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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 19-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

June 25, 2019

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

RE: State Plan Amendment Transmittal Number 19-012

Dear Ms. Corcoran:

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

Transmittal #19-012
- Updates to Ohio's Comprehensive Primary Care (Patient-Centered Medical Homes) Program
- Effective Date: January 1, 2019
- Approval Date: June 24, 2019

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
Deputy Director
Center for Medicaid & CHIP Services
Regional Operations Group

Enclosures

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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **19-012**	2. STATE **OHIO**
	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, 2019**	

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: Sec. 1905(t) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2019 $4,440 thousands b. FFY 2020 $5,920 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 29, pages 1-4 of 4 Attachment 4.19-B, Item 29, pages 1-~~8~~ 7 of 8 *Attachment 4.19-B, Item 29, page 8 of 8 (NEW)* (cd)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Item 29, page 1 of 4 (TN 17-015) Attachment 3.1-A, Item 29, pages 2-4 of 4 (TN 17-043) Attachment 4.19-B, Item 29, page 1 of 7 (TN 17-015) Attachment 4.19-B, Item 29, pages 2-6 of 7 (TN 17-043) Attachment 4.19-B, Item 29, page 7 of 7 (TN 17-015)

10. SUBJECT OF AMENDMENT: Updates to Ohio's Comprehensive Primary Care (Patient-Centered Medical Homes) Program

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: **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: March 29, 2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **March 29, 2019**	18. DATE APPROVED: **June 24, 2019**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 1, 2019**	20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**
21. TYPED NAME: **Ruth A. Hughes**	22. TITLE: **Deputy Director**

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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 is voluntary. A PCMH may be a single practice or a practice partnership.
- 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; 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 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 any practice participating in a practice partnership.

PCMHs 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. PCMHs 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. An enrolled PCMH 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 eight activity requirements, five efficiency metrics and 20 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.

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 who 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 in 2019, the PCMH must:

i. 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; or
ii. Be a practice that participated in the 2017 program year.

PCMH Characteristics

An enrolled PCMH must meet activity requirements within the timeframes below and have written policies where specified. Further descriptions of these activities can be found on the

ODM website, www.medicaid.ohio.gov. Upon enrollment and on an annual basis, the PCMH must attest that it will:

- Meet the "twenty-four-seven and same-day access to care" activity requirements in which the PCMH must: offer at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include, but is not limited to, e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings and weekends; within 24 hours of initial request, provide access to a primary care practitioner with access to the patient's medical record; and make patient clinical information available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed;

- Meet the "risk stratification" activity requirements in which the PCMH must have a developed method for documenting patient risk level that is integrated within the patient record and has a clear approach to implement this across the patient panel;

- Meet the "population health management" activity requirements in which the PCMH must identify patients in need of preventive or chronic services and begin outreach to schedule applicable appointments or identify additional services needed to meet the needs of the patient;

- Meet the "team-based care delivery" activity requirements in which the PCMH must define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM and other providers as applicable for patients in specific patient segments identified by the PCMH;

- Meet the "care management plans" activity requirements in which the PCMH must create care plans that include necessary elements for all high-risk patients as identified by the PCMH's risk stratification process;

- Meet the "follow-up after hospital discharge" activity requirements in which the PCMH must have established relationships with emergency departments and hospitals from which it frequently receives referrals and establish a process to ensure a reliable flow of information;

- Meet the "tests and specialist referrals" activity requirements in which the PCMH must have established bi-directional communication with specialists, pharmacist, laboratories and imaging facilities necessary for tracking referrals; and

- Meet the "patient experience" activity requirements in which the PCMH must orient all patients to the practice and incorporate patient preferences in the selection of a primary care provider to build continuity of patient relationships throughout the entire care process.

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 directly by ODM and the Medicaid managed care plans.

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.
- 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; (f) and 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 who 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. Foster care beneficiaries;
d. Beneficiaries in transition;
e. 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 PCMH that meets the provider type and specialty requirements. Attribution of PCMH members occurs quarterly using retrospective data. PCMH members will only be attributed to one PCMH at a time, and only one enrolled PCMH will receive PMPM payments for PCMH services per attributed beneficiary. Attribution will be done using a hierarchical process as follows:

a. PCMH member choice when expressed directly (i.e., communicated explicitly via contact with ODM or an MCP);
b. Individuals who do not express member choice explicitly will be attributed to a practice based on their claims history;
c. For individuals who do not express member choice and do not have any claims history, non-claims factors including but not limited to geographic proximity will be used for attribution.

Risk scoring:

i Methodology: ODM will score all members attributed to a PCMH (or attributed to a member practice for practice partnerships) based on health status using an evidence-based proprietary risk scoring methodology. Risk scoring will be done using 24 months of available Medicaid data plus at least six months of run-out. Members without Medicaid history will be assigned to the healthiest risk status, and will be reassigned once there is sufficient claims data to update the risk status.

ii Relationship to payment: The risk score is used both to determine PCMH PMPM payment amounts on a quarterly basis, and as an adjustment in the calculation of shared savings payments on an annual basis. The relationship to both payment streams is described in more detail below.

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

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

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

Effective January 1, 2019, the clinical quality and efficiency measures and thresholds are in effect for the 2019 and following performance years, 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 and managed care plans 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.

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 program. 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)

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.

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

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 or MCPs 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 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 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 two types of shared savings payments: payment based on self-improvement and payment for practices with the lowest TCOC. 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 to receive either type of shared savings payment. Enrolled PCMHs may receive either type of shared savings payment alone, or both types of shared savings payment. 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. Foster care beneficiaries;
   d. Beneficiaries in transition; and
   e. All other beneficiaries with third-party liability medical coverage.

(2) Attributed members who receive specific services, including:
   a. Neonatal Intensive Care Unit (NICU) members who utilize nursery level 3 or 4 services during first year of life;
   b. Members with a nursing home stay spanning more than 90 consecutive days within the 12-month reporting or performance period;
   c. Members with at least one Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) visit within the 12-month reporting or performance period; and
   d. Members in the top or bottom one percent of total cost of care within each Clinical Risk Group (CRG) category where there exists a high degree of cost variation across members.

i Payment based on self-improvement
   a. Definition: Shared savings payments are annual retrospective payments that may be made to an enrolled PCMH 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 PCMH is as follows:

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

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

c. Calculation of savings amount:

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

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

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

$$Savings\ amount = [savings\ percentage] * [enrolled\ PCMH's\ non\ risk\text{-}adjusted\ TCOC\ in\ the\ baseline\ year] * [\text{member practice's proportional share of risk} - \text{adjusted member months}]$$

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

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

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

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

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

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

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

ii 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.

Monitoring and Reporting

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

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

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

Ohio will:

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