



Ohio Administrative Code

Rule 5160-19-01 Comprehensive primary care (CPC) program: eligible providers.

Effective: December 12, 2024

(A) For purposes of rules 5160-19-01 and 5160-19-02 of the Administrative Code, the following definitions apply:

(1) "Attribution" is the process through which medicaid recipients are assigned to specific primary care practitioners (PCPs) who are able to participate in the medicaid program in accordance with rule 5160-1-17.2 of the Administrative Code. The Ohio department of medicaid (ODM) is responsible for attributing fee-for-service recipients; medicaid managed care organizations (MCOs) are responsible for attributing their enrolled recipients. CPC entities who are not able to participate in accordance with rule 5160-1-17.2 of the Administrative Code at the time of attribution or during the prospective payment period may not be attributed members or be eligible for payment until the next attribution period following the provider's reinstatement. The following hierarchy will be used in assigning recipients to PCPs under the CPC and CPC for kids program:

- (a) The recipient's choice of provider.
- (b) Claims data concerning the recipient.
- (c) Other data concerning the recipient.

(2) "Baseline year" is a twelve month calendar year, typically two years preceding the performance period unless otherwise specified by ODM. More information about baseline years can be found at www.medicaid.ohio.gov.

(3) "CPC attributed medicaid individuals" are Ohio medicaid recipients for whom PCPs have accountability under a CPC entity. A PCP's attributed medicaid individuals are determined by ODM or the MCOs. All medicaid recipients are attributed. 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) Recipients dually enrolled in both medicare and Ohio medicaid;
- (b) Recipients not eligible for the full range of medicaid benefits;
- (c) Recipients with third party benefits as defined in rule 5160-1-08 of the Administrative Code except for recipients with exclusively third party dental or third party vision coverage.
- (d) Recipients enrolled in a prepaid inpatient health plan, as defined in 42 C.F.R. 438.2 (as in effect on October 1, 2023), under contract with ODM.
- (e) Recipients attributed to other population health alternative payment models administered by ODM under Chapter 5160-19 of the Administrative Code.
- (4) "Convener" is the practice responsible for acting as the point of contact for ODM and the practices who form a practice partnership.
- (5) "CPC for kids" program is a voluntary enhancement to the CPC program focused on attributed pediatric medicaid covered individuals under twenty-one years of age.
- (6) "Eligible provider" is as defined in rule 5160-1-17 of the Administrative Code.
- (7) "A Patient-centered medical home (PCMH)" is a team-based care delivery model led by PCPs who comprehensively manage the health needs of individuals. Provider enrollment in ODM's PCMH program, known as the CPC program is voluntary. A CPC entity may be a single practice or a practice partnership.
- (8) "Performance period" is the twelve month calendar year period of participation in the CPC program by an enrolled CPC entity. An enrolled CPC entity's first performance period begins the first of January after their enrollment in the program.
- (9) "Practice Partnership" is a group of practices participating as a CPC entity whose performance will be evaluated as a whole. The practice partnership has to meet the following provisions:



- (a) Each member practice will have a minimum of one hundred fifty attributed medicaid individuals determined using claims-only data.
 - (b) Member practices will have a combined total of five hundred or more attributed individuals determined using claims-only data at each attribution period.
 - (c) Member practices will have a single designated convener that has participated as a CPC entity for at least one year.
 - (d) Each member practice will acknowledge to ODM its participation in the partnership.
 - (e) Each member practice will agree that summary-level practice information will be shared by ODM among practices within the partnership.
- (B) The following eligible providers may participate in ODM's CPC program through their contracts with MCOs or provider agreements for participation in medicaid fee-for-service in accordance with rule 5160-1-17.2 of the Administrative Code:
- (1) Individual physicians and practices.
 - (2) Professional medical groups.
 - (3) Rural health clinics.
 - (4) Federally qualified health centers.
 - (5) Primary care clinics.
 - (6) Public health department clinics.
 - (7) Professional medical groups billing under hospital provider types.



(C) The following eligible providers may participate in the delivery of primary care activities or services in the CPC program:

(1) Medical doctor (MD) or doctor of osteopathy (DO) as defined in section 4731.14 of the Revised Code with any of the following specialties or sub-specialties:

(a) Family practice.

(b) General practice.

(c) General preventive medicine.

(d) Internal medicine.

(e) Pediatric.

(f) Public health.

(g) Geriatric.

(2) Clinical nurse specialist, certified nurse midwife, or certified nurse practitioner as defined in section 4723.41 of the Revised Code and has any of the following specialties:

(a) Pediatric.

(b) Adult health.

(c) Geriatric.

(d) Family practice.

(3) Physician assistant as defined in section 4730.11 of the Revised Code.



(D) To be eligible for enrollment in the CPC program, the CPC will have at least five hundred attributed medicaid individuals determined using claims-only data, attest that it will participate in learning activities as determined by ODM or its designee, and attest that it will share all requested data with ODM and contracted MCOs;

(E) To be eligible for enrollment in the CPC for kids program, the CPC entity will:

(1) Be a CPC entity that participates in ODM's CPC program for the same performance period.

(2) Have at least one hundred fifty attributed pediatric medicaid individuals determined using claims-only data.

(F) It is the responsibility of an enrolled CPC entity to complete activities within the time frames stated in this rule 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 is expected to attest that it will:

(1) Complete the "twenty-four-seven and same-day access to care" activities in which the CPC entity will:

(a) 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.

(b) Provide twenty-four-seven and same-day access to a PCP with access to the attributed medicaid individual's medical record.

(c) Make clinical information of the attributed medicaid individual 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.

(2) Complete the "risk stratification" activities in which the CPC entity will have a developed



method for documenting patient risk level that is integrated within the attributed medicaid individual's record and has a clear approach to implement this across the practice's entire patient panel.

(3) Complete the "population health management" activities in which the CPC entity will identify attributed medicaid individuals 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 attributed medicaid individual.

(4) Complete the "team-based care delivery" activities in which the CPC entity will define care team members, roles, and qualifications and provide various care management strategies in partnership with payers, ODM, and other providers as applicable for attributed medicaid individuals in specific segments identified by the CPC entity.

(5) Complete 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 MCOs or community resources as appropriate.

(6) Complete the "follow-up after hospital discharge" activities in which the CPC entity will have established relationships with all emergency departments and hospitals from which it frequently receives referrals and has an established process to ensure a reliable flow of information.

(7) Complete the "tests and specialist referrals" activities in which the CPC entity will have established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.

(8) Complete the "patient experience" activities in which the CPC entity will:

(a) Orient all attributed medicaid individuals to the practice and incorporate patient preferences in the selection of a PCP to build continuity of attributed medicaid individual relationships throughout the entire care process.

(b) Ensure all staff who provides direct care or otherwise interacts with attributed medicaid



individuals completes cultural competency training, as deemed acceptable by ODM, within six months of program enrollment and annually thereafter.

(c) Ensure that new staff who will provide direct care or otherwise interact with attributed medicaid individuals complete cultural competency training within thirty days of their start date.

(d) Routinely assess demographics and adapt training needs based on demographics.

(e) Assess its approach to attributed medicaid individual experience and cultural competency at least once annually through the use of the patient and family advisory council (PFAC) or other quantitative and qualitative means, such as focus groups or a patient survey, that covers access to care, communication, coordination, and whole person care and self-management support.

(f) Use the information collected pursuant to paragraph (G)(8)(e) of this rule to identify and act on opportunities to improve attributed medicaid individual experience and reduce cultural disparities, including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. The CPC entity will report findings and opportunities to attributed medicaid individuals, the PFAC, payers, and ODM.

(9) Complete the "community services and supports integration" activities in which the CPC entity will identify medicaid covered individuals in need of community services and supports and maintains a process to connect attributed medicaid individuals to necessary services.

(10) Complete the "behavioral health integration" activities in which the CPC entity will use screening tools to identify attributed medicaid individuals in need of behavioral health services, tracks and follow up on behavioral health service referrals, and has a planned improvement strategy for behavioral health outcomes.

(11) Cooperate with and grant access to ODM or its designee for the purpose of conducting activity requirement evaluations.

(G) It is the responsibility of a CPC entity to pass the following efficiency metrics representing at least fifty per cent of applicable metrics, to be evaluated annually at the end of each performance



period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Inpatient admission for ambulatory care sensitive conditions (ACSCs).

(2) Emergency room visits per one thousand.

(3) Behavioral health related inpatient admissions per one thousand.

(4) Adherence to the single preferred drug list.

(H) It is the responsibility of a CPC entity to pass a number of the following clinical quality metrics representing at least fifty per cent of applicable metrics, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Well-child visits in the first fifteen months of life.

(2) Child and adolescent well-child visits for members who are three to eleven years of age.

(3) Child and adolescent well-child visits for members who are twelve to seventeen years of age.

(4) Weight assessment and counseling for nutrition and physical activity for children and adolescents. Body mass index (BMI) assessment for children and adolescents.

(5) Timeliness of prenatal care.

(6) Live births weighing less than two thousand five hundred grams.

(7) Postpartum care.

(8) Chlamydia screening for women.



- (9) Cervical cancer screening.
 - (10) Controlling high blood pressure.
 - (11) Asthma medication ratio.
 - (12) Statin therapy for attributed medicaid individuals with cardiovascular disease.
 - (13) Comprehensive diabetes care; HbA1c poor control (greater than nine per cent).
 - (14) Comprehensive diabetes care: blood pressure control.
 - (15) Comprehensive diabetes care: eye exam.
 - (16) Antidepressant medication management.
 - (17) Follow-up after hospitalization for mental illness.
 - (18) Preventive care and screening: tobacco use, screening and cessation intervention.
 - (19) Initiation and engagement of alcohol and other drug dependence treatment.
 - (20) Well visits for members who are eighteen to twenty-one years of age.
 - (21) Well visits for members who are fifteen to thirty months of age.
- (I) It is the responsibility of a CPC entity participating in CPC for kids to also pass at least fifty per cent of the applicable metrics from the following list of clinical quality metrics, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.
- (1) Lead screening in children.



- (2) Childhood immunization status.
 - (3) Immunizations for adolescents.
 - (4) Well-child visits in the first fifteen months of life.
 - (5) Child and adolescent well-child visits for members who are three to eleven years of age.
 - (6) Child and adolescent well-child visits for members who are twelve to seventeen years of age.
 - (7) Weight assessment and counseling for nutrition and physical activity for children and adolescents. BMI assessment for children and adolescents.
 - (8) Well visits for members who are eighteen to twenty-one years of age.
 - (9) Well visits for members who are fifteen to thirty months of age.
 - (10) Oral evaluation, dental services.
- (J) It is the responsibility of a CPC entity participating in CPC for kids to also pass at least one of the following clinical quality metrics when applicable, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.
- (1) Lead screening in children.
 - (2) Childhood immunization status.
 - (3) Immunizations for adolescents.
- (K) A CPC entity may utilize reconsideration rights as stated in rules 5160-70-01 and 5160-70-02 of the Administrative Code to challenge a decision of ODM concerning CPC or CPC for kids program enrollment or eligibility.