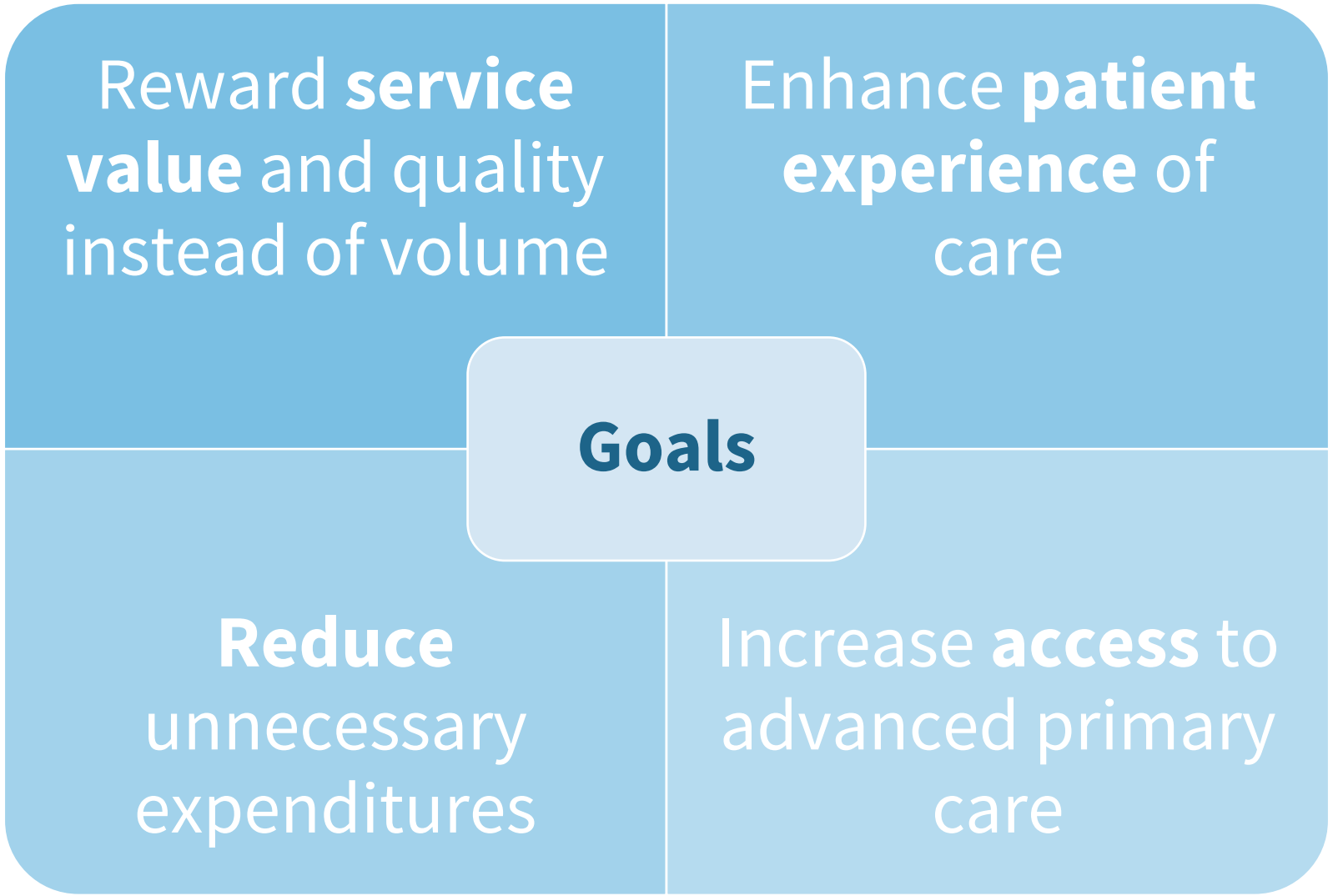
Comprehensive Primary Care (CPC)
Program Overview

2024

Department of Medicaid

CPC Overview



Department of Medicaid

CPC Overview

- Team-based care delivery model led by a primary care practice that **comprehensively** manages a patient's healthcare needs

- The goal is to improve **quality of care** while lowering costs by empowering practices to deliver the best care possible

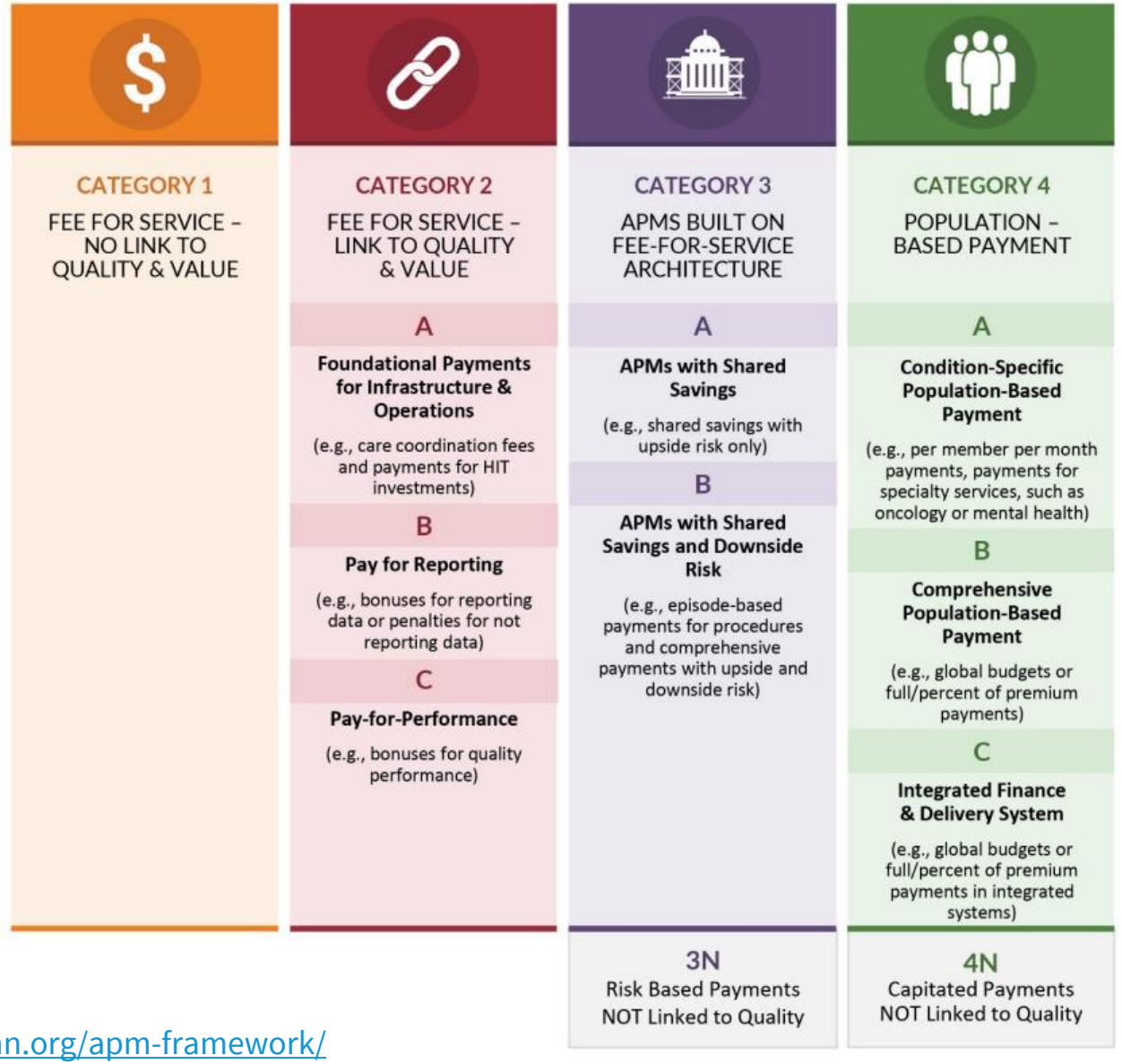
- The **program year** runs concurrently with the calendar year (i.e., 1/1/24-12/31/24)

- Program regulations are in the following **Ohio Administrative Code** rules:
  - 5160-19-01 at https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01
  - 5160-19-02 at https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-02

Value Based Payment

Framework

- Represents payments from public and private payers to provider organizations
- Accommodates payments in multiple categories that are made by a single payer or a single provider organization that receives payments in different categories
- Captures a continuum of clinical and financial risk for provider organizations
- CPC is currently a 3A program



Source: https://hcp-lan.org/apm-framework/

CPC Eligibility

Provider Type

Individual physicians and practices, professional medical groups, rural health clinics, federally qualified health centers, etc.*

Specialty

Medical doctor (MD), doctor of osteopathy (DO), clinical nurse specialist, certified nurse practitioner, or physician assistant with the appropriate specialty*

Size

At least 500 claims-only members to participate independently or as a partnership

At least 150 claims-only members to participate as a practice partnership

*A complete list of acceptable provider types, specialties, and subspecialties are listed in rule 5160-19-01 of the Ohio Administrative Code

CPC Activity Requirements

- 24/7 and same-day access to care
- Risk stratification
- Population health management
- Team-based care delivery
- Care coordination
- Follow-up after hospital discharge
- Tests and specialist referrals
- Patient experience
- Community services and supports integration
- Behavioral health integration

Ohio Department of Medicaid

CPC Clinical Quality Metrics

- Well-child visits in the 1st 15 months of life
- Child/adolescent well-child visits for members aged 3 to 11 years
- Child and adolescent well-child visits for members aged 12 to 17 years
- Weight assessment and counseling for nutrition and physical activity for children and adolescents. BMI assessment for children and adolescents
- Timeliness of prenatal care
- Live births weighing less than 2,500 grams
- Postpartum care
- Chlamydia screening for women
- Cervical cancer screening
- Controlling high blood pressure
- Asthma medication ratio
- Statin therapy for members with cardiovascular disease
- Comprehensive diabetes care; HbA1c poor control (greater than 9%)
- Comprehensive diabetes care: blood pressure control
- Comprehensive diabetes care: eye exam
- Antidepressant medication management
- Follow-up after hospitalization for mental illness
- Preventive care and screening: tobacco use, screening and cessation intervention
- Initiation and engagement of alcohol and other drug dependence treatment
- Well visits for members who are 18 to 21 years of age

CPC Efficiency Metrics

Inpatient admission for ambulatory care sensitive conditions (ACSCs)

Emergency room visits per one thousand

Behavioral health related inpatient admissions per one thousand

Adherence to the single preferred drug list

CPC Attribution

Defined

- Process through which Medicaid recipients are **assigned** to specific primary care practices that can participate in Medicaid's CPC program as described in rule 5160-19-01 of the Ohio Administrative Code

- The Ohio Department of Medicaid (ODM) is responsible for attributing fee-for-service (FFS) individuals **while** Managed Care Organizations (MCOs) are responsible for attributing their enrolled members

- **All** individuals are attributed to a primary care practice

CPC Attribution

Hierarchy

- The following is the **hierarchy** used to assign Medicaid individuals in the CPC and CPC for Kids programs:
  - The individual's **choice** of provider
  - **Claims** data concerning the individual
  - Other data concerning the individual (e.g., **geographic location**, age, gender)

CPC Attribution

Exclusions

- Individuals meeting **any** of the following criteria are excluded from triggering CPC payments:
  - Dually **enrolled** in Medicaid and Medicare
  - Not eligible for the **full range** of Medicaid benefits
  - With third-party benefits except for those with **only** dental or vision
  - Enrolled in a **prepaid** inpatient health plan
  - Attributed to other alternative payment models like **OhioRise**

CPC Attribution Examples

Member Re-Assigned

- **Example 1**
  - Member is assigned to Dr. Smith at ABC Clinic in the prior quarter's attribution file
  - During the next quarter, Dr. John at XYZ Clinic is identified as the provider that has seen the member the most during the look-back period
  - Member is then reassigned to Dr. John
- **Example 2**
  - Member is assigned to Dr. Doe at 789 Clinic in the prior quarter's attribution file
  - Member expressed their primary care provider choice during the quarter for Dr. Jane at 123 Clinic
  - Member is then reassigned to Dr. Jane

CPC Attribution Examples

Member Not Re-Assigned

- **Example 1**
  - Member is assigned to Dr. Smith at ABC Clinic in the prior quarter's attribution file
  - During the next quarter, Dr. Smith at XYZ Clinic is identified as the provider that has seen the member the most during the look-back period
  - The member is not reassigned because the rendering provider is unchanged
- **Example 2**
  - Member is assigned to Dr. Blue at 123 Clinic in the prior quarter's attribution file
  - During the next quarter, Dr. Johnson at 123 Clinic is identified as the provider that has seen the member the most during the look-back period
  - The member is not reassigned as the billing provider is unchanged

CPC PMPM Payments

Overview

- **PMPM payments** are prospective, quarterly, and risk-adjusted to support the program's activities

- PMPM payments begin in **January** following enrollment

- Activity requirements, clinical quality metrics, and efficiency metrics **must** be met

CPC PMPM Payments

Risk Assessment

- Risk for a patient is measured using a risk assessment tool called the Chronic Illness and Disability Payment System + Prescriptions **(CDPS + Rx)**

- Members are assigned a **unique** risk score developed from historical diagnoses, National Drug Codes (NDCs), and demographics

- Risk scores reflect a sum of components that have **cost weights** and are used to put members into three overall risk tiers for payment

Tier I

Risk Score <= 1.0

PMPM Payment = $1.80

Tier II

1.0 < Risk Score <= 5.0

PMPM Payment = $6.33

Tier III

Risk Score > 5.0

PMPM Payment = $10.20

CPC PMPM Payments

Payment Calculation

- Quarterly PMPM payments for CPC are **calculated** as follows:
  - 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
    - Note: The final multiplication is to accommodate the three months in the quarter

- Comprehensive Maternal Care (CMC) payments are deducted from CPC payments to prevent **dual payments** for one member

CPC Shared Savings Payments

Overview

- Annual **retrospective** payments based on savings on the total cost of care (TCOC)

- CPC activity requirements and quality and efficiency metrics **must** be met

- CPC entity must have **60,000** member months to calculate TCOC

- Can receive either or both of the following **two payments**:
  - Total cost of care relative to peers
  - Total cost of care relative to self

CPC Shared Savings Payments

Defined

TCOC Relative to Peers

- Based on an entity achieving a **low** TCOC relative to other eligible CPC entities
- ODM is the **paying** entity

TCOC Relative to Self

- Based on an entity's **improvement** on TCOC for their attributed patients compared to their own baseline TCOC
- MCOs are the **paying** entities (except for fee for service members, which ODM pays)

CPC Shared Savings Payments

Baseline

- TCOC for baseline and performance years are set based on the **point-in-time** attribution dates that occurred during that calendar year

- The member panel used for TCOC is based on the 4 quarters of point-in-time attribution that occurred during the **performance period**, not the patient panels used to calculate the PMPMs distributed during the program year

Point-in-Time Attribution Dates for the 2024 Performance Year		
	Point-in-Time Attribution Dates for PMPM Payments	**Point-in-Time Attribution Dates for Shared Savings Payments**
Q1 2024	September 1, 2023	March 1, 2024
Q2 2024	December 1, 2023	June 1, 2024
Q3 2024	March 1, 2024	September 1, 2024
Q4 2024	June 1, 2024	December 1, 2024

CPC Shared Savings Payments

Inclusions and Exclusions

	Inclusions	Exclusions
Patients	• All adult and pediatric members • All behavioral health members • Members with exclusively dental or vision third party liability (TPL) coverage	• Dual enrolled members • Members only eligible for limited benefits (e.g., family planning) • Members with TPL coverage • Members enrolled in a prepaid inpatient health plan • Members in other population health alternative payment models (i.e., CMC)
Services	• All non-excluded medical and prescription expenditures • Case management, durable medical equipment (DME), home health, and the 1st 90 days of long-term care (LTC) expenditures • Quarterly CPC PMPMs	• Waiver service expenditures • Expenditures on dental, vision, and transportation services • All expenditures in the 1st year of life for members with a level 3 or 4 NICU stay • Services provided past 1st 90 days in LTC • Outliers within each risk band (top and bottom 1%)

CPC Shared Savings Payments

Relative to Peers Calculation

- Shared savings payments relative to **peers** is calculated based on total spend for the attributed population based on:
  - Adjudicated (medical, Rx) claims
  - Received quarterly PMPM payments
  - Excludes spend at patient and service level
- Includes a **risk adjustment** factor to account for differences in risk profiles of patient panels across entities within the time frame (e.g., performance year)
- Members in each entity are assigned a **risk score** from the CDPS+Rx risk grouper
- PMPM TCOC payments across a category in CDPS+Rx is **compared** to the average PMPM TCOC across all categories
- Risk score is **calculated** at the practice level to compare practice specific risk to average risk
- Risk adjusted TCOC is calculated as the **TCOC/risk score**

CPC Shared Savings Payments

Relative to Self Calculation

- Shared savings payments relative to **self** is calculated based on performance against the entity's own baseline from a previous year

- For 2024, each CPC entity's performance on TCOC is compared to the entity's **baseline performance** from 2022 to determine whether shared savings was achieved
  - Baseline TCOC is calculated based on the patients attributed in calendar year (CY) 2022
  - Performance year TCOC is calculated based on the patients attributed in CY 2024

- Adjustments are done to **account** for:
  - Difference in risk mix (across years/practices)
  - Changes in the program across years (reimbursement fee schedule, drug prices)

- Total **spend** for attributed population is based on:
  - Adjudicated (medical, Rx) claims
  - Received quarterly PMPM payments
  - Excludes spend at patient and service level

- Other factors in the **calculation**:
  - Risk adjustments
  - Programmatic adjustments

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