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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 17-015

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

June 1, 2017

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

RE: State Plan Amendment Transmittal Number 17-015

Dear Ms. Sears:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #17-015
- Coverage & Limitations and Payment for Services: Patient-Centered Medical Homes
- Effective Date: January 1, 2017
- Approval Date: June 1, 2017

If you have any questions regarding this State Plan Amendment, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 17-015	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, 2017**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Sec. 1905(t) of the Social Security Act Sec. 1905(a)(25) of the Social Security Act (CO)	a. FFY 2017 $30,900 thousands b. FFY 2018 $56,700 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, page 12 Attachment 3.1-A, Item 29, pages ~~1-5 of 5~~ 1-4 of 4 (CO) Attachment 4.19-B, Item 29, pages 1-7 of 7	Attachment 3.1-A, page 12 (TN 12-004) (new) (new)

10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: Ohio Comprehensive Primary Care (Ohio Patient-Centered Medical Homes)

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **BARBARA R. SEARS**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: 3/29/17	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 29, 2017	18. DATE APPROVED: June 1, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers.

☑ Provided: ☐ No limitations ☑ With limitations ☐None licensed or approved

Please describe any limitations: Coverage and limitations are described under Attachment 3.1-A, Item 28

(ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center.

☑ Provided: ☐ No limitations ☑ With limitations (please describe below)

☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: Coverage and limitations are described under Attachment 3.1-A, Item 28

Please check all that apply:

☑ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

- physicians
- Certified nurse midwives
- Certified pediatric or family nurse practitioner services

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

29. Integrated Care Models

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on attachment.

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

Key definitions:

- PCMH practices are defined by Medicaid billing ID. These practices may include one practitioner or several under the same Medicaid billing ID.

PCMH practices that have enrolled in the PCMH 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 ensures 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. PCMH practices, either individually or as PCMH entities, enroll in the PCMH program to receive per-member-per-month payments for meeting the PCMH practice characteristics and to share savings in the total cost of care for certain services.

Program Goals

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

PCMH practices 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 who enroll in the PCMH program continue to provide services and submit claims in accordance with fee-for-service requirements.

Provider Qualifications

PCMH practices 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.

For a practice to enroll as a PCMH in 2016 for performance year 2017, one of the following must be met:

i. The practice has a minimum of five thousand attributed Medicaid members and national PCMH accreditation (National Committee for Quality Assurance (NCQA), Joint Commission, Utilization Review Accreditation Committee, or Accreditation Association for Ambulatory Health Care); or
ii. The practice is an Ohio Comprehensive Primary Care Plus (CPC+) practice and has five hundred or more attributed Medicaid members at each quarterly attribution period; or
iii. The practice has five hundred or more attributed Medicaid members determined through claims-only data at each quarterly attribution period and has NCQA III accreditation.

Practice Characteristics

PCMH participating practices must have at least 500 attributed Medicaid members, attest that they will participate in learning activities as determined by ODM or its designee, and share data with ODM.

Beginning January 1, 2017, all enrolled PCMH practices must implement the following activity requirements.

- Twenty-four hour access to care: the PCMH practice must provide a response within a reasonable time frame to patients seeking clinical advice whether the office is open or closed. The practice must provide interactive clinical advice to patients by telephone or secure video conferencing or messaging. The response must be provided by a primary care practitioner who has access to the patient's medical record;

- Team-based care management: the PCMH practice must designate and train staff to fill care manager roles aimed at overcoming barriers to the patients' receipt of needed evidence-based treatment, as well as define care team roles and relationships, partner with ODM to provide care coordination services, and develop high-quality care plans for high-risk patients;

- Follow-up after hospital discharge: the PCMH practice must form relationships with emergency departments and hospitals from which it frequently receives referrals and establish a process to ensure a reliable flow of information. The PCMH practice must track its attributed Medicaid patients who receive care at these hospitals and

emergency departments with whom they have relationships, and proactively provide follow-up care; and

- Patient experience: the PCMH practice must have a documented process to orient all patients to the practice and consider patient preferences in the selection of a primary care provider (if there are multiple providers within the PCMH practice). The practice must also regularly collect and act on information regarding patient experience.

Beginning July 1, 2017, in addition to the four activity requirements above, all enrolled PCMH practices must implement the following, additional activity requirements:

- Same-day appointments: the PCMH practice must provide same-day appointments within twenty-four hours of initial request, including some weekend hours to sufficiently meet patient demand. The PCMH practice may arrange this with other proximate providers who have access to the patient's records;

- Risk stratification: the PCMH practice must conduct comprehensive risk stratification using all available data, integrate patient risk status into patient records, and update risk stratification and corresponding care plans periodically to reflect changes in patient risk status;

- Population health management: the PCMH practice must identify and proactively reach out to patients with gaps in care, and implement a comprehensive strategy to improve health outcomes and quality; and

- Tests and specialist referrals: the PCMH practice must establish relationships with specialists to whom their attributed Medicaid patients are frequently referred, and have a documented process for identifying self-referrals and requesting reports from clinicians, tracking lab tests and imaging tests, tracking referrals, and tracking the fulfillment of pharmacy prescriptions;

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.

- 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 a PCMH entity.

Qualified PCMH practices are those that meet all eligibility criteria outlined above, have applied via the ODM website, and have had their application accepted by ODM. After their application is accepted, PCMH practices remain in the program until they either: (a) choose to disenroll by notifying ODM in writing of their desire to terminate participation, or (b) no longer meet the provider qualifications or practice characteristics, as outlined above.

Comprehensive Primary Care (CPC) Program, Payment Adjustment.

Payment for PCMH services can include two types of payments for PCMH practices: (1) per-member-per-month (PMPM) payments; and (2) shared savings payments. All PCMH practices are eligible for PMPM payments, and some may be eligible for shared savings payments. PMPM payments and shared savings payments are distributed to PCMH entities directly by ODM and the Medicaid managed care plans.

Definitions and key calculations applicable to all payment

PCMH entities are comprised of one PCMH practice or several PCMH practices grouped together that achieve the minimum number of Medicaid members (i.e., 60,000 member months in a year) required to calculate total cost of care.

Performance period is the 12-month calendar year period of participation in the PCMH program by a PCMH practice. A PCMH practice's first performance period begins January 1st after their enrollment in the program.

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. Duals demonstration beneficiaries (MyCare Ohio);

b. Beneficiaries with limited benefits;

c. All other beneficiaries with third-party liability medical coverage.

ii Methodology: ODM will attribute all non-excluded fee-for-service and managed care members to a practice 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 practice at a time, and only one provider 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 the 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 practice 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 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.

Quality and efficiency metrics required for PMPM and shared savings payments

PCMH practices must meet all of the effective activity requirements described above and in section 3.1-A, in addition to quality metrics and efficiency metrics described below, in order to receive any PMPM or shared savings payments.

PCMH practices must meet specific numerical thresholds on their performance on clinical quality and efficiency metrics. PCMH practices either pass or fail each 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 PCMH practices of the full set of metrics and thresholds by publishing them on the ODM website.

Effective January 1, 2017, the quality and efficiency measures are in effect for the 2017 performance year and can be found at the following link: http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600563-cpc-requirements. The effective date will be updated as necessary to reflect any changes to these measures.

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

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 http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/qualityMetricSpecs.pdf. PCMH practices must pass at least 50% of applicable metrics. Quality metrics are evaluated annually based on performance through the performance period plus six months of claims run-out.

Efficiency metrics: Efficiency metrics are measures of health system utilization and efficiency. The full set of efficiency metrics can be found at

http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/efficiencyMetricSpecs.pdf. PCMH practices must pass at least 50% of applicable metrics. Efficiency metrics are evaluated annually based on performance through the performance period plus six months of claims run-out.

Per-member-per-month (PMPM) payments

Definition: The PMPM payment is a prospective payment to PCMH practices that is both paid and risk-adjusted quarterly, and that supports the practices in conducting the activities required by the PCMH program. The unit of service is quarterly. PMPM payments begin in the first month of a PCMH practice's first performance period. Payment for PCMH services under the CPC 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. PCMH practices must meet the effective program requirements described above in order to receive PMPM payments. Failing any activity requirements results in PMPM payment suspension. Failing to pass 50% of either 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 a PCMH practice passes all activity requirements and 50% of both quality and efficiency metrics.

Risk tiers: Members attributed to PCMH practices are placed in the following risk tiers with associated PMPMs for each tier, effective January 1, 2017:

i Healthy members including those with history of disease ($1 PMPM);

ii Members with minor or significant chronic diseases ($8 PMPM);

iii Members with severe chronic conditions across multiple organ systems ($22 PMPM)

PMPM amounts may be updated no more frequently than annually.

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

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

Shared savings payments

Total cost of care (TCOC).

i Definition: Total cost of care for a PCMH entity is defined as the sum of all non-excluded payments made by ODM or MCPs for the Medicaid members attributed to that entity. 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 and encounter data from the managed care plans. Total cost of care is calculated by summing the total Medicaid fee-for-service claims and managed care plan encounters for the PCMH 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 PCMH entity, in addition to PMPM payments made to practices included in a PCMH entity. 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 a PCMH entity is calculated by dividing the PCMH entity's TCOC by the average risk score of the members attributed to the PCMH 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 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 two types of shared savings payments: payment based on self-improvement and payment for practices with the lowest TCOC. All PCMH practices within the PCMH entity must meet the effective activity requirements, clinical quality and efficiency metrics described above and in section 3.1-A in order for the PCMH entity to be eligible to receive either type of shared savings payment. PCMH entities may receive either type of shared savings payment alone, or both types of shared savings payment. PCMH entities must have at least 60,000 Medicaid member months over the performance period in order to be eligible for either type of shared savings payment.

i Payment based on self-improvement

a. Definition: Shared savings payments are annual retrospective payments that may be made to a PCMH 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 a PCMH entity is as follows:

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

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

c. Calculation of savings amount: The savings amount is calculated as follows:

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

d. Calculation of gainsharing percentage: If the savings amount, as calculated above, is positive, the PCMH entity 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. PCMH entities receive 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 PCMH entities, and/or are a participant in CPC+ Track 2. Practices will be notified of qualification for 65% shared savings no later than nine months following the completion of a performance year. Thresholds for 65% shared savings will be set utilizing data from the baseline year, identifying those that represent 10% of practices with the lowest total cost of care. Thresholds will be effective for performance year 2017. This information will be shared with all CPC practices no later than July 31, 2017.

ii. All other PCMH entities receive 50% of the total savings amount for their practice (as calculated above).

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

$$Shared\ savings\ payment = [PCMH\ entity's\ savings\ amount] * [gainsharing\ percentage]$$

This calculation is conducted annually for each PCMH entity's performance over the performance period. One payment is then made to the PCMH entity for each year-long performance period. 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%, a PCMH entity 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 PCMH entities includes both fee-for-service and managed care members, the payment that ODM makes to PCMH entities 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.

ii **Payment for practices with the lowest TCOC:** The 10% of enrolled PCMH entities 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. Effective January 1, 2017, lowest TCOC performance pool amount for the 2017 performance year can be found at the following link: http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600562-cpc-payments.

Monitoring and Reporting

ODM will collect data from and monitor PCMH practices in the following ways: 1) Upon enrollment, PCMH practices confirm proper PCMH accreditation as well as attesting to activity requirements as specified in the "Practice Characteristics" section. The PCMH activity requirements will be confirmed six months after enrollment, one year after enrollment and annually thereafter; 2) the state, or its designee, will monitor all PCMH practices enrolled in the 2017 PCMH program to verify and document that activity requirements are being met.

In addition, ODM will provide PCMH practices with quarterly progress reports which includes efficiency and quality metrics that are scheduled to be calculated and analyzed.

Further, ODM, or its designee, will evaluate the program to demonstrate improvement against past performance using cost and 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:

- Provide CMS, at least annually, with data and reports evaluating the success of the program against the goals of improving health, increasing quality and lowering the growth of health care costs;
- Provide CMS, at least annually, with applicable updates to the state's thresholds as defined above;
- 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.