population Mean})]/(\text{Population Standard Deviation})$); 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 except (e) which are only excluded from PMPM payments:
 - 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 members with a Z-score of 4 or greater; 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:

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

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-adjusted TCOC in the baseline year]
 - ii. The savings amount is calculated as follows for each member practice participating in a practice partnership: