Department of Medicaid

Detailed Business Requirements

Ohio Comprehensive Primary Care Program (CPC)

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1 INTRODUCTION

1.1 Versions and Revisions

Program design for the CPC program is an iterative process. Once the initial program design is finalized and the care model has been implemented, experience with the new payment model will generate new insights. These insights are leveraged to modify and improve the initial program design. To keep track of the version of the program model used at any given time, a versioning system consisting of three numbers is employed:

- The algorithm version reflects the version of the software code used in producing the outputs for CPC. It is indicated by a major and minor version number, e.g., a1.1. The major algorithm version never resets to zero. The minor algorithm version resets to zero when the major algorithm version is incremented.
- The configuration version reflects the version of the parameter settings and medical codes used in producing the outputs for CPC. The configuration includes, for example, the procedure codes used to calculate quality metrics. The configuration version is indicated by a two-digit number, e.g., c01. The version does not reset with updates to the algorithm.
- The documentation version reflects the version of the Detailed Business Requirements (DBR) describing the CPC program. It is indicated by a two-digit number, e.g., d01, and increments when a revision is made to the documentation without making a change to the algorithm or the configuration. It resets every time the algorithm or the configuration version changes.

Table 1. Versions

Version	Date	Changes
a1.0 c01 d01	2018-05-25	First version
a1.0 c01 d02	2018-06-29	Corrected timeframe for CRG run in section 5.4.2 under “CRG run timeframe for a 12-month rolling period”
a1.0 c01 d03	2018-07-16	• Updated episodes of care efficiency metric definition (see Appendix) • Updated rate calculations for efficiency metrics • Clarification on GIS input data
a1.0 c01 d04	2018-08-10	• Corrected parameters to set for Quarterly Attribution Bridge Table in section 5.1.5 • Corrected example pre-populated Quarterly Attribution Bridge Table month start date parameter in section 5.2.3
a1.0 c01 d05	2018-09-10	Corrected typo in Section 5.6.6 Calculate practice-level total cost of care
a1.0 c01 d06	2018-10-09	Updated episodes of care metric to include Wave 2 episodes
a1.0 c01 d07	2018-10-22	• Added note on logic for valid PCP and valid practice combination check • Corrected CRG version number

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		• Added detail on denied claims when calculating utilization flag • Added note to include denied claims in the CRG risk categorization • Corrected typo in calculation of practice_ra_tcoc_pmpm_final • Added guidance on CCS categories and CL1 and CL2 crosswalk information to the Appendix
a1.0 c01 d08	2018-10-31	Revised language for calculation of CRG outliers
a1.0 c01 d09	2018-11-05	• 2019 updates to practice eligibility section • Updated DBR appendix to include note about tying the Episodes of Care metric to payment in 2019 • Added information on how to obtain programmatic adjustment factors • Removed dual program codes (3053, 3054, 3055, 3056, 3057) from DBR Codesheet in "Codesheet" tab • Added note to set member_dob equal to null if the member was born after the month_end_date • Added note to avoid double-counting claims when calculating claims_spend_month_excluded if the claim is flagged through more than one exclusion type
a1.0 c01 d10	2018-11-08	• Corrected assignment of CRG value for members with no claims history in the Rolling Period Member Table (O.03) • Corrected calculation of practice_ra_tcoc_pmpm_final in Rolling Period Member Table (O.03)
a1.0 c01 d11	2018-11-09	Added clarification to sum member months in CRG risk score calculation when solving for the total_unadjusted_population_pmpm parameter
a1.0 c01 d12	2018-11-29	Revised fund code for File G2 in section 5.10.5
a1.0 c01 d13	2019-03-15	• Added “adjusted for programmatic changes” in the equation in the savings amount equation in section 3.8.1 (p.30) • Added “risk-adjusted” before “member months” in section 3.8.2 (p.31), for clarification • Updated Tables 5, 7, and 8 in sections 3.10, 4.4, and 4.5 respectively • Changed “practitioner” to “provider” in section 5.1.5 (p.49) • Changed “…where excl_standard_any on the Attribution Output Table (O.01) *equals 0*…” to “…where excl_standard_any on the Attribution

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		Output Table (O.01) *equals 1*…" in section 5.5.2 (p.83) • Changed "Practice-level *unadjusted* total cost of care …" to "Practice-level *risk-adjusted* total cost of care …" in section 5.6.6 (p.95) • Corrected the pass field definition for metrics in Table 21 section 5.7.4 from "is equal to 1" to "is equal to 0" • Corrected ppc_postpartum_rate and ppc_postpartum_pass in Table 21 section 5.7.4 • Modified '"cpc_plus_flag is equal to "1" to "cpc_plus_flag is equal to "T2"' in section 5.8.3 (p.116) • Added a shared savings relative to self section in 5.8.5 (p.118) • Corrected the current quarter members panel total definition to pull in members when month_id is equal to 12 (not 9) in section 5.10.10 (p.151) • Corrected "membes" to "members" (p.151) • Created a section for Files G3 and G4 in section 5.10.12 • Created a section for File G5 in section 5.10.13 • Created a Shared Savings Internal Calculations Table in section 5.10.14
a1.0 c01 d14	2019-03-28	Modified the DBR appendix by removing obstetric admissions in the PQI definitions
a1.0 c01 d15	2019-04-08	• Removed Fewer than 6 Months Eligibility Flag from the Rolling Period Member Table (O.03) (p. 66) • Clarified selection of high-cost outliers and their risk-score value (p. 80 – 83) • Updated references to risk tier vs. risk band for consistency (p. 137 File C, p. 129 File D, p. 143 File H, p. 154 – 155 File L)
a.1.0 c01 d16	2019-05-15	• Clarified claims run-out required for baseline and shared savings calculations (p.100) • Clarified members in scope for Episodes of Care Metric (p. 21 in Appendix) • Updated use of qm_pass flag to designate top and bottom paps (p. 23-27 in Appendix)
a.1.0 c01 d17	2019-06-13	• Clarified risk-adjustment member panel (p. 72) • Updated fields in Table 7 (p. 118, 119, 124) • Updated File G3 payout amount to be pulled from total_ss_peers_dollar and File G3/G4 issue date to reflect reporting year (p. 161) • Updated fields in ODF.17 to pull directly from Table 7 where applicable (p.167, 168)

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		• Updated aid category selection methodology to consider special cases with aid category "E" (p. 120) • Updated calculation of payout amounts for shared savings relative to self by payer to separate out payer payout proportions and fund code proportions (p. 121 – 125) and updated downstream logic in File G5 to reflect this (p. 166-167) • Updated issue date in File G3 and G4 to populate as date reports were sent out (p. 161 – 162)

a.1.0 c01 d18	2019-11-08	• Updated DBR Appendix
		• Updated Table of Contents
		• Added 5 rows to Section 1Table 1: Ohio CPC Clinical Quality and Efficiency Metrics to include CPC for Kids Metrics and modifications beginning 2020 performance year. (p3-4Section 1.1 Metrics Based on Standard HEDIS® Specifications updated to version 2018 of the HEDIS® Technical Specifications for Health Plans. 5
		• Section 1.1 added Lead Screening: One or more at 2 years of age (HEDIS LSC) p5
		• Section 1.2 Metrics Based on Modified HEDIS® Specifications p5 section 1.1.2. Added the following sections to p6:
		  ○ 1.2.3 Childhood Immunization Status, Modified (HEDIS CIS)
		  ○ 1.2.4 Immunization for Adolescents, Modified (HEDIS IMA)
		  ○ 1.3.1 Updated hyperlink to Specifications for the Tobacco Use: Screening and Cessation metric (NQF 0028) p7
		• Added Section 1.3.6 Tobacco Cessation and Intervention ages 12-17 and updated denominator to ages 12-17 p29
		• Added Section 1.3.7 Fluoride Varnish (Ohio Dept. Medicaid)

a.1.0 c02 d01	11/20/2020	The OH CPC DBR was consolidated to one document to include the following: • Updated to include Ohio CPC Entities Practice Partnerships Supplement • Updated CPC Program Implementation Schedule to include Program Changes and Practice counts current to 2020 • Updated PMPM payment amounts as of CY2019 Attribution
a.1.0 c02 d02	01/22/2021	• Added structured formatting throughout document • Updated verb tense from future to present • Updated link in footnote 3 (p.19)

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		• Updated section reference in 3.3.1 to ‘Section 5.5 • Updated language in section 3.3.6 to read “Appendix A: CPC Quality and Efficiency Metrics Specifications • Removed extra bullet from section 5.2.6 • Section 5.9: Added missing digit to ‘2017’ • Updated formatting in section 5.11.3 to clarify calculating excluded vision spend and excluded waiver spend • Section 5.12.1: updated numbering to start at 1 • Section 7.1.3: updated link • Updated ‘fileK’ and ‘fileL’ to ‘File K’ and ‘File L’ in section 7.3 and throughout document • Table 3: updated language for ‘Eligibility to receive PMPM’ to include partnership • Table 3: added ‘Eligibility for CPC for Kids PMPM’ and criteria; added ‘Eligibility for CPC for Kids Bonus Payment’ and criteria • Table 3: Updated footnote reference for ‘The practice must pass at least 50% of the efficiency measures for which the practice qualifies’ • Table 4: updated number of Activity Requirements to 10 • Table 4: updated language • Section 2.5: changed language to ‘Starting in 2020 program year, ODM initiated an option to also enroll in CPC for Kids program’. • Section 3.1: Updated from ‘practice-practitioner' to ‘practice’ • Section 3.1.2: Updated verb tense • Section 3.2.2: Clarified that exclusions are in addition to standard exclusions • Section 3.3.6: Updated language to ‘attributed to a CPC entity for at least 6 months’ • Section 3.3.6: Updated language to ‘entity quality and cost performance’ • Section 3.6- added CPC for Kids pass criteria • Section 3.6.4: added clarifying language that not all efficiency and quality metrics are HEDIS • Section 3.7.2: Updated language to read, ‘Shared savings payments relative to peer will be paid directly to each practice within the partnership based on existing methodology. This payment is calculated by multiplying annualized member months for the CPC practice during the performance period by $5 (this amount may be updated annually).’

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		• Section 3.7.6: Updated language to , 'This payment is calculated by multiplying annualized member months for the CPC practice during the performance period by $5 (this amount may be updated annually). The total outlay of this payment is capped at $1 million per entity annually, '. • Table 8: Added Shared Savings Partnership Supplement File • Table 11: corrected number of File M and N • Table 11: Added Shared Saings Supplement File • Table 24: removed 'threshold_next_year' and 'threshold_next_year' fields for CPC for Kids • Section 5.12.1: updated algorithm numbers and separated CPC for Kids • Section 5.12.5: Updated efficiency metric performance to include 5 metrics • Section 5.14: Added reason and fund codes for CPC for Kids • p. 231: updated age boundaries for CPC for Kids • p. 242: removed language, 'RA Total Spend PMPM ($) is set to -1, because it seems like RA spend cannot be calculated from fileK" • p.245: removed language, 'Average risk score is set as -1 since there doesn't seem to be a value for risk score in fileK'. • Appendix D Input & Output Tables Overview: Updated number of File M and N • Appendix D Input & Output Tables Overview: Added Shared Savings Partnership Supplement • Appendix D Output Table Fields: Updated descriptions for 'CPC_kids_pass_criteria_1' and 'CPC_kids_pass_criteria_2' • Appendix D Output Data Files and Fields: updated file type of G1, G2, G3, G4, and G5 to .csv files • Appendix D Output Data Files and Fields: deleted incorrect File H tab name • Appendix D Output Data Files and Fields: File K- updated Risk Tier values to include '0'. • Appendix D Output Data Files and Fields: File I- updated EOC threshold values to include those <0 • Appendix D Output Data Files and Fields: File L- deleted footnotes • Appendix D Output Data Files and Fields: Added File T- Shared Savings Supplement fields • Section 5.14.15: Added Shared Savings calculation information for Partnerships
a.1.0 c02 d03	02/08/2021	• Updated formatting throughout the document

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		• Table 24: The field 'threshold_criteria' has been removed from CPC for Kids measures to match the rest of the measures • Section 5.12.5: Language updated to reflect that GDR has been removed for PY 2020; therefore, there are 4 efficiency metrics for PY 2020 • Appendix D Input Table Fields: Updated I.M.05 fields to match original configuration file • Appendix D Input Table Fields: Removed I.M. 06-I.M.12 as extraneous
a.1.0 c02 d04	02/24/2021	• Added/Updated ? rows to Section 1T

a.1.0 c03 d01	03/05/2021	• Table 7 Clinical Quality and Efficiency Metrics and Thresholds
		  ○ Added Well-Child Visits in the First 30 Months of Life (W30)
		  ○ Added Child and Adolescent Well-Care Visits (WCV)
		  ○ Added Asthma Medication Ratio (AMR)
		• Table 22 Ohio CPC Clinical Quality Metrics
		  ○ Added Well-Child Visits in the First 30 Months of Life (W30)
		  ○ Updated the ending program year for Well-Child Visits in the First 15 Months of Life (W15) to PY2021
		  ○ Added Child and Adolescent Well-Care Visits (WCV)
		  ○ Updated the ending program year for Well-Child Visits in the 3rd, 4th, 5th, 6th Years of Life (W34) to PY2021
		  ○ Updated the ending program year for Adolescent Well-Care Visits (AWC) to PY2021
		  ○ Added Added Asthma Medication Ratio (AMR)
		  ○ Updated the ending program year for Medication Management for People with Asthma (MMA) to PY2021
		• Table 24 Metric Output Fields
		  ○ Added 6 new flags for W30
		  ○ Added 6 new flags for WCV
		  ○ Added 6 new flags for AMR
		• Section 5.14.8 File I
		  ○ Added W30 flag to the HEDIS Measures
		  ○ Added WCV flag to the HEDIS Measures
		  ○ Added AMR flag to the HEDIS Measures
		• Section 5.14.10 File L
		  ○ Added W30 to the HEDIS Measures

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		○ Added WCV to the HEDIS Measures ○ Added AMR to the HEDIS Measures • Table 33 File L Columns Tested ○ Added a row for W30 ○ Added a row for WCV ○ Added a row for AMR • Table 34 File K to File L Column Mappings ○ Added rows for W30 ○ Added rows for WCV ○ Added rows for AMR • Section 7.3 Appendix C: Reconciliations (under File J Checks) ○ Added rows for W30 ○ Added rows for WCV ○ Added rows for AMR
a.1. c03 d01	9/29/2022	Updates made for PY 2022, including: • AMR, W30, WCV, and PDL are now included for payment • Removed Episode of Care efficiency metric from .pdf reports and scoring • Added File G6 information to Table 8 and Table 11 • Added Table O.09 information to Table 10
a1.c04.d01	4/16/2024	Updates made for PY2024 • Eligible metrics document wide • Added CDPS attribution methodology • Removed CRG methodology
a1.c04.d02	09/12/2024	APM updates target date GO LIVE • Added eCQM supplemental data inclusion • Updated OhioRISE language to reflect: 'Recipients enrolled in a Prepaid Inpatient Health Plan (currently OhioRISE)' • Removed all retired Reporting metrics from all files (previously were maintained in L/K, but removed from the rest) • Updated nomenclature for previous iterations
a1.c04.d02	4/3/2025	Removed eCQM, as that is part of PY2025. Clarified Preview reporting section by adding detail. Added figure describing CDPS data flow to p. 25.
a1.c04.d03	4/10/2025	Added eCQM supplemental data kicking off for PY2025 to metric lists and program descriptive information. • p. 12: Added additional attestation requirements • p. 20: Updated CMC/other APM program standard exclusion to apply to PMPM, • but not reporting

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		• p. 28: updated metric counts for payment, CPC for Kids, information only. • p. 182: Preview details included for rolling periods and files sent. • p. 199: Added data validation details for eCQM supplemental data files. • p. 223: Added remaining metrics for PY2025 Document Wide: updated language to be 'eCQM supplemental data' per comment; updated language from 'single' to 'individual' for practices not part of partnerships in CPC, made formatting updates as recommended by ODM.
a1.c04.d03	5/8/2025	Added PY2025 metric threshold values
a2.0.c04.d01	10/27/2025	Updated DBR for code changes related to CCRB A20878 – Upgrade to CDPS+Rx 7.2 (from CDPS 7.0) effective PY2026
a2.0.c04.d01	2/19/2026	• Document name and version number • New/updated measures for PY2026 • Thresholds for PY2026 payment measures • Footnote reference to PY2026 measures on Ohio department of Medicaid website and Rule 5160-19-01 in Section 2.3 • Remove Chronic condition flag related information • Remove references to CMS-1500 and UB-40 claim forms in the logic for Limited Benefits exclusion, LTC exclusion and IP admits. • Calculation of long-term care member exclusion for encounter claims • Remove codes used for identification of chronic condition codes from Appendix D of the DBR • Update references to CRG and replace with CDPS in Appendix D of the DBR • Remove obsolete codes from Appendix D of the DBR • Modification of target TCOC calculation methodology • FUM/FUA age stratification and 7 and 30 day Follow up period Add new codes to Appendix D of the DBR as noted in A19202.20 and its detail requirements. • Standardized stylistic formatting to black font color, Arial (Body), Size 10. Link font size may vary to fit to page. Heading and sub headings vary in size, and are standardized throughout. Casing on variable names was also standardized. Some bolding was used for emphasis, but no standard rule applies.

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		• The CDPS process summary was updated to specify that prospective risk grouping is used • Footnote link was updated to include 2026 CPC Thresholds used in Table 6

1.2 Scope of This Document

The DBR document serves as a guide to understand the definition of the Ohio CPC program. The DBR addresses three audiences:

- The Ohio CPC program owner who is accountable for the Ohio CPC program design and implementation.
- The analytics team tasked with testing the design of the program and quality controlling the outputs from the algorithm.
- The IT team tasked with implementing the algorithm to produce outputs.

Section 2 of the DBR contains a description of the primary care transformation program implementation schedule and is written for the Ohio CPC program owner and the analytics team. It addresses the following questions:

- **Typical patient journey**: How does a patient enter and experience the Ohio CPC program?
- **Program implementation schedule:** How has the Ohio CPC program been rolled out through its initial implementation? What are the quarterly processes that support the program operations?

Section 3 of the DBR contains a description of the decisions that underlie the design of the program. It is written for the Ohio CPC program owner and the analytics team, and addresses the following questions:

- **Identify eligible members**: Which members are eligible for Ohio CPC?
- **Attribute members to CPC practices**: How are Ohio CPC members attributed to primary care practices and practitioners?
- **Risk-adjust members**: How should members and spending be risk-adjusted to account for differences in patient populations across CPC panels?
- **Define member panels**: How is the member panel for performance evaluation of each CPC Entity defined?
- **Calculate performance metrics**: How are performance metrics employed to inform CPC practices and partnerships about the quality and efficiency of care provided?
- **Calculate quarterly PMPM payments**: How are quarterly per member per month (PMPM) payment amounts determined?
- **Calculate TCOC**: How is the total cost of care (TCOC) amount used for shared savings calculations identified, both on an unadjusted and risk-adjusted basis?
- **Calculate shared savings payments**: How are outcome payment amounts determined?
- **Generate data for output data files and provider reports**: What inputs are needed to generate the provider reports?

Section 4 of the DBR explains the data flow for CPC. This section is written for the analytics and IT teams, and addresses the following questions:

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- **Input data**: What specific inputs are required to implement the program? Where do these data come from and with what frequency should they be collected and updated?
- **Codesheet**: What are the specific design parameters used to implement the program design?
- **Output tables** What data outputs are produced to support program implementation? How are these organized by table/product?
- **Provider reports**: Which outputs are shared with providers by participation/enrollment status? How are they produced and how frequently are they shared?

The DBR document **does not cover** the following topics:

- Background on how the Ohio CPC program compares to any current programs
- Clinical or other rationale for inclusions and exclusions
- Intermediate analyses used during Ohio CPC design
- Meeting materials used during Ohio CPC design
- Guidance on data collection/transformation/storage
- Specific guidance on the Ohio CPC algorithm coding approach

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2 DESCRIPTION OF THE CPC PROGRAM

2.1 CPC Program Description

The Ohio CPC program is a team-based care delivery model led by a primary care practitioner (PCP) that comprehensively manages a patient's health needs with the goal of improving quality of care and lowering costs by empowering practices to deliver the best care possible.

To participate in the Ohio CPC program, a practice must apply and be selected by the state to become an Ohio CPC practice. By participating, each practice commits to various value-based population health activities including but not limited to:

- **Patient-centered access** (e.g., providing same-day appointments for routine and urgent care).
- Continuous quality improvement (e.g., use of quality improvement projects, quality goals for outcome metrics or providing quality improvement education for staff).
- **Population health management** (e.g., using risk stratification for population management to address chronic and acute care services and inform outreach activities in groups or segments by using practice-defined common characteristics).
- **Care management support** (e.g., identifying high-need, high-risk patients for care management and care plans with self-care support recommendations for each of them).
- **Care coordination** (e.g., referral tracking, follow up, and coordination of care).
- **Performance measurement and improvement** (e.g., measuring and tracking performance on quality and efficiency metrics).

There are two payment streams that support and incentivize the goals of the CPC program:

- **Practice support payments**: these are PMPM payments made to Ohio CPC practices to support practice value-based population health activities, including infrastructure investment in technology, additional physician and staff time, and facility improvements. These payments are based on attributed members' risk levels and are paid to practices quarterly.
- **Outcome payments**: another important aspect of Ohio's CPC program is the focus on provider accountability for the outcomes of their patient panels. Larger CPC practices and partnerships with sufficient member panel size are eligible for payments based on improvement in total cost of care and or for achieving a low absolute total cost of care.

Finally, performance metrics are generated as part of the CPC program. These are calculated and reported on a quarterly basis to provide CPC practices with information on the composition of their attributed patients for them to better manage their practice and to equip them with quality and utilization information needed to improve and coordinate care delivery.

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2.2 Provider Enrollment

The following information is required to enroll in the Ohio CPC Program:

Table 2. 2025 CPC Provider Enrollment

Information Needed to Enroll	Additional Information Needed from Entity Conveners

• Eligible Medicaid Billing ID
• Tax Identification Number (TIN)
• Provider specialty
• NPI
• CPC Contact Name/Contact information
• Attestation to meeting these requirements:
  ○ Participating in data sharing
  ○ Participating in Technical Assistance Sessions
  ○ Meeting 10 activity requirements
  ○ To outreach to attributed members who are not their patients
  ○ If Pediatric specialty is selected, agreement to participate in CPC for Kids
	• Attestation forms to be completed by all practice partners except convener
	• Acknowledgement forms to be completed by convener and all practice partners
	• Current CPC ID

More information including template attestation forms and acknowledgment forms is available on the Ohio CPC website.[1] [2]

2.3 Provider Eligibility Requirements

The eligibility requirements for a practice to enroll as an Ohio CPC practice are outlined in the tables below.

Table 3. Ohio CPC Provider Eligibility Specifications

Level of Provider Eligibility	Eligibility Specifications

Ohio CPC Practice Eligibility	• Eligible provider type and specialty, stated in the table below
	• Minimum size:
	  ○ 500 attributed/assigned Medicaid members by Medicaid group ID at each attribution period to participate in the CPC program without a Partnership
	  ○ 150 attributed/assigned Medicaid members by Medicaid group ID. Any practice with <500 members must be a part of a Partnership with >=500 members

[1] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/2021-CPC-Acknowledgement-All-Partnership.pdf

[2] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/2021-CPC-Attestation-For-All.pdf

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	• Commitment:
	  ○ To sharing data with contracted payers / the state
	  ○ To participating in learning activities
	  ○ To meeting activity requirements as of January 1
	  ○ To outreach to attributed members who are not their current patients
	  ○ The practice must pass at least 50% of quality measures[3] for which the practice qualifies
	• The practice must pass at least 50% of efficiency measures[4] for which the practice qualifies

Partnership Enrollment and Eligibility Requirements	• Entities must have at least 500 claims-only attributed members in order to join CPC, whether they meet the requirement as a practice participating independently, or by joining a Partnership with other practices. • Practices with at least 150 claims-only attributed members are eligible to join Partnerships. • Each Partnership must be led by a convener practice, which must have previously participated in Ohio CPC for at least 1 year (the convener practice is not required to meet any other size requirements on its own). • The partnership must pass all activity requirements • The partnership must pass at least 50% of quality measures[3] for which the partnership qualifies • The partnership must pass at least 50% of efficiency measures[4] for which the partnership qualifies
Ohio CPC for Kids Provider Eligibility[2]	• The Entity must already be participating in CPC • Providers must have a minimum of 150 claims-based attributed pediatric individuals • Individuals under the age of 21, as of the anchor date June 1 of the enrollment year, to participate in the CPC for Kids program. • The Entity must pass at least 50% of pediatric quality measures[3] • The entity must qualify for and pass at least one additional CPC for Kids quality measure linked to payment
Eligible to Receive Shared Savings	• The entity must have at least 60,000 attributed member months among members with at least 6 months of attribution to the practice during the performance year • The entity must pass all activity requirements • The entity must pass at least 50% of quality measures[3] for which the entity qualifies • The entity must pass at least 50% of efficiency measures[4] for which the entity qualifies
Eligibility for CPC for Kids Bonus Payment	• The entity must pass all of the CPC program requirements (Activities and metrics)

[3] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/PY2025_QM_09182025.pdf

[4] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/2025CPCEfficiencyMetrics.pdf

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	• The entity must be among the highest performing in the CPC for Kids activities based on the CPC for Kids bonus score card

Table 4. Provider Type and Specialty Requirements, and Activity Requirements

Level of Provider Eligibility	Specifications
Eligible Provider Types	Practices are eligible for Ohio CPC if they are one of the following provider types[5]: • Individual physicians and practices • Professional medical groups • Rural health clinics • Federally qualified health centers • Primary care or public health clinics • Professional medical groups billing under hospital provider types

Eligible Provider Specialties	Practices are eligible for Ohio CPC if specific provider specialties[6], as listed below:
	• For Medical Doctor or Doctor of Osteopathy:
	  ○ Family practice
	  ○ General practice
	  ○ General preventive medicine
	  ○ Internal medicine
	  ○ Pediatric
	  ○ Public health
	  ○ Geriatric
	• For clinical nurse specialists, certified nurse midwives or certified nurse practitioners:
	  ○ Pediatric
	  ○ Adult health
	  ○ Geriatric
	  ○ Family practice
	Physician assistants do not have formal specialties

Activity Requirements	It should be noted that eligible practices should pass all 10 activity requirements[7]: • 24/7 and same day access to care • Risk stratification • Population health management • Continuous quality improvement • Care coordination • Follow up after hospital discharge • Tests and specialist referrals

[5] Paragraph (B): Rule 5160-19-01 - Ohio Administrative Code | Ohio Laws
[6] Paragraph (C): Rule 5160-19-01 - Ohio Administrative Code | Ohio Laws
[7] Paragraph (F): Rule 5160-19-01 - Ohio Administrative Code | Ohio Laws

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Level of Provider Eligibility	Specifications
	• Patient, staff and provider experience • Community services and supports integration • Behavioral health integration
Partnership Activity Requirements	• One practice from each Partnership, if selected by the evaluator, is monitored for activity requirement performance. • The entire Partnership is assessed as an individual entity based on the performance of the randomly selected practice (that practice must pass activity requirements for the entire Partnership to pass activity requirements). • If the randomly selected practice fails to satisfy activity requirements, the entire Partnership fails, regardless of the performance of the other practices within the Partnership.

2.4 Practice Partnerships in the Ohio CPC Algorithm

Practice Partnerships allow two or more practices that don't independently meet the 500 claims only attributed members requirement to "join" together and participate in the Ohio CPC program as an individual entity. It also allows practices that do not meet the 60,000 member month eligibility requirement to join together to become eligible for shared savings as a Partnership. Practices joining together as a Partnership may already be affiliated with one another, or may not have a pre-existing relationship. The Ohio CPC algorithm and reports are tailored to accommodate the Partnership design structure, as described below.

When discussing the CPC algorithm, there are instances in which the DBR references "Practices," "Partnerships," and "Entities." "Practices" refers to practices as defined at the Medicaid billing ID level, including practices participating independently and those participating through Partnerships (but not including the Partnership itself). The program is administered at the Entity level, which refers to both practices participating independently and Partnerships (but not to the individual practices that make up Partnerships).

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2.5 CPC for Kids Practices in the Ohio CPC Algorithm

Starting in the 2020 program year, ODM initiated an option to allow entities to also enroll in the CPC for Kids program. CPC for Kids is an optional add-on program specific to pediatric practices that includes additional quality metrics and bonus incentives. Incentives are based on performance on additional metrics related to pediatrics as well as additional CPC for Kids activities.

2.6 CPC Program Implementation Schedule

The Ohio CPC program was implemented statewide for qualified Ohio CPC practices, as shown below. CPC Program Implementation Schedule provides additional detail on program highlights since formal implementation began.

Table 5. CPC Program Implementation Schedule

Calendar Year	CPC +	Ohio CPC Practices	Program Highlights
2016		92 Practices Enrolled in CPC	Formal implementation of the program began in the fall of calendar year 2016, which culminated in enrollment of 92 practices Ohio CPC practices for participation in performance year 2017.
2017	19	50 additional Practices enrolled in CPC	The second round of CPC enrollment occurred in the spring of 2017, when an additional 19 practices were enrolled in the program as part of a special enrollment period for practices participating in Medicare's Comprehensive Primary Care Plus (CPC+) model.
2018	19	161 participating practices	The third round of CPC enrollment occurred in the fall of 2017, when an additional 50 primary care practices were added to Ohio CPC, for a total of 161 practices participating for program year 2018. The Ohio CPC program is implemented statewide for qualified Ohio CPC practices.
2019	19	• 250 Total CPC Practices • 20 Partnership Entities • 143 Practice Entities	Practice Partnerships are a new way for practices to participate in the Ohio CPC program starting in 2019.
2020	18	• 297 Total CPC Practices • 34 Partnership Entities • 133 Practice Entities • 232 Practices Participating in CPC for Kids	CPC for Kids Practices are eligible to enroll in CPC in calendar year 2020. CPC for Kids reporting is included in performance year 2020.

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2021		• 313 Total CPC Practices • 34 Partnership Entities (182 Practices participating) • 131 Practice Entities • 138 Entities Participating in CPC for Kids (260 practices total participating)	The CPC program continues to grow with expansion in both Partnership and CPC for Kids participation for 2021.
2022	NA	• 303 Total CPC Practices • 38 Partnership Entities (189 Practices participating) • 114 Practice Entities • 126 Entities Participating in CPC for Kids (254 practices total participating)	Partnership participation continues to grow during 2022, as individual entities decline and CPC for Kids participation remain steady.
2023	NA	• 317 Total CPC Practices • 41 Partnership Entities (196 Practices Participating) • 121 Practice Entities • 127 Entities Participating in CPC for Kids (255 practices total participating)	Participation continues to increase for the CPC program. Partnership and CPC for Kids participation remain strong.
2024	NA	• 300 Total CPC Practices • 35 Partnership Entities (184 Practices Participating) • 116 Practice Entities • 115 Entities Participating in CPC for Kids (240 practices total participating)	In the ninth year of the program, entity participation appears to have leveled off/is slightly decreased from 2023.
2025	NA	• 315 Total CPC Practices • 41 Partnership Entities (199 Practices Participating) • 116 Practice Entities • 117 Entities Participating in CPC for Kids (246 practices total participating)	In the 10th year of the program, participation continues to appear relatively level. This year, we note a similar number of practice partnerships to 2023, which is a bit of an increase from 2024.
2026	NA	• 315 Total CPC Practices • 40 Partnership Entities (200 Practices Participating) • 115 Practice Entities • 113 Entities Participating in CPC for Kids (240 practices total participating)	In the 11th year of the program, participation continues to appear at a relative level. This year, we note a similar number of practices compared to 2025

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3 OHIO CPC PROGRAM DESIGN

Designing and building the CPC program comprises ten dimensions, as shown below. Section 4 of this document provides additional detail on the CPC data flow.

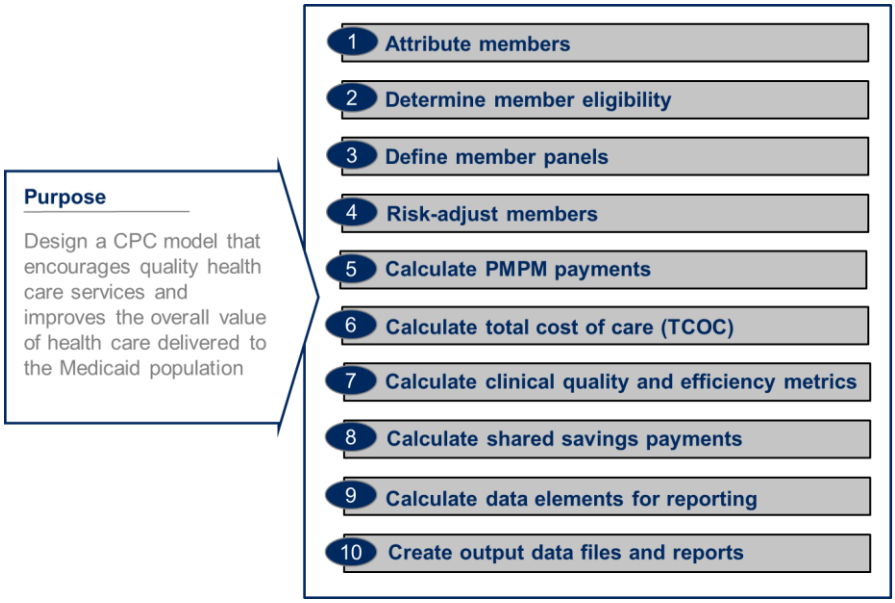

Figure 1. CPC Program Design Dimensions

3.1 Attribute Members to Primary Care Practices

3.1.1 Overview of Attribution

The purpose of attribution is to determine the relationship between a patient and a practice. For population health programs to be successful, all patients must have an established primary care practice who is responsible for the care of each patient.

All Ohio Medicaid members are attributed to a primary care practice for purposes of the Ohio CPC program. However, only members attributed to practices participating in the Ohio CPC program are considered members included in the Ohio CPC program. Attribution is conducted each quarter, and thus a member's attributed practice may change on an ongoing basis.

Attribution for Ohio CPC is conducted by ODM for fee-for-service (FFS) members and by each of the seven Medicaid managed care Organizations (MCOs) for their own members. These eight separate attribution runs are aggregated to create the final list of *pre-exclusion* attributed members. After *pre-exclusion* attribution is finalized, the member exclusions described in Sections 3.2.1 and 3.2.2 are applied to determine *post-exclusion* attribution. *Post-exclusion* attribution represents the final set of attributed members eligible for Ohio CPC and serves as the basis for the remainder of the Ohio CPC program.

All Medicaid members are initially included in the attribution process, and thus every Medicaid member should be attributed to a primary care practice on a *pre-exclusion* basis.

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3.1.2 Attribution to Practices within a Partnership

There are no changes to the attribution process for practices within a partnership. MCOs will continue the current Ohio CPC attribution process using practices defined at the billing ID level. FFS members will continue to be attributed in the same manner as well.

Each Ohio CPC practice will continue to receive its own, separate attribution list. No consolidated attribution lists are sent to the other practices within the Partnership. However, practices within a Partnership may establish their own data-sharing process if they would like to share lists of attributed members with one another.

3.1.3 Attribution Algorithm

Attribution of members occurs quarterly using retrospective data. Members are only attributed to one CPC practice.

Attribution is done quarterly using a hierarchical process as follows:

- First criteria: assign members based on member choice (i.e., communicated explicitly via contact with ODM through the Medicaid Consumer Hotline or through contact with the MCOs).
- Second criteria: if member choice is not available, attribute members to the practice with whom they have the most claims (i.e., the practice that they have visited the most).
    - The look-back period for identifying relevant evaluation and management (E&M) visits through claims is 18 months from the date of attribution with no claims run-out period.
        - To attribute, look at which rendering and billing provider combination(s) occurred the most in the 18-month period. If there is a tie, the rendering and billing provider combination with the most recent claim is used.
- Third criteria: if neither member choice nor visit claims are available, assign members based on non-claims considerations (e.g., geography proximity and demographic data)
    - To map by geography, map member x/y coordinates, map provider x/y coordinates by provider type, or use ArcGIS Near and Point Distance tools to determine closest facilities in order of proximity.
    - To map based on demographic data, choose a provider type based on appropriate age group (i.e., pediatric members assigned to pediatric practices) or assign based on available capacity (potentially measured as number of Medicaid members / physician).
    - If there are no claims received during the look-back period, the member is not reassigned. If the identified rendering and billing provider are both different than the previous quarter's attribution, then the member is assigned to the newly identified rendering/billing provider. If either the rendering or billing provider match the prior quarters rendering or billing provider, do not reassign the member.

Attribution can be changed based on member preference (i.e., member exhibits new or changed choice) or member behavior (i.e., assess through claims from visits).

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For a provider to receive attribution, they must have an active Ohio Medicaid Billing ID and must have one of the approved provider types with any of the eligible specialties or sub-specialties, listed in *Section 2.3 Provider Eligibility Requirements*. The Ohio CPC program is intended for primary care practices serving the comprehensive needs of patients – as a result, urgent care centers are considered ineligible for attribution, as are non-primary care specialists.

3.2 Determine Member Eligibility

3.2.1 Ohio CPC Standard Member Exclusions

The intent of the Ohio CPC program is to be as broad and inclusive as possible and has been designed to include as many of the state's Medicaid members as possible. However, some members are excluded from the Ohio CPC model due to a lack of available data for the member (typically when a second payer is paying claims on behalf of the member).

Members with Medicaid eligibility at time of attribution are automatically eligible for inclusion in the Ohio CPC program. However, members are excluded from all member panels if they meet any of the following standard Ohio CPC exclusion criteria:

- Are not eligible for Medicaid
- Have dual eligibility for Medicaid and Medicare benefits
- Have Third-Party-Liability (TPL) coverage, other than exclusively third-party dental or vision
- Have access to only limited Medicaid benefits (e.g., family planning, premium assistance)
- Are in transition from FFS to MCO (i.e., have future enrollment dates with MCOs)
- Are participating in a Prepaid Inpatient Health Plan (currently OhioRISE) (starting 7/1/2022)
- Are recipients attributed to other population health alternative payment models administered by ODM (excluded from PMPM payment receipt due to other program involvement, but these members are still included in CPC metric and TCOC calculations).

It is important to note that not all members eligible for attribution to a practice will ultimately be attributed to an enrolled CPC (e.g., their PCP/practice may opt not to participate in Ohio CPC program). Furthermore, all members may receive care at a CPC practice and need not be attributed to the practice to receive care. However, only members attributed to the CPC practice are included in the member panels for purposes of determining practice performance and PMPM payment eligibility.

3.2.2 Total Cost of Care Expenditure Exclusions

Certain members are included in the Ohio CPC program for purposes of attribution and PMPM payments, but are excluded from a practice's TCOC calculation because the member had an event or status leading to costs outside the control of an Ohio CPC primary care practice. In addition to those with standard exclusions, the following members are also excluded from a practice's total cost of care calculation:

- Neonatal intensive care unit (NICU) members who utilize nursery level 3 or 4 services during first year of life
- Members with a long-term care facility stay spanning more than 90 consecutive days within the 12-month reporting or performance period

  Members with a calculated Z-Score for risk greater than 4

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3.3 Define Member Panels

Member panels are used in the Ohio CPC program to define sets of members and track the status of each member at various points throughout the year. For example, member panels are used to determine which members are attributed to a CPC practice for purposes of paying quarterly PMPM payments, for determining quality and efficiency metrics performance, and for determining performance on total cost of care. Four member panels are used in the Ohio CPC program, as described below.

For Partnerships, members must have been attributed to the Partnership for at least 6 non-excluded months of the last 12-months to be included in the Partnership's quality and efficiency and TCOC member panels. For example, a member would count toward the Partnership's total cost of care if they had been attributed to a different practice within the Partnership each quarter, even though they would not appear on any individual practice's quarterly practice report.

3.3.1 Quarterly Attribution Member Panel

The quarterly attribution member panel is used to calculate PMPM payments to CPC practices. This panel identifies the set of members attributed to the CPC practice in the given quarter, after program exclusions, and is used to determine the prospective PMPM payments for each Ohio CPC practice for the quarter. Members are excluded from the quarterly attribution panel due to any of the following criteria: Medicaid ineligibility, dual-eligible status, third-party liability, limited benefits, transition status, participation in a Prepaid Inpatient Health Plan (currently OhioRISE) (exclusion effective 7/1/2022) or attributed to other population health alternative payment models administered by ODM.

For Practice Partnerships, prospective PMPM payments will continue to be calculated at the practice level, as defined in Section 5.5 of this document. However, the quarterly attribution member panel is used as a basis for determining if a member has been attributed to a Partnership for at least 6 of the last 12 months for purposes of quality and efficiency or TCOC calculations.

3.3.2 Risk-adjustment Member Panel

The risk-adjustment member panel is used to determine the set of members included in the risk-score calculation, and who will receive risk scores for a given 12-month reporting or performance period. The risk-adjustment member calculations are defined for all entities. This panel consists of all Medicaid members (not just Ohio CPC members), excluding:

- Members who are excluded due to standard Ohio CPC exclusions for 6 or more months during the 12-month performance or reporting period (includes members ineligible for Medicaid, members with third-party liability, limited benefits, dual-eligible status, transition status, participation in a Prepaid Inpatient Health Plan (currently OhioRISE) [exclusion starts 7/1/2022]), and members attributed to other population health alternative payment models administered by ODM.
- NICU members who utilize nursery level 3 or 4 services during their first year of life
- Members with a long-term care facility stays spanning more than 90 consecutive days within the 12-month reporting or performance period
- Members with a calculated Z-Score for risk greater than 4

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3.3.3 Practice 6-month Quality and Efficiency Metrics Member Panel

The 6-month quality and efficiency metrics member panel is used to determine the set of patients included in the clinical quality and efficiency metric calculations for an Ohio CPC practice. This panel consists of members who are:

- Attributed to an individual CPC practice for at least 6 of the 12 months during the reporting or performance period, with the most recent attribution serving as a tie-breaker. Months need not be consecutive.
- Not excluded during the months counted toward 6-month attribution, due to Medicaid ineligibility, dual-eligible status, third-party liability, limited benefits, transition status, enrollment in a prepaid inpatient health plan (OhioRISE) or those attributed to other population health alternative payment models administered by ODM.

3.3.4 Partnership 6-month Quality and Efficiency Metrics Member Panel

The 6-month quality and efficiency metrics member panel is used to determine the set of patients included in the clinical quality and efficiency metric calculations for an Ohio CPC Partnership. This panel consists of members who are:

- Attributed to a single CPC Partnership for at least 6 of the 12 months during the reporting or performance period, with the most recent attribution serving as a tiebreaker. Months need not be consecutive.
- Not excluded during the months counted toward 6-month attribution, due to Medicaid ineligibility, dual-eligible status, third-party liability, limited benefits, transition status, enrollment in a prepaid inpatient health plan (OhioRISE) or those attributed to other population health alternative payment models administered by ODM.

3.3.5 6-month Total Cost of Care Member Panel

The 6-month total cost of care member panel is used for determining the set of patients included in the total cost of care calculations for an Ohio CPC practice. The total cost of care member panel consists of members included in the 6-month quality and efficiency metrics member panel (i.e., members attributed to an individual practice for 6 or more months during the reporting or performance period), and additionally excludes:

- NICU members who utilize nursery level 3 or 4 services during first year of life
- Members with a long-term care facility stay spanning more than 90 consecutive days within the 12-month reporting or performance period
- Members who have a calculated Z-Score of greater than 4

These additional member exclusions are applied to total cost of care to mitigate systematic bias against caring for high-need members. It ensures CPC practices are not penalized for having an extremely high-cost attributed member, and ensures no incentives are inadvertently created to reduce care provided to high-need members.

To calculate the 6-month total cost of care member panel for Partnerships, use the set of members defined in the Partnership 6-month quality and efficiency metric panel (defined in *Section 3.3.4*) and then further exclude LTC, NICU, and CDPS outlier members.

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3.3.6 Point-in-time Attribution Versus 6-month Attribution

The quarterly attribution member panel represents members attributed to a CPC entity at a given point-in-time, on the attribution date. Point-in-time quarterly attribution is used to make prospective PMPM payments and determine the patients attributed to the entity for the upcoming quarter. Four point-in-time attribution dates are used to construct a 12-month rolling period, which serves as the basis for the creation of the Ohio CPC reports.

The 6-month quality and efficiency metrics member panel and the 6-month total cost of care member panel represent the set of members attributed to a CPC entity for at least 6 months over the course of a rolling 12-month period (with additional exclusions applied to the member panels). These panels are used to assess entity quality and cost performance during a 12-month reporting period or program year.

3.4 Risk-adjust Members

Risk adjustment is an essential analytic element of the Ohio CPC program and has application in nearly every aspect of the payment model. Risk adjustment is used in the Ohio CPC program in two ways:

- Quarterly PMPM payments made for each Ohio CPC member are adjusted for risk based on the members' risk tier
- Total cost of care is adjusted for risk when used to calculate shared savings payments to Ohio CPC practices on an annual basis

The Ohio CPC program changed from the 3M™ Clinical Risk Grouping (CRG) software to the Chronic Illness and Disability Payment System (CDPS) software for program year 2024. Risk scores are updated quarterly, based on previous 24 months of claims history with either 3 or 7 months of claims run-out, depending on whether the risk scores are used for calculating PMPM payments or total cost of care for a program year. Prospective risk groupings are used for purposes of the Ohio CPC program. Furthermore, denied claims are included in the CDPS assignment as they contain potentially-informative clinical information about the member.

- The version of the 3M™ Clinical Risk Grouping software used in Ohio CPC for the 2017 and 2018 program year is version 2016.0.1, reflecting version 1.12 of the CRG software. The version of the 3M™ Clinical Risk Grouping software used in Ohio CPC for the 2019, 2020, 2021, and 2022 program year is version 2018.2.0, reflecting version 2.1 of the CRG software.
- The version of the 3M Clinical Risk Grouping software used in Ohio CPC for the 2023 program year is version 2.2 of the CRG software.
- CDPS software used in Ohio CPC for the 2026 program year is version 7.2.

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3.4.1 Generate CDPS Score

Risk scores are calculated for members to determine risk-adjusted total cost of care as part of the Ohio CPC program. For PY 2025 and on, risk scores are determined using CDPS software. CDPS risk scores are assigned using ICD codes to assign CDPS Categories that indicate illness burden related to major body systems (e.g. cardiovascular) or types of chronic disease (e.g. diabetes). Members are given a risk score based on hierarchical CDPS categories with assigned weights, which are additive across major categories. Members are risk adjusted separately for attribution and reporting. Data flow through the CDPS process is summarized in the six step image below.

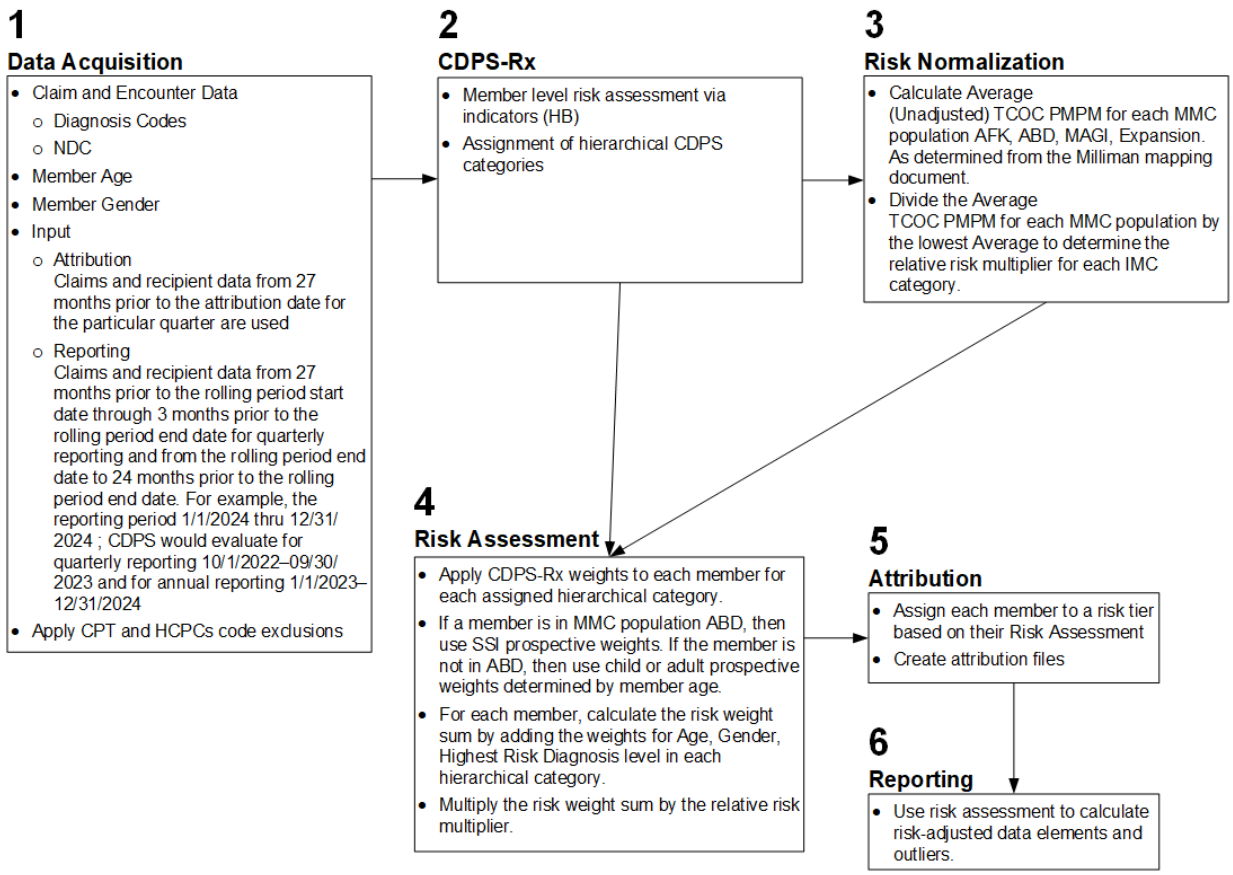

Figure 2: CDPS Process Summary

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3.4.1.1 Calculate PMPM Payments

Ohio CPC practices are paid a prospective PMPM payment for each attributed CPC member to cover the costs associated with implementing and continuing to meet the ten Ohio CPC activity requirements. PMPM payments are made prospectively at the beginning of each quarter for the members included in the quarterly attribution member panel. The prospective PMPM payments made under the Ohio CPC program are *not* reconciled at the end of a quarter with actual attribution during the quarter.

Quarterly PMPM payments are adjusted for member risk, with practices receiving a higher PMPM payment for higher-risk members, reflecting a higher level of resources required to implement the activity requirements for these members.

Quarterly PMPM payments will continue to be made directly to each practice within a Partnership. No combined payments are made to the Partnership.

Quarterly PMPM payments for all participating practices are rolled up at the Partnership level for purposes of calculating the total cost of care.

PMPM payments fall into one of three payment tiers, depending on the risk of each member:

- Tier 1 (lowest risk members): Payment amount: $1.80 PMPM
- Tier 2 (medium risk members): Payment amount: $6.33 PMPM
- Tier 3 (highest risk members): Payment amount: $10.20 PMPM

An Ohio CPC practice's quarterly PMPM payment is calculated as:

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.

$$Quarterly\ PMPM\ Payment\ = \left[\left(\begin{matrix} Tier\ 1 \\ Members \end{matrix} * \$1.80\right) + \left(\begin{matrix} Tier\ 2 \\ Members \end{matrix} * \$6.33\right) + \left(\begin{matrix} Tier\ 3 \\ Members \end{matrix} * \$10.20\right)\right] * 3\ months$$

The CPC for Kids PMPM payment is a flat rate of $1 PMPM and is contingent on the entity to pass at least 50% of the applicable pediatric quality metrics and at least one of the three CPC for Kids metrics.

CPC practices are eligible to receive PMPM payments for the duration of their participation in the Ohio CPC program, contingent upon meeting minimum activity, clinical quality, and efficiency metrics requirements. As of Ohio CPC program year 2025, all CPC practices must meet the following requirements (assessed annually) to continue to receive PMPM payments:

- Must pass all activity requirements
- Must pass at least 50% of qualifying efficiency measures
- Must pass at least 50% of qualifying quality measures

3.5 Calculate TCOC

TCOC for purposes of Ohio CPC represents the total claims costs associated with a CPC practice's attributed members during the 12-month performance period, as well as the Ohio CPC PMPM payments made for a member during the program year.

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3.5.1 Definition of Total Cost of Care

3.5.1.1 Definition

Total cost of care for a CPC entity is defined as the sum of all non-excluded payments made by ODM or MCOs for the Medicaid individuals attributed to that entity. Details of the calculation are below.

3.5.1.2 Core expenditures

Expenditures included in the baseline year and performance period TCOC are:

- All non-excluded medical expenditures
- All non-excluded prescription expenditures
- All long-term care expenditures for members with fewer than 90 consecutive days in long-term care
- Expenditures for services that are often excluded from other population health programs, including case management, durable medical equipment and home health

Excluded expenditures: Expenditures not included in the baseline year and performance period TCOC are:

- Waiver services
- Currently underutilized services as determined by the state (initially to include dental, vision, and transportation)
- All expenditures for members with a NICU stay (Nursery 3 and 4)
- LTC expenditures for members with at least 90 consecutive days in a LTC facility
- All expenditures associated with members who have a calculated Z-Score of greater than 4
- Prepaid Inpatient Health Plan expenditures starting with the Q4 2022 Attribution cycle from performance period only (not baseline) Total Cost of Care Calculations

3.5.1.3 Calculation of member-level TCOC

TCOC for the baseline period and the performance period are calculated retrospectively, using FFS claims and encounter data submitted by the Ohio MCOs. Member-level, non-risk-adjusted total cost of care is calculated by summing the total FFS claims and managed care encounters for a member of a CPC entity during the relevant period (i.e., baseline year or performance period), excluding the Ohio CPC service level exclusions detailed in *Section 3.3 Define Member Panels*.

Member-level risk-adjusted TCOC is calculated by dividing the member's non-risk-adjusted total cost of care by the member's time-weighted risk score, as determined using the approach described in the member-level methodology section.

3.5.1.4 Calculation of practice-level TCOC

Member-level TCOC is aggregated to a practice level to determine each CPC practice's total cost of care during a 12-month performance period. Practice-level, non-risk adjusted TCOC is calculated by summing the total FFS claims and managed care encounters for the CPC entity's attributed members during the relevant period (i.e., baseline year or performance period). Only non-excluded members with at least 6 months of attribution with the practice are considered in this calculation. Practice-level TCOC includes both members' core expenditures, as well as the PMPM payments made to practices for each member.

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Risk-adjusted TCOC for a CPC practice is calculated by dividing the CPC entity's non-risk-adjusted TCOC by the aggregated time-weighted risk score of the members attributed to the CPC entity, as determined using the approach described in practice-level methodology sections.

3.5.1.5 Calculation of partnership-level TCOC

TCOC will continue to be calculated at the member-level before calculating at the entity level.

For purposes of calculating the TCOC for Partnerships, TCOC is aggregated to the Partnership level by summing included expenditures across the individual members in the Partnership's 6-month TCOC member panel (those with at least 6 included attribution months in the Partnership, need not be same practice).

3.5.2 Baseline TCOC

Baseline TCOC represents the historical costs for a CPC practice used to set the practice's target TCOC, against which a practice's costs during a program year are measured to determine shared savings. Baseline TCOC for a CPC practice is the risk-adjusted TCOC during the 12-month period two years prior to the program year. For example, for the 2025 performance period, baseline TCOC year is calculated using the 2023 calendar year.

3.5.3 Baseline TCOC for Practice Partnerships

The baseline year TCOC—used to set the Partnership's TCOC target for the program year—is calculated individually for each practice and then aggregated to the Partnership level. This is achieved by summing members' TCOC across all practices within the Partnership and applying the aggregated risk scores and member months for the 6-month members in the partnership during the baseline period, to obtain a baseline risk-adjusted TCOC.

3.5.3.1 Target TCOC

Target TCOC is the figure against which the CPC practice's actual TCOC is assessed when determining performance for outcome payments. The target is calculated by multiplying baseline TCOC by an adjustment factor used to adjust for programmatic changes between the baseline year and program year. Adjustment factors are updated annually by ODM and each factor is specific to the practice and its members.

3.5.4 Programmatic Adjustment Factors

Programmatic adjustment factors are used to adjust baseline TCOC to account for changes over time to costs outside of the practice's control, such as policy changes, changes in managed care rates, and drug price changes. Adjustment factors are practice-specific, weighted averages of the programmatic changes for the members that make up each practice.

Programmatic adjustment factors are established each year by ODM. Composite base figures are used in the CPC program to adjust target TCOC figures from the baseline year to the program year to develop a practice's target TCOC.

Programmatic adjustment factors are calculated by ODM through an actuarial vendor. Programmatic adjustment factors for a given baseline year are developed for each practice enrolled in Ohio CPC. These factors are calculated based on the set of members in each practice's *6-month total cost of care member panel* during the baseline year.

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For the actuarial vendor to calculate programmatic adjustment factors, the vendor will need to understand which members in the *6-month total cost of care member panel* for each practice for which a programmatic adjustment factor is created. Typically, this requires a file to be created and shared with the actuarial vendor with each of the enrolled Ohio CPC practices (using their practice billing ID) and the Member Medicaid IDs for attributed members in the practice's *6-month total cost of care member panel*.

The member-level practice report csv data ("File K") that includes data for 1/1 to 12/31 of the baseline year (typically delivered ~6 months after the end of the baseline year) contains the required data. Similarly, the underlying data can be found in the Rolling Period Member Table (O.03) with a rolling_period_start_date and rolling_period_end_date that align with the calendar baseline year.

3.5.5 Programmatic Adjustment Factors for Practice Partnerships

Programmatic adjustment factors for Practice Partnerships are developed by ODM as they traditionally are for individual CPC practices, but instead considering all members attributed to the individual practices that make up a Partnership as an "individual" practice for purposes of generating adjustment factors. In other words, all members across practices within a Partnership are aggregated into a single population for which a programmatic adjustment factor is assigned. Practice Partnerships will each have a single adjustment factor, and associated total cost of care target, that is applied to all practice within that Partnership. Individual practices making up a Partnership continue to have their own adjustment factors and total cost of care targets.

3.6 Calculate Clinical Quality and Efficiency Metrics

3.6.1 Overview of Ohio CPC Metrics

The Ohio CPC program uses a variety of quality and efficiency metrics to assess the performance of primary care practices enrolled in the model. Providers must meet at least 50% of applicable quality measures and at least 50% of applicable efficiency measures to continue to qualify for and receive PMPM payments and to be eligible for TCOC shared savings. In addition, those providers electing to participate in CPC for Kids must meet at least 50% of the Ohio CPC pediatric quality metrics and qualify for and pass at least one of the additional CPC for Kids quality metrics linked to payment.

Clinical quality and efficiency metrics are calculated only for non-excluded members as defined in Section 3.3.3 and are calculated for an entity over an entire 12-month reporting or performance period.

3.6.1.1 eCQM Supplemental Data

Starting during PY2025 performance reporting (not for preview reporting), providers can start submitting supplemental data to be used in future reports for electronic Clinical Quality Metrics (eCQM supplemental data). These will first appear on CPC reports as INFORMATION ONLY for participating entities. GWT will receive clinical data extracts for the following metrics:

- HEDIS MY 2025 Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents - WCC
- HEDIS MY 2025 Controlling High Blood Pressure - CBP
- HEDIS MY 2025 Glycemic Status Assessment for Patients with Diabetes: Glycemic Status <8.0% or Glycemic Status >9.0% - GSD

Participating providers are responsible for submitting eCQM supplemental data files for the applicable measures.

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Metrics for Program year 2026 and eCQM supplemental data:

- 24 payment quality metrics that are scored
- 4 payment efficiency metrics that are scored
- 3 informational only eCQM supplemental data
- 2 informational only quality metrics
- Total Cost of Care vs. Target

CPC for Kids metrics (displayed separately on PDFs):

- 10 payment quality metrics that are scored
- 3 CPC for Kids metrics for payment, of which providers MUST pass one
- 2 informational only quality metrics

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The following table lists each of the clinical quality and efficiency metrics used in the Ohio CPC program[8] [9]:

Table 6. PY 2026 CPC Clinical Quality and Efficiency Metrics and Thresholds for CPC

Category	Metric Name	Source	2025 Threshold	2026 Threshold
Pediatric Health	HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months	HEDIS W30	≥61.88%	≥62.88%
Pediatric Health	HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: Well-Child Visits 15-30 months	HEDIS W30	≥63.25%	≥64.25%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 3-11 years	HEDIS WCV	≥36.40%	≥39.40%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 12-17 years	HEDIS WCV	≥43.85%	≥44.85%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 18-21 years	HEDIS WCV	≥16.71%	≥17.71%
Pediatric Health	HEDIS MY 2025 Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	HEDIS WCC	≥41.60%	≥42.60%
Supplemental eCQM	eCQM Supplemental Data- HEDIS MY 2025 Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	HEDIS WCC-eCQM supplemental data	Informational	Informational
Women's Health	HEDIS MY 2025 Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS PPC	≥80.21%	≥81.21%
Women's Health	Live Births Weighing Less than 2,500 grams	ODM	<=9.20%	<=9.20%
Women's Health	HEDIS MY 2025 Prenatal and Postpartum Care: Postpartum Care	HEDIS PPC	≥69.12%	≥70.12%
Women's Health	HEDIS MY 2025 Cervical Cancer Screening	HEDIS CCS	≥52.47%	≥53.47%
Women's Health	HEDIS MY 2025 Chlamydia Screening in Women	HEDIS CHL	≥44.31%	≥45.31%

[8] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/2025_CPC_Thresholds_D2.pdf

[9] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/PaymentInnovation/CPC/2026_CPC_Thresholds_D1.pdf

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Category	Metric Name	Source	2025 Threshold	2026 Threshold
Informational Measures	HEDIS MY 2025 Oral Evaluation, Dental Services	HEDIS OED	Informational	Informational
Adult Health	HEDIS MY 2025 Controlling High Blood Pressure	HEDIS CBP	≥47.71%	≥48.71%
Supplemental eCQM	eCQM Supplemental Data - HEDIS MY 2025 Controlling High Blood Pressure	HEDIS CBP-eCQM supplemental data	Informational	Informational
Adult Health	HEDIS MY 2025 Asthma Medication Ratio	HEDIS AMR	≥56.91%	≥57.91%
Adult Health	HEDIS MY 2025 Statin Therapy for Patients with Cardio Disease	HEDIS SPC	≥80.75%	≥81.75%
Adult Health	HEDIS MY 2025 Blood Pressure Control for Patients With Diabetes	HEDIS BPD	≥18.82%	≥19.82%
Adult Health	HEDIS MY 2025 Eye Exam for Patients With Diabetes	HEDIS EED	≥43.01%	≥44.01%
Adult Health	HEDIS MY 2025 Glycemic Status Assessment for Patients with Diabetes	HEDIS GSD	≤55.81%	≤56.81%
Supplemental eCQM	eCQM Supplemental Data - HEDIS MY 2025 Glycemic Status Assessment for Patients with Diabetes	HEDIS GSD eCQM supplemental data	Informational	Informational
Behavioral Health	HEDIS MY 2025 Follow Up After Hospitalization for Mental Illness	HEDIS FUH	≥35.56%	≥36.56%
Behavioral Health	Preventive care and screening: tobacco use: screening and cessation intervention	NQF 0028	≥12.48%	≥13.48%
Behavioral Health	HEDIS MY 2025 Initiation and Engagement of alcohol and other drug dependence (AOD) treatment: Engagement	HEDIS IET	≥47.70%	≥48.70%

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Category	Metric Name	Source	2025 Threshold	2026 Threshold
Informational Measures	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years	HEDIS FUM	Informational	Informational
Informational Measures	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years	HEDIS FUM	Informational	Informational
Informational Measures	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 65 years and older	HEDIS FUM	Informational	Informational
Behavioral Health	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Mental Illness – Total	HEDIS FUM	Informational	≥35.00%
Informational Measures	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years	HEDIS FUM	Informational	Informational
Informational Measures	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years	HEDIS FUM	Informational	Informational
Informational Measures	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 65 years and older	HEDIS FUM	Informational	Informational
Behavioral Health	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Mental Illness – Total	HEDIS FUM	Informational	≥55.00%
Informational Measures	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 13 -17 years	HEDIS FUA	Informational	Informational
Informational Measures	HEDIS MY 2025 7 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 18 years and older	HEDIS FUA	Informational	Informational
Behavioral Health	HEDIS MY 2025	HEDIS FUA	Informational	≥30.00%

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Category	Metric Name	Source	2025 Threshold	2026 Threshold
	7 Day Follow-Up After Emergency Department Visit for Substance Use – Total			
Informational Measures	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 13 -17 years	HEDIS FUA	Informational	Informational
Informational Measures	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 18 years and older	HEDIS FUA	Informational	Informational
Behavioral Health	HEDIS MY 2025 30 Day Follow-Up After Emergency Department Visit for Substance Use – Total	HEDIS FUA	Informational	≥40.00%
Informational Measures	HEDIS MY 2025 Colorectal Cancer Screening	HEDIS COL-E	NA	Informational
Informational Measures	HEDIS MY 2025 Pharmacotherapy for Opioid Use Disorder	HEDIS POD	NA	Informational
Efficiency	ED Visits	ODM	<=81.71	<=81.71
Efficiency	Mental Health Utilization (inpatient)	ODM	<=1.94	<=1.94
Efficiency	Ambulatory care-sensitive inpatient admits per 1,000	ODM	<=2.0	<=2.0
Efficiency	PDL-Antidiabetics, Insulin, Lantus only	ODM	≥.85	≥.85
Efficiency	PDL-Antidiabetics, DPPIV inhibitors	ODM	≥.75	≥.75
Efficiency	PDL- Asthma	ODM	≥.95	≥.95
Efficiency	PDL-COPD	ODM	≥.95	≥.95

Table 7: PY 2026 CPC Clinical Quality and Efficiency Metrics and Thresholds for CPC for Kids

Category	Metric Name	Source	2025 Threshold	2026 Threshold
CPC for Kids	HEDIS MY 2025 Childhood Immunization Status (HEDIS combinations 3)	HEDIS CIS	≥30.00%	≥31.00%
CPC for Kids	HEDIS MY 2025 Immunization for Adolescents (HEDIS combinations 2)	HEDIS IMA	≥20.00%	≥23.00%

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Category	Metric Name	Source	2025 Threshold	2026 Threshold
CPC for Kids	HEDIS MY 2025 Lead Screening: One or more at 2 years of age	HEDIS LSC	≥20.80%	≥23.80%
CPC for Kids Informational	Tobacco use: Screening and Cessation Intervention - Ages 12- 17	Modified NQF 0028	Informational	Informational
CPC for Kids Informational	HEDIS MY 2025 Topical Fluoride for Children	ODM	Informational	Informational
Pediatric Health	HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months	HEDIS W30	≥61.88%	≥62.88%
Pediatric Health	HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: Well-Child Visits 15-30 months	HEDIS W30	≥63.25%	≥64.25%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 3-11 years	HEDIS WCV	≥36.40%	≥39.40%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 12-17 years	HEDIS WCV	≥43.85%	≥44.85%
Pediatric Health	HEDIS MY 2025 Child and Adolescent Well-Care Visits - Ages 18-21 years	HEDIS WCV	≥16.71%	≥17.71%
Pediatric Health	HEDIS MY 2025 Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	HEDIS WCC	≥41.60%	≥42.60%
Pediatric Health	HEDIS MY 2025 Oral Evaluation, Dental Services	HEDIS OED	≥34.00%	≥35.00%

3.6.2 Minimum Denominator Requirements

Practices and partnerships are only scored on quality and efficiency metrics for which they qualify. CPC practices qualify for most metrics if they have at least 30 members in the denominator of the metric during the given reporting period. Some metrics have a minimum of 30 events to qualify for the denominator (example: Follow up after Hospitalization for Mental Illness and Initiation and Engagement of Substance Use Disorder Treatment) Practices must pass at least 50% of the quality metrics for which they qualify and, separately, at least 50% of the efficiency metrics for which they qualify.

For example, if a practice has at least 30 patients in the denominator for 12 of the total clinical quality metrics, the practice must pass at least 6 of the 12 clinical quality metrics to meet the 50% passing rate requirement.

Minimum Denominator Requirements for Partnerships

Consistent with the overall practice metric performance calculations, 30 members are required in the minimum denominator requirements for metric scoring to be applied at the Partnership level using the

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aggregated denominator figures and reported in the Partnership quality metrics report. For example, if three individual practices with 20 members each in the denominator of a given metric receive individual CPC Practice Reports, the individual CPC Practice Reports will show they each do not meet minimum denominator requirements. However, at the entity level, there is a total of 60 members in the aggregated denominator and the entity has enough members in the denominator to qualify for scoring of the metric, which is reflected in the overall Partnership report sent to all practices in the Partnership.

3.6.3 Ohio CPC Quality and Efficiency Metric Specifications

The clinical quality and efficiency metrics versions used include:

- HEDIS® quality and efficiency metrics:
  - Program year 2017 & 2018: NCQA 2016 HEDIS Technical Specifications for Health Plans
  - Program year 2019: NCQA 2018 HEDIS Technical Specifications for Health Plans
  - Program year 2020: NCQA 2020 (MY2019) HEDIS Technical Specifications for Health Plans
  - Program year 2021: NCQA 2021 (MY 2020) HEDIS Technical Specifications for Health Plans
  - Program year 2022: NCQA 2022 (MY 2021) HEDIS Technical Specifications for Health Plans
  - Program year 2023: NCQA 2023 (MY 2022) HEDIS Technical Specifications for Health Plans
  - Program year 2024: NCQA (MY 2023) HEDIS Technical Specifications for Health Plans
  - Program year 2025: NCQA (MY 2024) HEDIS Technical Specifications for Health Plans
  - Program year 2026: NCQA (MY 2025) HEDIS Technical Specifications for Health Plans
- Live Births Weighing Less than 2,500 grams: Refer to Section 7.1.3
- Tobacco Use: Screening and Cessation (NQF 28): Refer to Section 7.1.15
- Inpatient Admissions for Ambulatory Care Sensitive Conditions (PQI 90): Refer to Version 5.5 of the AHRQ specifications
- Preferred Drug List: Refer to Section 7.1.16

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3.6.4 Metrics Based on Standard HEDIS® Specifications

Beginning Program year 2026, the following Ohio CPC quality and efficiency metrics are certified to meet the criteria of Measure Year 2025 HEDIS® Technical Specifications for Health Plans.

- HEDIS MY 2025 Ambulatory Care (AMB)
- HEDIS MY 2025 Asthma Medication Rato (AMR)
- HEDIS MY 2025 Chlamydia Screening in Women
- HEDIS MY 2025 Oral Evaluation, Dental Services (OED)
- HEDIS MY 2025 Controlling High Blood Pressure (CBP)
- HEDIS MY 2025 Cervical Cancer Screening (CCS)
- HEDIS MY 2025 Blood Pressure Control for Patients With Diabetes (BPD)
- HEDIS MY 2025 Eye Exam for Patients With Diabetes (EED)
- HEDIS MY 2025 Glycemic Status Assessment for Patients With Diabetes (GSD)
- HEDIS MY 2025 Childhood Immunization Status (CIS)
- HEDIS MY 2025 Follow-Up After Hospitalization for Mental Illness (FUH)
- HEDIS MY 2025 Initiation and Engagement of Substance Use Disorder Treatment (IET)
- HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use (FUA)
- HEDIS MY 2025 Immunizations for Adolescents (IMA)
- HEDIS MY 2025 Lead Screening in Children (LSC)
- HEDIS MY 2025 Topical Fluoride for Children (TFC)
- HEDIS MY 2025 Prenatal and Postpartum Care (PPC)
- HEDIS MY 2025 Statin Therapy for Patients with Cardiovascular Disease (SPC)
- HEDIS MY 2025 Well-Child Visits in the First 30 months of Life: first 15 months (W30)
- HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: 15-30 (W30)
- HEDIS MY 2025 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- HEDIS MY 2025 Child and Adolescent Well-Care Visits (WCV): 3-11 years
- HEDIS MY 2025 Child and Adolescent Well-Care Visits (WCV): 12-17 years
- HEDIS MY 2025 Child and Adolescent Well-Care Visits (WCV): 18-21 years
- HEDIS MY 2025 Colorectal Cancer Screening (COL-E)
- HEDIS MY 2025 Pharmacotherapy for Opioid Use Disorder (POD)

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3.7 Calculate Shared Savings Payments

3.7.1 Overview of Shared Savings Payments

There are two types of shared savings payments as part of the Ohio CPC program:

- Payment based on self-improvement between the baseline and program years, and
- Payment for CPC entities among the 10% lowest absolute total cost of care during a program year

CPC practices must meet the activity requirements, clinical quality and efficiency metrics to receive either type of shared savings payment. Furthermore, CPC entities must have at least 60,000 Medicaid member months over the performance period to be eligible for either type of shared savings payment, counting only members who were attributed to the practice for at least six months during the program year and who were not excluded during those months due to Ohio CPC exclusion criteria.

CPC practices may receive either type of shared savings payment alone, or both types of shared savings payments.

Shared savings payments are typically made approximately nine months after the end of the performance period (to allow six months of data run out and three months of data processing).

3.7.2 Shared Savings Payments for Practices in a Partnership

Shared savings is calculated at the aggregated Partnership level for participating Practice Partnerships.

Shared savings payments relative to self are made directly to each practice within the Partnership based on the proportionate share of risk-adjusted member months used to calculate payment (e.g., if a practice is responsible for 30% of a Partnership's risk adjusted member months, then 30% of the Partnership's shared savings is attributed to that practice. This number is then multiplied by the practice-specific gainsharing percentage to calculate the shared savings payment that practice receives).

Shared savings payments relative to peer are paid directly to each practice within the partnership based on existing methodology. This payment is calculated by multiplying annualized member months for the CPC practice during the performance period by $5 (this amount may be updated annually).

3.7.3 Practice Payment Based on Self-improvement

Shared savings payments are annual retrospective payments that may be made to eligible CPC practices for saving on the TCOC of their attributed members. In general, a CPC practice's total cost of care is compared to its baseline total cost of care, adjusted for programmatic changes, to determine whether a practice achieved savings. If the CPC practice achieved savings, the practice earns a portion of the savings based on the gainsharing rate.

The components of this calculation are outlined below.

3.7.3.1 Calculation of savings percentage

$$Savings\ percentage = \frac{\left(\begin{matrix}average\ risk-adjusted\ TCOC\ for\ the\ members \\ attributed\ to\ the\ CPC\ in\ the\ baseline\ year\end{matrix}\right) - \left(\begin{matrix}average\ risk-adjusted\ TCOC\ for\ the\ members \\ attributed\ to\ the\ CPC\ in\ the\ performance\ period\end{matrix}\right)}{average\ risk-adjusted\ TCOC\ for\ the\ members\ attributed\ to\ the\ CPC\ in\ the\ baseline\ year}$$

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

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3.7.3.2 Calculation of savings amount

$$Savings\ amount =$$

$$(Savings\ percentage) * (CPC\ entity's\ non - risk - adjusted\ TCOC\ in\ the\ baseline\ year,\ adjusted\ for\ programmatic\ changes)$$

3.7.3.3 Calculation of gainsharing percentage

If the savings amount, as calculated above, is positive, the CPC entity receives a percentage of this savings amount as a lump-sum payment which may vary depending upon the contractual requirements between the individual practice and the MCO. This percentage is called the gainsharing percentage, and is determined as follows:

- CPC entities receive 65% of the savings amount for their practice (as calculated above) if they have an average risk-adjusted TCOC below a specific threshold set to identify the lowest-cost CPC entities.
- All other CPC entities receive 50% of the total savings amount for their practice

3.7.3.4 Overall calculation of shared savings amount paid to CPC entities

Shared savings payments are annual retrospective payments that may be made to a CPC entity for saving on the TCOC of their attributed members. The shared savings payment is calculated as follows:

$$Shared\ savings\ payment =$$

$$(CPC\ entity's\ savings\ amount) * (gainsharing\ percentage)$$

This calculation is conducted annually for each CPC entity's performance over the 12-month performance period. One payment is then made to eligible CPC practices that achieve savings during a performance period (i.e., where the practice's risk-adjusted TCOC in the performance period is lower than the practice's target TCOC, and where the savings percentage is greater than or equal to 1%)

3.7.3.5 Payments made by ODM and Medicaid MCOs

While the determination of the baseline risk-adjusted TCOC includes both FFS and managed care enrollees, the payment that ODM makes to CPC entities for its FFS patients is the share of the shared savings payment described above, pro-rated based on risk-adjusted member months for FFS members. Similarly, each MCO is responsible for making payment based on the share of the shared savings payment achieved by CPC practices, for their members, pro-rated based on risk-adjusted member months for members enrolled with the MCO and as agreed upon in the contractual agreement between the practice and the MCO.

3.7.4 Entity Payment Based on Self-improvement

Consistent with the calculations outlined in sections 3.7.4 and 5.13.5 of the Ohio CPC DBR, the risk-adjusted total cost of care for the entity is compared to the baseline total cost of care for the entity, adjusted for programmatic changes, to determine whether an entity achieved savings. If the entity achieved savings, participating entities will earn a portion of the savings based on their individual gainsharing rate.

To determine a Partnership's savings amount, the percentage of shared savings is calculated as defined below, at the Partnership level:

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- Calculation of savings percentage

$$\text{Savings percentage} = \frac{\left(\begin{array}{c}\text{average risk-adjusted TCOC for the members}\\ \text{attributed to the CPC Partnership in the baseline year}\end{array}\right) - \left(\begin{array}{c}\text{average risk-adjusted TCOC for the members}\\ \text{attributed to the CPC Partnership in the performance period}\end{array}\right)}{\text{average risk-adjusted TCOC for the members attributed to the CPC Partnership in the baseline year}}$$

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

The savings percentage will then be multiplied by the non-risk-adjusted baseline TCOC for the Partnership, adjusted for programmatic changes, to determine the Partnership's savings amount:

- Calculation of savings amount

$$\text{Savings amount} = (\text{Savings percentage}) * (\text{CPC entity's non-risk-adjusted TCOC in the baseline year})$$

Each participating practice will receive shared savings payments (relative to self) at a gain sharing rate of 50% gainsharing payments. Partnerships with risk-adjusted total cost of care PMPY below the lowest 10% of baseline risk-adjusted PMPY among enrolled CPC practices in the program year, a gainsharing rate of 65% will apply to all participating practices in the Partnership.

3.7.5 Payment for Entities with the Lowest TCOC

The 10% of enrolled CPC entities with the lowest average risk-adjusted TCOC during the program year will receive a bonus payment from ODM. This payment is a lump sum amount calculated retrospectively and paid annually. This payment is calculated by multiplying the number of members attributed to the CPC entity during the performance period by $5 (this amount may be updated annually). The total outlay of this payment is capped at $1 million annually.

To determine the 10% of enrolled CPC entities with the lowest average risk-adjusted TCOC PMPM each practice participating independently and Partnerships are considered. In other words, the aggregated risk-adjusted total cost of care for the Partnership is used when calculating TCOC percentiles for all CPC entities (not the TCOC for individual practices participating in a Partnership).

3.7.5.1 Payment distribution for practices within Partnerships

If the Partnership overall is in the lowest 10% of all standalone practices and Partnerships, then each individual practice in the Partnership qualifies and is paid out per existing methodology. This payment is calculated by multiplying annualized member months for the CPC practice during the performance period by $5 (this amount may be updated annually). The total outlay of this payment is capped at $1 million per entity annually.

3.7.6 CPC for Kids Bonus Payment

The CPC for Kids bonus payment is not part of Shared Savings calculations. The list of practices earning this payment is provided by ODM in File B, and fund codes are added to produce File G6.

3.8 Calculate Data Elements for Reporting

Ohio CPC program reporting consists of a robust set of demographic, clinical quality and efficiency, cost, event, and other clinical data. These data elements are intended to inform ODM, Ohio CPC practices,

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and MCOs on Ohio CPC members. These data elements are calculated and aggregated before being included in the standard Ohio CPC outputs and reports.

3.9 Create Output Data Files and Reports

The Ohio CPC program consists of a set of final reports containing data on the program to help providers understand who their attributed members are, their patients' disease profiles, and cost and quality information on their patient panels. There are three sets of reports received by providers, as well as several interim reports generated on behalf of ODM for data validation purposes.

The following table lists the complete set of all Ohio CPC deliverables and their contents:

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Table 8. Ohio CPC Deliverables and Descriptions

File name	Description	Received by
File C	Post-exclusion ODM member-level master payment and attribution file	ODM
File D	Post-exclusion MCO payment and validation file	MCOs
File G1	ODM FFS expenditure data file	ODM
File G2	ODM MCO expenditure data file	ODM
File H	Provider attribution member-level payment file	Providers
File I	Member-level provider report CSV data files	Providers
File J	Ohio CPC entity Reports	Providers
File K	Member-level data from the Ohio CPC practice reports	ODM
File L	Provider-level data from the Ohio CPC practice reports	ODM
File L MCO	Provider-level data from the Ohio CPC practice reports	MCOs
File S	Partnership-level data from the Ohio CPC partnership report	ODM
File S MCO	Partnership-level data from the Ohio CPC partnership report	MCOs
File O	MCO-specific collection of provider reports, limited to members enrolled with the MCO	MCOs
File G3	Shared savings payment file for practices with lowest TCOC	ODM
File G4	Shared savings payment file for self-improvement for FFS	ODM
File G5	Shared savings payment file for self-improvement for MCOs	MCOs
File G6	CPC for Kids Bonus Payment file	ODM
Shared Savings Internal Calculations Table – Entity	Shared Savings calculations file created annually by vendor for internal ODM review. Two files are created: • File T – entity level shared savings calculations. Created annually. • File T Supplement – shared savings split between practices in a partnership. Created annually.	ODM
Shared Savings Internal Calculations Table – Practices in Partnerships	Shared savings relative to self and peers divided proportionally among practices within partnerships	ODM
File P	Member-level annual enrollment file enrollment file	ODM
File P Summary	Provider-level annual enrollment summary file	ODM
File T	Entity-level shared savings calculations. Created annually.	ODM
File T Supplement	Shared savings split between practices in a partnership. Created annually.	ODM

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File name	Description	Received by
GAR File	Fund-code level provider file generated when a previous PMPM payment needs to be adjusted for providers	ODM

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4 DATA FLOW

This section describes the various inputs into the Ohio CPC algorithm, CPC configuration file(s), output tables, and detailed information on the CPC data files and provider reports.

4.1 Input Data

To build and run the Ohio CPC algorithm, the following input files are required:

Table 9. Ohio CPC Algorithm Input Data

File or Table Name	Description
Input files	
Claims Data	
Member Extract (I.C.01)	List of members and their health insurance enrollment information
Provider Extract (I.C.02)	List of participating providers and their addresses
Claims Extract (I.C.03)	Institutional claims (UB-04 claim form) professional claims (CMS-1500 claim form), and pharmacy claims (NCPDP claim form) at the member level
Attribution/Enrollment Files	
Fee-For-Service Member Choice Attribution (I.A.01)	Member to practice attribution based on claims data for all Ohio members
Fee-For-Service Claims-Based Attribution (I.A.02)	Member to practice attribution based on members' choice for FFS members
Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03)	Member to practice attribution based on geography, for FFS members. Data from both the Pediatric and Adult files are combined and inserted into a single table for purposes of this DBR
Managed Care Attribution (I.A.05)	Member to practice attribution for members under managed care (File Q), conducted by each MCO
Activity Requirements input file	Activity Requirements status provided by ODM for annual program enrollment eligibility
Supplemental Input Files	
Active Providers (I.S.02)	*Active list of Ohio providers (not utilized in this DBR)*
Provider Contracts (I.S.03)	*Contract spans for Ohio providers (not utilized in this DBR)*
Provider Specialty (I.S.04)	Specialty type data for Ohio providers
Members with TPL (I.S.06)	Current list of members with third-party liability insurance
Ohio CPC Practices List (I.S.08)	List of Ohio CPC practices currently enrolled in the program
Programmatic Adjustment Factors (I.S.09)	Factors used to adjust target TCOC based on programmatic changes over time
Ohio Aid Category to Fund Code Crosswalk (I.S.10)	Crosswalk between aid category and fund code used for the creation of File G

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File or Table Name	Description
Prepaid Inpatient Health Plan (currently OhioRISE)	Current list of members who are participating in Prepaid Inpatient Health Plan (currently OhioRISE)
File B CPC for Kids Bonus Payments	List of CPC for Kids Bonus payment earners and the amount for a given annual report.
Quality and Efficiency Metric Input Files	
Low Birthweight Data (I.M.01)	Data from ODM on members with low birthweight (note: 9-month lag on this data file)
Provider eCQM supplemental data files	eCQM supplemental data from providers for the supplemental eCQM supplemental data metrics
Immunization Data	ImpactSiis immunization data extract provided quarterly by ODM
Lead Screening Data	Lead screening extract provided quarterly by ODM
PDL NDC Codes	List of NDC codes for the below categories: • Antidiabetics, Insulin • Antidiabetics, Non-Insulin • Asthma • COPD
Quality and Efficiency Metric Thresholds	Thresholds for meeting quality and efficiency metric performance
Quality and Efficiency Metric Performance Data	Outputs from the quality and efficiency metric runs (e.g., numerator and denominator performance by member)

In *Appendix D: Ohio CPC Configuration File* is included a list of the required input fields using the source field abbreviations and source table names provided in the Ohio Vendor Extracts Companion Guides and source table names for supplemental input files. The algorithm logic (*Section 5* Ohio CPC Algorithm) describes the use of each input field. In the algorithm logic, input fields are referred to by the “Source field name in DBR”.

The date range for the claims data must include the 12 months duration reporting period as well as at least 13 months preceding the reporting period. The months preceding the reporting period are needed for the identification of risk factors and comorbidities, to provide sufficient input data to identify the service start date and end date, and to calculate certain clinical quality metrics.

The claims data must contain only unique and paid claims. For Ohio Medicaid, the methods provided by the State are used to remove duplicate and void claims.

Attribution data for purposes of Ohio CPC is generated by each of the MCOs and by ODM for FFS members. Each MCO is responsible for the accuracy of submitted attribution data.

4.2 Ohio CPC Algorithm

The intent of the Ohio CPC algorithm is detailed in Section 5 *Ohio CPC Algorithm*.

4.3 Ohio CPC Configuration

The parameters and medical codes needed to define and run the Ohio CPC algorithm are listed in the configuration file, which is provided as an attachment to the DBR. The file includes:

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- Version Change Log
- Input & Output Tables Overview
- Input Table Fields: A list of all input tables and associated fields, including the name of the field used in this DBR and, where applicable, the source table and source field names
- Output Table Fields: A list of all output tables and associated fields, including the section within this DBR where the field is calculated
- Output Data Files and Fields: A list of all output data files, including the field names, field types, and possible values
- Codesheet: Medical, provider, and other codes used to identify various aspects of the Ohio CPC program, for example codes used to identify members in long-term care, NICU patients, dental services, etc.

The algorithm logic explains the intended use of the parameters and medical codes by the Ohio CPC algorithm.

4.4 Output Tables

Using the input data tables and the configuration file, the Ohio CPC algorithm creates 7 output tables used to operate the Ohio CPC program. These output tables are internal tables used to create output data files and reports.

Table 10. Ohio CPC Output Tables

Name	Description
Output tables	
Attribution Output Table (O.01)	Quarterly attribution and payment information for Ohio CPC members
Monthly Member Table (O.02)	Monthly member-level table used to capture Ohio CPC exclusions calculated on a monthly basis
Rolling Period Member Table (O.03)	Member-level reporting data over a 12-month performance or reporting period
Rolling Period Practice Table (O.04)	Practice-level reporting data over a 12-month performance or reporting period
Rolling Period Partnership Table (O.04)	Partnership-level reporting data over a 12-month performance or reporting period
Quarterly Attribution Bridge Table (O.05)	Helper table used to create the Monthly Member Table (O.02) from the Attribution Output Table (O.01)
Practice Baseline Total Cost of Care Table (O.06)	Baseline year data for practices, including baseline and target total cost of care
Partnership Baseline Total Cost of Care Table (O.06)	Baseline year data for partnerships, including baseline and target total cost of care
Entity Shared Savings Table (O.07a)	Shared savings calculations for Entities over a 12-month performance period

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Name	Description
Entity Shared Savings Table (O.07c)	Shared savings calculations for practices in a Partnership over a 12-month performance period
Practice Shared Savings Payments Table (O.08)	Shared savings payments calculations for practices over a 12-month performance period, broken down by fund code and payer
CPC for Kids Annual Bonus Table (O.09)	CPC for Kids Annual Bonus payments as presented by ODM for practices over a 12-month performance period, broken down by fund code

The algorithm logic (*Section 5 Ohio CPC Algorithm*) describes the definition of each output field within each table. Within the algorithm logic, output fields are referred to by the output field names and field identifiers provided in the tables.

4.5 Output Data Files and Reports

Various output data files are created at different points throughout a quarterly period of operations. Output data files are files intended to be sent to third parties including ODM, MCOs, and Ohio CPC practices. Output data files are created after certain portions of the Ohio CPC algorithm have been run and are populated using the output tables described in *Section 4.4 Output Tables*.

The following is a list of the Ohio CPC output data files including those not covered as part of the scope of this DBR:

Table 11. Ohio CPC Algorithm Output Data Files

Name	Description	Recipient	Number of Files	Reporting Frequency
File A (ODF.01)	Pre-exclusion ODM MCO attribution QA reports (not included in this DBR)	ODM	ODM	Quarterly
File C (ODF.02)	ODM master QA attribution member-level file	ODM	1	Quarterly
File D (ODF.03)	MCO payment and attribution validation file package contains four tabs: • Quarterly PMPM payment aggregated for each practice • Member-level quarterly PMPM payment for attributed members • Member-level information for all attributed members, pre-exclusion • CMC Quarterly PMPM takeback information for each practice	MCOs	1 per MCO	Quarterly
File G1 (ODF.04)	ODM FFS expenditure upload file	ODM	1	Quarterly

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Name	Description	Recipient	Number of Files	Reporting Frequency
File G2 (ODF.05)	ODM MCO expenditure upload file	ODM	1	Quarterly
File H (ODF.06)	Provider attribution member-level payment files	CPC practices	1 per CPC practice	Quarterly
File I (ODF.07)	Member-level provider report CSV data file, for providers	Practices	1 per CPC practice	Quarterly/Annual
File J (ODF.08)	Entity report PDF file (not included in this DBR)	Practices	1 per CPC practice	Quarterly/Annual
File K (ODF.09)	Member-level provider report CSV data file, for ODM	ODM	1	Quarterly/Annual
File L (ODF.10)	Provider-level provider report CSV data file, for ODM	ODM/MCOs	1 for ODM and 1 per MCO	Quarterly/Annual
File S	Partnership-level CSV file for ODM	ODM/MCOs	1 for ODM and 1 per MCO	Quarterly/Annual
File O (ODF.13)	Member-level provider report CSV data file, for MCOs	MCOs	1 per MCO	Quarterly/Annual
File G3 (ODF.14)	Provider-level shared savings (relative to peers) payment files for ODM	ODM	1	Annual
File G4 (ODF.15)	Provider-level shared savings (relative to self) payment files for ODM	ODM	1	Annual
File G5 (ODF.16)	Provider-level shared savings (relative to self) payment files for MCOs	MCOs	1 per MCO	Annual
File G6	Provider-level CPC for Kids Bonus Payment	ODM	1	Annual
Shared Savings Internal Calculations Table – entity	Shared Savings calculations file created annually by vendor for internal ODM review. Two files are created: • File T – entity level shared savings calculations. Created annually. • File T Supplement – shared savings split between practices in a partnership. Created annually.	ODM	1	Annual
Shared Savings Internal Calculations Table Supplement - practices in partnerships	Breakdown of practices in partnership shared savings (relative to self and peers) payments earned	ODM	1	Annual
File P	Member-level annual enrollment file	ODM	1	Annual

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Name	Description	Recipient	Number of Files	Reporting Frequency
File P Summary	Provider-level annual enrollment summary file	ODM	1	Annual
File T	Entity-level shared savings calculations.	ODM	1	Annual
File T Supplement	Shared savings split between practices in a partnership.	ODM	1	Annual
GAR File	Fund-code level provider file generated when a previous PMPM payment needs to be adjusted for providers	ODM	1	Ad hoc

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5 OHIO CPC ALGORITHM

This section describes the technical details related to each of the Ohio CPC program design elements, and represents a detailed, end-to-end methodology for the Ohio CPC production algorithm.

Detailed code lists and configuration parameters are included in *Appendix D: Ohio CPC Configuration File*.

Terminology for Section 5 Ohio CPC Algorithm:

- Parameters are variables set before running the Ohio CPC algorithm, and may change based on the run, for example: start date and end date of the 12-month rolling period of analysis are parameters
- Codelists are sets of codes referenced within the algorithm, for example the set of specialty and provider type codes used to identify primary care practitioners
- Input fields are variables from an input file, or an output table previously created as part of the algorithm and are used as inputs into portions of the algorithm
- Output fields are variables calculated as part of the algorithm
    - For example, member date of birth is an input field when calculating the output field age
- Input files/tables and output tables are the sets of tables either referenced (input) or created (output) as part of the algorithm
- Single letter indicators are used to test specific values or conditions such as *the* derived *input field on the* Member Extract (I.C.01) *is equal to 'E.'*

  The full set of single letter values is listed in the table below:

Table 12: Single Letter Indicator Values

Table	Single Letter Indicator	Description
Claims Extract (I.C.01)		
	A	Assignment Plan Enrollment
	C	MC Special Condition
	D	Aid Category Eligibility
	E	Managed Care Enrollment/Ohio Rise
	H	Waiver Enrollment
	I	Medicare Part B Enrollment
	J	Nursing Home Enrollment
	K	PACT Program Enrollment
	L	Medicare Part A Enrollment
	N	TPL Enrollment
	G	Medicare Part D Enrollment
	O	Medicare Part C Enrollment
	T	Totals Record
Member Extract (I.C.03)		
	D	Detail
	E	Encounter
	F	FFS

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	H	Header
	P	Paid
	Y	Yes

5.1 Attribute Members to Primary Care Practices

5.1.1 Overview

This section describes the algorithm logic to combine MCO and FFS attribution input files to generate quarterly attribution for Ohio CPC.

Parameters

- attribution_date: the point-in-time date of attribution for a given quarter, set as the first day of the last month of the quarter (for example, for a quarter spanning 1/1/2023 to 3/31/2023, the date of attribution is 3/1/2023)

Configuration file codelists

- cpc_pcp_attribution

Input tables

- Member Extract (I.C.01), Provider Extract (I.C.02), Fee-For-Service Member Choice Attribution (I.A.01), Fee-For-Service Claims-Based Attribution (I.A.02), Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03), Managed Care Attribution (I.A.05)

Output tables

- Attribution Output Table (O.01), Quarterly Attribution Bridge Table (O.05)

5.1.2 Determine MCO Member-to-practice Attribution

5.1.2.1 Define the MCO base population and determine each member's payer

For all Ohio Medicaid members:

- Confirm the member was actively enrolled in Medicaid and in an MCO on the attribution date by confirming <u>all</u> the following criteria are true:
- the attribution_date is greater than or equal to (≥) eligibility_start_date from the Member Extract (I.C.01)
- <u>either</u> (a) the attribution_date is less than or equal to (≤) eligibility_end_date from the Member Extract (I.C.01) or (b) the eligibility_end_date indicates an open date range
    - the derived input field on the Member Extract (I.C.01) is equal to 'E'
- Disregard all members who were not enrolled in Medicaid on the attribution_date
- Depending on the sender of File Q, assign the member's MCO name to this sender
- For any members that have more than one unique MCO in the step above, set the member's MCO to *null* to indicate an ambiguous MCO assignment.

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Note: these members cannot be attributed because they have an ambiguous MCO assignment but may still be included in attribution if they have a valid FFS attribution as determined in *Section 5.1.3 Determine FFS Member-to-practice Attribution*.

5.1.2.2 Combine the Managed Care Attribution (I.A.05) input files from each MCO

- Each MCO submits one Managed Care Attribution (I.A.05) input file per quarter.
- Combine the Managed Care Attribution (I.A.05) input files (via a union) into a single input file and use the combined Managed Care Attribution (I.A.05) input file for the remainder of this section.
- On the combined Managed Care Attribution (I.A.05) input file, create three additional fields to differentiate the timeframe and source of the records:
  - Set attribution_date to the attribution_date parameter (e.g., "6/1/2023")
  - Set quarter_id to the quarter in which the attribution date parameter resides:
    - 1 if the attribution date is March 1
    - 2 if the attribution date is June 1
    - 3 if the attribution date is September 1
    - 4 if the attribution date is December 1
- Set attribution_mco to the name of the MCO that sourced the original Managed Care Attribution (I.A.05) input file:

  Note: because there is no field indicating the name of the MCO; the file name of each MCO attribution file must be used to determine which MCO submitted the file

- Each MCO submits an attribution file (formally called the *MCO Primary Care Practice Attribution Data File* which is referred to in this DBR as the Managed Care Attribution (I.A.05) input file); these files adhere to the following file naming convention:
  - “MMCPCPxxxmmyy.99”
  - Position 7–9 (represented by “xxx” in the file name above) represents the Submitter ID, referring to:

Table 13. MCO Attribution File to MCO Name Crosswalk

MCO Submitter ID	MCO
420	Buckeye
315	CareSource
731	Molina
761	United
192	AmeriHealth

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MCO Submitter ID	MCO
191	Humana
293	Anthem

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5.1.2.3 Segment members based on member choice, claims, and other methods

Segment the Managed Care Attribution (I.A.05) input file into three groups of members based on the attribution assignment method, “Member Choice”, “Claims”, and “Other”.

Begin with the MCO base population.

For each member in the MCO base population, perform the following steps on each of the three combined Managed Care Attribution (I.A.05) input files that were segmented based on “Member Choice”, “Claims”, and “Other”:

1. *Identify the member’s attributed practice*

- For each member, set practice_medicaid_id to the most recent practice with a valid attribution span (using the most recent primary_care_provider_billing_start_date) found in the Managed Care Attribution (I.A.05) input file where both of the following are true:
    - the attribution_date is greater than or equal to (≥) the primary_care_provider_billing_start_date
    - either (a) the attribution_date is less than or equal to (≤) the primary_care_provider_billing_end_date, or (b) the primary_care_provider_billing_end_date indicates an open date range
- If two or more practices with valid spans are identified and the billing IDs for the practices (primary_care_provider_billing_medicaid_reporting_id) in the Managed Care Attribution (I.A.05) input file are *the same* across the multiple records, attribute the member to the practice
- If two or more practices with valid spans are identified and the billing IDs for the practices (primary_care_provider_billing_medicaid_reporting_id) in the Managed Care Attribution (I.A.05) input file are *different* and the primary_care_provider_billing_start_date for each practice is the same, the member is unattributed (not included in attribution). In this instance, the attribution record on the MCO attribution table should be updated as follows:
    - Set practice_medicaid_id to *null* to indicate ambiguous attribution
    - Set practice_name to *null* to indicate ambiguous attribution

2. Confirm payer consistency between the Member Extract (I.C.01) and Managed Care Attribution (I.A.05) input files

- Members are attributed to a practice only if the MCO assigned to the member through the Member Extract (I.C.01) in the sub-section above, “Determine each member’s payer”, matches the payer that provided the attribution record in the Managed Care Attribution (I.A.05) input files. For members where there is a mismatch, or ambiguity in the case of multiple payers, the member remains unattributed for the quarter
- To perform this check:

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- For members where a valid practice attribution span was identified in the previous step, "*Identify the member's attributed practice*", confirm the attribution_mco on the combined Managed Care Attribution (I.A.05) input file matches the payer assigned via the Member Extract (I.C.01) in the sub-section above, "Determine each member's payer"
- If the payers match, then the member is attributed
- If the payers do not match, then the member remains unattributed, and MCO attribution table should be updated as follows:
  - Set practice_medicaid_id to *null* to indicate ambiguous attribution
  - Set practice_name to null to indicate ambiguous attribution
    - For example, if the member's assigned payer from the Member Extract (I.C.01) is CareSource, but in the combined Managed Care Attribution (I.A.05) input file United attributes the member to a valid practice, the member is considered unattributed for the quarter because of the inconsistency in payers between the two sources

3. Identify the member's attributed PCP

- If there is only a single attribution record for the member-practice combination in the attribution file, set practitioner_medicaid_id to the primary_care_provider_rendering_medicaid_reporting_id on the attribution record associated with the member-practice combination
- If there are two or more attribution records for the member-practice combination in the attribution file, and where on the attribution records the practice_medicaid_id is the same but the primary_care_provider_rendering_medicaid_reporting_id is different, set practitioner_medicaid_id to the PCP (primary_care_provider_rendering_medicaid_reporting_id) from the attribution file with the most recent primary_care_provider_rendering_start_date. If there is a tie in the number of attribution records, set the set practitioner_medicaid_id to the PCP (primary_care_provider_rendering_medicaid_reporting_id) from the attribution file with the most recent primary_care_provider_rendering_start_date.
    - If no unambiguous attribution record can be selected based on the most recent primary_care_provider_rendering_start_date, then the member remains unattributed. In this instance, the attribution record on the MCO attribution table should be updated:
  - Set practitioner_medicaid_id to *null* to indicate ambiguous attribution
  - Set practitioner_name to null to indicate ambiguous attribution

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Note: The Managed Care Attribution (I.A.05) input files use two different defaults for indicating an open enrollment span: 1900-01-01 and 9999-12-31. These two different open enrollment default dates must be considered as part of attribution. One potential approach is to standardize these open enrollment span indicator dates to a single date value at some point in the future (e.g., 2299-12-31).

5.1.2.4 Combine all members based on the hierarchy: member choice > claims > other

Once attribution is determined within each attribution assignment method, create the final MCO attribution table by selecting members in hierarchical order:

- Start by including all members attributed by member choice
- Next, add any members attributed by claims who were not already selected with member choice
- Finally, add any members attributed by other means who were not already included via member choice or claims

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Perform these steps for each MCO's set of attribution files and concatenate the results into a single, final MCO attribution table. Retain all fields from the original Managed Care Attribution (I.A.05) input files. Add two additional fields:

- Set payer to "MCO"
- Set payer_detail to the name of the MCO that attributed the member as determined in the sub-section above, "Determine each member's payer"

  Note: practice attribution is determined within each assignment method and then aggregated using the hierarchy (choice > claims > other) to avoid duplication.

5.1.3 Determine FFS Member-to-practice Attribution

FFS attribution is determined for each member through two steps:

- Define the FFS base population
- Identify members' FFS attribution based on hierarchy (choice > claims > GIS/other)

  Note: FFS attribution is determined at this stage for all members, even those enrolled with an MCO. During a later step, MCO and FFS attribution results are combined to determine a single attribution for each member during the quarter

5.1.3.1 Define the FFS base population

For all Ohio Medicaid members, include members in the FFS base population if they are enrolled in Medicaid on the attribution date with a valid aid category

- Confirm the member was actively enrolled in Medicaid with a valid aid category on the attribution date by confirming <u>all</u> the following criteria are true:
  - the attribution_date is greater than or equal to (≥) eligibility_start_date from the Member Extract (I.C.01)
  - <u>either</u> (a) the attribution_date is less than or equal to (≤) eligibility_end_date from the Member Extract (I.C.01) or (b) the eligibility_end_date indicates an open date range
  - The member is enrolled with a valid aid category where the aid_category field from the Member Extract (I.C.01) has a numeric value and is not *null*

These members constitute the FFS base population. All other members are not eligible on the attribution date and should be disregarded.

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5.1.3.2 Identify members' FFS attribution based on hierarchy (choice > claims > GIS/other)

For each FFS base population member, determine the member's attribution information by looking for the member's medicaid_id in each of the FFS attribution files:

- Fee-For-Service Member Choice Attribution (I.A.01)
- Fee-For-Service Claims-Based Attribution (I.A.02)
- Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03)

If a member appears in more than one of the three FFS attribution files, use the following logic to determine a member's FFS attribution:

- If a member appears in both the member choice and claims attribution files and the practice_medicaid_id for the member is the same between the two files, use the Fee-For-Service Member Choice Attribution (I.A.01) file to source the attribution record
- If a member appears in both the member choice and claims attribution files and the practice_medicaid_id for the member is different between the two files, compare the member_call_date from Fee-For-Service Member Choice Attribution (I.A.01) file to the prior_visit_date from Fee-For-Service Claims-Based Attribution (I.A.02)
    - If member_call_date is greater than or equal to (≥) prior_visit_date, use the Fee-For-Service Member Choice Attribution (I.A.01) file to source the attribution record
    - Otherwise, use the Fee-For-Service Claims-Based Attribution (I.A.02) file to source the attribution record
- For all other members that appear in more than one of the three FFS attribution files, source the attribution record from the member choice file first, from the claims attribution file second, and from the FFS GIS attribution file last

5.1.4 Combine FFS and MCO Attribution to Determine Final Quarterly Attribution

Final attribution is determined by combining the results of MCO and FFS attribution. A member should only appear once in an attribution quarter following this step.

Determine final attribution through the following three steps:

1. Include all members from MCO attribution with a valid attributed practice
2. Add any members who are not in MCO attribution from the first step, but who have a valid FFS attribution with a valid attributed practice
3. Finally, add all unattributed members from MCO attribution where practice is *null* and who were not included in either of the first two steps

The final set of attributed members as described above is also summarized in the table below:

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Table 14. Summary of Source of Final Attribution

Step from above	MCO Attribution	FFS Attribution	Final member attribution comes from…	Final payer assignment comes from…
1	Attributed	Attributed	MCO	MCO
1	Attributed	Unattributed	MCO	MCO
1	Attributed	Does not appear	MCO	MCO
2	Unattributed	Attributed	FFS	FFS
2	Does not appear	Attributed	FFS	FFS
3	Unattributed	Unattributed	Unattributed	MCO

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5.1.5 Update Output Fields

Update the following fields in the Attribution Output Table (O.01) for the given quarter:

- Set member_medicaid_id to member_id from the Member Extract (I.C.01)
- Set quarter_id to the quarter in which the attribution_date parameter resides:
    - 1 if the attribution date is March 1
    - 2 if the attribution date is June 1
    - 3 if the attribution date is September 1
    - 4 if the attribution date is December 1
- Set attribution_date to the attribution_date parameter (e.g., "6/1/2018")
- Set quarter_start_date to the first day of the quarter in which attribution occurs (e.g., if the attribution_date is 12/1/2018, set quarter_start_date to 10/1/2018)
- Set quarter_end_date to the last day of the quarter in which attribution occurs (e.g., if the attribution_date is 12/1/2018, set quarter_end_date to 12/31/2018)
- Set the month start and end dates for each month within the quarter:
    - Set month_1_start_date equal to the first day of first month of the quarter
    - Set month_1_end_date equal to the last day of first month of the quarter
    - Set month_2_start_date equal to the first day of second month of the quarter
    - Set month_2_end_date equal to the last day of second month of the quarter
    - Set month_3_start_date equal to the first day of third month of the quarter
    - Set month_3_end_date equal to the last day of third month of the quarter
- Set member_dob to the input field date_of_birth from the Member Extract (I.C.01) input file for the given member
- Set member_gender to the input field member_gender from the Member Extract (I.C.01) input file for the given member
- Set member_age to the number of months between member_dob and the attribution_date

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- Set member_fund_code via the following steps:
- For each member, select the member's aid_category with the most recent eligibility_start_date and latest (most recent) eligibility_end_date, where all the following are true:
    - aid_category is not equal to 'E'
    - quarter_start_date plus (+) 6 months is greater than or equal to (≥) eligibility_start_date
    - quarter_end_date plus (+) 6 months is less than or equal to (≤) eligibility_end_date
- For all members with a valid aid_category identified in the previous step, set member_fund_code equal to fund_code from the Ohio Aid Category to Fund Code Crosswalk (I.S.10) input file where the aid_category identified in the previous step is equal to mits_aid_category_code on the Ohio Aid Category to Fund Code Crosswalk (I.S.10) input file
- For members who did not have a valid aid_category identified in the first step, set member_fund_code equal to 'REG'
- Set payer to "MCO" if the member was attributed through Managed Care Attribution (I.A.05), or to "FFS" otherwise
- Set payer_detail to the name of the CPC Participating MCO (PY 2026 MCOs are Buckeye, CareSource, Molina, United, Humana, AmeriHealth, Anthem) that attributed the member or to "FFS" for members attributed through FFS

  Note: If the member was attributed via MCO attribution, the member's attributed MCO for payer_detail should be obtained from the MCO sub-section, "Determine each member's payer" under *Section 5.1.2 Determine MCO Member-to-practice Attribution*

- Set practice_medicaid_id to the input field primary_care_provider_billing_medicaid_reporting_id from MCO Attribution (I.A.05) if the record was sourced from the MCO attribution files or to the following fields, if the record was sourced from one of the FFS attribution files:
    - practice_medicaid_id from Fee-For-Service Member Choice Attribution (I.A.01)
    - practice_medicaid_id from Fee-For-Service Claims-Based Attribution (I.A.02)
    - provider_id from Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03)
- Set practice_name to the provider_name from the Provider Extract (I.C.02) where practice_medicaid_id on the Attribution Output Table (O.01) equals provider_id from the Provider Extract (I.C.02)
- Set practice_tax_id to provider_tax_id from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id from the Attribution Output Table (O.01)

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- Set practice_npi to provider_npi from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id from the Attribution Output Table (O.01)
- Set enrollment_period to enrollment_period from the Ohio CPC Practices List (I.S.08) where practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08)
    - For practices not included in the Ohio CPC Practices List (I.S.08), set enrollment_period equal to 0
- Set active_practice_flag to active_practice_flag from the Ohio CPC Practices List (I.S.08) where practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08) and where the ohio_cpc_performance_year from the Ohio CPC Practices List (I.S.08) refers to the set of enrolled Ohio CPC practices that are intended to receive PMPM payments for the quarter for which the Attribution Output Table (O.01) is being created
    - For practices not included in the Ohio CPC Practices List (I.S.08), set active_practice_flag equal to 0
- Set practitioner_medicaid_id to primary_care_provider_rendering_medicaid_reporting_id if the record was sourced from the MCO attribution files, or to the following fields if the record was sourced from one of the FFS attribution files:
    - pcp_medicaid_id from Fee-For-Service Member Choice Attribution (I.A.01)
    - pcp_medicaid_id from Fee-For-Service Claims-Based Attribution (I.A.02)
    - *null* to indicate a blank value if the record was sourced from the Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03) input file
- Set practitioner_name to the provider_name from the Provider Extract (I.C.02) where the practitioner_medicaid_id equals provider_id from the Provider Extract (I.C.02)

  Note: if practitioner_medicaid_id is set to “null” in an earlier step, set practitioner_name equal to null

- Set practitioner_npi to provider_npi from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practitioner_medicaid_id from the Attribution Output Table (O.01)
- Set attribution_method to the following, depending on where the attribution record was sourced:
    - The value of PCP Assignment Method from MCO Attribution (I.A.05) if sourced from the MCO attribution files

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- "C" if sourced from Fee-For-Service Member Choice Attribution (I.A.01)
- "A" if sourced from Fee-For-Service Claims-Based Attribution (I.A.02)
- "O" if sourced from Fee-For-Service Geographic Information System (GIS) Attribution (I.A.03)

- Set valid_practice to 1 if the specialty type and provider type of the practice_medicaid_id for each member on the Attribution Output Table (O.01) matches one of the valid specialty type and practice type combinations, as specified on the cpc_pcp_attribution codelist, and 0 otherwise. Check for valid specialty and practitioner type combinations as of the point-in attribution_date.
- Set valid_practitioner to 1 if the specialty type and provider type of the practice_medicaid_id for each member on the Attribution Output Table (O.01) matches one of the valid specialty type and provider type combinations, as specified on the cpc_pcp_attribution codelist, and 0 otherwise. Check for valid specialty and practitioner type combinations as of the point-in attribution_date.
- Set utilization_flag to 1 (and 0 otherwise) if the member had at least one of any type of claim with their attributed practice within the 24 months (730 days) prior to the attribution_date, that is, where both of the following are true:
  - billing_provider_id on the claim matches practice_medicaid_id for the member on the Attribution Output Table (O.01)
  - header_to_date_of_service on the claim is greater than or equal to (≥) 730 days prior to the attribution_date and less than or equal to (≤) the attribution_date

5.1.6 Create Quarterly Attribution Bridge Table (O.05)

The final step in attribution is to create a quarterly attribution bridge table, which is used to keep track of the practice to which each member is attributed during each of the four quarters of attribution during a 12-month rolling period. The Quarterly Attribution Bridge Table (O.05) is created using the outputs from each of the four Attribution Output Table (O.01) output files that make up a 12-month rolling period.

5.1.6.1 Define the timeframe parameters

- Set the rolling_period_start_date parameter to the first day of the rolling period to be created (e.g., 1/1/2025 for a rolling period of 1/1/2025 to 12/31/2025)
- Set the rolling_period_end_date parameter to the last day of the rolling period to be created (e.g., 12/31/2023 for a rolling period of 1/1/2023to 12/31/2023)

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5.1.6.2 Identify the four quarterly attribution periods to construct the rolling period

Identify the four quarterly attribution periods used to construct the rolling period using the table below; each quarterly Attribution Output Table (O.01) is used to construct the base population for the Rolling Period Member Table (O.03):

Table 15. Example Attribution Dates Used to Construct Each Rolling Period

Example Rolling Period	Quarter	Date of Attribution	Attribution Output Table (O.01) First Day of Quarter	Attribution Output Table (O.01) Last Day of Quarter
1/1/2024 to 12/31/2024	1	3/1/2024	1/1/2024	3/31/2024
	2	6/1/2024	4/1/2024	6/30/2024
	3	9/1/2024	7/1/2024	9/30/2024
	4	12/1/2024	10/1/2024	12/31/2024
4/1/2024 to 3/31/2025	1	6/1/2024	4/1/2024	6/30/2024
	2	9/1/2024	7/1/2024	9/30/2024
	3	12/1/2024	10/1/2024	12/31/2024
	4	3/1/2025	1/1/2025	3/31/2025
7/1/2024 to 6/30/2025	1	9/1/2024	7/1/2024	9/30/2024
	2	12/1//2024	10/1/2024	12/31/2024
	3	3/1/2025	1/1/2025	3/31/2025
	4	6/1/2025	4/1/2025	6/30/2025
10/1/2024 to 9/30/2025	1	12/1/2024	10/1/2024	12/31/2024
	2	3/1/2025	1/1/2025	3/31/2025
	3	6/1/2025	4/1/2025	6/30/2025
	4	9/1/2025	7/1/2025	9/30/2025

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- Set the following parameters based on the table above:
  - Set quarter_id equal to 1, 2, 3, or 4 based on the first, second, third, and fourth quarter during the rolling period
  - Set attribution_date equal to the date of attribution for the given quarter
  - Set quarter_start_date equal to the first day of the quarter
  - Set quarter_end_date equal to the last day of the quarter

5.1.6.3 Pre-populate the Quarterly Attribution Bridge Table (O.05)

- Pre-populate the Quarterly Attribution Bridge Table (O.05) with a distinct list of all members appearing in any of the four Attribution Output Table (O.01) files corresponding to each of the four quarters (as identified using the table above), and set each member's member_medicaid_id on the Quarterly Attribution Bridge Table (O.05) to the member_medicaid_id from each Attribution Output Table (O.01)
- For each member_medicaid_id on the Quarterly Attribution Bridge Table (O.05), expand the unique member record to four records for each member, and set quarter_id to the quarter_id parameter (1, 2, 3, or 4) for each of the newly created records
- For each member and for each quarter_id, set the attribution_date equal to the attribution_date parameter
- For each member and for each quarter_id, set the quarter_start_date equal to the quarter_start_date parameter and the quarter_end_date equal to the quarter_end_date parameter
- For all members, set rolling_period_start_date equal to the rolling_period_start_date parameter and set rolling_period_end_date equal to the rolling_period_end_date parameter

The result should be a table containing four records for each member. For example, for a rolling period of 1/1/2025 to 12/31/2025, the pre-populated Quarterly Attribution Bridge Table (O.05) should contain:

Table 16. Example Pre-populated Quarterly Attribution Bridge Table (O.05)

member_medicaid_id	quarter_id	attribution_date	quarter_start_date	quarter_end_date
Member A	1	3/1/2025	1/1/2025	3/31/2025
Member A	2	6/1/2025	4/1/2025	6/30/2025
Member A	3	9/1/2025	7/1/2025	9/30/2025
Member A	4	12/1/2025	10/1/2025	12/31/2025

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5.1.6.4 Construct the Quarterly Attribution Bridge Table (O.05)

For each of the Attribution Output Table (O.01) files corresponding to each of the four quarters (as identified using the table above), construct the set the following fields on the Quarterly Attribution Bridge Table (O.05):

- Set payer_detail on the Quarterly Attribution Bridge Table (O.05) equal to payer_detail on the Attribution Output Table (O.01)
- Set payer equal to payer
- Set practice_medicaid_id equal to practice_medicaid_id
- Set practice_name equal to practice_name
- Set practitioner_medicaid_id equal to practitioner_medicaid_id
- Set practitioner_name equal to practitioner_name
- Set attribution_method equal to attribution_method

5.1.6.5 Complete the Quarterly Attribution Bridge Table (O.05) for members not attributed in a quarter

Some members may not be attributed in all four quarters during a rolling period, and therefore may be missing from one or more of the quarterly Attribution Output Table (O.01) files. These members should still have four records in the Quarterly Attribution Bridge Table (O.05), although the data for the following fields should be set to *null* to indicate missing data for any quarters where the member does not appear in the quarter's Attribution Output Table (O.01): payer_detail, payer, practice_medicaid_id, practice_name equal, practitioner_medicaid_id, practitioner_name

5.2 Determine Member Eligibility

5.2.1 Overview

This section covers how to determine three types of member eligibility:

1. **Standard member exclusions for attribution and payment**, used for determining which members are included in attribution and receiving quarterly PMPM payments
2. **Standard member exclusions for a 12-month rolling period**, which are calculated in the same manner as the standard member exclusions for attribution and payment, but using slightly different timeframes that constitute more complete data; these are used for determining which members are included in a practice's panel for TCOC and quality metric calculations
3. **TCOC member exclusions**, which are special exclusions that only apply to TCOC calculations (but not quality metric calculations, for example)

This section also details how to create the **base population for two output tables**

4. The Monthly Member Table (O.02), a table with one record per member-and-month combination, for each of the 12 months in the rolling period; this table is used to keep track of whether members are excluded during a given month of the rolling period
5. The Rolling Period Member Table (O.03), a table with one record per member per 12 month rolling period; this table is used to determine final attribution, payer, exclusions, cost, and quality calculations for a member during the 12-month rolling period

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5.2.1.1 Parameters

- attribution_date, month_1_start_date, month_1_end_date, month_2_start_date, month_2_end_date, month_3_start_date, month_3_end_date, rolling_period_start_date, rolling_period_end_date

  Note: a rolling period describes a 12-month period of performance for Ohio CPC. This may correspond to an Ohio CPC performance period (a calendar year) or a 12-month Ohio CPC reporting period (e.g., 4/1/2016 to 3/31/2017) for which an Ohio CPC Practice Report is generated.

5.2.1.2 Configuration file codelists

- eligibility_valid_program, dual_program, crossover_claim_type, tpl_valid_program, limitedben_program, valid_program_eligibility, nicu_revenue, ltc_claim_type, ltc_provider_type, ltc_revenue_ffs, ltc_revenue_buckeye, ltc_revenue_caresource, ltc_revenue_molina, ltc_revenue_amerihealth, ltc_revenue_united, ltc_revenue_humana, ltc_revenue_anthem, icf_iid_provider_type

5.2.1.3 Input tables

- Member Extract (I.C.01), Claims Extract (I.C.03), Attribution Output Table (O.01), Quarterly Attribution Bridge Table (O.05), Attribution Output Table (O.01), Members in Transition (I.S.01), Foster Care (I.S.05), Members with TPL (I.S.06)

5.2.1.4 Output tables

- Attribution Output Table (O.01), Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04)

5.2.2 Standard Ohio CPC Member Exclusions for Quarterly Attribution

Standard Ohio CPC member exclusions are calculated for each month in a quarter for purposes of determining quarterly attribution. These quarterly exclusions are used to determine whether a member is excluded from attribution and PMPM payments for a given quarter.

Exclusions *for quarterly attribution and payment* are determined each month in three possible ways: based on eligibility/enrollment data, based on claims data, or based on an input file. Some exclusions are calculated based on more than one eligibility criteria

Table 17. Methods for Determining Ohio CPC Exclusions

Exclusion	Eligibility / Enrollment	Claims	Quarterly Exclusion File
TPL	x		
Limited Benefits	x	x	
Program Eligibility	x		
Dual	x	x	
Transition			x
Prepaid Inpatient Health Plan (currently OhioRISE)	x		

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For each method of exclusion, a different timeframe or set of months is used to determine the exclusion when calculating exclusions for quarterly attribution:

Table 18. Timeframe for Determining Exclusions for Quarterly Attribution

Method	Timeframe for Determining Exclusions
Eligibility / Enrollment	Only eligibility / enrollment on the first day of the last month of the quarter is used to determine exclusion status for the entire quarter
Claims	Claims during the first two months of the quarter, but not the third, are used to determine claims-based exclusions
Quarterly Exclusion File	Members in an input file indicating an exclusion are excluded from the entire quarter

To calculate the standard Ohio CPC member exclusions for a given quarter for purposes of quarterly attribution and PMPM payment eligibility, calculate the following exclusions for each member on the Attribution Output Table (O.01):

- Establish timeframe parameters by setting the following parameters equal to their values from the Attribution Output Table (O.01) (note: these parameters should be the same for all members):
    - Set attribution_date to attribution_date
    - Set month_1_start_date to month_1_start_date and month_1_end_date to month_1_end_date
    - Set month_2_start_date to month_2_start_date and month_2_end_date to month_2_end_date
    - Set month_3_start_date to month_3_start_date and month_3_end_date to month_3_end_date
- **Calculate the no eligibility exclusion**: member is not Medicaid-eligible on the date of attribution
    - Set excl_noelig on the Attribution Output Table (O.01) to 1 (and 0 otherwise) if the member does not have an aid_category from the Member Extract (I.C.01) in the eligibility_valid_program code list, where:
        - eligibility_start_date for the aid_category is less than or equal to (≤) the attribution_date and

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  - eligibility_end_date for the aid_category is greater than or equal to (≥) the attribution_date or where the eligibility_end_date indicates an open date range

- **Calculate the dual-eligible exclusion**: member is identified as a dual-eligible member based on eligibility or claims:
  - Set excl_dual on the Attribution Output Table (O.01) to 1 if any of the following three criteria are true, and 0 otherwise:

1. Member had a dual-eligible eligibility program code on the date of attribution
   - Member has an aid_category from the Member Extract (I.C.01) in the dual_program code list, where <u>both</u> of the following are true:
     - eligibility_start_date for the aid_category is less than or equal to (≤) the attribution_date
     - eligibility_end_date for the aid_category is greater than or equal to (≥) the attribution_date or where the eligibility_end_date indicates an open date range
2. Member had a claim indicating dual-eligibility any time during the first two months of the quarter:
   - Member had a claim where on the Claims Extract (I.C.03) header_from_date_of_service is greater than or equal to (≥) month_1_start_date and where header_to_date_of_service is less than or equal to month_2_end_date, and where program_code on the claim is in the dual_program code list
3. Member had a dual-eligible crossover claim any time during the first two months of the quarter:
   - Member had a claim where on the Claims Extract (I.C.03) header_from_date_of_service is greater than or equal to (≥) month_1_start_date and where header_to_date_of_service is less than or equal to month_2_end_date, and where claim_type on the claim is in the crossover_claim_type code list

- **Calculate the TPL exclusion**: member has an active third-party liability payer of non-dental, non-vision type:
  - Set excl_tpl on the Attribution Output Table (O.01) to 1 (and 0 otherwise) if the field dte_effective from the Members with TPL (I.S.06) input file is less than or equal to (≤) the attribution_date and where dte_end is greater than or equal to (≥) the attribution_date and where cde_coverage from the Members with TPL (I.S.06) input file is <u>not</u> in the tpl_valid_program code set

- **Calculate the limited benefits exclusion**: member is identified as having limited benefits during the quarter through eligibility or claims:

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- Set excl_limitedben on the Attribution Output Table (O.01) to 1 if either of the following criteria are true, and 0 otherwise:

1. Member had a limited benefits eligibility program code on the date of attribution:
   - Member has an aid_category from the Member Extract (I.C.01) in the limitedben_program code list, where eligibility_start_date for the aid_category is less than or equal to (≤) the attribution_date, and eligibility_end_date for the aid_category is greater than or equal to (≥) the attribution_date
2. Member had a claim indicating limited benefits any time during the first two months of the quarter:
   - Member had a claim where all the following are true on the Claims Extract (I.C.03):
     - header_from_date_of_service is greater than or equal to (≥) month_1_start_date from the Monthly Member Table (O.02)
     - header_to_date_of_service is less than or equal to (≤) month_2_end_date from the Monthly Member Table (O.02)
     - program_code on the claim is in the limitedben_program code list
     - type_of_bill on the claim is not *null*

- **Calculate the transition exclusion**: member is identified as being in transition between FFS and managed care:
  - Set excl_transition on the Attribution Output Table (O.01) to 1 (and 0 otherwise) if member_medicaid_id from the Attribution Output Table (O.01) equals member_medicaid_id from the Members in Transition (I.S.01) input table and where quarter_id from the Attribution Output Table (O.01) equals quarter_id from the Members in Transition (I.S.01) input table
- **Calculate the Prepaid Inpatient Health Plan (currently OhioRISE) exclusion**: member is identified as participating in A Prepaid Inpatient Health Plan (currently OhioRISE) (starting 7/1/2022):
  - Set excl_RISE on the Attribution Output Table (O.01) to 1 (and 0 otherwise) if member_medicaid_id from the Attribution Output Table (O.01) equals member_medicaid_id from the Prepaid Inpatient Health Plan (currently OhioRISE) input table

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and where quarter_id from the Attribution Output Table (O.01) equals quarter_id from the Prepaid Inpatient Health Plan (currently OhioRISE) input table

- **Calculate the standard any exclusion flag**: member is excluded from Ohio CPC during the quarter due to the presence of one or more of the standard Ohio CPC exclusions listed above:
  - Set excl_standard_any on the Attribution Output Table (O.01) to 1 if any of excl_noelig, excl_dual, excl_tpl, excl_limitedben, excl_transition , excl_RISE from the Attribution Output Table (O.01) are equal to 1, and 0 otherwise

5.2.3 Base Population for the Monthly Member Table (O.02)

The Monthly Member Table (O.02) contains data on each month within a 12-month rolling period and includes all Ohio CPC members who were attributed at least one month during that time. The Monthly Member Table (O.02) is defined and populated in this section and subsequently is used to create flags related to each of the member panels, as well as to construct the Rolling Period Member Table (O.03).

5.2.3.1 Define the rolling period timeframe parameters

- Set the rolling_period_start_date parameter to the first day of the rolling period to be created (e.g., 1/1/2018 for a rolling period of 1/1/2018 to 12/31/2018)
- Set the rolling_period_end_date parameter to the last day of the rolling period to be created (e.g., 12/31/2018 for a rolling period of 1/1/2018 to 12/31/2018)

5.2.3.2 Identify the four quarterly attribution periods to construct the rolling period

- Identify the four quarterly attribution periods used to construct the rolling period using the table below; information from each quarterly Attribution Output Table (O.01) and from the Quarterly Attribution Bridge Table (O.05) is used to construct the base population for the Rolling Period Member Table (O.03):

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Table 19. Example Attribution Dates Used to Construct Each Rolling Period

Example Rolling Period	Quarter	Date of Attribution	Attribution Output Table (O.01) First Day of Quarter	Attribution Output Table (O.01) Last Day of Quarter
1/1/2025 to 12/31/2025	1	3/1/2025	1/1/2025	3/31//2025
	2	6/1/2025	4/1/2025	6/30/2025
	3	9/1/2025	7/1/2025	9/30/2025
	4	12/1/2025	10/1/2025	12/31/2025
4/1/2025 to 3/31/2026	1	6/1/2025	4/1/2025	6/30/2025
	2	9/1/2025	7/1/2025	9/30/2025
	3	12/1/2025	10/1/2025	12/31/2025
	4	3/1/2026	1/1/2026	3/31/2026
7/1/2025 to 6/30/2026	1	9/1/2025	7/1/2025	9/30/2025
	2	12/1/2025	10/1/2025	12/31/2025
	3	3/1/2026	1/1/2026	3/31/2026
	4	6/1/2026	4/1/2026	6/30/2026
10/1/2025 to 9/30/2026	1	12/1/2025	10/1/2025	12/31/2025
	2	3/1/2026	1/1/2026	3/31/2026
	3	6/1/2026	4/1/2026	6/30/2026
	4	9/1/2026	7/1/2026	9/30/2026

5.2.3.3 Populate the Monthly Member Table (O.02)

On the Monthly Member Table (O.02), each record represents a single month for a given member, and therefore each member should have 12 total records, one for each month during the rolling period. To pre-populate the Monthly Member Table (O.02):

- Begin by populating the Monthly Member Table (O.02) with <u>all records and all fields</u> from the Quarterly Attribution Bridge Table (O.05) for the given rolling period to include all the following fields:
    - member_medicaid_id, rolling_period_start_date, rolling_period_end_date, quarter_id, attribution_date, quarter_start_date, quarter_end_date, payer_detail, payer, practice_medicaid_id, practice_name, practitioner_medicaid_id,

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practitioner_name, and attribution_method

- For each member_medicaid_id on the Monthly Member Table (O.02), expand the four records (one for each quarter) to twelve (12) total records
    - When expanding the records, repeat the data for each quarter three times so that there are three identical records for each member and for each quarter
- For each member_medicaid_id, set month_id to the sequential count of 1 through 12, with 1 corresponding to the month of the rolling_period_start_date and 12 corresponding to the month of the rolling_period_end_date
    - The month_id should also correspond sequentially to each quarter_id, for example:
        - Where quarter_id = 1, month_id = 1, 2, and 3
        - Where quarter_id = 2, month_id = 4, 5, and 6
        - Where quarter_id = 3, month_id = 7, 8, and 9
        - Where quarter_id = 4, month_id = 10, 11, and 12
        - For example, for a rolling period of 7/1/2023 to 6/30/2024, month_id equals 1 for 7/2023, 2 for 8/2023, 3 for 9/2023, etc.
- For each of the 12 months in the rolling period, set month_start_date to the first day of the month and month_end_date to the last day of the month
- Set member_dob to the input field date_of_birth from the Member Extract (I.C.01) input file for the given member
- Set member_gender to the input field member_gender from the Member Extract (I.C.01) input file for the given member
- Set member_age to the number of months between member_dob from the Member Extract (I.C.01) and month_end_date from the Monthly Member Table (O.02) and to *null* if the member was born after the month_end_date

The resulting pre-populated Monthly Member Table (O.02), should contain 12 records per member as in the example below:

Table 20. Example Pre-populated Quarterly Attribution Bridge Table (O.05)

Member_ Medicaid_ID	Quarter_ID	Month_ID	Attribution_Date	Month_ Start_Date	Month_ End_Date
Member A	1	1	3/1/2025	1/1/2025	1/31/2025
Member A	1	2	3/1/2025	2/1/2025	2/28/2025
Member A	1	3	3/1/2025	3/1/2025	3/31/2025
Member A	2	4	6/1/2025	4/1/2025	4/30/2025

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Member_ Medicaid_ID	Quarter_ID	Month_ID	Attribution_Date	Month_ Start_Date	Month_ End_Date
Member A	2	5	6/1/2025	5/1/2025	5/31/2025
Member A	2	6	6/1/2025	6/1/2025	6/30/2025
Member A	3	7	9/1/2025	7/1/2025	7/31/2025
Member A	3	8	9/1/2025	8/1/2025	8/31/2025
Member A	3	9	9/1/2025	9/1/2025	9/30/2025
Member A	4	10	12/1/2025	10/1/2025	10/31/2025
Member A	4	11	12/1/2025	11/1/2025	11/30/2025
Member A	4	12	12/1/2025	12/1/2025	12/31/2025

Note: Fields not shown: *member_age, rolling_period_start_date, rolling_period_end_date, quarter_start_date, quarter_end_date, payer_detail, payer, practice_medicaid_id, practice_name, practitioner_medicaid_id, practitioner_name*

5.2.4 Standard Ohio CPC Member Exclusions for a 12-month Rolling Period

When calculating standard Ohio CPC member exclusions for purposes of determining a 12-month rolling period, the same exclusions and criteria apply as when calculated for quarterly attribution. However, when calculated for a 12-month rolling period, each exclusion is checked during all 12 of the months in the rolling period:

Table 21. Timeframe for Determining Exclusions for a 12-month Rolling Period

Method	Timeframe for Determining Exclusions
Eligibility / Enrollment	Eligibility / enrollment on the first day of each month of the quarter is used to determine exclusion status for each month
Claims	Claims during each month of the quarter are used to determine claims-based exclusions for the given month
Input File	Members in an input file indicating an exclusion are excluded from each month during the quarter

To calculate the standard Ohio CPC member exclusions for a 12-month rolling period, calculate the following exclusions for each medicaid_member_id and month_id in the Monthly Member Table (O.02):

Note: if a claim has a multiple header dates, the claim should be considered in the earliest month, not in both months

- **Calculate the no eligibility exclusion**: member is not Medicaid-eligible on the first day of the month:
    - Set excl_month_noelig to 1 if the member does not have an aid_category from the Member

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Extract (I.C.01) in the eligibility_valid_program code list, where:

- eligibility_start_date for the valid aid_category is less than or equal to (≤) the month_start_date from the Monthly Member Table (O.02) and:
- eligibility_end_date for the valid aid_category is greater than or equal to (≥) the month_start_date from the Monthly Member Table (O.02) or where the eligibility_end_date indicates an open date range

- **Calculate the dual-eligible exclusion**: member is identified as a dual-eligible member in each month based on eligibility or claims:

Set excl_month_dual to 1 if any of the following three criteria are true for the member during a given month, and 0 otherwise:

1. Member had a dual-eligible eligibility program code on the first day of the month
   - Member has an aid_category from the Member Extract (I.C.01) in the dual_program code list, where <u>both</u> of the following are true:
     - eligibility_start_date for the aid_category is less than or equal to (≤) the month_start_date from the Monthly Member Table (O.02), and
     - eligibility_end_date for the aid_category is greater than or equal to (≥) the month_start_date from the Monthly Member Table (O.02) or where the eligibility_end_date indicates an open date range
2. Member had a claim indicating dual-eligibility during the month:
   - Member had a claim where on the Claims Extract (I.C.03) header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_to_date_of_service is less than or equal to month_end_date from the Monthly Member Table (O.02), and where program_code on the claim is in the dual_program code list
3. Member had a dual-eligible crossover claim during the month:
   - Member had a claim where on the Claims Extract (I.C.03) header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_to_date_of_service is less than or equal to month_end_date, and where claim_type on the claim is in the crossover_claim_type code list

- **Calculate the TPL exclusion**: member has an active third-party liability payer of non-dental, non-vision type on the first day of the month:
  - Set excl_month_tpl to 1 (and 0 otherwise) if the field dte_effective from the Members with TPL (I.S.06) input file is less than or equal to (≤) the month_start_date from the Monthly Member Table (O.02) and where dte_end is greater than or equal to (≥) the month_start_date from the

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Monthly Member Table (O.02) and where cde_coverage is not in the tpl_valid_program code set

- **Calculate the limited benefits exclusion**: member is identified as having limited benefits in a given month through eligibility or claims:
  - Set excl_month_limitedben to 1 if either of the following criteria are true for a given month, and 0 otherwise:

1. Member had a limited benefits eligibility program code on the first day of the month
   - Member has an aid_category from the Member Extract (I.C.01) in the limitedben_program code list, where eligibility_start_date for the aid_category is less than or equal to (≤) the month_start_date from the Monthly Member Table (O.02), and eligibility_end_date for the aid_category is greater than or equal to (≥) the month_start_date from the Monthly Member Table (O.02)
2. Member had a claim indicating limited benefits during the month
   - Member had a claim where all the following are true on the Claims Extract (I.C.03):
     - header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02)
     - header_to_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02)
     - program_code on the claim is in the limitedben_program code list
     - type_of_bill on the claim is not null

- **Calculate the transition exclusion**: member is identified as being in transition between FFS and managed care during the month:
  - Set excl_month_transition to 1 if member_medicaid_id from the Monthly Member Table (O.02) equals member_medicaid_id from the Members in Transition (I.S.01) input table and where quarter_id from the Monthly Member Table (O.02) equals quarter_id from the Members in Transition (I.S.01) input table, and to 0 otherwise

- **Calculate the Prepaid Inpatient Health Plan (currently OhioRISE) exclusion**: member is identified as participating in A Prepaid Inpatient Health Plan (currently OhioRISE) (starting 7/1/2022):
  - Set excl_RISE to 1 if member_medicaid_id from the Monthly Member Table (O.02) equals member_medicaid_id from

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	the Prepaid Inpatient Health Plan (currently OhioRISE) input table and where quarter_id from the Monthly Member Table (O.02) equals quarter_id from the Prepaid Inpatient Health Plan (currently OhioRISE) input table, and to 0 otherwise

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- **Calculate the standard any exclusion flag**: member is considered excluded from Ohio CPC during a given month due to the presence of one or more of the standard Ohio CPC exclusions listed above:
    - Set excl_month_standard_any on the Monthly Member Table (O.02) to 1 if any of excl_month_noelig, excl_month_dual, excl_month_tpl, excl_month_limitedben, excl_month_transition, excl_monthRISE are equal to 1, and 0 otherwise

Note: Beginning PY2020, foster care is no longer a standard exclusion for reporting. Set excl_month_foster to 0 in the Monthly Member Table (O.02)

5.2.5 Base Population for the Rolling Period Member Table (O.03)

The Rolling Period Member Table (O.03) contains data on a 12-month rolling period and includes all Ohio CPC members who were attributed at least one month during that time. The Rolling Period Member Table (O.03) "rolls up" the Monthly Member Table (O.02) from a monthly level to a 12-month period.

5.2.5.1 Define the base population

- Begin by populating the Rolling Period Member Table (O.03) with all unique members from the Monthly Member Table (O.02)
    - For each unique member, set member_medicaid_id on the Rolling Period Member Table (O.03) equal to member_medicaid_id from the Monthly Member Table (O.02)

5.2.5.2 Define the rolling period timeframe parameters

- Set the rolling_period_start_date parameter to the first day of the rolling period to be created (e.g., 1/1/2025 for a rolling period of 1/1/2025 to 12/31/2025)
- Set the rolling_period_end_date parameter to the last day of the rolling period to be created (e.g., 12/31/2025 for a rolling period of 1/1/2025 to 12/31/2025)

Update output table fields

Update the following fields on the Rolling Period Member Table (O.03). Note that *null* values should be ignored when updating these fields. Each of the following fields should be set to the <u>same value</u> for all members:

- Set reporting_year to the year (YYYY) of the rolling_period_end_date
- Set reporting_quarter to the quarter ('Q1', 'Q2', 'Q3' or 'Q4') equal to two quarters after the quarter ending with the rolling_period_end_date; for example, reporting_quarter would be set to 'Q4' for a rolling_period_end_date of 6/30/2025
- Set rolling_period_start_date to the rolling_period_start_date
- Set rolling_period_end_date to the rolling_period_end_date

Update the following fields on the Rolling Period Member Table (O.03) for each member, using data from the Monthly Member Table (O.02)**:**

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- Set member_dob to the input field date_of_birth from the Member Extract (I.C.01) input file for the given member
- Set member_gender to the input field member_gender from the Member Extract (I.C.01) input file for the given member
- Set member_age to the number of months between member_dob and the rolling_period_end_date from the Rolling Period Member Table (O.03)
- Set excl_noelig_months to the sum of excl_month_noelig
- Set excl_dual_months to the sum of excl_month_dual
- Set excl_tpl_months to the sum of excl_month_tpl
- Set excl_limitedben_months to the sum of excl_month_limitedben
- Set excl_transition_months to the sum of excl_month_transition
- Set excl_foster_months to the sum of excl_month_foster

  Note: Beginning PY 2020, foster care is no longer a standard exclusion therefore the sum of excl_month_foster is expected to be '0'.

- Set excl_RISE to the sum of excl_month_RISE
- Set excl_standard_months to the sum of excl_month_standard
- Set excl_nicu_months to the sum of excl_month_nicu

5.2.6 TCOC Member Exclusions

Additional members are included in Ohio CPC for purposes of attribution and PMPM payments, but are excluded from a practice's TCOC calculation.

- **Calculate NICU member exclusion**: members are excluded from the total cost of care calculation if they had nursery level 3 or 4 services within their first year of life

The NICU exclusion is calculated monthly, and a member is considered excluded if both of the following criteria are true for a given member:

1. member_age as for the month on the Monthly Member Table (O.02) is less than or equal to (≤) 12 months
2. The member had a paid claim where on the Claims Extract (I.C.03) header_paid_status equals 'P' on the claim and where detail_from_date_of_service is greater than or equal to (≥) 12 months prior to the month_start_date on the Monthly Member Table (O.02) and less than or equal to (≤) the month_start_date, and where the detail line revenue_code on the claim is in the nicu_revenue code list

If both criteria are true for a given month, set excl_month_nicu on the Monthly Member Table (O.02) to 1, and 0 otherwise.

On the Rolling Period Member Table (O.03), for each member set excl_nicu_months to the sum of excl_month_nicu on the Monthly Member Table (O.02)

Note: if a claim has a multiple header dates, the claim should be considered in the earliest month, not in both months

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- Set the provider Medicaid Billing ID that is used to determine provider type and specialty for each claim for purposes of total cost of care member exclusions
- When checking provider specialty and provider type on each claim for purposes of identifying long-term care exclusions, the Ohio CPC logic first considers the specialty/type of the billing provider on the claim, and if none exists the logic uses the specialty/type information available in the Provider Extract (I.C.02) across billing, facility, attending, and rendering provider:
    - Set the specialty_and_type_provider_id parameter for each claim equal to following fields from the Claims Extract (I.C.03):
        - billing_provider_id
        - If the previous field is not populated, set to facility_provider_id
        - If the previous field is not populated, set to attending_provider_id
        - If the previous field is not populated, set to rendering_provider_id
- **Calculate long-term care member exclusion**: long-term care TCOC member exclusions are calculated over an entire 12-month rolling period. A member is identified as being excluded from TCOC during the 12-month rolling period if either of the following criteria are true:

1. Long-term care (LTC) exclusion

   Member had a stay at a nursing facility spanning more than 90 consecutive days where all 90 consecutive days fell within the 12-month rolling period.

   Long-term care stays spanning more than 90 consecutive days are identified through three steps, using claims input fields from the Claims Extract (I.C.03):

   a. Identify base set of claims meeting all the following conditions:
      i. Start date of service (for claim numbers / ICNs starting with “E” (encounter indicator), use header_from_date_of_service, otherwise use detail_from_date_of_service) greater than or equal to (≥) the rolling_period_start_date
      ii. End date of service (for claim numbers / ICNs starting with “E” (encounter indicator), use header_to_date_of_service, otherwise use detail_to_date_of_service) less than or equal to (≤) the rolling_period_end_date
      iii. claim_type equal to the value in the ltc_claim_type code list
      iv. The provider on the claim has a provider type that matches a long-term care provider type, where either of the following are true:
         1. billing_provider_type on the Claims Extract (I.C.03) is in the ltc_provider_type codelist
         2. the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the ltc_provider_type codelist
      v. type_of_bill on the claim is not *null*
   b. Confirm LTC services using payer-specific revenue codes

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1. If ind_claim equals 'F' then the payer is fee-for-service, otherwise use mco_id to identify the payer
2. Consider the claim an LTC service if the revenue_code on the claim is in payer-specific code list as specified in the table below:

Table 22. Long-term Care Revenue Codes by Payer

Payer	Codelist
Fee-for-service	ltc_revenue_ffs
Buckeye	ltc_revenue_buckeye
CareSource	ltc_revenue_caresource
Molina	ltc_revenue_molina
United	ltc_revenue_united
AmeriHealth	ltc_revenue_amerihealth
Anthem	ltc_revenue_anthem
Humana	ltc_revenue_humana

Note: Since a payer may be associated with multiple *mco_id* values, the input field *mco_id* must be cross-walked to a payer name. An updated crosswalk including current and historical *mco_id* values must be used for each reporting period.

c. Calculate length of stay

i. Calculate the length of stay as:
(Last Date of Service - Start Date of Service + 1 day)

ii. For claim numbers / ICNs starting with "E" (encounter indicator), use:

- header_from_date_of_service as the Start Date of Service
- header_to_date_of_service as the End Date of Service

iii. For all remaining relevant claims, use:

- detail_from_date_of_service as the Start Date of Service
- detail_to_date_of_service as the End Date of Service

The member is identified as having a long-term care stay spanning more than 90 consecutive days if they have claims during the 12-month rolling period identified in the first two steps, and where the length of stay calculated in the last step is greater than (>) 90 days.

2. ICFs/IID Exclusion

Member had any claim where header_from_date_of_service is between (inclusive) the rolling_period_start_date and rolling_period_end_date and where the provider on the claim has a provider type that matches a long-term care provider type, where either of the following are true:

a. billing_provider_type on the Claims Extract (I.C.03) is in the icf_idd_provider_type codelist

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b. the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the icf_idd_provider_type codelist

If the member is identified as being excluded either due to the long-term care or ICFs/IID exclusions described above, set excl_ltc_flag equal to 1 for the member on the Rolling Period Member Table (O.03), and 0 otherwise.

Calculate CDPS outlier exclusion: members are excluded if their Z-Score calculated based on CDPS risk score is greater than 4.

5.2.7 Base Practices for the Rolling Period Practice Table (O.04)

The Rolling Period Practice Table (O.04) contains data at a practice-level over a 12-month rolling period and includes all practices participating in the Ohio CPC program. The Rolling Period Practice Table (O.04) "rolls up" members attributed to the practice during the 12-month rolling period, pulling from the Rolling Period Member Table (O.03).

5.2.7.1 Define the base practice population

- Begin by populating the Rolling Period Practice Table (O.04) with all enrolled Ohio CPC practices. For each unique practice in the Ohio CPC Practices List (I.S.08) where active_practice_flag is equal to 1:
  - Set reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04) to practice_medicaid_billing_id from the Ohio CPC Practices List (I.S.08):
  - Set reporting_practice_name to practice_name
  - Set member_medicaid_id on the Rolling Period Member Table (O.03) equal to member_medicaid_id from the Monthly Member Table (O.02)

5.2.7.2 Define the rolling period timeframe parameters

- Set the rolling_period_start_date parameter to the first day of the rolling period to be created (e.g., 1/1/2025 for a rolling period of 1/1/2025 to 12/31/2025)
- Set the rolling_period_end_date parameter to the last day of the rolling period to be created (e.g., 12/31/2025 for a rolling period of 1/1/2025 to 12/31/2025)

5.2.7.3 Update output table fields

Update the following fields on the Rolling Period Practice Table (O.04). Note that *null* values should be ignored when updating these fields. Each of the following fields should be set to the <u>same value</u> for all practices:

- Set reporting_year to the year (YYYY) of the rolling_period_end_date

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- Set reporting_quarter to the quarter ('Q1', 'Q2', 'Q3' or 'Q4') equal to two quarters after the quarter ending with the rolling_period_end_date; for example, reporting_quarter would be set to 'Q4' for a rolling_period_end_date of 6/30/2025
- Set rolling_period_start_date to the rolling_period_start_date
- Set rolling_period_end_date to the rolling_period_end_date

5.3 Define Member Panels

5.3.1 Overview

Member panels are used in the Ohio CPC program to define sets of members and track the status of each member at various points throughout the year. Four member panels are used in the Ohio CPC program, the creation of which are described in this section.

5.3.1.1 Parameters

None

5.3.1.2 Configuration file codelists

None

5.3.1.3 Input tables

Attribution Output Table (O.01), Rolling Period Member Table (O.03), Monthly Member Table (O.02), Rolling Period Practice Table (O.04)

5.3.1.4 Output tables

Rolling Period Member Table (O.03), Monthly Member Table (O.02), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04)

5.3.2 Quarterly Attribution Member Panel

The quarterly attribution member panel is defined as the set of members in the Attribution Output Table (O.01) as defined in Section *5.1.2 Determine MCO Member-to-practice Attribution*.

5.3.3 Risk-adjustment Member Panel

The risk-adjustment member panel consists of the set of members for whom risk scores are calculated over a 12-month rolling period. Note that high-cost outlier members are ultimately also excluded from the risk score calculation, even though they are included in the initial risk-adjustment member panel. These members and the high-cost exclusion are detailed in Section 3.3.2.

To create the risk-adjustment member panel:

- For each member_medicaid_id on the Rolling Period Member Table (O.03) set member_panel_risk_adjustment equal to 1 for members where excl_standard_months is less than or equal to (≤) 6 and where excl_nicu_months is less than or equal to (≤) 6 and where excl_ltc_flag is equal to 0
- Set member_panel_risk_adjustment equal to 0 for all other members

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5.3.4 Practice 6-month Quality and Efficiency Metrics Member Panel

The 6-month quality and efficiency metrics member panel is defined as the set of members who have been attributed to an individual practice for at least 6 months during the 12-month rolling period, counting only months where the member was not excluded based on standard CPC exclusion criteria.

The 6 or more months of attribution do not need to be consecutive, and logic is specified below.

5.3.4.1 Determine a member's 6-month attribution practice:

- For each member_medicaid_id and for each month_id on the Monthly Member Table (O.02), set valid_attribution_month_metrics to 1 (and 0 otherwise) if the member's practice_medicaid_id is not null and if excl_month_standard_any is equal to 0
- For each member_medicaid_id on the Monthly Member Table (O.02), group by the practice_medicaid_id and calculate the sum of valid_attribution_month_metrics for each member-practice combination
    - If the member was attributed to only one practice_medicaid_id for 6 or more non-excluded months during the rolling period (that is, where the sum of valid_attribution_month_metrics is greater than or equal to (≥) 6) then:
        - Set practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the single, unique practice_medicaid_id for the member
        - Set practice_name_6_month on the Rolling Period Member Table (O.03) equal to practice_name from the Monthly Member Table (O.02) for the practice_medicaid_id identified in the previous step
    - In the event of a tie, where a member was attributed to <u>two different</u> practices during the rolling period (that is, where the sum of valid_attribution_month_metrics is equal to 6 for both practices):
        - Set practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the most recent practice_medicaid_id for the member during the rolling period
        - Set practice_name_6_month on the Rolling Period Member Table (O.03) equal to practice_name from the Monthly Member Table (O.02) for the practice_medicaid_id identified in the previous step
    - If a member is not attributed to any practice for 6 or more non-excluded months during the rolling period:

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  - Set practice_medicaid_id_6_month and practice_name_6_month equal to *null* to indicate the member did not have a 6-month attributed practice

Update fields on the Rolling Period Member Table (O.03)

- For members who were attributed to an individual practice for 6 or more non-excluded months (that is, where practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) is not *null*), set member_panel_metrics equal to 1, and 0 otherwise
- For each member on the Rolling Period Member Table (O.03), set metrics_eligible_months to the sum of valid_attribution_month_metrics across all months for the member on the Monthly Member Table (O.02)

Update fields on the Rolling Period Practice Table (O.04)

- For each practice on the Rolling Period Practice Table (O.04), set practice_member_months_metrics to the sum of metrics_eligible_months on the Rolling Period Member Table (O.03) where practice_medicaid_id_6_month for each member equals reporting_practice_medicaid_id. Calculate member months for Partnerships
- For all member months related fields, member months are aggregated to the Partnership level by summing applicable member months across the practices that make up the Partnership.

5.3.5 Partnership 6-month Quality and Efficiency Metrics Member Panel

The 6-month quality and efficiency metrics member panel is used to determine the set of patients included in the clinical quality and efficiency metric calculations for an Ohio CPC Partnership. This panel consists of members who are:

- Attributed to a single CPC Partnership for at least 6 of the 12 months during the reporting or performance period, with the most recent attribution serving as a tiebreaker. Months need not be consecutive.
- Not excluded during the months counted toward 6-month attribution, due to Medicaid ineligibility, dual-eligible status, third-party liability, limited benefits, transition status, enrollment in a prepaid inpatient health plan (OhioRISE) or those attributed to other population health alternative payment models administered by ODM.

5.3.5.1 Determine a Member's 6-month Attribution Practice

The following updates can be made to the Rolling Period Member Table (O.03) to identify member panels for Partnerships:

- For each member_medicaid_id and for each month_id on the Monthly Member Table (O.02), set valid_partnership_attribution_month_metrics to 1 (and 0 otherwise) for members attributed to the Partnership and if excl_month_standard_any is equal to 0
- For each member_medicaid_id on the Monthly Member Table (O.02), group by the partnership_medicaid_id and calculate the sum of valid_partnership_attribution_month_metrics for each member-Partnership combination
- If the member was attributed to only one partnership_medicaid_id for 6 or more non-excluded months during the rolling period (that is, where the sum of valid_partnership_attribution_month_metrics is greater than or equal to (≥) 6) then:

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- Set partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the single, unique partnership_medicaid_id for the member
- Set partnership_name_6_month on the Rolling Period Member Table (O.03) equal to partnership_name from the Monthly Member Table (O.02) for the partnership_medicaid_id identified in the previous step

- In the event of a tie, where a member was attributed to two different Partnerships during the rolling period (that is, where the sum of valid_partnership_attribution_month_metrics is equal to 6 for both practices):
  - Set partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the most recent partnership_medicaid_id for the member during the rolling period
  - Set partnership_name_6_month on the Rolling Period Member Table (O.03) equal to partnership_name from the Monthly Member Table (O.02) for the partnership_medicaid_id identified in the previous step
- If a member is not attributed to any Partnership for 6 or more non-excluded months during the rolling period:
  - Set partnership_medicaid_id_6_month and partnership_name_6_month equal to null to indicate the member did not have a 6-month attributed partnership
- For any members that have 6 months of attribution with a Partnership and a 6 month practice that is not in the Partnership, then the practice attribution rules (defined in Section 5.3.4 of the Ohio CPC DBR) take precedent:
  - Set partnership_medicaid_id_6_month and partnership_name_6_month equal to null to indicate the

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member did not have a 6-month attributed practice

5.3.5.2 Update fields on the Rolling Period Member Table (O.04)

- For members who were attributed to a single Partnership for 6 or more non-excluded months (that is, where partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) is not null), set member_panel_partnership_metrics equal to 1, and 0 otherwise
- For each member on the Rolling Period Member Table (O.03), set metrics_eligible_months_partnership to the sum of valid_partnership_attribution_month_metrics across all months for the member on the Monthly Member Table (O.02)

5.3.6 Practice 6-month TCOC Member Panel

The 6-month TCOC member panel is defined as the set of members for a given practice who have been attributed to the practice for at least 6 months during the 12-month period of analysis, counting only months where the member was not excluded due to any of standard CPC exclusion criteria or due to having a long-term care stay spanning more than 90 days, a NICU stay during the first year of life, or being an outlier .

To calculate the 6-month total cost of care member panel, use the set of members defined in the 6-month quality and efficiency metric panel (defined in S*ection 5.2.6 TCOC Member Exclusions*) and then further exclude LTC, NICU, and outlier members:

- For each member_medicaid_id and for each month_id on the Monthly Member Table (O.02), set valid_attribution_month_tcoc to 1 (and 0 otherwise) if valid_attribution_month_metrics is equal to 1 and if excl_month_nicu is equal to 0
- Set member_panel_tcoc equal to 1 (and 0 otherwise), if <u>all</u> the following are true:
    - The sum of valid_attribution_month_tcoc on the on the Monthly Member Table (O.02) where practice_medicaid_id is equal to the practice_medicaid_id_6_month from the Rolling Period Member Table (O.03) is greater than or equal to (≥) 6
    - excl_ltc_flag for the member on the Rolling Period Member Table (O.03) is equal to 0
    - cdps_outlier_flag for the member on the Rolling Period Member Table (O.03) is equal to 0
- For each member on the Rolling Period Member Table (O.03), set tcoc_eligible_months to the sum of valid_attribution_month_tcoc across all months for the member on the Monthly Member Table (O.02)

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- For each practice on the Rolling Period Practice Table (O.04), set practice_member_months_tcoc to the sum of tcoc_eligible_months on the Rolling Period Member Table (O.03) where practice_medicaid_id_6_month for each member equals reporting_practice_medicaid_id

5.3.7 Partnership 6-month TCOC Member Panel

To calculate the 6-month TCOC member panel for Partnerships, use the set of members defined in the Partnership 6-month quality and efficiency metric panel (defined in *Section 5.2.6 TCOC Member Exclusions*) and then further exclude LTC, NICU, and outlier members.

The logic described in Section 5.3.5 of the Ohio CPC DBR can be used for defining member panels for a Partnership's total cost of care member panel by aggregating at the Partnership level:

- For each member_medicaid_id and for each month_id on the Monthly Member Table (O.02), set valid_partnership_attribution_month_tcoc to 1 (and 0 otherwise) if valid_partnership_attribution_month_metrics is equal to 1 and if excl_month_nicu is equal to 0
- Set partnership_member_panel_tcoc equal to 1 (and 0 otherwise), if all the following are true:
    - The sum of valid_partnership_attribution_month_tcoc on the on the Monthly Member Table (O.02) where partnership_medicaid_id is equal to the partnership_medicaid_id_6_month from the Rolling Period Member Table (O.03) is greater than or equal to (≥) 6
    - excl_ltc_flag for the member on the Rolling Period Member Table (O.03) is equal to 0
    - cdps_outlier_flag for the member on the Rolling Period Member Table (O.03) is equal to 0
- For each member on the Rolling Period Member Table (O.03), set partnership_tcoc_eligible_months to the sum of valid_partnership_attribution_month_tcoc across all months for the member on the Monthly Member Table (O.02)
- For each Partnership on the Rolling Period Partnership Table, set partnership_member_months_tcoc to the sum of tcoc_eligible_months on the Rolling Period Member Table (O.03) where partnership_medicaid_id_6_month for each member equals reporting_partnership_medicaid_id

5.3.8 Other 6-month Flags

5.3.8.1 Determine member's payer during the 12-month rolling period

- For each member_medicaid_id on the Monthly Member Table (O.02), group by payer_detail and calculate the sum of valid_attribution_month_metrics for each member/payer combination

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    - If the member was had only one payer (payer_detail) for 6 or more non-excluded months during the 12-month rolling period (that is, where the sum of valid_attribution_month_metrics is greater than or equal to (≥) 6) then:
  - Set payer_detail_6_month on the Rolling Period Member Table (O.03) equal to the single, unique payer_detail for the member
    - In the event of a tie, where a member had <u>two different</u> payers during the 12-month rolling period (that is, where the sum of valid_attribution_month_metrics is equal to 6 for both payers):
  - Set payer_detail_6_month on the Rolling Period Member Table (O.03) equal to the most recent payer_detail for the member during the rolling period
    - If a member did not have any payer for 6 or more non-excluded months during the rolling period:
  - Set payer_detail_6_month equal to *null* to indicate the member did not have a payer during the 12-month rolling period
- If payer_detail_6_month on the Rolling Period Member Table (O.03) is equal to *null*, set payer_6_month to *null*; otherwise, if payer_detail_6_month is 'FFS' set payer_6_month equal to 'FFS' and otherwise set payer_6_month to 'MCO'

5.3.8.2 Determine member's payer-practice combination during the 12-month rolling period

This section determines the payer-practice combination for the member, where the member was both attributed to a practice and was with the same payer for at least 6 non-excluded months during the 12-month rolling period.

The payer-practice combination is used to populate several of the final output data files.

To calculate the payer-practice combination:

- For each member_medicaid_id on the Monthly Member Table (O.02), group by payer_detail and practice_medicaid_id and calculate the sum of valid_attribution_month_metrics for each member/payer/practice combination
    - If the member had only one payer-practice combination (using payer_detail and practice_medicaid_id) for 6 or more non-excluded months during the 12-month rolling period (that is, where the sum of

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valid_attribution_month_metrics is greater than or equal to (≥) 6) then:

- Set payer_practice_detail_6_month on the Rolling Period Member Table (O.03) equal to the single, unique payer_detail for the member using payer_detail from the payer-practice combination identified above
    - In the event of a tie, where a member had two different payer-practice combinations during the 12-month rolling period (that is, where the sum of valid_attribution_month_metrics is equal to 6 for both payer-practice combinations):
- Set payer_practice_detail_6_month on the Rolling Period Member Table (O.03) equal to the most recent payer_detail for the member during the rolling period, using payer_detail from the payer-practice combination identified above
    - If a member did not have any payer-practice combination for 6 or more non-excluded months during the rolling period:
- Set payer_practice_detail_6_month equal to *null* to indicate the member did not have a payer-practice combination during the 12-month rolling period

- If payer_practice_detail_6_month on the Rolling Period Member Table (O.03) is equal to *null*, set payer_practice_6_month to *null*; otherwise, if payer_practice_detail_6_month is 'FFS' set payer_practice_6_month equal to 'FFS' and otherwise set payer_practice_6_month to 'MCO'

5.3.8.3 Determine member's primary care practitioner during the 12-month rolling period

- For each member_medicaid_id on the Monthly Member Table (O.02), group by the practitioner_medicaid_id and calculate the sum of valid_attribution_month_metrics for each member-practitioner combination
    - If the member was attributed to only one practitioner_medicaid_id for 6 or more non-excluded months during the rolling period (that is, where the sum of valid_attribution_month_metrics is greater than or equal to (≥) 6) then:
- Set practitioner_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the single, unique practitioner_medicaid_id for the member
- Set practitioner_name_6_month on the Rolling Period Member Table (O.03) equal to practitioner_name from the Monthly Member Table (O.02) for the practitioner_medicaid_id identified in the previous step

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- In the event of a tie, where a member was attributed to two different practitioners during the rolling period (that is, where the sum of valid_attribution_month_metrics is equal to 6 for both practitioners):

  - Set practitioner_medicaid_id_6_month on the Rolling Period Member Table (O.03) equal to the most recent practitioner_medicaid_id for the member during the rolling period
  - Set practitioner_name_6_month on the Rolling Period Member Table (O.03) equal to practitioner_name from the Monthly Member Table (O.02) for the practitioner_medicaid_id identified in the previous step

- If a member was not attributed to any practitioner for 6 or more non-excluded months during the rolling period:

  - Set practitioner_medicaid_id_6_month and practitioner_name_6_month equal to *null* to indicate the member did not have a 6-month attributed practitioner

5.3.8.4 Determine member's attribution method during the 12-month rolling period

- For each member_medicaid_id on the Monthly Member Table (O.02), group by the attribution_method and calculate the sum of valid_attribution_month_metrics for each attribution method

  - If the member had only one attribution_method for 6 or more non-excluded months during the rolling period (that is, where the sum of valid_attribution_month_metrics is greater than or equal to (≥) 6) then:

    - Set attribution_method_6_month on the Rolling Period Member Table (O.03) equal to the single, unique attribution_method for the member
    - In the event of a tie, where a member had two different attribution methods during the rolling period (that is, where the sum of valid_attribution_month_metrics is equal to 6 for both attribution methods):
    - Set attribution_method_6_month on the Rolling Period Member Table (O.03) equal to the most recent attribution_method for the member during the rolling period
    - If a member did not have an attribution_method for 6 or more non-excluded months during the rolling period:
    - Set attribution_method_6_month equal to *null* to indicate the member did not have a 6-month attribution method

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5.4 Risk-adjust Members

5.4.1 Overview

The sections below describe the process for creating risk scores:

- Quarterly PMPM payments made for each Ohio CPC member are adjusted for risk based on the members' risk tier
- Total cost of care is adjusted for risk when used to calculate shared savings payments to Ohio CPC practices on an annual basis

5.4.1.1 Parameters

- cdps_run_start_date, cdps_run_end_date, member_spend_pmpm, cdps_spend_pmpm, total_unadjusted_population_pmpm, cdps_risk_score

5.4.1.2 Configuration file codelists

None

5.4.1.3 Input tables

- Member Extract (I.C.01), Attribution Output Table (O.01), CDPS Output (I.S.07), Rolling Period Member Table (O.03)

5.4.1.4 Output tables

- CDPS Output (I.S.07), Attribution Output Table (O.01), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04)

5.4.2 Generate CDPS Score

The Ohio CPC program utilizes the Chronic Illness and Disability Payment + Prescriptions (CDPS + Rx) system software to calculate risk score for purposes of risk-adjusting per-member-per-month payments and risk scores for risk-adjusting TCOC.

CDPS scores are calculated using claims history over a two-year lookback period, Denied claims are included when running the CDPS software.

5.4.2.1 Overview of generating CDPS for all Medicaid members

- Run the CDPS risk adjustment software on all Medicaid members, with the run ranging from the CLM_STARTDTE to the CLM_ENDDTE parameters
- Insert the results of the CDPS run into the CDPS Output input table, which is used as inputs into additional steps throughout this process
    - Set member_medicaid_id to member_id from the Member Extract (I.C.01) for each member sent through the grouper
    - Set CLM_STARTDTE to the CLM_STARTDTE parameter

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- Set CLM_ENDDTE to the CLM_ENDDTE parameter

5.4.2.2 CDPS run timeframe for quarterly PMPM payments

CDPS scores are calculated each quarter and are used to determine the quarterly per-member-per-month payment made to each practice for each of their non-excluded, attributed members

- Set the CLM_STARTDTE parameter to 27 months prior to the month_1_start_date from the Attribution Output Table (O.01)
- Set the CLM_ENDDTE parameter to 3 months prior to the month_1_start_date from the Attribution Output Table (O.01)

5.4.2.3 CDPS run timeframe for a 12-month rolling period

When generating CDPS + Rx for a 12-month rolling period:

- Set the CLM_STARTDTE parameter to 27 months prior to the rolling_period_end_date from the Rolling Period Member Table (O.03)
- Set the CLM_ENDDTE parameter to 3 months prior to the rolling_period_end_date from the Rolling Period Member Table (O.03)

5.4.2.4 CDPS run timeframe for special case 12-month rolling periods: baseline year and final program year calculations

There are two special cases of 12-month rolling periods: the baseline and final program year calculations. For only these two special cases, CDPS scores are calculated using slightly different two-year lookback period:

- Set the CLM_STARTDTE parameter to 12 months prior to the rolling_period_start_date from the Rolling Period Member Table (O.03)
- Set the CLM_ENDDTE parameter to the rolling_period_end_date from the Rolling Period Member Table (O.03)

5.4.2.5 Update the Attribution Output Table (O.01)

If the calculated CDPS scores are being used for purposes of determining PMPM payments for a quarterly attribution period, for each member_medicaid_id on the Attribution Output Table (O.01) update the following fields:

- Set cdps_risk_score to the raw cdps risk score output
- Normalize the data using the following: (sum(total_spend_post_exclusions)/(sum(tcoc_eligible_months)* average_tcoc_ threshold)
- Group by Medicaid Managed Care population

5.4.3 Identify Risk Score Outliers

5.4.3.1 Overview

There are two steps to identifying outliers:

1. Since Risk Groups are no longer generated with the implementation of CDPS software, starting with PY2024, the spend associated with high risk outliers will be identified using a Z-Score with a

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threshold of 4. The Z-Score method compares the risk score of each member to the mean of the population and assigns a Z -score. The calculation used is:

[(Observed Value) – (Population Mean)]/(Population Standard Deviation).

If this calculated value is >4, the member is flagged as an outlier, and they will NOT be included in the TCOC member panel.

2. The Rolling Period Member Table (O.03) is updated to reflect both members identified as CDPS outliers, as well as the calculated risk scores for each member.

5.4.3.2 Identify high-risk outliers

- Begin with all members in the Rolling Period Member Table (O.03) where member_panel_risk_adjustment is equal to 1
- Set risk_score on Rolling Period Member Table (O.03) equal to cdps_risk score for the member on the CDPS_output table.
    - As described in *Section 5.4.2 Generate CDPS Risk Score*, members that were not found in the CDPS_output input table due to not having a claims history should have their cdps_risk_score set to 0.
- Calculate the Z-Score for each member using risk_score calculated above:
    - Set Z_Score for each member where the member_panel_risk_adjustment = 1 on Rolling Period Member Table (O.03) equal to [(risk_score) – ((sum(risk_score where member_panel_risk_adjustment = 1)/(count of observations in the risk_score sum))]/standard deviation (risk_score where member_panel_risk_adjustment = 1)

5.4.3.3 Update the Rolling Period Member Table (O.03)

Update the following fields on for each reporting_practice_medicaid_id on the Rolling Period Member Table (O.03):

- For cases where member Z-Score is greater than 4, populate cdps_outlier_flag = 1, 0 otherwise
    - Additionally, members that where cdps_outlier_flag = 1 should have their risk_score set to 0
- Set the time_weighted_risk_score for each member by multiplying the member's risk_score by tcoc_eligible_months on the Rolling Period Member Table (O.03) (the number of non-excluded member months for total cost of care for the member)

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Note: the time_weighted_risk_score is used to calculate member-level and practice-level per-member-per-month (PMPM) risk-adjusted total cost of care, and factors in both the member's risk as well as the length of enrollment of the member over the 12-month period

5.4.3.4 Update the Rolling Period Practice Table (O.04)

Update the following fields for each reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04):

- Set practice_time_weighted_risk_score equal to the sum of time_weighted_risk_score on the Rolling Period Member Table (O.03) across all the practice's six-month attributed members, that is, where practice_medicaid_id_6_month for each member equals reporting_practice_medicaid_id

5.5 Calculate PMPM Payments

5.5.1 Overview

This section covers the creation of the Ohio CPC PMPM prospective payments made to Ohio CPC practices.

5.5.1.1 Parameters

None

5.5.1.2 Configuration file codelists

None

5.5.1.3 Input tables

- Attribution Output Table (O.01), Rolling Period Member Table (O.03)

5.5.1.4 Output tables

- Attribution Output Table (O.01), Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04)

5.5.2 Assign PMPM Payment Tiers and Associated Payments for Non-excluded Members

- Members who are excluded from attribution during a quarter do not receive PMPM payments. As a result:
    - For members in the *Quarterly attribution member panel* where excl_standard_any on the Attribution Output Table (O.01) equals 1, set the members' pmpm_payment_tier to 0, the monthly_pmpm_payment to 0, and the quarterly_pmpm_payment_amount to 0

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- For all non-excluded members (where excl_standard_any on the Attribution Output Table (O.01) equals 0) in the *Quarterly attribution member panel*, the pmpm_payment_tier on the Attribution Output Table (O.01) to the following:
  - 1 if the member's cdps_risk_score on the Attribution Output Table (O.01) <= 1.0
  - 2 if the member's cdps_risk_scoreon the Attribution Output Table (O.01) 1.0 < Risk Score <= 2.5 (Effective PY2026)
  - 3 if the member's cdps_risk_score on the Attribution Output Table (O.01) > 2.5 (Effective PY2026)

- For all non-excluded members (where excl_standard_any on the Attribution Output Table (O.01) equals 0) in the *Quarterly attribution member panel*, set the monthly and quarterly PMPM payment amounts on the Attribution Output Table (O.01) to the following:
  - If the pmpm_payment_tier on the Attribution Output Table (O.01) is equal to 1, set the monthly_pmpm_payment to $1.80, and the quarterly_pmpm_payment_amount to $5.40
  - If the pmpm_payment_tier on the Attribution Output Table (O.01) is equal to 2, set the monthly_pmpm_payment to $6.33, and the quarterly_pmpm_payment_amount to $18.99
  - If the pmpm_payment_tier on the Attribution Output Table (O.01) is equal to 1, set the monthly_pmpm_payment to $10.20, and the quarterly_pmpm_payment_amount to $30.60
- For all excluded members (where excl_standard_any on the Attribution Output Table (O.01) equals 1) in the *Quarterly attribution member panel*, set the pmpm_payment_tier on the Attribution Output Table (O.01) to 0
- For all excluded members (where excl_standard_any on the Attribution Output Table (O.01) equals 1) in the *Quarterly attribution member panel*, set the monthly and quarterly PMPM payment amounts on the Attribution Output Table (O.01) to the following:
  - Set monthly_pmpm_payment to 0
  - Set quarterly_pmpm_payment_amount to 0

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5.5.3 Update Output Tables

- Use the four Attribution Output Table (O.01) files identified in *Section 5.2.3* Base Population for the Monthly Member Table (O.02) to update the PMPM payment amount on the Monthly Member Table (O.02)
    - For each month and for each member, set monthly_pmpm_payment on the Monthly Member Table (O.02) to the monthly_pmpm_payment from the Attribution Output Table (O.01)
    - If a member was not present on a given quarter's Attribution Output Table (O.01), set the monthly_pmpm_payment on the Monthly Member Table (O.02) to *null* to indicate no value was present
- On the Rolling Period Member Table (O.03) for each member, set rolling_period_pmpm_payment to the sum of monthly_pmpm_payment from the Monthly Member Table (O.02)
- On the Rolling Period Practice Table (O.04) for each practice, set practice_cpc_pmpm_payment to the sum of rolling_period_pmpm_payment on the Rolling Period Member Table (O.03) for members where both of the following are true:
    - member_panel_tcoc **on the** Rolling Period Member Table (O.03) **is equal to 1**
    - practice_medicaid_id_6_month **on the** Rolling Period Member Table (O.03) for the member is equal to reporting_practice_medicaid_id

5.6 Calculate Data Elements for Reporting

5.6.1 Overview

This section covers the calculation of certain data elements required for generating Ohio CPC Practice Reports and other Ohio CPC output data.

5.6.1.1 Parameters

- specialty_and_type_provider_id

5.6.1.2 Configuration file codelists

- pcp_provider_type, pcp_specialty_type

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5.6.1.3 Input tables

- Provider Extract (I.C.02), Claims Extract (I.C.03), Attribution Output Table (O.01), Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Provider Specialty (I.S.04)

5.6.1.4 Output tables

- Attribution Output Table (O.01), Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04)

5.6.2 Service Categories

5.6.2.1 Determine service category spend for members on the Monthly Member Table (O.02)

Each member's unadjusted claims spend, after Ohio CPC total cost of care service exclusions, is summed for the month and categorized according to service category.

Claims should be flagged with the service category of the claim according to following logic:

> **Note:** this section uses Clinical Classifications Software for Services and Procedures (CCS-Services and Procedures) categories from the Healthcare Cost and Utilization Project (HCUP), a Federal-State-Industry partnership sponsored by the Agency for Healthcare Research and Quality. The latest version can be found here:

https://www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp

Furthermore, the crosswalk for procedure codes to code level 1 (CL1) and code level 2 (CL2) for procedure codes described in Appendix D, Section 7.2.5 *Care Types* can be found in the Ohio CPC Configuration File under the tab, "CL1 and CL2 Crosswalk".

5.6.3 Calculate the Spend by Service Categories

To calculate spend by service category for each member on the Monthly Member Table (O.02), repeat the methodology used to calculate total cost of care to calculate tcoc_unadjusted_month on the Monthly Member Table (O.02), segmented by the service category of the claim.

Set the spend by service category fields for each member on the Monthly Member Table (O.02) as follows:

- Set tcoc_unadjusted_month_hospital_inpatient equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to "HI"
- Set tcoc_unadjusted_month_ed equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to "ED"
- Set tcoc_unadjusted_month_hospital_outpatient equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to "HO"
- Set tcoc_unadjusted_month_office_and_clinic equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to "OC"
- Set tcoc_unadjusted_month_institutional equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to "INST"

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- Set tcoc_unadjusted_month_home_and_community_based equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “HC”
- Set tcoc_unadjusted_month_rx equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “RPH”
- Set tcoc_unadjusted_month_specialty_rx equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “SPH”
- Set tcoc_unadjusted_month_lab_and_pathology equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “LAB”
- Set tcoc_unadjusted_month_radiology equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “RAD”
- Set tcoc_unadjusted_month_ancillary equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “ANC”
- Set tcoc_unadjusted_month_dme equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “DME”
- Set tcoc_unadjusted_month_ptotst equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “PTOTST”
- Set tcoc_unadjusted_month_other equal to tcoc_unadjusted_month where claims used to calculate tcoc_unadjusted_month have a service category on the claim equal to “OCARE” or “OLOC” or “AMB”

5.6.3.1 Determine service category spend for practices on the Rolling Period Member Table (O.03)

Spend by service category is set on the Rolling Period Member Table (O.03) for each member by summing the following fields from the Monthly Member Table (O.02):

- Set hospital_inpatient_care_spend to the sum of tcoc_unadjusted_month_hospital_inpatient
- Set ed_care_spend to the sum of tcoc_unadjusted_month_ed
- Set hospital_outpatient_care_spend to the sum of tcoc_unadjusted_month_hospital_outpatient
- Set office_and_clinic_care_spend to the sum of tcoc_unadjusted_month_office_and_clinic
- Set institutional_care_spend to the sum of tcoc_unadjusted_month_institutional
- Set home_and_community_based_care_spend to the sum of tcoc_unadjusted_month_home_and_community_based
- Set prescription_drugs_spend to the sum of tcoc_unadjusted_month_rx
- Set specialty_pharmaceuticals_spend to the sum of tcoc_unadjusted_month_specialty_rx
- Set lab_and_pathology_spend to the sum of tcoc_unadjusted_month_lab_and_pathology
- Set radiology_spend to the sum of tcoc_unadjusted_month_radiology
- Set ancillary_services_spend to the sum of tcoc_unadjusted_month_ancillary
- Set dme_and_supplies_spend to the sum of tcoc_unadjusted_month_dme

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- Set physical_occupational_and_speech_therapies_spend to the sum of tcoc_unadjusted_month_ptotst
- Set others_spend to the sum of tcoc_unadjusted_month_other

5.6.3.2 Determine service category spend for practices on the Rolling Period Practice Table (O.04)

Spend by service category is set on the Rolling Period Practice Table (O.04) or Rolling Period Partnership Table (O.04) for each entity by summing member-level service category spend from the Rolling Period Member Table (O.03) for members meeting both of the following criteria:

- member_panel_tcoc on the Rolling Period Member Table (O.03) is equal to 1, or for partnership, partnership_member_panel_tcoc = 1.
- practice_medicaid_id_6_month for the member on the Rolling Period Member Table (O.03) is equal to reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04); for partnership, partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to practice_partnership_id on the Rolling Period Partnership Table (O.04)

Including only members meeting the above criteria, update the following fields on the Rolling Period Practice Table (O.04) or Rolling Period Partnership Table (O.04) using the corresponding fields from the Rolling Period Member Table (O.03):

- Set hospital_inpatient_care_spend to the sum of hospital_inpatient_care_spend
- Set ed_care_spend to the sum of ed_care_spend
- Set hospital_outpatient_care_spend to the sum of hospital_outpatient_care_spend
- Set office_and_clinic_care_spend to the sum of office_and_clinic_care_spend
- Set institutional_care_spend to the sum of institutional_care_spend
- Set home_and_community_based_care_spend to the sum of home_and_community_based_care_spend
- Set prescription_drug_spend to the sum of prescription_drug_spend
- Set specialty_pharma_spend to the sum of specialty_pharma_spend
- Set lab_and_pathology_spend to the sum of lab_and_pathology_spend
- Set radiology_spend to the sum of radiology_spend
- Set ancillary_services_spend to the sum of ancillary_services_spend
- Set dme_and_supplies_spend to the sum of dme_and_supplies_spend
- Set pt_ot_st_spend to the sum of pt_ot_st_spend
- Set others_spend to the sum of others_spend

5.6.4 Member Utilization Flags

5.6.4.1 Set the provider Medicaid Billing ID that is used to determine provider type and specialty for each claim for purposes of member utilization flags

When checking provider specialty and provider type on each claim for purposes of determining member utilization flags, the Ohio CPC logic first considers the specialty/type of the rendering provider on the

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claim, and if none exists the logic uses the specialty/type information available in the Provider Extract (I.C.02) across rendering, attending, billing, and facility provider. Note that denied claims are included for the purposes of calculating the utilization flag.

- Set the specialty_and_type_provider_id parameter for each claim equal to following fields from the Claims Extract (I.C.03):
  - rendering_provider_id
  - If the previous field is not populated, set to attending_provider_id
  - If the previous field is not populated, set to billing_provider_id
  - If the previous field is not populated, set to facility_provider_id

5.6.4.2 Update utilization flags on the Monthly Member Table (O.02)

- Count the number of emergency department (ED) visits the member had during each month of the 12-month rolling period; for each member and each month on the Monthly Member Table (O.02):
  - If excl_month_standard_any is equal to 1, set ed_visit_count equal to 0
  - Otherwise, set ed_visit_count equal to the count of distinct ED visits during the month where:
    - The service category on the claim is equal to “ED”, according to the claims categorization described in *Appendix C: Service Categories*
      - header_from_date_of_service from the Claims Extract (I.C.03) is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date
        - To count distinct ED visits, consider any ED visit with the same service date (based on header_from_date_of_service on the claim) as a single ED visit
- Count the number of inpatient (IP) admissions the member had during each month of the 12-month rolling period; for each member and each month on the Monthly Member Table (O.02):
  - If excl_month_standard_any is equal to 1, set ip_admit_count equal to 0
  - Otherwise, set ip_admit_count equal to the count of distinct IP admissions during the month where:
    - type_of_bill on the Claims Extract (I.C.03) is not *null.* The service category on the admission is equal to “HI” (hospital inpatient), according to the claims categorization described in *Appendix C: Service Categories*

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  - header_from_date_of_service from the Claims Extract (I.C.03) is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date
  - At least one detail line within the admission is not excluded due to total cost of care claims exclusions detailed in *Section 5.7.3 Calculate Member-level Service Exclusions*; in other words, if all detail lines within the admissions are excluded due to Ohio CPC service exclusions, the admission is not counted

- Count the number of primary care visits the member had during each month of the 12-month rolling period; for each member and each month on the Monthly Member Table (O.02):
  - If excl_month_standard_any is equal to 1, set pcp_visit_count equal to 0
  - Otherwise, set pcp_visit_count equal to the count of distinct PCP visits during the month where all the following criteria are true:
  - type_of_bill on the Claims Extract (I.C.03) is *null*
  - Where excl_month_standard_any on the on the Monthly Member Table (O.02) is equal to 0 and where excl_month_nicu on the Monthly Member Table (O.02) is equal to 0
  - detail_from_date_of_service from the Claims Extract (I.C.03) is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where detail_from_date_of_service is less than or equal to (≤) month_end_date
  - The detail claim line is not excluded due to total cost of care claims exclusions detailed in Section 5.7.3 *Calculate Member-level Service Exclusions*
  - The provider on the claim has a provider type or specialty type that matches a primary care provider or specialty type, where any of the following are true:
    - rendering_provider_type on the Claims Extract (I.C.03) is in the pcp_provider_type codelist
    - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the pcp_provider_type codelist
    - rendering_provider_specialty on the Claims Extract (I.C.03) is in the pcp_specialty_type codelist
    - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the pcp_specialty_type codelist

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- To count distinct PCP visits, consider any PCP visit with the same service date (based on detail_from_date_of_service on the claim) as a single PCP visit

5.6.4.3 Update utilization flags on the Rolling Period Member Table (O.03)

- Flag members who had three or more ED visits during the 12-month rolling period
  - Set 3_or_more_ed_flag on the Rolling Period Member Table (O.03) equal to 1 (and 0 otherwise) if the sum of ed_visit_count on the Monthly Member Table (O.02) for the member is greater than or equal to (≥) 3
- Flag members who had 1 or more IP admissions during the 12-month rolling period
  - Set 1_or_more_ip_admit_flag on the Rolling Period Member Table (O.03) equal to 1 (and 0 otherwise) if the sum of ip_admit_count on the Monthly Member Table (O.02) for the member is greater than or equal to (≥) 1
- Flag members who did not have a PCP visit during the 12-month rolling period
  - Set no_pcp_visit_flag on the Rolling Period Member Table (O.03) to 1 (and 0 otherwise) if the sum of pcp_visit_count on the Monthly Member Table (O.02) for the member is equal to 0

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5.6.4.4 Update utilization flags on the Rolling Period Practice Table (O.04) or Rolling Period Partnership Table (O.04)

- Set members_with_3_or_more_ed_flag on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) for a given practice/partnership equal to the count of members on the Rolling Period Member Table (O.03) where:
  - 3_or_more_ed_flag is equal to 1
  - practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04)/partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to practice_partnership_id on Rolling Period Partnership Table (O.04).
- Set members_with_1_or_more_ip_admit_flag on the Rolling Period Practice Table (O.04) for a given practice equal to the count of members on the Rolling Period Member Table (O.03) where:
  - 1_or_more_ip_admit_flag is equal to 1
  - practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04)/ partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to practice_partnership_id on Rolling Period Partnership Table (O.04).
- Set members_with_no_pcp_visit_flag on the Rolling Period Practice Table (O.04) for a given practice equal to the count of members on the Rolling Period Member Table (O.03) where:
  - no_pcp_visit_flag is equal to 1
  - practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04)/ partnership_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to practice_partnership_id on Rolling Period Partnership Table (O.04).

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5.6.5 Other Reporting Elements

Update activity requirements passing flag on the Rolling Period Practice Table (O.04)

- Set activity_requirements_pass_flag on the Rolling Period Practice Table (O.04) Rolling Period Partnership Table (O.04) equal to 1 for a given practice if the practice/partnership has met all 10 Ohio CPC activity requirements for the program year, as determined by ODM and to 0 otherwise

  Note: for purposes of initially implementing the Ohio CPC algorithm, the *activity_requirements_pass_flag* may be set to 1 for all practices; however, when determining actual shared savings for a program year, the data needed to accurately populate this flag must be obtained from ODM

5.6.5.1 Update the member's percentile rank of risk-adjusted total cost of care within their practice on the Rolling Period Member Table (O.03)

- For each member, determine the percentile rank of each member's risk-adjusted total cost of care, relative to other members in the practice's 6-month total cost of care member panel:
  - Begin with the Rolling Period Member Table (O.03)
  - For each practice_medicaid_id_6_month, consider only members where member_panel_tcoc is equal to 1
  - Within each practice, set spend_percentile_within_practice to the percentile rank of each member's risk-adjusted total cost of care (member_ra_tcoc), with possible values ranging from 0 to 100
  - For members where member_panel_tcoc is equal to 0, set spend_percentile_within_practice equal to *null*

5.7 Calculate TCOC

5.7.1 Overview

This section describes the calculation of total cost of care, both unadjusted and risk-adjusted, as well as the baseline and target total cost of care.

5.7.1.1 Parameters

- specialty_and_type_provider_id, baseline_period_start_date, baseline_period_end_date

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5.7.1.2 Configuration file codelists

- transportation_procedure_code_1, transportation_modifier_code_1, transportation_provider_type, transportation_specialty_type, vision_procedure_code_1, vision_modifier_code_1, vision_provider_type, vision_specialty_type, dental_procedure_code_1, dental_modifier_code_1, dental_procedure_code_2, dental_procedure_provider_type_2, dental_procedure_prefix, dental_provider_type, dental_specialty_type, waiver_procedure_code, waiver_provider_type, waiver_specialty_type, crossover_claim_type

5.7.1.3 Input tables

- Monthly Member Table (O.02), Claims Extract (I.C.03), Provider Extract (I.C.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Quarterly Attribution Bridge Table (O.05), Programmatic Adjustment Factors (I.S.09), Provider Specialty (I.S.04)

5.7.1.4 Output tables

- Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Practice Baseline Total Cost of Care Table (O.06), Rolling Period Partnership Table (O.04), Partnership Baseline Total Cost of Care Table (O.06)

5.7.2 Calculate Member-level Unadjusted Total Claims Spend

- For each month and each member on the Monthly Member Table (O.02), calculate total spend for the member by setting claims_spend_month_total equal to the sum of all the following from the Claims Extract (I.C.03):

  Note: while detail-paid claims costs should use the paid amount fields at the detail claim level, the header date of service is used to determine whether all of a claim's costs are included in the given month

Note: if a claim has a multiple header dates, the claim should be considered in the earliest month, not in both months

- All FFS spend for header-paid claims as the sum of header_ffs_paid_amount where:
  - ffs_or_mco_indicator is equal to 'F'
  - header_or_detail_indicator is equal to 'H'
  - header_paid_status is equal to 'P'
  - header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02)
- All FFS spend for detail-paid claims as the sum of detail_ffs_paid_amount where:

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  - ffs_or_mco_indicator is equal to 'F'
  - header_or_detail_indicator is equal to 'D'
  - detail_paid_status is equal to 'P'
  - header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02)
- All managed care spend for header-paid claims as the sum of header_mco_paid_amount where:
  - ffs_or_mco_indicator is equal to 'E'
  - header_or_detail_indicator is equal to 'H'
  - header_paid_status is equal to 'P'
  - header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02)
- All managed care spend for detail-paid claims as the sum of detail_mco_paid_amount where:
  - ffs_or_mco_indicator is equal to 'E'
  - header_or_detail_indicator is equal to 'D'
  - detail_paid_status is equal to 'P'
  - header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤)

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month_end_date from the Monthly Member Table (O.02)

5.7.3 Calculate Member-level Service Exclusions

5.7.3.1 Set the provider Medicaid Billing ID that is used to determine provider type and specialty for each claim for purposes of total cost of care

When checking provider specialty and provider type on each claim for purposes of determining exclusions, the Ohio CPC logic first considers the specialty/type of the rendering provider on the claim, and if none exists the logic uses the specialty/type information available in the Provider Extract (I.C.02) across rendering, attending, billing, and facility provider:

- Set the specialty_and_type_provider_id parameter for each claim equal to following fields from the Claims Extract (I.C.03):
    - rendering_provider_id
    - If the previous field is not populated, set to attending_provider_id
    - If the previous field is not populated, set to billing_provider_id
    - If the previous field is not populated, set to facility_provider_id

5.7.3.2 Calculate excluded transportation spend

Note: Unless otherwise specified, only the detail line of the transportation claims meeting the criteria below should be excluded (and therefore included in the excluded transportation spend calculation)

Note: While detail-paid claims costs should use the paid amount fields at the detail claim level, the header date of service is used to determine whether all of a claim's costs are included in the given month.

- Set claims_spend_month_transportation on the Monthly Member Table (O.02) equal to the sum of all the following:
    - detail_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and detail_paid_status is equal to 'P' and header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where any of the following are true:
    - detail_procedure_code is in the transportation_procedure_code_1

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codelist and modifier_1_4 is in the transportation_modifier_code_1 codelist

- The provider on the claim has a provider type that matches a transportation provider type, where <u>either</u> of the following are true:

  - rendering_provider_type on the Claims Extract (I.C.03) is in the transportation_provider_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the transportation_provider_type codelist

- The provider on the claim has a valid specialty span that matches a transportation specialty, where <u>either</u> of the following are true:

  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the transportation_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the transportation_specialty_type codelist

- detail_mco_paid_amount for claims where ffs_or_mco_indicator is equal to ‘E’ and detail_paid_status is equal to ‘P’ and detail_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where detail_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where <u>any</u> of the following are true:

  - detail_procedure_code is in the transportation_procedure_code_1 codelist and modifier_1_4 is in the transportation_modifier_code_1 codelist
  - The provider on the claim has a provider type that matches a transportation provider type, where <u>either</u> of the following are true:

    - rendering_provider_type on the Claims Extract (I.C.03) is in the transportation_provider_type codelist

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- the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the transportation_provider_type codelist
    - The provider on the claim has a valid specialty span that matches a transportation specialty, where <u>either</u> of the following are true:
- rendering_provider_specialty on the Claims Extract (I.C.03) is in the transportation_specialty_type codelist
- the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the transportation_specialty_type codelist

5.7.3.3 Calculate excluded vision spend

Note: Unless otherwise specified, only the detail line of the vision claims meeting the criteria below should be excluded (and therefore included in the excluded vision spend calculation)

Note: While detail-paid claims costs should use the paid amount fields at the detail claim level, the header date of service is used to determine whether all of a claim's costs are included in the given month.

- Set claims_spend_month_vision on the Monthly Member Table (O.02) equal to the sum of <u>all</u> the following:
    - detail_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and detail_paid_status is equal to 'P' and header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where <u>any</u> of the following are true:
    - detail_procedure_code is in the vision_procedure_code_1 codelist and modifier_1_4 is in the vision_modifier_code_1 codelist

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- The provider on the claim has a provider type that matches a vision provider type, where <u>either</u> of the following are true:
  - rendering_provider_type on the Claims Extract (I.C.03) is in the vision_provider_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the vision_provider_type codelist
- The provider on the claim has a valid specialty span that matches a vision specialty, where <u>either</u> of the following are true:
  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the vision_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the vision_provider_type codelist
- the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the vision_specialty_type codelist

- detail_mco_paid_amount for claims where ffs_or_mco_indicator is equal to ‘E’ and detail_paid_status is equal to ‘P’ and detail_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where detail_from_date_of_service

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is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where any of the following are true:

- detail_procedure_code is in the vision_procedure_code_1 codelist and modifier_1_4 is in the vision_modifier_code_1 codelist
- The provider on the claim has a provider type that matches a vision provider type, where either of the following are true:
  - rendering_provider_type on the Claims Extract (I.C.03) is in the vision_provider_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the vision_provider_type codelist
- The provider on the claim has a valid specialty span that matches a vision specialty, where either of the following are true:
  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the vision_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the vision_specialty_type codelist

5.7.3.4 Calculate excluded dental spend

Note: Unless otherwise specified, only the detail line of the dental claims meeting the criteria below should be excluded (and therefore included in the excluded dental spend calculation). The entire claim should only be excluded when checking for the claim type exclusion as noted below.

Note: While detail-paid claims costs should use the paid amount fields at the detail claim level, the header date of service is used to determine whether all of a claim's costs are included in the given month.

- Set claims_spend_month_dental on the Monthly Member Table (O.02) equal to the sum of all the following:
  - detail_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and detail_paid_status is equal to 'P' and

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header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where <u>any</u> of the following are true:

- detail_procedure_code is in the dental_procedure_code_1 codelist and modifier_1_4 is in the dental_modifier_code_1 codelist
- detail_procedure_code is in the dental_procedure_code_2 codelist and rendering_provider_type is in the dental_procedure_provider_type_2 codelist
- detail_procedure_code contains a procedure code beginning with the value in the dental_procedure_prefix codelist (indicates a CDT code)
- The provider on the claim has a provider type that matches a dental provider type, where <u>either</u> of the following are true:
  - rendering_provider_type on the Claims Extract (I.C.03) is in the dental_provider_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the dental_provider_type codelist

- The provider on the claim has a valid specialty span that matches a dental specialty, where <u>either</u> of the following are true:
  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the dental_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input

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file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the dental_specialty_type codelist

- detail_mco_paid_amount for claims where ffs_or_mco_indicator is equal to 'E' and detail_paid_status is equal to 'P' and header_from_date_of_service is greater than or equal to (≥) month_start_date from the Monthly Member Table (O.02) and where header_from_date_of_service is less than or equal to (≤) month_end_date from the Monthly Member Table (O.02) and where <u>any</u> of the following are true:
    - detail_procedure_code is in the dental_procedure_code_1 codelist and modifier_1_4 is in the dental_modifier_code_1 codelist
    - detail_procedure_code is in the dental_procedure_code_2 codelist and rendering_provider_type is in the dental_procedure_provider_type_2 codelist
    - detail_procedure_code contains any procedure code beginning with the letter "D" (indicating a CDT code)
    - The provider on the claim has a provider type that matches a dental provider type, where <u>either</u> of the following are true:
        - rendering_provider_type on the Claims Extract (I.C.03) is in the dental_provider_type codelist
        - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the dental_provider_type codelist
    - The provider on the claim has a valid specialty span that matches

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a dental specialty, where either of the following are true:

  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the dental_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the dental_specialty_type codelist

- header_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and header_paid_status is equal to 'P' and where claim_type is in the dental_claim_type codelist
- header_mco_paid_amount for claims where ffs_or_mco_indicator is equal to 'E' and header_paid_status is equal to 'P' and where claim_type is in the dental_claim_type codelist

5.7.3.5 Calculate excluded waiver spend

Note: Unless otherwise specified, only the detail line of the waiver claims meeting the criteria below should be excluded (and therefore included in the excluded waiver spend calculation).

Note: While detail-paid claims costs should use the paid amount fields at the detail claim level, the header date of service is used to determine whether all of a claim's costs are included in the given month.

- Set claims_spend_month_waiver equal to the sum of all the following:
  - detail_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and detail_paid_status is equal to 'P' and any of:
  - detail_procedure_code is in the waiver_procedure_code codelist
  - The provider on the claim has a provider type that matches a waiver provider type, where either of the following are true:
    - rendering_provider_type on the Claims Extract (I.C.03) is in the waiver_provider_type codelist
    - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the waiver_provider_type codelist
  - The provider on the claim has a valid specialty span that matches

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a waiver specialty, where either of the following are true:

  - rendering_provider_specialty on the Claims Extract (I.C.03) is in the waiver_specialty_type codelist
  - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the waiver_specialty_type codelist

- detail_mco_paid_amount for claims where ffs_or_mco_indicator is equal to 'E' and detail_paid_status is equal to 'P' and any of:
  - detail_procedure_code is in the waiver_procedure_code codelist
  - The provider on the claim has a provider type that matches a waiver provider type, where either of the following are true:
    - rendering_provider_type on the Claims Extract (I.C.03) is in the waiver_provider_type codelist
    - the specialty_and_type_provider_id parameter for the claim equals provider_id from the Provider Extract (I.C.02) and provider_type on the Provider Extract (I.C.02) is in the waiver_provider_type codelist
    - The provider on the claim has a valid specialty span that matches a waiver specialty, where either of the following are true:
    - rendering_provider_specialty on the Claims Extract (I.C.03) is in the waiver_specialty_type codelist
    - the specialty_and_type_provider_id parameter for the claim equals provider_medicaid_id from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is greater than or equal to (≥) specialty_effective_date from the Provider Specialty (I.S.04) input file and header_from_date_of_service on the claim is less than or equal to (≤) specialty_end_date from the Provider Specialty (I.S.04) input file and where specialty_code on the Provider Specialty (I.S.04) input file associated with the valid span is in the waiver_specialty_type codelist

5.7.3.6 Calculate excluded crossover claim spend

Note: Unless otherwise specified, the entire claim meeting the criteria below for crossover claims should be excluded (and therefore included in the excluded crossover spend calculation).

- Set claims_spend_month_crossover equal to the sum of all the following:

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- header_ffs_paid_amount for claims where ffs_or_mco_indicator is equal to 'F' and header_paid_status is equal to 'P' and where claim_type is in the crossover_claim_type codelist
- header_mco_paid_amount for claims where ffs_or_mco_indicator is equal to 'E' and header_paid_status is equal to 'P' and where claim_type is in the crossover_claim_type codelist

5.7.3.7 Set total excluded spend for the month

- Set claims_spend_month_excluded for each member and each month equal to the sum of the following from the Monthly Member Table (O.02): claims_spend_month_waiver, claims_spend_month_transportation, claims_spend_month_dental, claims_spend_month_vision, and claims_spend_month_crossover
- Overlapping claims in each of the categories should not be double-counted. For example, if a claim is identified as excluded in two or more categories, the claim should only be counted once when calculating claims_spend_month_excluded

  Note: that this will result in duplicate claims being counted in the individual claims_spend_month_[service] fields, but that claims_spend_month_excluded should be a unique summation of excluded claims that avoids double-counting. The duplication across excluded claim service fields is expected because these fields are used for diagnostic/understanding purposes only and are not used elsewhere in the algorithm

5.7.4 Calculate Member-level Unadjusted TCOC

5.7.4.1 Calculate unadjusted TCOC on the Monthly Member Table (O.02)

- Calculate each member's non-excluded, unadjusted TCOC for each month on the Monthly Member Table (O.02), which is equal to total claims spend for the month minus excluded claims spend. For months where the member was excluded during the month due to standard exclusions or NICU/other exclusions, the member's non-excluded, unadjusted TCOC is zero:
  - If either of excl_month_standard_any or excl_month_nicu on the Monthly Member Table (O.02) for the month are equal to 1, set tcoc_unadjusted_month equal to 0
  - For all other members, set tcoc_unadjusted_month equal to claims_spend_month_total minus (-) claims_spend_month_excluded

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5.7.4.2 Calculate unadjusted TCOC on the Rolling Period Member Table (O.03)

- Calculate each member's non-excluded, unadjusted TCOC for the rolling period on the Rolling Period Member Table (O.03), which is equal to total claims spend (after spend exclusions) for each of the 12 months during the rolling period, considering only months the member was not excluded due to standard exclusions, NICU, long-term care or outlier:
    - Set total_spend_post_exclusions equal to 0 if excl_ltc_flag for the member equals 1
    - Otherwise, set total_spend_post_exclusions equal to the sum of tcoc_unadjusted_month from the Monthly Member Table (O.02)

5.7.5 Calculate Member-level Risk-adjusted TCOC

Calculate each member's risk-adjusted TCOC for the rolling period on the Rolling Period Member Table (O.03) by setting member_ra_tcoc equal to the member's total_spend_post_exclusions divided by (÷) time_weighted_risk_score

5.7.6 Calculate Practice-level TCOC

Practice-level TCOC is calculated over a rolling 12-month basis for each practice. Practice-level TCOC is determined by taking the sum of member-level TCOC for all members who have been attributed to the practice for six or more non-excluded months during the year (i.e., members in the 6-month total cost of care member panel).

5.7.6.1 Practice-level unadjusted TCOC

Practice-level unadjusted TCOC is calculated as the total cost across the 12-month rolling period for all members in the practice's 6-month TCOC member panel, after spend exclusions, standard Ohio CPC exclusions, and TCOC exclusions.

- For each reporting_practice_medicaid_id on the Rolling Period Practice Table (O.04):
    - Set practice_unadj_tcoc equal to the sum of total_spend_post_exclusions on the Rolling Period Member Table (O.03) for members where member_panel_tcoc is equal to 1
    - Set practice_unadj_tcoc_pmpm equal to practice_unadj_tcoc, as calculated in the step above, divided by (÷) practice_member_months_tcoc

Practice-level risk-adjusted total cost of care

Practice-level risk-adjusted total cost of care is calculated as the unadjusted total cost of care across the 12-month rolling period for all members in the practice's 6-month total cost of care member panel, after

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spend exclusions, standard Ohio CPC exclusions, and total cost of care exclusions, adjusted for the risk of each member on a time-weighted basis.

- For each practice (reporting_practice_medicaid_id) on the Rolling Period Practice Table (O.04):
  - Set practice_ra_tcoc_pmpm equal to practice_unadj_tcoc divided by (÷) practice_time_weighted_risk_score
  - Set practice_ra_tcoc_pmpm_final equal to (practice_unadj_tcoc plus (+) practice_cpc_pmpm_payment) divided by (÷) practice_time_weighted_risk_score

5.7.7 Calculate Partnership-level TCOC

For purposes of calculating the TCOC for Partnerships, TCOC is aggregated to the Partnership level by summing TCOC across the individual members in the Partnership's 6-month TCOC member panel.

5.7.7.1 Partnership level unadjusted TCOC

Partnership level unadjusted TCOC is calculated as the total cost across the 12month rolling period for all members in the Partnership's 6-month TCOC member panel, after spend exclusions, standard Ohio CPC exclusions, and TCOC exclusions.

- For each reporting_partnership_medicaid_id on the Rolling Period Partnership Table:
  - Set partnership_unadj_tcoc equal to the sum of total_spend_post_exclusions on the Rolling Period Member Table (O.03) for members where partnership_member_panel_tcoc is equal to 1
  - Set partnership_unadj_tcoc_pmpm equal to partnership_unadj_tcoc, as calculated in the step above, divided by (÷) partnership_member_months_tcoc

5.7.7.2 Partnership level risk-adjusted TCOC

Partnership level risk-adjusted TCOC is calculated as the unadjusted TCOC across the 12-month rolling period for all members in the partnership's 6-month TCOC member panel, after spend exclusions, standard Ohio CPC exclusions, and TCOC exclusions, adjusted for the risk of each member on a time-weighted basis.

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Risk-adjusted total cost of care for a CPC Partnership is calculated by dividing the CPC entity's non-risk-adjusted total cost of care by the time-weighted risk score of the members attributed to the CPC entity.

- To calculate the risk-adjusted total cost of care for a Partnership, components of the TCOC calculation is aggregated at the Partnership level, for example:

- Set partnership_time_weighted_risk_score equal to the sum of time_weighted_risk_score on the Rolling Period Member Table (O.03) across all the Partnership's six-month attributed members, that is, where partnership_medicaid_id_6_month for each member equals practice_partnership _id

  With the aggregated Partnership level values, calculate risk-adjusted total cost of care at the Partnership level.

  - For each practice_partnership_id on the Rolling Period Partnership Table (O.04):
    - Set partnership_ra_tcoc_pmpm equal to partnership_unadj_tcoc divided by (÷) partnership_time_weighted_risk_score
    - Set partnership_ra_tcoc_pmpm_final equal to (partnership_unadj_tcoc plus (+) the sum of rolling_period_pmpm_payment on the Rolling Period Member Table (O.03), for all members where partnership_member_panel_tcoc is equal to 1) divided by (÷) partnership_time_weighted_risk_score

5.7.8 Calculate Baseline TCOC

Baseline TCOC is defined as a member's risk-adjusted TCOC, after standard Ohio CPC and total cost of care exclusions, from the 12-month rolling period two years prior to the Ohio CPC program year. For example, for an Ohio CPC program year of 1/1/2025 to 12/31/2025, the baseline year is 1/1/2023 to 12/31/2023

To create baseline total cost of care, a 12-month rolling period is created in the same manner as for an Ohio CPC performance period, but for the baseline timeframe. For purposes of the Ohio CPC algorithm, once the baseline is calculated only certain fields are retained in the Practice Baseline Total Cost of Care Table (O.06)/ Partnership Baseline Total Cost of Care Table (O.06).

5.7.8.1 To create baseline total cost of care

- **Define the time period of the baseline:**
  - Set the baseline_period_start_date parameter to the first day of the baseline 12-month rolling period to be created (e.g., 1/1/2022 for a

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baseline year of 1/1/2022 to 12/31/2022)

- Set the baseline_period_end_date parameter to the last day of the baseline 12-month rolling period to be created (e.g., 12/31/2022 for a baseline year of 1/1/2022 to 12/31/2022)

- Run each of the four quarters of attribution as described in Section 5.1 Attribute Members to Primary Care Practices
- Create the Quarterly Attribution Bridge Table (O.05) and Monthly Member Table (O.02) for the baseline year
- Construct the 12-month Rolling Period Member Table (O.03)
- Run risk-adjustment for the baseline year
  - See note under *Section 5.4.2 Generate CDPS Score*, "CDPS run timeframe for special case 12-month rolling periods: baseline year and final program year calculations"
- Calculate member-level unadjusted and risk-adjusted total cost of care for the baseline year according to *Section 5.7 Calculate TCOC*
- Construct the 12-month Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) for the baseline year

5.7.8.2 Update output tables

- **Update the** Practice Baseline Total Cost of Care Table (O.06)/ Partnership Baseline Total Cost of Care Table (O.06) **as follows:**
  - Set baseline_year to the year (YYYY) of the baseline_period_start_date parameter
  - Set baseline_rolling_period_start_date to the baseline_period_start_date parameter
  - Set baseline_rolling_period_end_date to the baseline_period_end_date parameter
- Set the following fields from the Rolling Period Practice Table (O.04):

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Note: In this sub-section, references to the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) refer to the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) created in the step above, using data from the baseline year

- Set baseline_practice_medicaid_id/baseline_partnership_id to reporting_practice_medicaid_id/practice_partnership_id
- Set baseline_practice_name/baseline_partnership_name to reporting_practice_name/partnership_name
- Set practice_baseline_cpc_pmpm_payment/partnership_baseline_cpc_pmpm_payment to practice_cpc_pmpm_payment/partnership_cpc_pmpm_payment
- Set baseline_practice_member_months_tcoc/ baseline_partnership_member_months_tcoc to practice_member_months_tcoc/ partnership_member_months_tcoc
- Set baseline_practice_time_weighted_risk_score/ baseline_partnership_time_weighted_risk_score to practice_time_weighted_risk_score/ partnership_time_weighted_risk_score
- Set baseline_practice_unadj_tcoc/ baseline_partnership_unadj_tcoc to practice_unadj_tcoc/ partnership_unadj_tcoc
- Set baseline_practice_unadj_tcoc_pmpm/ baseline_partnership_unadj_tcoc_

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pmpm to practice_unadj_tcoc_pmpm/ partnership_unadj_tcoc_pmpm

- Set baseline_practice_ra_tcoc_pmpm/ baseline_partnership_ra_tcoc_pmpm to practice_ra_tcoc_pmpm/ partnership_ra_tcoc_pmpm
- Set baseline_practice_ra_tcoc_pmpm_final/ baseline_partnership_ra_tcoc_pmpm_final to practice_ra_tcoc_pmpm_final/ partnership_ra_tcoc_pmpm_final

5.7.8.3 Notes on baseline total cost of care

- Quality and efficiency metrics do not need to be calculated for the baseline year
- Quarterly Ohio CPC PMPM payment amounts should be calculated for each quarter during the baseline year and included in the total cost of care
- However, PMPM payments included in the baseline calculations should accurately represent the PMPM payments actually paid to practices during the baseline year, i.e., should not recalculate PMPMs during this process
- For certain baseline years where the Ohio CPC program was not operational (i.e., 2020 for COVID-19), all PMPM payments included in the baseline period should be $0
  - The baseline must be created using at least 7 months of claims run-out, equivalent to the run-out period used when calculating shared savings at the end of the Ohio CPC program year

5.7.9 Calculate Target TCOC

- Target TCOC represents an entity's baseline TCOC, adjusted for the programmatic changes that occur between the baseline year and the program year:
  - Set program_adjustment_factor to the practice or partership's annualized_adjustment_factor from the Programmatic Adjustment Factors (I.S.09) input file where performance_year from the Programmatic Adjustment Factors (I.S.09) input file is two years following the baseline_year from the Practice Baseline Total

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Cost of Care Table (O.06)/ Partnership Baseline Total Cost of Care Table (O.06)

- Set target_ra_tcoc_pmpm_final equal to baseline_practice_ra_tcoc_pmpm_final/ baseline_partnership_ra_tcoc_pmpm_final from the Practice Baseline Total Cost of Care Table (O.06)/ Partnership Baseline Total Cost of Care Table (O.06) times (×) [1 plus (+) program_adjustment_factor] times (×) [1 plus (+) program_adjustment_factor] Set baseline_practice_adj_tcoc/baseline_partnership_unadj_tcoc equal to baseline_practice_unadj_tcoc/baseline_partnership_unadj_tcoc from the Practice Baseline Total Cost of Care Table (O.06)/ Partnership Baseline Total Cost of Care Table (O.06) times (×)[1 plus (+) program_adjustment_factor] times (×) [1 plus (+) program_adjustment_factor]

5.8 Calculate Clinical Quality and Efficiency Metrics

5.8.1 Overview

Ohio CPC clinical quality and efficiency metrics are calculated for each member in the program, and then aggregated to a practice-level for purposes of Ohio CPC. This section focuses on incorporating the metrics into the Ohio CPC algorithm, and provides high-level guidance on the generation of the clinical quality and efficiency metrics.

The process of incorporating clinical quality and efficiency metrics into the Ohio CPC algorithm consists of four steps:

1. Generate clinical quality and efficiency metrics
2. Incorporate metrics into the Rolling Period Member Table (O.03)
3. Aggregate quality and efficiency metrics to the practice level and calculate practice-level rates
4. Establish thresholds, apply minimum denominator criteria, and determine practice pass-fail status

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Additional implementation detail and the quality and efficiency metric specifications may be found in Section 7.1 Appendix A: Ohio CPC Quality and Efficiency Metrics Specifications.

5.8.1.1 Parameters

- metric_run_start_date, metric_run_end_date

5.8.1.2 Configuration file codelists

None

5.8.1.3 Input tables

- Member Extract (I.C.01), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04), Low Birthweight Data (I.M.01), , Quality and Efficiency Metric Performance Data (I.M.05), Quality and Efficiency Metric Thresholds (I.M.04)

5.8.1.4 Output tables

- Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Rolling Period Partnership Table (O.04), Quality and Efficiency Metric Performance Data (I.M.05)

5.8.2 Generate Clinical Quality and Efficiency Metrics

This section describes the calculation of clinical quality and efficiency metrics at a high-level. Additional detail on the metric specifications may be found in Section 7.1 Appendix A: Ohio CPC Quality and Efficiency Metrics Specifications.

The result of these calculations is binary flags for each member as to whether they are included in the metric denominator or numerator. If the metric is event- or quantity-based (such as the number of ED visits), the count of events or quantity is calculated instead.

5.8.2.1 Define the timeframe for the clinical quality and efficiency metric runs

- Metrics are calculated over a 12-month rolling period:
    - Set the metric_run_start_date parameter to the rolling_period_start_date from the Rolling Period Member Table (O.03)
    - Set the metric_run_end_date parameter to the rolling_period_end_date from the Rolling Period Member Table (O.03)

5.8.2.2 Generate the metrics

- Generate the clinical quality and efficiency metrics according to the metric specifications. Output the results of the calculations to the Quality and Efficiency Metric Performance Data (I.M.05) input file, including the following fields:

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- Set rolling_period_start_date to the metric_run_start_date parameter
- Set rolling_period_end_date to the metric_run_end_date parameter
- Set member_medicaid_id to member_id from the Member Extract (I.C.01) for each member for whom metrics are calculated

For each clinical quality and efficiency metric, set the member-level denominator flag, numerator flag, event count, Rx count, or episode count based on the results of the metric calculation.

For example, a member who is included in the denominator of the Asthma Medication Ratio (AMR) metric calculation and who is numerator-compliant should have amr_den_flag and amr_num_flag set to 1 on the Quality and Efficiency Metric Performance Data (I.M.05) input file.

5.8.3 Incorporate Member-level Quality and Efficiency Metrics

Ohio CPC clinical quality and efficiency metrics are calculated over a 12-month rolling period. Update the Rolling Period Member Table (O.03) by setting each of the following fields equal to the corresponding fields from:

- the Low Birthweight Data (I.M.01) input file for the Low Birthweight metric
- the Quality and Efficiency Metric Performance Data (I.M.05) input file for all other metrics
- For each member_medicaid_id and where the rolling_period_start_date and rolling_period_end_date match between the input and output files:

Table 23. PY2025 Ohio CPC Clinical Quality Metrics

Metric	Rate	Numerator Field	Denominator Field	Status
HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: First 15 Months	n/a	w30a_num_flag	w30a_den_flag	PY2021 - Current
HEDIS MY 2025 Well-Child Visits in the First 30 Months of Life: 15 to 30 Months	n/a	w30b_num_flag	w30b_den_flag	PY2021 - Current
HEDIS MY 2025 Child and Adolescent Well-Care Visits 3-11 years	n/a	wcv11_num_flag	wcv11_den_flag	PY2021 – Current
HEDIS MY 2025 Child and Adolescent Well-Care Visits 12-17 years	n/a	wcv17_num_flag	wcv17_den_flag	PY2021 – Current
HEDIS MY 2025 Child and Adolescent Well-Care Visits 18-21 years	n/a	wcv21_num_flag	wcv21_den_flag	PY2021 - Current

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Metric	Rate	Numerator Field	Denominator Field	Status
HEDIS MY 2025 Weight Assessment and Counseling	BMI assessment	wcc_num_flag	wcc_den_flag	PY2017-Current
eCQM Supplemental Data - HEDIS MY 2025 Weight Assessment and Counseling[1]	BMI assessment	wcc_supp_num_flag	wcc_supp_den_flag	PY2025 - Current
HEDIS MY 2025 Prenatal and Postpartum Care: Timeliness of prenatal care	Timeliness of prenatal care	ppc_prenatal_num_flag	ppc_prenatal_den_flag	PY2017-Current
Low-birthweight	n/a	lbw_num_flag (*)	lbw_den_flag (*)	PY2017-Current
HEDIS MY 2025 Prenatal and Postpartum Care: Postpartum care	Postpartum care	ppc_postpartum_num_flag	ppc_postpartum_den_flag	PY2017-Current
HEDIS MY 2025 Cervical Cancer Screening	n/a	ccs_num_flag	ccs_den_flag	PY2017-Current
HEDIS MY 2025 Blood Pressure Control for Patients with Diabetes	n/a	bpd_num_flag	bpd_den_flag	PY2023-Current
HEDIS MY 2025 Eye Exam for Patients with Diabetes	n/a	eed_num_flag	eed_den_flag	PY2023-Current
HEDIS MY 2025 Controlling High Blood Pressure	n/a	cbp_num_flag	cbp_den_flag	PY2017-Current
eCQM Supplemental Data- HEDIS MY 2025 Controlling High Blood Pressure[1]	n/a	cbp_supp_num_flag	cbp_supp_den_flag	PY2025 - Current
eCQM Supplemental Data – HEDIS 2025 Glycemic Status Assessment for Patients with Diabetes		gsd_supp_num_flag	gsd_supp_denom_flag	PY2025 - Current
HEDIS MY 2025 Statin Therapy for Patients with Cardiovascular Disease	Received statin therapy	spc_num_flag	spc_den_flag	PY2017-Current
HEDIS MY 2025 Oral Evaluation, Dental Services[1*]	n/a	oed_num_flag	oed_den_flag	PY2024-Current
HEDIS MY 2025 Chlamydia Screening in Women	n/a	chl_num_flag	chl_den_flag	PY2024-Current

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Metric	Rate	Numerator Field	Denominator Field	Status
HEDIS MY 2025 Asthma Medication Ratio	n/a	amr_num_flag	amr_den_flag	PY2021 - Current
HEDIS MY 2025 Follow-up After Hospitalization for Mental Illness	7 days	fuh_num_flag	fuh_den_flag	PY2017- Current
HEDIS MY 2025 Initiation & Engagement of Alcohol and Other Drug Dependence Treatment	Engagement	iet_num_flag	iet_den_flag	PY2017- Current
HEDIS MY 2024 Glycemic Status Assessment for Patients with Diabetes	n/a	gsd_num_flag	gsd_den_flag	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years[1]	7 days	fua_7_6_num_count	fum_7_6_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years[1]	7 days	fum_7_18_num_count	fum_7_18_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 65 and older [1]	7 days	fum_7_65_num_count	fum_7_65_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness - Total	7 days	fum_7_num_count	fum_7_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years[1]	30 days	fum_30_6_num_count	fum_30_6_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years[1]	30 days	fum_30_18_num_count	fum_30_18_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness – Ages 65 and older [1]	30 days	fum_30_65_num_count	fum_30_65_den_count	PY2025 - Current

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Metric	Rate	Numerator Field	Denominator Field	Status
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Mental Illness - Total	30 days	fum_30_num_count	fum_30_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use – Ages 13 -17 years[1]	7 days	fua_7_13_num_count	fua_7_13_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use – Ages 18 and older[1]	7 days	fua_7_18_num_count	fua_7_18_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use - Total	7 days	fua_7_num_count	fua_7_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use – Ages 13 -17 years[1]	30 days	fua_30_13_num_count	fua_30_13_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use – Ages 18 and older[1]	30 days	fua_30_18_num_count	fua_30_18_den_count	PY2025 - Current
HEDIS MY 2025 Follow-Up After Emergency Department Visit for Substance Use - Total	30 days	fua_30_num_count	fua_30_den_count	PY2025 - Current
Tobacco Use: Screening and Cessation Intervention	n/a	tci_num_flag	tci_den_flag	PY2017-Current
HEDIS MY 2025 Lead Screening in Children	n/a	lsc_cpck_num	lsc_cpck_den	PY2020-Current
HEDIS MY 2025 Childhood Immunization Status	Combination Rate 3	cis_cpck_num	cis_cpck_den	PY2020-Current
HEDIS MY 2025 Immunization for Adolescents	Combination Rate 2	ima_cpck_num	ima_cpck_den	PY2020-Current
Tobacco use: Screening and Cessation Intervention ages 12- 17[1]	Ages 12-17	tci_cpck_num	tci_cpck_den	PY2020-Current

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Metric	Rate	Numerator Field	Denominator Field	Status
HEDIS MY 2025 Topical Fluoride for Children[1]	n/a	tfc_num_flag	tfc_den_flag	PY2024-Current
HEDIS MY 2025 Colorectal Cancer Screening[1]	n/a	col_e_num_flag	col_e_den_flag	PY2026
HEDIS MY 2025 Pharmacotherapy for Opioid Use Disorder[1]	Ages 16+	pod_num_flag	pod_den_flag	PY2026

[1] Metric information only forPY 2026; *For PY2026, OED is informational for regular CPC, and for payment for CPC for Kids participants.

Table 24. Ohio CPC Efficiency Metrics

Metric	Rate	Field	Status
HEDIS MY 2024 Ambulatory Care	ED Visits	amb_er_visit_count	PY2017- Current
Avoidable Inpatient Admissions per 1,000 Annualized Members	n/a	pqi_90_ip_admit_count	PY2017- Current
Mental Health Utilization (inpatient)	Inpatient	mpt_bh_related_ip_admit_count	PY2017- Current
Preferred Drug List Adherence: Antidiabetics, Insulin, Lantus only	n/a	pdl_ail_num	PY 2021-Current
Preferred Drug List Adherence: Antidiabetics, DPPIV inhibitors	n/a	pdl_adi_num	PY 2021- Current
Preferred Drug List Adherence: Asthma	n/a	pdl_asth_num	PY 2021- Current
Preferred Drug List Adherence: COPD	n/a	pdl_copd_num	PY 2021- Current

5.8.3.1 Aggregate Metrics and Calculate Metric Performance

Practice Level

Clinical quality metrics are aggregated to the practice level for most metrics by summing the numerator and denominators across members attributed to the Ohio CPC practice and who are in the 6-month quality and efficiency metrics member panel. A similar process is used for aggregating the efficiency metrics to the practice-level, although the sum of metric events, Rx scripts, or episodes is taken (depending on the efficiency metric) instead of member numerator and denominator status.

The table on the following page outlines the calculation for each clinical quality and efficiency metric.

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Note: the "Output fields" column refers to fields that are to be set on the *Rolling Period Practice Table (O.04)* and the "Calculation from input fields" column refers to input fields from the *Rolling Period Member Table (O.03)*

Note: metric calculations for each practice should consider only attributed members in the 6-month quality and efficiency metrics panel, where both of the following are true:

- *member_panel_metrics* for each member on the *Rolling Period Member Table (O.03)* is equal to 1
- *practice_medicaid_id_6_month* for the member on the *Rolling Period Member Table (O.03)* is equal to *reporting_practice_medicaid_id* on the *Rolling Period Practice Table (O.04)*

5.8.3.2 Partnership Level

Clinical quality and efficiency metrics for partnerships are calculated using the partnership member panel metrics.

The table on the following page outlines the calculation for each clinical quality and efficiency metric.

- The "Output fields" column refer to fields that are to be set on the Rolling Period Partnership Table (O.04) and the "Calculation from input fields" column refers to input fields from the Rolling Period Member Table (O.03)
- Metric calculations for each partnership should consider only attributed members in the 6-month quality and efficiency metrics panel, where both of the following are true:
    - member_panel_partnership_metrics for each member on the Rolling Period Member Table (O.03) is equal to 1
    - partnership_medicaid_id_6_month for the member on the Rolling Period Member Table (O.03) is equal to practice_partnership_id on the Rolling Period Partnership Table (O.04)
- **The calculations below reflect the appropriate direction for determining whether a practice meets or exceeds the threshold for a given metric. The direction of performance (whether higher or lower performance is better for a given metric) can be confirmed using the** performance_direction_indicator **field on the** Quality and Efficiency Metric Thresholds (I.M.04) **table.**

Table 25. Metric Output Field Calculations

Output fields	Calculation from input fields
w30a_num	Sum of w30a_num from the Rolling Period Member Table (O.03)
w30a_den	Sum of w30a_den from the Rolling Period Member Table (O.03)
w30a_rate	w30a_num (divided by (÷) w30a_den
w30a_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the w30a metric

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Output fields	Calculation from input fields
w30a_min_den_flag	1 if w30a_den is greater than or equal to (≥) 30, and 0 otherwise
W30a_pass	*null* if w30a_min_den_flag is equal to 0, otherwise 1 if w30a_rate is greater than or equal to (≥) w30a_threshold and 0 otherwise
w30b_num	Sum of w30b_num from the Rolling Period Member Table (O.03)
w30b_den	Sum of w30b_den from the Rolling Period Member Table (O.03)
w30b_rate	w30b_num (divided by (÷) w30b_den
w30b_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the w30b metric
w30b_min_den_flag	1 if w30b_den is greater than or equal to (≥) 30, and 0 otherwise
W30b_pass	*null* if w30b_min_den_flag is equal to 0, otherwise 1 if w30b_rate is greater than or equal to (≥) w30b_threshold and 0 otherwise
wcv11_num	Sum of wcv11_num from the Rolling Period Member Table (O.03)
wcv11_den	Sum of wcv11_den from the Rolling Period Member Table (O.03)
wcv11_rate	wcv11_num divided by (÷) wcv11_den
wcv11_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the wcv11 metric
wcv11_pass	*null* if wcv11_min_den_flag is equal to 0, otherwise 1 if wcv11_rate is greater than or equal to (≥) wcv11_threshold, and 0 otherwise
wcv11_min_den_flag	1 if wcv11_den is greater than or equal to (≥) 30, and 0 otherwise
wcv17_num	Sum of wcv17_num from the Rolling Period Member Table (O.03)
wcv17_den	Sum of wcv17_den from the Rolling Period Member Table (O.03)
wcv17_rate	wcv17_num divided by (÷) wcv17_den
wcv17_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the wcv17 metric
wcv17_pass	*null* if wcv17_min_den_flag is equal to 0, otherwise 1 if wcv17_rate is greater than or equal to (≥) wcv17_threshold, and 0 otherwise
wcv17_min_den_flag	1 if wcv17_den is greater than or equal to (≥) 30, and 0 otherwise
wcv21_num	Sum of wcv21_num from the Rolling Period Member Table (O.03)
wcv21_den	Sum of wcv21_den from the Rolling Period Member Table (O.03)
wcv21_rate	wcv21_num divided by (÷) wcv21_den
wcv21_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the wcv21 metric
wcv21_pass	*null* if wcv21_min_den_flag is equal to 0, otherwise 1 if wcv21_rate is greater than or equal to (≥) wcv21_threshold, and 0 otherwise
wcv21_min_den_flag	1 if wcv21_den is greater than or equal to (≥) 30, and 0 otherwise
wcc_num	Sum of wcc_num from the Rolling Period Member Table (O.03)
wcc_den	Sum of wcc_den from the Rolling Period Member Table (O.03)

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Output fields	Calculation from input fields
wcc_rate	wcc_num divided by (÷) wcc_den
wcc_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the wcc metric
wcc_pass	*null* if wcc_min_den_flag is equal to 0, otherwise 1 if wcc_rate is greater than or equal to (≥) wcc_threshold, and 0 otherwise
wcc_min_den_flag	1 if wcc_den is greater than or equal to (≥) 30, and 0 otherwise
wcc_supp_num	Sum of wcc_supp_num_flag from the Rolling Period Member Table (O.03)
wcc_supp_den	Sum of wcc_supp_den from the Rolling Period Member Table (O.03)
wcc_supp_rate	wcc_supp_num divided by (÷) wcc_supp_den
wcc_supp_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the wcc metric
wcc_supp_pass	*null* if wcc_supp_min_den_flag is equal to 0, otherwise 1 if wcc_supp_rate is greater than or equal to (≥) wcc_supp_threshold, and 0 otherwise
wcc_supp_min_den_flag	1 if wcc_supp_den is greater than or equal to (≥) 30, and 0 otherwise
ppc_prenatal_num	Sum of ppc_prenatal_num from the Rolling Period Member Table (O.03)
ppc_prenatal_den	Sum of ppc_prenatal_den from the Rolling Period Member Table (O.03)
ppc_prenatal_rate	ppc_prenatal_num divided by (÷) ppc_prenatal_den
ppc_prenatal_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the ppc_prenatal metric
ppc_prenatal_pass	*null* if ppc_prenatal_min_den_flag is equal to 0, otherwise 1 if ppc_prenatal_rate is greater than or equal to (≥) ppc_prenatal_threshold, and 0 otherwise
ppc_prenatal_min_den_flag	1 if ppc_prenatal_den is greater than or equal to (≥) 30, and 0 otherwise
lbw_num	Sum of lbw_num from the Rolling Period Member Table (O.03)
lbw_den	Sum of lbw_den from the Rolling Period Member Table (O.03)
lbw_rate	lbw_num divided by (÷) lbw_den
lbw_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the lbw metric
lbw_pass	*null* if lbw_min_den_flag is equal to 0, otherwise 1 if lbw_rate is less than or equal to (≤) lbw_threshold, and 0 otherwise
lbw_min_den_flag	1 if lbw_den is greater than or equal to (≥) 30, and 0 otherwise
ppc_postpartum_num	Sum of ppc_postpartum_num from the Rolling Period Member Table (O.03)
ppc_postpartum_den	Sum of ppc_postpartum_den from the Rolling Period Member Table (O.03)

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Output fields	Calculation from input fields
ppc_postpartum_rate	ppc_postpartum_num divided by (÷) ppc_postpartum_den
ppc_postpartum_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the ppc_postpartum metric
ppc_postpartum_pass	*null* if ppc_min_den_flag is equal to 0, otherwise 1 if ppc_postpartum_rate is greater than or equal to (≥) ppc_postpartum_threshold, and 0 otherwise
ppc_postpartum_min_den_flag	1 if ppc_postpartum_den is greater than or equal to (≥) 30, and 0 otherwise
ccs_num	Sum of ccs_num from the Rolling Period Member Table (O.03)
ccs_den	Sum of ccs_den from the Rolling Period Member Table (O.03)
ccs_rate	ccs_num divided by (÷) ccs_den
ccs_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the ccs metric
ccs_pass	*null* if ccs_min_den_flag is equal to 0, otherwise 1 if ccs_rate is greater than or equal to (≥) ccs_threshold, and 0 otherwise
ccs_min_den_flag	1 if ccs_den is greater than or equal to (≥) 30, and 0 otherwise
chl_num	Sum of chl_num from the Rolling Period Member Table (O.03)
chl_den	Sum of chl_den from the Rolling Period Member Table (O.03)
chl_rate	chl_num divided by (÷) chl_den
chl_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the chl metric
chl_pass	*null* if chl_min_den_flag is equal to 0, otherwise 1 if chl_rate is greater than or equal to (≥) chl_threshold, and 0 otherwise
chl_min_den_flag	1 if chl_den is greater than or equal to (≥) 30, and 0 otherwise
oed_num	Sum of oed_num from the Rolling Period Member Table (O.03)
oed_den	Sum of oed_den from the Rolling Period Member Table (O.03)
oed_rate	oed_num divided by (÷) oed_den
oed_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the oed metric
oed_pass	*null* if oed_min_den_flag is equal to 0, otherwise 1 if oed_rate is greater than or equal to (≥)oed_threshold, and 0 otherwise
oed_min_den_flag	1 if oed_den is greater than or equal to (≥) 30, and 0 otherwise
eed_min_den_flag	1 if eed_den is greater than or equal to (≥) 30, and 0 otherwise
eed_num	Sum of eed_num from the Rolling Period Member Table (O.03)
eed_den	Sum of eed_den from the Rolling Period Member Table (O.03)
eed_rate	eed_num divided by (÷) eed_den
eed_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the eed metric

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Output fields	Calculation from input fields
eed_pass	*null* if eed_min_den_flag is equal to 0, otherwise 1 if eed_rate is greater than or equal to (≥) eed_threshold, and 0 otherwise
eed_min_den_flag	1 if eed_den is greater than or equal to (≥) 30, and 0 otherwise
cbp_num	Sum of cbp_num from the Rolling Period Member Table (O.03)
cbp_den	Sum of cbp_den from the Rolling Period Member Table (O.03)
cbp_rate	cbp_num divided by (÷) cbp_den
cbp_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the cbp metric
cbp_pass	*null* if cbp_min_den_flag is equal to 0, otherwise 1 if cbp_rate is greater than or equal to (≥) cbp_threshold, and 0 otherwise
cbp_min_den_flag	1 if cbp_den is greater than or equal to (≥) 30, and 0 otherwise
cbp_supp_num	Sum of CPB_Supp_num_flag from the Rolling Period Member Table (O.03)
cbp_supp_den	Sum of CBP_Supp_den_flag from the Rolling Period Member Table (O.03)
cbp_supp_rate	cbp_supp_num divided by (÷) cbp_supp_den
cbp_supp_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the cbp metric
cbp_supp_pass	*null* if cbp_supp_min_den_flag is equal to 0, otherwise 1 if cbp_supp_rate is greater than or equal to (≥) cbp_supp_threshold, and 0 otherwise
cbp_supp_min_den_flag	1 if cbp_supp_den is greater than or equal to (≥) 30, and 0 otherwise
spc_num	Sum of spc_num from the Rolling Period Member Table (O.03)
spc_den	Sum of spc_den from the Rolling Period Member Table (O.03)
spc_rate	spc_num divided by (÷) spc_den
spc_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the spc metric
spc_pass	*null* if spc_min_den_flag is equal to 0, otherwise 1 if spc_rate is greater than or equal to (≥) spc_threshold, and 0 otherwise
spc_min_den_flag	1 if spc_den is greater than or equal to (≥) 30, and 0 otherwise
amr_num	Sum of amr_num from the Rolling Period Member Table (O.03)
amr_den	Sum of amr_den from the Rolling Period Member Table (O.03)
amr_rate	amr_num divided by (÷) amr_den
amr_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the amr metric
amr_pass	*null* if amr_min_den_flag is equal to 0, otherwise 1 if amr_rate is greater than or equal to (≥) amr_threshold, and 0 otherwise
amr_min_den_flag	1 if amr_den is greater than or equal to (≥) 30, and 0 otherwise

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Output fields	Calculation from input fields
bpd_num	Sum of bpd_num from the Rolling Period Member Table (O.03)
bpd_den	Sum of bpd_den from the Rolling Period Member Table (O.03)
bpd_rate	bpd_num divided by (÷) bpd_den
bpd_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the bpd metric
bpd_pass	*null* if bpd_min_den_flag is equal to 0, otherwise 1 if bpd_rate is greater than or equal to (≥) bpd_threshold, and 0 otherwise
bpd_min_den_flag	1 if bpd_den is greater than or equal to (≥) 30, and 0 otherwise
gsd_num	Sum of gsd_num from the Rolling Period Member Table (O.03)
gsd_den	Sum of gsd_den from the Rolling Period Member Table (O.03)
gsd_rate	gsd_num divided by (÷) gsd_den
gsd_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the gsd metric
gsd_pass	*null* if gsd_min_den_flag is equal to 0, otherwise 1 if gsd_rate is greater than or equal to (≥) gsd_threshold, and 0 otherwise
gsd_min_den_flag	1 if gsd_den is greater than or equal to (≥) 30, and 0 otherwise
pod_num	Sum of pod_num from the Rolling Period Member Table (O.03)
pod_den	Sum of pod_den from the Rolling Period Member Table (O.03)
pod_rate	pod_num divided by (÷) pod_den
pod_threshod	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pod metric
pod_pass	*null* if pod_min_den_flag is equal to 0, otherwise 1 if pod_rate is greater than or equal to (≥) pod_threshold, and 0 otherwise
pod_min_den_flag	1 if pod_den is greater than or equal to (≥) 30, and 0 otherwise
col_e_num	Sum of col_e_num from the Rolling Period Member Table (O.03)
col_e_den	Sum of col_e_den from the Rolling Period Member Table (O.03)
col_e_rate	col_e_num divided by (÷) col_e_den
col_e_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the col_e metric
col_e_pass	*null* if cpl_e_min_den_flag is equal to 0, otherwise 1 if col_e_rate is greater than or equal to (≥) col_e_threshold, and 0 otherwise
col_e_min_den_flag	1 if col_e_den is greater than or equal to (≥) 30, and 0 otherwise
fuh_num	Sum of fuh_num from the Rolling Period Member Table (O.03)
fuh_den	Sum of fuh_den from the Rolling Period Member Table (O.03)

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Output fields	Calculation from input fields
fuh_rate	fuh_num divided by (÷) fuh_den
fuh_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the fuh metric
fuh_pass	*null* if fuh_min_den_flag is equal to 0, otherwise 1 if fuh_rate is greater than or equal to (≥) fuh_threshold, and 0 otherwise
fuh_min_den_flag	1 if fuh_den is greater than or equal to (≥) 30, and 0 otherwise
iet_num	Sum of iet_num from the Rolling Period Member Table (O.03)
iet_den	Sum of iet_den from the Rolling Period Member Table (O.03)
iet_rate	iet_num divided by (÷) iet_den
iet_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the iet metric
iet_pass	*null* if iet_min_den_flag is equal to 0, otherwise 1 if iet_rate is greater than or equal to (≥) iet_threshold, and 0 otherwise
iet_min_den_flag	1 if iet_den is greater than or equal to (≥) 30, and 0 otherwise
tci_num	Sum of tci_num from the Rolling Period Member Table (O.03)
tci_den	Sum of tci_den from the Rolling Period Member Table (O.03)
tci_rate	tci_num divided by (÷) tci_den
tci_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the tci metric
tci_pass	*null* if tci_min_den_flag is equal to 0, otherwise 1 if tci_rate is greater than or equal to (≥) tci_threshold, and 0 otherwise
tci_min_den_flag	1 if tci_den is greater than or equal to (≥) 30, and 0 otherwise
amb_count	Sum of amb_er_visit_count from the Rolling Period Member Table (O.03)
amb_den_member_months	Sum of metrics_eligible_months from the Rolling Period Member Table (O.03)
amb_rate	amb_count divided by (÷) [amb_den_member_months divided by (÷) 1,000]
amb_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the amb metric
amb_pass	1 if amb_rate is less than or equal to (≤) amb_threshold, and 0 otherwise
amb_min_den_flag	1 if amb_den_member_months is greater than or equal to (≥) 30, and 0 otherwise
pqi_90_count	Sum of pqi_90_ip_admit_count from the Rolling Period Member Table (O.03)
pqi_90_den_member_months	Sum of metrics_eligible_months from the Rolling Period Member Table (O.03) where member_age is greater than or equal to (≥) 216 months (indicating members age 18 years and up)

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Output fields	Calculation from input fields
pqi_90_rate	pqi_90_count divided by (÷) [pqi_90_den_member_months divided by (÷) 1,000]
pqi_90_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pqi_90 metric
pqi_90_pass	1 if pqi_90_rate is less than or equal to (≤) pqi_90_threshold, and 0 otherwise
pqi_90_min_den_flag	1 if pqi_90_den_member_months is greater than or equal to (≥) 30, and 0 otherwise
mpt_count	Sum of mpt_bh_related_ip_admit_count from the Rolling Period Member Table (O.03)
mpt_den_member_months	Sum of metrics_eligible_months from the Rolling Period Member Table (O.03)
mpt_rate	mpt_count divided by (÷) [mpt_den_member_months divided by (÷) 1,000]
mpt_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the mpt metric
mpt_pass	1 if mpt_rate is less than or equal to (≤) mpt_threshold, and 0 otherwise
mpt_min_den_flag	1 if mpt_den_member_months is greater than or equal to (≥) 30, and 0 otherwise
pdl_ail_num	Sum of pdl_ail_num from the Rolling Period Member Table (O.03)
pdl_ail_den	Sum of pdl_ail_den from the Rolling Period Member Table (O.03)
pdl_ail_rate	pdl_ail_num divided by (÷) pdl_ail_den
pdl_ail_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pdl_ail metric
pdl_ail_pass	*null* if pdl_ail_min_den_flag is equal to 0, otherwise 1 if pdl_ail_rate is greater than or equal to (≥) pdl_ail_threshold, and 0 otherwise
pdl_ail_min_den_flag	1 if pdl_ail_den is greater than or equal to (≥) 30, and 0 otherwise
pdl_adi_num	Sum of pdl_adi_num from the Rolling Period Member Table (O.03)
pdl_adi_den	Sum of pdl_adi_den from the Rolling Period Member Table (O.03)
pdl_adi_rate	pdl_adi_num divided by (÷) pdl_adi_den
pdl_adi_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pdl_adi metric
pdl_adi_pass	*null* if pdl_adi_min_den_flag is equal to 0, otherwise 1 if pdl_adi_rate is greater than or equal to (≥) pdl_adi_threshold, and 0 otherwise
pdl_adi_min_den_flag	1 if pdl_adi_den is greater than or equal to (≥) 30, and 0 otherwise
pdl_ asth _num	Sum of pdl_asth_num from the Rolling Period Member Table (O.03)

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Output fields	Calculation from input fields
pdl_ asth _den	Sum of pdl_asth_den from the Rolling Period Member Table (O.03)
pdl_ asth _rate	pdl_asth_num divided by (÷) pdl_asth_den
pdl_ asth _threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pdl_asth metric
pdl_ asth _pass	*null* if pdl_asth_min_den_flag is equal to 0, otherwise 1 if pdl_asth_rate is greater than or equal to (≥) pdl_asth_threshold, and 0 otherwise
pdl_ asth _min_den_flag	1 if pdl_asth_den is greater than or equal to (≥) 30, and 0 otherwise
pdl_ copd _num	Sum of pdl_copd_num from the Rolling Period Member Table (O.03)
pdl_ copd _den	Sum of pdl_copd_den from the Rolling Period Member Table (O.03)
pdl_ copd _rate	pdl_copd_num divided by (÷) pdl_asth_den
pdl_ copd _threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table for the pdl_copd metric
pdl_ copd _pass	*null* if pdl_copd_min_den_flag is equal to 0, otherwise 1 if pdl_copd_rate is greater than or equal to (≥) pdl_copd_threshold, and 0 otherwise
pdl_ copd _min_den_flag	1 if pdl_copd_den is greater than or equal to (≥) 30, and 0 otherwise
pdl_pass_criteria	1 if passing as least two of the pdl categories, and 0 otherwise.
lsc_cpck_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
lsc_cpck_den	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
lsc_cpck_rate	Metric numerator divided by denominator
lsc_cpck_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
lsc_cpck_pass	Set to null if minimum denominator flag is '0' indicating the practice does not have at least 30 members in the denominator. Otherwise set to '1' indicating the practice passes the metric based on threshold and threshold criteria. Set to '0' indicating the practice fails the metric based on the threshold and threshold criteria.
lsc_cpck_min_den_flag	Flag indicating practice is a CPC for Kids practice AND has at least 30 members included in metric denominator.
cis_cpck_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
cis_cpck_den	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.

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Output fields	Calculation from input fields
cis_cpck_rate	Metric numerator divided by denominator
cis_cpck_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
cis_cpck_pass	Set to null if minimum denominator flag is '0' indicating the practice does not have at least 30 members in the denominator. Otherwise set to '1' indicating the practice passes the metric based on threshold and threshold criteria. Set to '0' indicating the practice fails the metric based on the threshold and threshold criteria.
cis_cpck_min_den_flag	Flag indicating practice is a CPC for Kids practice AND has at least 30 members included in metric denominator.
ima_cpck_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
ima_cpck_den	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
ima_cpck_rate	Metric numerator divided by denominator
ima_cpck_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
ima_cpck_pass	Set to null if minimum denominator flag is '0' indicating the practice does not have at least 30 members in the denominator. Otherwise set to '1' indicating the practice passes the metric based on threshold and threshold criteria. Set to '0' indicating the practice fails the metric based on the threshold and threshold criteria.
ima_cpck_min_den_flag	Flag indicating practice is a CPC for Kids practice AND has at least 30 members included in metric denominator.
tci_cpck_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
tci_cpck_den	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
tci_cpck_rate	Metric numerator divided by denominator
tci_cpck_threshold	Threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
tci_cpck_pass	Set to null if minimum denominator flag is '0' indicating the practice does not have at least 30 members in the denominator. Otherwise set to '1' indicating the practice passes the metric based on threshold and threshold criteria. Set to '0' indicating the practice fails the metric based on the threshold and threshold criteria.
tci_cpck_min_den_flag	Flag indicating practice is a CPC for Kids practice AND has at least 30 members included in metric denominator.
tfc_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
tfc_den	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.

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Output fields	Calculation from input fields
tfc_rate	Metric numerator divided by denominator
tfc_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
tfc_pass	Set to null if minimum denominator flag is '0' indicating the practice does not have at least 30 members in the denominator. Otherwise set to '1' indicating the practice passes the metric based on threshold and threshold criteria. Set to '0' indicating the practice fails the metric based on the threshold and threshold criteria.
tfc_min_den_flag	Flag indicating practice is a CPC for Kids practice AND has at least 30 members included in metric denominator.
fum_7 fum_7_6_1_rate	Metric numerator divided by denominator
fum_30_6_17_rate	Metric numerator divided by denominator
fum_7_18_64_rate	Metric numerator divided by denominator
fum_30_18_64_rate	Metric numerator divided by denominator
fum_7_65_rate	Metric numerator divided by denominator
fum_30_65_rate	Metric numerator divided by denominator
fum_7_total_rate	Metric numerator divided by denominator
fum_30_total_rate	Metric numerator divided by denominator
fum_7_6_17_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fum_30_6_17_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fum_7_18_64_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fum_30_18_64_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.

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Output fields	Calculation from input fields
fum_7- 6_17_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_30_6_17_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_7_18_64_hreshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_30_18_64_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_7_65_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_30_65_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_7_total_hreshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_30_total_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fum_7_6_17_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_6_17_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_18_64_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_18_64_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_65_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_65_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_t_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_total_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_6_17_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30-_6_17_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_18_64_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_18_64_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_65_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.

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Output fields	Calculation from input fields
fum_30_65_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_7_total_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fum_30_total_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_13_17_rate	Metric numerator divided by denominator
fua_30_13_17_rate	Metric numerator divided by denominator
fua_7_18_rate	Metric numerator divided by denominator
fua_30_18_rate	Metric numerator divided by denominator
fua_7_total_rate	Metric numerator divided by denominator
fua_30_total_rate	Metric numerator divided by denominator
fua_7_13_17_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_30_13_17_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_7_18_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_30_18_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_7_total_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_30_total_pass	Set to N/A if minimum denominator flag is '0' indicating the practice does not have at least 30 visits in the denominator. Otherwise set to 'Yes' indicating the practice passes the metric based on threshold

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Output fields	Calculation from input fields
	and threshold criteria. Set to 'No' indicating the practice fails the metric based on the threshold and threshold criteria.
fua_7_13_17_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_30_13_17_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_7_18_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_30_18_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_7_total_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_30_total_threshold	threshold from the Quality and Efficiency Metric Thresholds (I.M.04) table
fua_7_13_17_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_ 13_17_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_18_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_18_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_total_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_total_num	Sum of metric numerator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_13_17_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_ 13_17_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_18_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_ 18_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_7_total_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.
fua_30_total_denom	Sum of metric denominator flag from the Rolling Period Member Table (O.03) aggregated by each CPC Practice medicaid ID.

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5.8.4 Calculate Overall Practice Metric Performance

For each practice on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04), calculate the number of metrics for which the practice/partnership qualifies, as well as the practice's overall metric performance on each of the clinical quality metrics and efficiency metrics.

5.8.4.1 Calculate clinical quality metric performance

- For each practice/partnership on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04):
  - Set quality_metrics_qualify equal to the sum of the minimum denominator flags of metrics that are NOT information only on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04), representing the number of clinical quality metrics for which the practice is eligible:

    wcc_min_den_flag + ppc_prenatal_min_den_flag + lbw_min_den_flag + ppc_postpartum_min_den_flag + ccs_min_den_flag + chl_min_den_flag + bpd_min_den_flag + eed_min_den_flag + cbp_min_den_flag + spc_min_den_flag + fuh_min_den_flag + iet_min_den_flag + tci_min_den_flag + w30a_min_den_flag + w30b_min_den_flag + wcv11_min_den_flag + gsd_min_den_flag +wcv17_min_den_flag + wcv21_min_den_flag + amr_min_den_flag + fua_7_min_den_flag + fua_30_min_den_flag + fum_7_min_den_flag + fum_30_min_den_flag

  - For PY 2026, information-only metrics NOT included in the calculation include:

    oed_min_den_flag + wcc_supp_min_den_flag + cbp_supp_min_den_flag + gsd_supp_min_den_flag + fum_7_6_min_den_flag + fum_30_6_min_den_flag + fum_7_18_min_den_flag + fum_30_18_min_den_flag + fum_7_65_min_den_flag + fum_30_65_min_den_flag + fua_7_13_min_den_flag + fua_30_13_min_den_flag + fua_7_18_min_den_flag + fua_30_18_min_den_flag + pod_min_den_flag + col_e_min_den_flag

    - For those participating in CPC for Kids, the set of metrics below are scored separately for CPC for Kids for clinical quality:

      w30a_min_den_flag + w30b_min_den_flag + wcv11_min_den_flag + wcv17_min_den_flag + wcv21_min_den_flag + wcc_min_den_flag + oed_min_den_flag + lsc_cpck_min_den_flag + cis_cpck_min_den_flag + ima_cpck_min_den_flag

    - For those participating in CPC for Kids, the set of metrics below are scored separately for CPC for Kids

  - Must pass one of the below:
    - lsc_cpck_min_den_flag + cis_cpck_min_den_flag + ima_cpck_min_den_flag

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CPC for Kids information only metrics NOT included in the calculation include:

- tci_kids_min_den_flag + tfc_min_den_flag

  - Set quality_metrics_qualify_pass equal to the sum of the number of clinical quality metrics where the practice meets the minimum denominator and where the entity passes the performance metric, i.e., the sum of:

(w30a_min_den_flag * NVL(w30a_pass,0)) + (w30b_min_den_flag * NVL(w30b_pass, 0))+ (wcv11_min_den_flag * NVL(wcv11_pass,0)) + (wcv17_min_den_flag * NVL(wcv17_pass,0)) + (wcv21_min_den_flag * NVL(wcv21_pass,0)) + (wcc_min_den_flag * NVL(wcc_pass,0))+ (amr_min_den_flag * NVL(amr_pass,0)) + (ppc_prenatal_min_den_flag * NVL(ppc_prenatal_pass,0)) +(lbw_min_den_flag * NVL(lbw_pass,0)) + (ppc_postpartum_min_den_flag * NVL(ppc_postpartum_pass,0)) + (fua_7_min_den_flag * NVL(fua_7_pass,0)) + (fua_30_min_den_flag * NVL(fua_30_pass,0)) + (fum_7_min_den_flag * NVL(fum_7_pass,0)) + (fum_30_min_den_flag * NVL(fum_30_pass,0)) +

(ccs_min_den_flag * NVL(ccs_pass,0)) + (chl_min_den_flag * NVL(chl_pass,0))) +

(gsd_min_den_flag * NVL(gsd_pass,0)) + (eed_min_den_flag * NVL(eed_pass,0)) + (bpd_min_den_flag * NVL(bpd_pass,0)) +(cbp_min_den_flag * NVL(cbp_pass,0)) +

(spc_min_den_flag * NVL(spc_pass,0)) +

(fuh_min_den_flag * NVL(fuh_pass,0)) +

(iet_min_den_flag * NVL(iet_pass,0)) +(tci_min_den_flag * NVL(tci_pass,0))

  - For those participating in CPC for Kids, there are 3 additional metrics for which they may qualify:

(lsc_cpck_min_den_flag* NVL(lsc_cpck_pass,0)) +(cis_cpck_min_den_flag * NVL(cis_cpck_pass,0)) +(ima_cpck_min_den_flag * NVL(ima_cpck_pass,0))

- Set quality_metrics_pass_rate equal to quality_metrics_qualify_pass divided by (÷) quality_metrics_qualifyIf the entity is not participating in CPC for Kids, the CPC for Kids metrics will not be scored for performance.

5.8.4.2 Calculate efficiency metric performance

- For each practice/partnership on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04):

  - Set efficiency_metrics_qualify equal to the sum of the minimum denominator flags on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) across all 4 of the efficiency metrics, representing

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the number of efficiency metrics for which the practice is eligible:

amb_min_den_flag + pqi_90_min_den_flag + pdl_ail_min_den_flag + pdl_adi_min_den_flag + pdl_asth_min_den_flag + pdl_copd_min_den_flag + mpt_min_den_flag

Note: Among the 4 pdl measures listed above, we will count them as 1 only if at least 2 of the pdl metrics qualify.

- Set efficiency_metrics_qualify_pass equal to the sum of the number of efficiency metrics where the practice meets the minimum denominator and where the practice passes the performance metric, i.e., the sum of:

(amb_min_den_flag * amb_pass) + (pqi_90_min_den_flag * pqi_90_pass) + (pdl_ail_min_den_flag * pdl_ail_pass) + (pdl_adi_min_den_flag * pdl_adi_pass) + (pdl_asth_min_den_flag * pdl_asth_pass) + (pdl_copd_min_den_flag * pdl_copd_pass) + (mpt_min_den_flag * mpt_pass)

Note: Among the 4 pdl measures listed above, we will count them as 1 only if atleast 2 of the pdl metrics qualify_pass.

- Set efficiency_metrics_pass_rate equal to efficiency_metrics_qualify_pass divided by (÷) efficiency_metrics_qualify

5.8.4.3 Calculate CPC for kids Clinical Quality metric performance

- For each practice/partnership For those participating in CPC for Kids on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04):
  - Set pediatric_metrics_qualify equal to the sum of the minimum denominator flags on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) across all 10 of the pediatric metrics, representing the number of pediatric metrics for which the practice is eligible:
    w30a_min_den_flag + w30b_min_den_flag + wcv11_min_den_flag + wcv17_min_den_flag + wcv21_min_den_flag + wcc_min_den_flag + oed_min_den_flag + lsc_cpck_min_den_flag + cis_cpck_min_den_flag + ima_cpck_min_den_flag

  - Set pediatric_metrics_qualify_pass: equal to the sum of the number of pediatric metrics where the practice meets the minimum denominator and where the practice passes the performance metric, i.e., the sum of:
    w30a_min_den_flag * NVL(w30a_pass,0)) +(w30b_min_den_flag * NVL(w30b_pass, 0))+

    (wcv11_min_den_flag * NVL(wcv11_pass,0)) +(wcv17_min_den_flag * NVL(wcv17_pass,0)) + (wcv21_min_den_flag * NVL(wcv21_pass,0)) + (wcc_min_den_flag * NVL(wcc_pass,0))+(oed_min_den_flag * NVL(oed_pass,0)) +(cis_min_den_flag *

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NVL(cis_pass,0)) +(ima_min_den_flag * NVL(ima_pass,0)) +(lsc_min_den_flag * NVL(lsc_pass,0))

- Set metrics_pass_rate: equal to pediatric_metrics_qualify_pass divided by (÷) pediatric_metrics_qualify

5.8.4.4 Calculate CPC for kids Clinical Quality metric performance

- For each practice/partnership For those participating in CPC for Kids on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04):
  - Set kids_metrics_qualify equal to the sum of the minimum denominator flags on the Rolling Period Practice Table (O.04)/ Rolling Period Partnership Table (O.04) across all 3 of the kids metrics, representing the number of kids metrics for which the practice is eligible:
    lsc_cpck_min_den_flag + cis_cpck_min_den_flag + ima_cpck_min_den_flag
  - Set kids_metrics_qualify_pass: equal to the sum of the number of pediatric metrics where the practice meets the minimum denominator and where the practice passes the performance metric, i.e., the sum of:
    cis_min_den_flag * NVL(cis_pass,0)) +(ima_min_den_flag * NVL(ima_pass,0)) +(lsc_min_den_flag * NVL(lsc_pass,0))
  - Set kids_pass_rate: equal to kids_metrics_qualify_pass divided by (÷) kids_metrics_qualify

5.9 Calculate Shared Savings Payments

5.9.1 Overview

Shared savings is calculated over a 12-month rolling period reflective of an Ohio CPC program year. Shared savings calculations are conducted at the end of a performance period, after 6 months of claims-runout. There are two types of shared savings:

- Shared savings relative to self
- Shared savings (bonus payment) relative to peers

Practices and partnerships must be eligible to receive shared savings payments by having at least 60,000 attributed member months, among members who have been attributed to the entity for at least 6 months, and who are not excluded due to standard Ohio CPC or total cost of care exclusions. Practices and partnerships must also pass at least 50% of each of the quality and efficiency metrics for which they qualify, as well as pass all Ohio CPC activity requirements (determination to be made by ODM).

5.9.1.1 Parameters

- performance_period_start_date, performance_period_end_date

5.9.1.2 Configuration file codelists

None

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5.9.1.3 Input tables

- Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Quarterly Attribution Bridge Table (O.05), Practice Baseline Total Cost of Care Table (O.06), Ohio CPC Practices List (I.S.08), Rolling Period Partnership Table (O.04), Partnership Baseline Total Cost of Care Table (O.06)

5.9.1.4 Output tables

- Practice Baseline Total Cost of Care Table (O.06), Partnership Baseline Total Cost of Care Table (O.06), Entity Shared Savings Table (O.07a), Entity Shared Savings Table (O.07c)

5.9.2 Run the Ohio CPC Algorithm for the Program Year Rolling Period

- **Define the period covering the Ohio CPC program year:**
  - Set the performance_period_start_date parameter to the first day of 12-month rolling period representing the Ohio CPC program year (e.g., 1/1/2024 for a program year of 1/1/2024 to 12/31/2024)
  - Set the performance_period_end_date parameter to the last day of 12-month rolling period representing the Ohio CPC program year (e.g., 12/31/2024 for a program year of 1/1/2024 to 12/31/2024)
  - Run each of the four quarters of attribution as described in Section 5.1 *Attribute Members to Primary Care Practices*
  - Create the Quarterly Attribution Bridge Table (O.05) and Monthly Member Table (O.02) for the program year
  - Construct the 12-month Rolling Period Member Table (O.03)
  - Run risk-adjustment for the program year
  - Calculate member-level unadjusted and risk-adjusted total cost of care for the program year according to *Section 5.7* Calculate TCOC

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- Construct the 12-month Rolling Period Practice Table (O.04) Rolling Period Partnership Table (O.04) for the program year

Note: The program year 12-month rolling period should be created after 6 months of claims run-out following the end of the program year

5.9.3 Update Output Tables

- For each practice, populate the following fields on the Entity Shared Savings Table (O.07a):
  - Set performance_year to the year (YYYY) of the performance_period_start_date parameter
  - Set performance_rolling_period_start_date to the performance_period_start_date parameter
  - Set performance_rolling_period_end_date to the performance_period_end_date parameter
  - For practice entities that are not in a partnership, set performance_practice_medicaid_id to the reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04)
  - For partnership entities, set performance_practice_medicaid_id to the reporting_partnership_medicaid_id from the Rolling Period Partnership Table (O.04)
  - For practice entities that are not in a partnership, set performance_practice_name to the reporting_practice_name from the Rolling Period Practice Table (O.04)
  - For partnership entities, set performance_practice_name to

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the reporting_practice_name from the Rolling Period Partnership Table (O.04)

- For practice entities that are not in a partnership,set practice_member_months_tcoc to practice_member_months_tcoc from the Rolling Period Practice Table (O.04)
- For partnership entities, set practice_member_months_tcoc to partnership_member_months_tco c from the Rolling Period Partnership Table (O.04)
- For practice entities that are not in a partnership,set cpc_plus_flag to the cpc_plus_flag on the Ohio CPC Practices List (I.S.08) input file
- For partnership entities, set cpc_plus_flag to the cpc_plus_flag to null, this field is calculated at the practice level in a later step.
- For practice entities that are not in a partnership,set quality_metrics_pass_rate equal to quality_metrics_pass_rate from the Rolling Period Practice Table (O.04)
- For partnership entities, set quality_metrics_pass_rate equal to quality_metrics_pass_rate from the Rolling Period Partnership Table (O.04)
- For practice entities that are not in a partnership,set efficiency_metrics_pass_rate equal to efficiency_metrics_pass_rate from the Rolling Period Practice Table (O.04)
- For partnership entities,set efficiency_metrics_pass_rate equal to efficiency_metrics_pass_rate from

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the Rolling Period Partnership Table (O.04)

- For practice entities that are not in a partnership,set activity_requirements_pass_flag to activity_requirements_pass_flag from the Rolling Period Practice Table (O.04)
- For partnership entities,set activity_requirements_pass_flag to activity_requirements_pass_flag from the Rolling Period Partnership Table (O.04)
- For practice entities that are not in a partnership,set baseline_practice_ra_tcoc_pmpm_final equal to baseline_practice_ra_tcoc_pmpm_final from the Practice Baseline Total Cost of Care Table (O.06)
- For partnership entities,set baseline_practice_ra_tcoc_pmpm_final equal to baseline_partnership_ra_tcoc_pmpm_final from the Partnership Baseline Total Cost of Care Table (O.06)
- For practice entities that are not in a partnership,set performance_practice_ra_tcoc_pmpm_final equal to practice_ra_tcoc_pmpm_final from the Rolling Period Practice Table (O.04)
- For partnership entities,set performance_practice_ra_tcoc_pmpm_final equal to practice_ra_tcoc_pmpm_final from the Rolling Period Partnership Table (O.04)
- For practice entities that are not in a partnership,set baseline_practice_unadj_tcoc

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equal to baseline_practice_unadj_tcoc from the Practice Baseline Total Cost of Care Table (O.06)

- For partnership entities,set baseline_practice_unadj_tcoc equal to baseline_partnership_unadj_tcoc from the Partnership Baseline Total Cost of Care Table (O.06)
- For practice entities that are not in a partnership,set gain_sharing_rate equal to 0.65 for practices meeting the following criteria (and to 0.5 otherwise):

– baseline__practice_ra_tcoc_pmpm_final from the Practice Baseline Total Cost of Care Table (O.06) times (×) 12 is less than or equal to (≤) the threshold set for 65% gain sharing

Note: Thresholds for 65% gain sharing are set utilizing data from the baseline year, identifying those that represent 10% of practices with the lowest total cost of care. Thresholds are effective for each program year. This information is shared with all CPC practices no later than July 31st of the program year.

- For partnership entities, gain_sharing_rate is calculated at the practice level using the same methodology defined above.
- For all partnership entities, set Is_Partnership to 'Y' indicating the entity is a Partnership, otherwise 'N' as identified on the Ohio CPC Practices List (I.S.08) input file.

5.9.4 Identify Entities Eligible for Shared Savings

Ohio CPC practices and partnerships are eligible to receive shared savings payments by having at least 60,000 attributed member months, among members who have been attributed to the practice for at least 6 months, and who are not excluded due to standard Ohio CPC or total cost of care exclusions. Practices and partnerships must also pass at least 50% of each of the quality and efficiency metrics for which they qualify, as well as pass all Ohio CPC activity requirements (determination to be made by ODM).

- Set shared_savings_eligible on the Entity Shared Savings Table (O.07a) equal to 1 (and 0 otherwise) if <u>all</u> the following conditions are true:
  - practice_member_months_tcoc on the Entity Shared Savings

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Table (O.07a) is greater than or equal to (≥) 60,000

- quality_metric_pass_rate on the Entity Shared Savings Table (O.07a) is greater than or equal to (≥) 0.5
- efficiency_metric_pass_rate on the Entity Shared Savings Table (O.07a) is greater than or equal to (≥) 0.5
- activity_requirements_pass_flag on the Entity Shared Savings Table (O.07a) is equal to 1

5.9.5 Calculate TCOC Relative to Self

5.9.5.1 Set adjusted baseline cost fields

- To calculate total cost of care relative to self, begin by setting the adjusted baseline cost fields from the Practice Baseline Total Cost of Care Table (O.06) and Partnership Baseline Total Cost of Care Table (O.06):
  - For practice entities that are not in a partnership,set performance_target_ra_tcoc_pmpm_final on the Entity Shared Savings Table (O.07a) equal to target_ra_tcoc_pmpm_final from the Practice Baseline Total Cost of Care Table (O.06)
  - For partnership entities,set performance_target_ra_tcoc_pmpm_final on the Entity Shared Savings Table (O.07a) equal to target_ra_tcoc_pmpm_final from the Partnership Baseline Total Cost of Care Table (O.06)
  - For practice entities that are not in a partnership,set baseline_practice_adj_tcoc on the Entity Shared Savings Table (O.07a) equal to baseline_practice_adj_tcoc from the Practice Baseline Total Cost of Care Table (O.06)

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- For partnership entities,set baseline_practice_adj_tcoc on the Entity Shared Savings Table (O.07a) equal to baseline_partnership_adj_tcoc from the Partnership Baseline Total Cost of Care Table (O.06)

5.9.5.2 Calculate the savings rate

The savings rate is the percentage change between a practice's risk-adjusted TCOC in the program year, and their target risk-adjusted TCOC (represents the percentage of savings generated by the practice)

- Set savings_rate on the on the Entity Shared Savings Table (O.07a) equal to [performance_target_ra_tcoc_pmpm_final minus (–) performance_practice_ra_tcoc_pmpm_final] divided by (÷) performance_target_ra_tcoc_pmpm_final

5.9.5.3 Determine payment amount for shared savings relative to self for practice entities that are not in a partnership

The payment amount for shared savings relative to self is determined by applying the savings rate calculated in the previous step to the practice's aggregate, unadjusted target total cost of care. If the savings rate for a practice is less than 1 percent, no shared savings are earned.

- For entities where savings_rate is less than (<) 0.01 or shared_savings_eligible = 0, set shared_savings_self_earned equal to 0
- For practices that are not in a partnership, where savings_rate is greater than or equal to (≥) 0.01 and shared_savings_eligibile = 1:
  - Set shared_savings_self_earned equal to 1
  - Set shared_savings_self_amount equal to [baseline_practice_adj_tcoc times (×) savings_rate times (×) gain_sharing_rate]
- Determine payment amount for shared savings relative to self for practice entities that are not in a partnership
- After calculating Shared Savings eligibility at the Entity level, an intermediary step is implemented for practices within a partnership. Create the Practice Partnerships Shared Savings Table (O.07c). For each practice where the Partnership_ID is not null on the Ohio CPC Practices List (I.S.08) input file, generate the following fields:
  - performance_year
  - performance_rolling_period_start_date
  - performance_rolling_period_end_date

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- Set performance_practice_medicaid_id to the Medicaid_ID from the Ohio CPC Practices List (I.S.08) input file where the Partnership_ID is not null.
- Set performance_practice_name to the Practice_Name from the Ohio CPC Practices List (I.S.08) for each performance_practice_medicaid_id
- Set Partnership_ID to the practice's Partnership_ID from the Ohio CPC Practices List (I.S.08).
- Generate for each Practice within the Partnership values calculated at the entity level from Shared Savings Entity Table (O.07a Entity) where Is_Partnership= 'Y' for the following fields:
    - quality_metrics_pass_rate
    - efficiency_metrics_pass_rate
    - activity_requirements_pass_flag
    - shared_savings_eligible
    - baseline_practice_ra_tcoc_pmpm_final
    - performance_target_ra_tcoc_pmpm_final
    - performance_practice_ra_tcoc_pmpm_final
    - savings_rate- calculated as defined in partnership supplement
    - baseline_practice_unadj_tcoc
    - baseline_practice_adj_tcoc
    - shared_savings_self_earned
- Set gain_sharing_rate equal to 0.65 for practices meeting <u>either</u> of the following criteria (and to 0.5 otherwise):
    - baseline__practice_ra_tcoc_pmpm_final from the Partnership Baseline Total Cost of Care Table (O.06) times (×) 12 is less than or equal to (≤) the threshold set for 65% gain sharing

Note: Thresholds for 65% gain sharing are set utilizing data from the baseline year, identifying those that represent 10% of practices with the lowest total cost of care. Thresholds are effective for each program year. Add the following fields to calculate the proportionate share of risk-adjusted member months:

- Set Partnership_ID to the Partnership Medicaid ID from the Ohio CPC Practices List (I.S.08) input file.

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- For all members in Rolling Period Member Table (O.03) where all the following are true:
  - partnership_medicaid_id_6_month is not null
  - excl_ltc_flag is equal to 0
  - cdps_outlier_flag is equal to 0
    - Set Practice_TWRS to the sum of member_risk_score where valid_attribution_month_tcoc = 1 and practice_medicaid_id in Monthly Member Table (O.02) is equal to performance_practice_medicaid_id in the Entity Shared Savings Table (O.07c).
- Set Entity_TWRS to the sum (+) of practice_twrs for each practice within the Partnership.
- Set Proportion_TWRS equal to practice_twrs divided by (÷) entity_twrs on the Practice Partnerships Shared Savings Table (O.07c)

- Calculate Shared Savings Self as defined in this document, and multiply by the proportionate share calculated in the previous step:
  - For practices where savings_rate is greater than or equal to (≥) 0.01 and shared_savings_eligibile = 1
  - Set shared_savings_self_earned equal to 1
  - Set shared_savings_self_amount equal to [baseline_adj_tcoc times (×) savings_rate times (×) gain_sharing_rate] (x) proportion_twrs

5.9.6 Calculate TCOC Relative to Peers

5.9.6.1 Calculate practice deciles based on risk-adjusted total cost of care

- Determine each practice's decile of risk-adjusted TCOC per-member-per-month, across enrolled Ohio CPC practices:
  - For each entity on the Entity Shared Savings Table (O.07a), which should represent all Ohio CPC practices and partnerships enrolled during the program year, set tcoc_decile to the entity's decile rank based on

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performance_practice_ra_tcoc_pmpm_final across all entities

- The value of tcoc_decile should range from 1 to 10, with 1 being the lowest cost decile and 10 being the highest-cost decile

5.9.6.2 Determine payment amount for shared savings relative to peers

- For each entity on the Entity Shared Savings Table (O.07a):
  - If the practice is **not** in the lowest decile of risk-adjusted total cost of care, that is, where tcoc_decile is **not** equal to 1 or is **not** eligible for shared savings, that is, where shared_savings_eligible = 0:
    - Set shared_savings_peers_earned for the practice equal to 0
    - Set shared_savings_peers_amount for the practice equal to 0
  - If the practice is in the lowest decile of risk-adjusted total cost of care, that is, where tcoc_decile is equal to 1 and shared_savings_eligible = 1:
    - Set shared_savings_peers_earned for the practice equal to 1
  - For practice entities that are not in a partnership, shared_savings_peers_amount for the practice equal to [practice_member_months_tcoc divided by (÷) 12] times (×) 5
- For each practice on the Entity Shared Savings Table (O.07c):
  - Generate for each Practice within the Partnership values calculated at the entity level from Shared Savings Entity Table (O.07a Entity) where Is_Partnership= ‘Y’ for the following fields:
  - shared_savings_peers_earned
  - shared_savings_peers_amount
  - Set practice_member_months_tcoc to practice_member_months_tcoc from the Rolling Period Practice Table (O.04) for each practice on the Practice Shared Savings Practice Partnerships Table (O.07c).

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- Calculate Shared Savings relative to Peers for each practice on the Practice Shared Savings Practice Partnerships Table (O.07c).

– For each practice within a Partnership that has shared_savings_peers_earned = '1', Set shared_savings _peers_amount to [practice_member_months_tcoc divided by (÷) 12 times (×) 5]

- Calculate total shared savings proportionate share of payment.

– Set shared_savings_total_amount to the sum of shared_savings_self_amount (+)shared_savings_peers_amount

– Update the Shared Savings Entity Table (O.07a Entity) for Partnership Entities:

– Set shared_savings_self_amount to the sum of shared_savings_self_amount of practices within the Partnership.

– Set shared_savings_peers_amount to the sum of shared_savings_peers_amount of practices within the Partnership from the Practice Shared Savings Practice Partnerships Table (O.07c).

– Set shared_savings_total_amount to the sum of shared_savings_total_amount of practices within the Partnership from the Practice Shared Savings Practice Partnerships Table (O.07c).

5.9.6.3 Confirm total outlays do not exceed $1,000,000 during a program year

- If the sum of shared_savings_peers_amount across all Ohio CPC practices during a program year exceeds $1,000,000, scale down each practice's shared_savings_peers_amount equally and proportionally until total outlays equal $1,000,000.

5.9.6.4 Update final shared savings totals

- For practice entities that are not in a partnership, calculate the total shared savings payment amount across both shared savings payment streams by setting shared_savings_total_amount equal to shared_savings_self_amount plus (+) shared_savings_peers_amount

5.9.7 Calculate the Shared Savings Proportionate Share of Payments

As described in section 3.8.2, the payments for shared savings relative to self are paid by both ODM and MCOs, with the share of payments pro-rated based on risk-adjusted member months for FFS and each MCO, respectively. This section outlines the logic used to establish the shared savings payments across the different payers.

- Create the Practice Shared Savings Payments Table (O.08a)

- For each practice in the Entity Shared Savings Table (O.07a) where is_Partnership= 'N' shared_savings_total_amount is greater than 0, populate the following fields in the Practice

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Shared Savings Payments Table (O.08a)

Note: All fields that are calculated from the member level should be restricted to members where member_panel_tcoc is equal to 1 in Rolling Period Member Table (O.03)

- Set performance_year to the year (YYYY) of the performance_period_start_date parameter
- Set performance_rolling_period_start_date to January 1 of the performance_year
- Set performance_rolling_period_end_date to December 31 of the performance_year
- Set practice_medicaid_id to the performance_practice_medicaid_id from the Entity Shared Savings Table (O.07a)
- Set practice_name to the performance_practice_name from the Entity Shared Savings Table (O.07a)
- Set practice_shared_savings_self_amount to the shared_savings_self_amount from the Entity Shared Savings Table (O.07a)
- Set practice_shared_savings_peers_amount to the shared_savings_peers_amount from the Entity Shared Savings Table (O.07a)
- Set practice_shared_savings_total_amount to the shared_savings_total_amount from the Entity Shared Savings Table (O.07a)

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- Set practice_shared_savings_eligible to the shared_savings_eligible from the Entity Shared Savings Table (O.07a)

- Set member_aid_category in the Monthly Member Table (O.02) equal to aid_category from the Member Extract Table (I.C.01) where:
  - member_medicaid_id in the Monthly Member Table (O.02) is equal to member_id in the Member Extract Table (I.C.01) and,
  - The month as defined by month_id in the Monthly Member Table (O.02) lies between the eligibility_start_date and eligibility_end_date in the Member Extract Table (I.C.01)
    - If the member has more than one (>1) aid_category in a given month_id, choose the aid_category with the largest number of days in that month
    - Otherwise, if the member has two or more (≥2) aid categories with the <u>same</u> count of days in a given month_id, choose the most recent aid_category in that month
- Set member_fund_code in the Monthly Member Table (O.02) equal to fund_code in Ohio Aid Category to Fund Code Crosswalk (I.S.10) via the following steps:
  - Ensure member_aid_category in the Monthly Member Table (O.02) is equal to mits_aid_category_code from the Ohio Aid Category to Fund Code Crosswalk (I.S.10)
  - For members who did <u>not</u> have a valid member_aid_category as defined above, set member_fund_code equal to 'REG'
- Set member_risk_score in the Monthly Member Table (O.02) equal to risk_score in Rolling Period Member Table (O.03) where:
  - member_medicaid_id in the Monthly Member Table (O.02) is equal to member_medicaid_id in the Rolling Period Member Table (O.03) and
  - rolling_period_start_date in the Monthly Member Table (O.02) is

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equal to rolling_period_start_date in the Rolling Period Member Table (O.03) and

- rolling_period_end_date in the Monthly Member Table (O.02) is equal to rolling_period_end_date in the Rolling Period Member Table (O.03)

- Group by practice_medicaid_id and fund_code on the Monthly Member Table (O.02), and calculate the sum of valid_attribution_month_tcoc for each practice-fund combination for all members where member_panel_tcoc is equal to 1 in Rolling Period Member Table (O.03)
  - Set buckeye_mm in the Practice Shared Savings Payments Table (O.08) as the sum of valid_attribution_month_tcoc where payer_detail in Monthly Member Table (O.02) is equal to “BUCKEYE”
  - Set caresource_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “CARESOURCE”
  - Set molina_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “MOLINA”
  - Set united_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “UNITED”
  - Set amerihealth_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “AMERIHEALTH”
  - Set anthem_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “ANTHEM”
  - Set humana_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “HUMANA”

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- Set ffs_mm as the sum of valid_attribution_month_tcoc where payer_detail is not equal to any of the above (i.e., “BUCKEYE”, or “CARESOURCE”, or “MOLINA”, or “UNITED”, or “AMERIHEALTH”, or “ANTHEM”, or “HUMANA”.)

- Set total_mm in the Practice Shared Savings Payments Table (O.08) as the sum (+) of buckeye_mm, caresource_mm, molina_mm, , united_mm, amerihealth_mm, anthem_mm, humana_mm and ffs_mm

- Calculate total payer member months for each practice, grouping by practice_medicaid_id on the Monthly Member Table (O.02), and calculating the sum of valid_attribution_month_tcoc for all members where member_panel_tcoc is equal to 1 in Rolling Period Member Table (O.03)
- Set buckeye_mm in the Practice Shared Savings Payments Table (O.08) as the sum of valid_attribution_month_tcoc where payer_detail in Monthly Member Table (O.02) is equal to “BUCKEYE”
- Set caresource_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “CARESOURCE”
- Set molina_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “MOLINA”
- Set united_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “UNITED”
- Set amerihealth_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “AMERIHEALTH”
- Set anthem_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “ANTHEM”
- Set humana_mm as the sum of valid_attribution_month_tcoc where payer_detail is equal to “HUMANA”
- Set ffs_mm as the sum of valid_attribution_month_tcoc where payer_detail is not equal to any of the above (i.e., “BUCKEYE”, or “CARESOURCE”, or “MOLINA”, or “UNITED”, or “AMERIHEALTH”, or “ANTHEM”, or “HUMANA”.)

- For a given practice-fund combination, determine the proportion of shared savings paid out by each of the 8 payers (FFS and 7 MCOs) – portioned by fund-code:

  Note: All payer_mm_total values in the denominator of following proportions are practice level fields, as described in the previous section

  - Set buckeye_proportion_mm on the on the Practice Shared Savings Payments Table (O.08)

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equal to buckeye_mm divided by (÷) buckeye_mm_total

- Set caresource_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to caresource_mm divided by (÷) caresource_mm_total
- Set molina_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to molina_mm divided by (÷) molina_mm_total
- Set united_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to united_mm divided by (÷) united_mm_total
- Set amerihealth_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to amerihealth_mm divided by (÷) amerihealth_mm_total
- Set anthem_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to anthem_mm divided by (÷) anthem_mm_total
- Set humana_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to humana_mm divided by (÷) humana_mm_total
- Set ffs_proportion_mm on the on the Practice Shared Savings Payments Table (O.08) equal to ffs_mm divided by (÷) ffs_mm_total
- Set total_proportion_mm on the Practice Shared Savings Payments Table (O.08) equal to total_mm divided by (÷) the sum of the aggregate total_mm across that practice

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- **Calculate total payer risk score time weighted for each practice**, grouping by practice_medicaid_id on the Monthly Member Table (O.02), and calculating the sum of member_risk_score for each practice combination where valid_attribution_month_tcoc = 1 for all members where member_panel_tcoc is equal to 1 in Rolling Period Member Table (O.03)
    - Set buckeye_time_weighted_risk_score in the Practice Shared Savings Payments Table (O.08) as the sum of member_risk_score where payer_detail in Monthly Member Table (O.02) is equal to “BUCKEYE” and where valid_attribution_month_tcoc = 1
    - Set caresource_ time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to “CARESOURCE” and where valid_attribution_month_tcoc = 1
    - Set molina_time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to “MOLINA” and where valid_attribution_month_tcoc = 1
    - Set united_time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to “UNITED” and where valid_attribution_month_tcoc = 1
    - Set amerihealth_time_weighted_risk_ score as the sum of member_risk_score where payer_detail is equal to “AMERIHEALTH” and where valid_attribution_month_tcoc = 1
    - Set anthem_time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to “ANTHEM” and where valid_attribution_month_tcoc = 1

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- Set humana_time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to "HUMANA" and where valid_attribution_month_tcoc = 1
- Set ffs_time_weighted_risk_score as the sum of member_risk_score where payer_detail is equal to "FFS" and where valid_attribution_month_tcoc = 1 <u>and</u> payer_detail is <u>not</u> equal to any of the above (i.e., "BUCKEYE", or "CARESOURCE", or "MOLINA", or "UNITED", or "AMERIHEALTH", or "ANTHEM", or "HUMANA")
- Set total_time_weighted_risk_score for each practice in the Practice Shared Savings Payments Table (O.08) as the sum (+) of buckeye_time_weighted_risk_score, caresource_time_weighted_risk_score, molina_time_weighted_risk_score, , united_time_weighted_risk_score, amerihealth_time_weighted_risk_score, anthem_time_weighted_risk_score, humana_time_weighted_risk_score and ffs_time_weighted_risk_score

- Determine the proportion of shared savings paid out by each of the 8 payers (FFS and MCOs) by calculating payer risk score time weighted proportions for each practice
  - Set buckeye_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to buckeye_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score

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- Set caresource_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to caresource_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set molina_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to molina_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set united_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to united_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set amerihealth_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to amerihealth_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set anthem_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to anthem_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set humana_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to humana_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score
- Set ffs_proportion on the on the Practice Shared Savings Payments Table (O.08) equal to ffs_time_weighted_risk_score divided by (÷) total_time_weighted_risk_score

- **Calculate the shared savings <u>relative to self</u> amounts for each practice** in the Practice Shared Savings Payments Table (O.08), by multiplying the proportions calculated in the previous step with the overall shared savings relative to self amount

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- Set buckeye_shared_savings_self_amount by multiplying buckeye_proportion with shared_savings_self_amount
- Similarly, set caresource_shared_savings_self_amount by multiplying caresource_proportion with shared_savings_self_amount
- Similarly, set molina_shared_savings_self_amount by multiplying molina_proportion with shared_savings_self_amount
- Similarly, set united_shared_savings_self_amountby multiplying united_proportion with shared_savings_self_amount
- Similarly, set ffs_shared_savings_self_amount by multiplying ffs_proportion with shared_savings_self_amount
- Similarly, set amerihealth_shared_savings_self_amount by multiplying amerihealth_proportion with shared_savings_self_amount
- Similarly, set anthem_shared_savings_self_amount by multiplying anthem_proportion with shared_savings_self_amount
- Similarly, set humana_shared_savings_self_amount by multiplying humana_proportion with shared_savings_self_amount

- **Calculate the shared savings <u>relative to self</u> amounts for each practice-fund combination** in the Practice Shared Savings Payments Table (O.08), by multiplying the payer shared savings self amount calculated in the previous step with the payer member months proportions at the fund code level

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- Set total_ss_self_dollar in the Practice Shared Savings Payments Table (O.08) by multiplying total_proportion_mm with shared_savings_self_amount in the Practice Shared Savings Payments Table (O.08)

  - Similarly, set buckeye_ss_self_dollar by multiplying buckeye_proportion_mm with buckeye_shared_savings_self_amount
  - Similarly, set caresource_ss_self_dollar by multiplying caresource_proportion_mm with caresource_shared_savings_self_amount
  - Set molina_ss_self_dollar by multiplying molina_proportion with molina_shared_savings_self_amount
  - Set united_ss_self_dollar by multiplying united_proportion with united_shared_savings_self_amount
  - Set amerihealth_ss_self_dollar by multiplying amerihealth_proportion with amerihealth_shared_savings_self_amount
  - Set anthem_ss_self_dollar by multiplying anthem_proportion with anthem_shared_savings_self_amount
  - Set humana_ss_self_dollar by multiplying humana_proportion with humana_shared_savings_self_amount
  - Set ffs_ss_self_dollar by multiplying ffs_proportion with ffs_shared_savings_self_amount

- **Calculate the shared savings <u>relative to peers</u> amounts for each practice-fund combination** in the Practice Shared Savings Payments Table (O.08), by multiplying the proportions calculated in the previous step with the overall shared savings relative to peers amount at the fund code level

  - Set total_ss_peers_dollar in the Practice Shared Savings Payments Table (O.08a) by multiplying total_proportion_mm with shared_savings_peers_amount in the Practice Shared Savings Payments Table (O.08)
  - Create the Entity Shared Savings Payments Table (O.08b)

  - For each practice in the Entity Shared Savings Table (O.07c) where shared_savings_total_amount is greater than 0, populate all of the fields as calculated in the previous step in the Practice Shared Savings Payments Table (O.08b)

    Note: All fields that are calculated from the member level data for the partnership practices should be restricted to members that meet the following criteria:

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  - Partnership_medicaid_id_6_month is not null in Rolling Period Member Table (O.03)
  - Excl_ltc_flag is equal to 0 in Rolling Period Member Table (O.03)
  - cdps_outlier_flag is equal to 0 in Rolling Period Member Table (O.03)

- Create the final Shared Savings Payments Table (O.08) by completing a final union of the Practice Shared Savings Payments Table (O.08a) & Entity Shared Savings Payments Table (O.08b).

5.10 Create Output Data Files and Reports

5.10.1 Overview

This section describes the creation of output data files and reports. These differ from output tables in that the output data files and reports are created for external consumption by ODM, MCOs, and Ohio CPC practices.

> **Note:** Throughout this section, this document describes the fields to create the output data files. In some cases, additional formatting steps are needed to confirm to the specifications of the files, which are not covered in the text of this document. For example, this DBR may describe the creation of a field as having values of 1 or 0. These may need to be converted to a “Yes” or “No” for the final output file. The format and possible values of the output files are described on the “Output data files and fields” tab of the Ohio CPC Configuration File.

5.10.1.1 Parameters

- cpc_practice_medicaid_id, current_quarter_members_panel_total, previous_quarter_members_panel_total

5.10.1.2 Configuration file codelists

None

5.10.1.3 Input tables

- Member Extract (I.C.01), Attribution Output Table (O.01), Monthly Member Table (O.02), Rolling Period Member Table (O.03), Rolling Period Practice Table (O.04), Practice Shared Savings Table (O.07), Provider Specialty (I.S.04)

5.10.1.4 Output tables

- File C (ODF.02), File D (ODF.03), File G1 (ODF.04), File G2 (ODF.05), File G6, File H (ODF.06), File I (ODF.07), File K (ODF.09), File L (ODF.10), File O (ODF.13), File G3 (ODF.14), File G4 (ODF.15), File G5 (ODF.16), Shared Savings Internal Calculations Table (ODF.17), File J (ODF.08), File S, File P, File GAR

5.10.2 File A

File A (ODF.01) is the pre-exclusion attribution QA file, shared with ODM prior to exclusions being applied. This file is outside of the scope of the Ohio CPC DBR.

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5.10.3 File C

File C (ODF.02) represents the “master” attribution table which is shared with ODM for purposes of validating quarterly attribution and quarterly PMPM payments made to Ohio CPC practices.

File C (ODF.02) contains all Ohio Medicaid members who were attributed to both enrolled Ohio CPC practices, and non-CPC practices, including both included and excluded members.

The structure of File C (ODF.02) is one row per member.

- Begin with all members on the Attribution Output Table (O.01)
- Update the File C (ODF.01) output data file using the following fields from the Attribution Output Table (O.01), unless otherwise noted, for the corresponding quarter:
    - Set Payer to payer
    - Set Payer Details to payer_detail
    - Set Member Medicaid ID to member_medicaid_id
    - Set Member First Name to member_first_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set Member Last Name to member_last_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set ExclNoElig to excl_noelig
    - Set ExclDual to excl_dual
    - Set ExclTPL to excl_tpl
    - Set ExclLimitedBen to excl_limitedben
    - Set ExclTransition to excl_transition
    - Set FosterCare to foster_care
    - Set ExclAny to excl_standard_any
    - Set Member Date of Birth to member_dob
    - Set Member Age to member_age

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- Set Member Gender to member_gender
- Set Enrollment Period to enrollment_period
- Set Practice Medicaid ID to practice_medicaid_id
- Set Practice Name to practice_name
- Set Practice NPI to practice_npi
- Set Rendering Provider Medicaid ID to practitioner_medicaid_id
- Set Rendering Provider Name to practitioner_name
- Set Rendering Provider NPI to practitioner_npi
- Set Risk Band to risk_tier
- Set Valid Practice Indicator to valid_practice
- Set PCP Medicaid ID to practitioner_medicaid_id
- Set PCP Name to practitioner_name
- Set Valid PCP Indicator to valid_practitioner
- Set Assignment Method to attribution_method
- Set Claims Last 24 Months Flag to utilization_flag
- Set Risk Score to cdps_risk_score
- Set Attribution Year to Attribution_Year
- Set Attribution Quarter to Attribution_Quarter
- Set Quarterly CPC Regular PMPM Amount to Quarterly_CPC_Regular_PMPM_Amount
- Set Quarterly CPC Kids Enhanced PMPM Amount to

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Quarterly_CPC_Kids_Enhanced_PMPM_Amount

- Set Previous_Quarter_Practice_Medicaid_ID to Previous_Quarter_Practice_Medicaid_ID
- Set Previous_Quarter_Payer to Previous_Quarter_Payer
- Set ExclOhiorise to excl_Ohiorise
- Set CPC_Month1_Current_Quarter_Takeback_Amount to CPC_Month1_Current_Quarter_Takeback_Amount
- Set CPC_Month2_Current_Quarter_Takeback_Amount to CPC_Month2_Current_Quarter_Takeback_Amount
- Set CPC_Month3_Current_Quarter_Takeback_Amount to CPC_Month3_Current_Quarter_Takeback_Amount
- Set Total Quarterly PMPM Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)

5.10.4 File D

File D (ODF.03) represents a “package” of attribution and payment validation files, used by MCOs to confirm quarterly attribution, payment, and the results of Ohio CPC standard exclusions. File D (ODF.03) consists of three sets of data, contained on separate tabs within an Excel deliverable:

- Tab 1 - MCO PMPM payment provider-level data
- Tab 2 - MCO PMPM payment member-level data

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- Tab 3 - MCO master attribution payment member-level file
- Tab 4 – CMC Takeback amounts

Note: The following steps should be taken once for each MCO. One File D (ODF.03) output data file is created for each MCO.

Note: because of limitations in Excel around number of allowable rows of data, the data on Tab 3 may be limited to 800,000 rows and a "Tab 4" may be created with the remaining rows of data.

5.10.4.1 Create Tab 1 - MCO PMPM payment provider-level data

- Begin with all members from the Attribution Output Table (O.01)
- Filter the data to contain only records where payer on the Attribution Output Table (O.01) is equal to the MCO for which the file is being created (i.e., that each MCO's File D only contains attributed members covered under their plan)
- Filter the data to retain only non-excluded members for whom quarterly PMPM payments are made, by only keeping records where excl_standard_any on the Attribution Output Table (O.01) is equal to 0
- Filter the data to retain only members enrolled in active Ohio CPC practices, that is, where active_practice_flag on the Attribution Output Table (O.01) is equal to 1
- Group the data by the practice_medicaid_id on the Attribution Output Table (O.01) and set the following fields on the first tab within File D (ODF.03), "*Tab 2 - MCO PMPM payment member-level data*", using the Attribution Output Table (O.01), unless otherwise specified:
    - Set Payer to payer
    - Set Enrollment Period to enrollment_period from the Ohio CPC Practices List (I.S.08) where practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08)
    - Set Practice Medicaid ID to practice_medicaid_id
    - Set Practice Name to practice_name
    - Set Practice Tax ID to provider_tax_id
    - Set Practice NPI to practice_npi
    - Set Practice CPC Kids Participation Flag (Y/N) set to Y if the following criteria are true:

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- practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08)
- Active_Practice_Flag is equal to '1' from the Ohio CPC Practices List (I.S.08)
- Is_cpc_kids is equal to 'Y' from the Ohio CPC Practices List (I.S.08)
    - Set Total Quarterly PMPM Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)
    - Set Quarterly CPC Regular PMPM Amount to the sum of quarterly_pmpm_payment_amount across all members attributed to the practice (after the payer and member-level exclusions have been applied, as described in the previous steps)
    - Set Quarterly CPC Kids Enhanced PMPM Amount to the quarterly_cpc_kids_enhanced pmpm_amount

Note: Quarterly CPC for Kids Enhanced PMPM Amount - Starting Q1 2020, Enhanced PMPM amount for CPC for Kids (the additional dollar per member) if applicable only applies when the practice is enrolled in the CPC for Kids program and the member is under the age of 21 on the point in attribution date.

5.10.4.2 Create Tab 2 - MCO PMPM payment member-level data

- Begin with all members from the Attribution Output Table (O.01)
- Filter the data to contain only records where payer on the Attribution Output Table (O.01) is equal to the MCO for which the file is being created (i.e., that each MCO's File D only contains attributed members covered under their plan)
- Filter the data to retain only members enrolled in active Ohio CPC practices, that is, where active_practice_flag on the Attribution Output Table (O.01) is equal to 1
- Set the following fields on the second tab within File D (ODF.03), "*Tab 2 - MCO PMPM payment member-level data*", using the Attribution Output Table (O.01), unless otherwise specified:

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- Set Payer to payer
- Set Member Medicaid ID to member_medicaid_id
- Set Member First Name to member_first_name
- Set Member Last Name to member_last_name
- Set Member DOB to member_dob
- Set Enrollment Period to enrollment_period
- Set Practice Medicaid ID to practice_medicaid_id
- Set Practice NPI to practice_npi
- Set Practice CPC Kids Participation Flag (Y/N) set to Y if the following criteria are true:

– practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08)

– Active_Practice_Flag is equal to ‘1’ from the Ohio CPC Practices List (I.S.08)

– Is_cpc_kids is equal to ‘Y’ from the Ohio CPC Practices List (I.S.08)

- Set Rendering Provider Medicaid ID to practitioner_medicaid_id
- Set Rendering Provider NPI to practitioner_npi
- Set Risk Band to risk_tier
- Set Total Quarterly PMPM Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)
- Set Quarterly CPC Regular PMPM Amount to the sum of quarterly_pmpm_payment_amount across all members attributed to

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the practice (after the payer and member-level exclusions have been applied, as described in the previous steps)

- Set Quarterly CPC Kids Enhanced PMPM Amount to the quarterly_cpc_kids_enhanced pmpm_amount

Note: Quarterly CPC for Kids Enhanced PMPM Amount - Enhanced PMPM amount for CPC for Kids (the additional dollar per member) if applicable only applies when the practice is enrolled in the CPC for Kids program and the member is under the age of 21 on the point in attribution date.

5.10.4.3 Create Tab 3 - MCO master attribution payment member-level file

- Begin with all members from the Attribution Output Table (O.01)
- Filter the data to contain only records where payer on the Attribution Output Table (O.01) is equal to the MCO for which the file is being created (i.e., that each MCO's File D (ODF.03) only contains attributed members covered under their plan)
- Set the following fields on the third tab within File D (ODF.03), "*Tab 3 - MCO master attribution payment member-level file*", using the Attribution Output Table (O.01), unless otherwise specified:
  - Set Payer to payer
  - Set Enrollment Period to enrollment_period
  - Set Practice Medicaid ID to practice_medicaid_id
  - Set Practice Name to practice_name
  - Set Practice NPI to practice_npi
  - Set Practice CPC Kids Participation Flag (Y/N) set to Y if the following criteria are true:
    - practice_medicaid_id from the Attribution Output Table (O.01) equals practice_medicaid_id from the Ohio CPC Practices List (I.S.08)
    - Active_Practice_Flag is equal to '1' from the Ohio CPC Practices List (I.S.08)
    - Is_cpc_kids is equal to 'Y' from the Ohio CPC Practices List (I.S.08)
  - Set Rendering Provider Medicaid ID to practitioner_medicaid_id
  - Set Rendering Provider Name to practitioner_name

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- Set Rendering Provider NPI to practitioner_npi
- Set Member Medicaid ID to member_medicaid_id
- Set Member First Name to member_first_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member Last Name to member_last_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member DOB to member_dob
- Set ExclNoElig to excl_noelig
- Set ExclDual to excl_dual
- Set ExclTPL to excl_tpl
- Set ExclLimitedBen to excl_limitedben
- Set ExclTransition to excl_transition
- Set FosterCare to foster_care
- Set Exclohioriseto Exclohiorise starting 7/1/2022
- Set ExclAny to excl_standard_any
- Set Risk Band to risk_tier
- Set Total Quarterly PMPM Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount +

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CPC_Month3_Current_Quarter_Takeback_Amount)

- Set Quarterly CPC Regular PMPM Amount to the sum of quarterly_pmpm_payment_amount across all members attributed to the practice (after the payer and member-level exclusions have been applied, as described in the previous steps)
- Set Quarterly CPC Kids Enhanced PMPM Amount to the quarterly_cpc_kids_enhanced pmpm_amount

Note: Quarterly CPC for Kids Enhanced PMPM Amount - Enhanced PMPM amount for CPC for Kids (the additional dollar per member) if applicable only applies when the practice is enrolled in the CPC for Kids program and the member is under the age of 21 on the point in attribution date.

5.10.4.4 Create Tab 4 - CMC Take Back Amounts

- Begin with all members from the Attribution Output Table (O.01)
- Filter the data to contain only records where payer on the Attribution Output Table (O.01) is equal to the MCO for which the file is being created (i.e., that each MCO's File D (ODF.03) only contains attributed members covered under their plan)
- Set the following fields on the fourth tab within File D (ODF.03), "*Tab 4 – CMC Take Back Amounts*", using the Attribution Output Table (O.01), unless otherwise specified:
  - Set Member Medicaid ID to member_medicaid_id
  - Set Practice_Medicaid_ID to practice_medicaid_id
  - Set Payer_Detail to payer_detail
  - Set CPC Month 1 Current Quarter Take back Amount to cpc_month_1_current_quarter_take_back_amount
  - Set CPC Month 2 Current Quarter Take back Amount to cpc_month_2_current_quarter_take_back_amount
  - Set CPC Month 3 Current Quarter Take back Amount to cpc_month_3_current_quarter_take_back_amount

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5.10.5 Files G1 and G2

File G1 (ODF.04) and File G2 (ODF.05) are the expenditure upload files required by ODM to process quarterly PMPM payments. File G1 (ODF.04) is the expenditure upload file for FFS members, whereby quarterly PMPM payments are issued directly to practices. File G2 (ODF.05) is the expenditure upload file for MCOs, whereby quarterly PMPM payments are issued to the MCOs, which in turn issue payments to CPC practices.

5.10.5.1 Create File G1 – the expenditure upload file for FFS

- Begin with all members on the Attribution Output Table (O.01) who are not excluded in the quarter due to standard Ohio CPC exclusions, that is, where excl_standard_any is equal to 0
- Include only Ohio CPC practices that are actively enrolled in the program, for which quarterly PMPM payments are made, that is, where active_practice_flag on the Attribution Output Table (O.01) is equal to 1
- Include only FFS members, that is, where payer on the Attribution Output Table (O.01) is equal to “FFS”
- Group by practice_medicaid_id and member_fund_code on the Attribution Output Table (O.01) and update the following fields on File G1:
    - Set Payee ID to practice_npi from the Attribution Output Table (O.01)
    - Set Payee Type to “P”
    - Set Reason to “8422” (CPC) or “8424” (CPC for Kids)
    - Set Fund Code to the concatenation of “4502” (CPC) “4402” (CPC for Kids) and member_fund_code from the Attribution Output Table (O.01)
    - For example, if member_fund_code is equal to “REG” then Fund Code should be set to “4602REG”
    - Set Associated FFYQ to blank (no value)
- Set Payout Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)
    - Set Process Type to “R”

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- Set Issue Date to six months after quarter_start_date from the Attribution Output Table (O.01)
- Set Provider Type to “MCD”
- Set Invoice Type to ‘PIP CPC’
- Set Business Unit to ‘MD’

5.10.5.2 Create File G2 – the expenditure upload file for MCOs

- Begin with all members on the Attribution Output Table (O.01) who are not excluded in the quarter due to standard Ohio CPC exclusions, that is, where excl_standard_any is equal to 0
- Include only Ohio CPC practices that are actively enrolled in the program, for which quarterly PMPM payments are made, that is, where active_practice_flag on the Attribution Output Table (O.01) is equal to 1
- Include only members attributed via MCOs, that is, where payer on the Attribution Output Table (O.01) is equal to “MCO”
- Group by payer_detail and member_fund_code on the Attribution Output Table (O.01) and update the following fields on File G1:
  - Set Payee ID equal to the following values, based on the value of PayerDetail:
  - If PayerDetail is equal to “BUCKEYE” then set Payee ID to “0077148”
  - If PayerDetail is equal to “CARESOURCE” then set Payee ID to “0077193”
  - If PayerDetail is equal to “MOLINA” then set Payee ID to “0077186”
  - If PayerDetail is equal to “UNITED” then set Payee ID to “0077115”
  - If PayerDetail is equal to “AMERIHEALTH” then set Payee ID to '0462293'
  - If PayerDetail is equal to “ANTHEM” then set Payee ID to '0464229'
  - If PayerDetail is equal to “HUMANA” then set Payee ID to '0462285'
  - Set Payee Type equal to “P”

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- Set Reason to “8423” (CPC) or “8425” (CPC for Kids)
- Set Fund Code to the concatenation of “4572” (CPC) or “4472” (CPC for Kids) and member_fund_code from the Attribution Output Table (O.01)
- For example, if member_fund_code is equal to “REG” then Fund Code should be set to “4572REG”
- Set Associated FFYQ to blank (no value)
- Set Payout Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)
- Set Process Type to “R”
- Set Issue Date to six months after quarter_start_date from the Attribution Output Table (O.01)
- Set Provider Type to “MCD”
- Set Invoice Type to ‘PIP CPC’
- Set Business Unit to ‘MD’

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5.10.6 File H

File H (ODF.06) is the provider attribution and payment file (sometimes referred to as the “attribution roster). Ohio CPC practices receive File H (ODF.06) through MITS, and the file contains the practice’s attributed members and corresponding per-member-per-month payment amounts for the upcoming quarter.

Each practice receives a separate copy of File H (ODF.06), containing only members attributed to the practice for the given quarter.

- To create File H (ODF.06) for each practice:
  - Begin with all members from the Attribution Output Table (O.01)
  - Filter the data to contain only records where practice_medicaid_id on the Attribution Output Table (O.01) is equal to the Ohio CPC practice for which the file is being created

Note: Typically, this consists of all active participating Ohio CPC practices, as identified in the Ohio CPC Practices List (I.S.08)

  - Set the following fields on the File H (ODF.06) output data file, using the Attribution Output Table (O.01), unless otherwise specified:
  - Set Member Medicaid ID to member_medicaid_id
  - Set Member First Name to member_first_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
  - Set Member Last Name to member_last_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
  - Set Payer to payer
  - Set Risk Band to risk_tier

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- Set Attribution Method (Claims/Geo/Member Choice) to attribution_method
- Set Member Excluded (Y/N) to ExclAny
- Set No Eligibility Exclusion to excl_noelig
- Set Dual Exclusion to excl_dual
- Set TPL Exclusion to excl_tpl
- Set Limited Benefits Exclusion to excl_limitedben
- Set Members in Transition Exclusion to excl_transition
- Set Foster Care to foster_care
- Set OhioRISE Exclusion to excl_Ohiorise
- Set Provider Billing Medicaid ID to practice_medicaid_id
- Set Provider Billing NPI to practice_npi
- Set Rendering Provider Medicaid ID to practitioner_medicaid_id
- Set Rendering Provider Name to practitioner_name
- Set Rendering Provider NPI to practitioner_npi
- Set Member Date of Birth to member_dob
- Set Member Gender to member_gender
- Set Member Phone Number to member_phone_number from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member Address 1 to member_address_1 from the Member Extract (I.C.01) where member_medicaid_id from the

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Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)

- Set Member Address 2 to member_address_2 from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member City to member_city from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member County to member_county from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member State to member_state from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member Zip Code to member_zip_code from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Quarterly_CPC_Regular_PMPM_Amount to quarterly_cpc_regular_pmpm_amount
- Set Quarterly_CPC_Kids_Enhanced_PMPM_Amount to

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quarterly_cpc_kids_enhanced_pmpm_amount

- Set CPC Month 1 Current Quarter Takeback Amount to CPC_Month1_Current_Quarter_Takeback_Amount
- Set CPC Month 2 Current Quarter Takeback Amount to CPC_Month2_Current_Quarter_Takeback_Amount
- Set CPC Month 3 Current Quarter Takeback Amount to CPC_Month3_Current_Quarter_Takeback_Amount
- Set Total Quarterly PMPM Amount to (Quarterly_CPC_Regular_PMPM_Amount + Quarterly_CPC_Kids_Enhanced_PMPM_Amount) - (CPC_Month1_Current_Quarter_Takeback_Amount + CPC_Month2_Current_Quarter_Takeback_Amount + CPC_Month3_Current_Quarter_Takeback_Amount)

5.10.7 File J

File J (ODF.08) is the summarized, practice-level CPC Practice Report PDF file received each quarter, as informational reports, and annually, as final reports, by Ohio CPC practices and partnerships. Annual reports differ from quarterly reports in that they have the Shared Savings status filled in, the PMPM amount received by the entity for the year, instead of the quarter, and represent 7 months of claims run out (paid through 7/31 of the following year). The claims run out period for File J is not different from what is used in other elements of Annual reporting.

While the creation of File J (ODF.08) is outside the scope of the Ohio CPC DBR, the data elements needed to generate the reports are contained within the following output tables

- Attribution Output Table (O.01)
- Rolling Period Practice Table (O.04)
- Rolling Partnership Practice Table (O.04)
- Practice Shared Savings Table (O.07)

Each practice participating individually will receive the PDF report summarizing their performance for the quarter or the year. If the practice is participating in a partnership, they will receive a PDF report summarizing the performance of the partnership. Following the partnership performance, the summary report for each practice in the partnership is provided.

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5.10.8 File I

File I (ODF.07) is the member-level CPC Practice Report CSV file received each quarter by Ohio CPC practices through MITS.

One output of File I (ODF.07) is created for each enrolled Ohio CPC practice that will receive a CPC Practice report for the quarter

- Set the cpc_practice_medicaid_id parameter equal to the Ohio CPC practice's practice_medicaid_id for which the File I (ODF.07) is being created

File I (ODF.07) contains all members that were attributed to a practice for at least 1 quarter during the 12-month rolling period. The entirety of the member's information for the 12-month rolling period is shared with the practice, even if the member was only attributed to the practice for one quarter during the 12-month rolling period. There are select fields that are populated and shared only with the members' 6-month attribution practice. These fields are noted below.

5.10.8.1 Determine each practice's base population for File I (ODF.07)

- Find all members who were attributed to the practice for at least 1 quarter during the 12-month rolling period:
    - Begin with the Quarterly Attribution Bridge Table (O.05) where the rolling_period_start_date and rolling_period_end_date match the timeframe of the File I (ODF.07) to be created
    - Select all members (member_medicaid_id) from the Quarterly Attribution Bridge Table (O.05) where practice_medicaid_id equals the cpc_practice_medicaid_id parameter
    - The resulting set of members is the base population for the given practice for File I (ODF.07)

5.10.8.2 Update the following fields on File I (ODF.07) using the Rolling Period Member Table (O.03):

- Begin with the Rolling Period Member Table (O.03) where the rolling_period_start_date and rolling_period_end_date match the timeframe of the File I (ODF.07) to be created, and filter the Rolling Period Member Table (O.03) to only include members in the base population for File I (ODF.07) identified in the previous step.
- Update the fields on File I (ODF.07) for the practice as follows, pulling the associated fields from the Rolling Period Member Table (O.03) unless otherwise specified:
    - Set Reporting Year to reporting_year

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- Set Reporting Quarter to reporting_quarter
- Set Performance Period ID to 1
- Not part of File K or File O
- Set Performance Period Start Date to rolling_period_start_date
- Set Performance Period End Date to rolling_period_end_date
- Set Reporting Practice Medicaid ID to the cpc_practice_medicaid_id parameter

Note: This field indicates that the member was attributed to this practice at least once during the 12-month rolling period

- Set Reporting Practice Name to practice_name from the Quarterly Attribution Bridge Table (O.05), where the cpc_practice_medicaid_id parameter equals practice_medicaid_id on the Quarterly Attribution Bridge Table (O.05)
- Set Member Medicaid ID to member_medicaid_id
- Set Member First Name to member_first_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Member Last Name to member_last_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
- Set Ineligible Months to excl_noelig_months

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- Set Dual Months to excl_dual_months
- Set TPL Coverage Months to excl_tpl_months
- Set Limited Benefit Months to excl_limitedben_months
- Set FFS MCO Transition Months to excl_transition_months
- Set Foster Children Exclusion Months to excl_foster_months
- Should be populated with ‘0’ starting PY 2020 and later
- Set OhioRISE Exclusion Months to excl_RISE_months starting 7/1/2022
- Set Measure Exclusion Months to excl_standard_months
- Set NICU Months to excl_nicu_months
- Set Measure Eligible Months to metrics_eligible_months
- Set TCOC Eligible Months to tcoc_eligible_months
- Set TCOC Exclusion Months to 12 minus (-) tcoc_eligible_months
- Set TCOC Exclusion Flag to 1 if member_panel_tcoc is equal to 0, and 0 otherwise
- Set LTC Flag to excl_ltc_flag
- Set Fewer than 6 Months Eligibility Flag to 1 if tcoc_eligible_months is less than (<) 6, and 0 otherwise
- Set Practice 6-Month Attribution Flag for Measure to 1 (and 0 otherwise) if member_panel_metrics is equal to 1 and the cpc_practice_medicaid_id parameter is equal to practice_medicaid_id_6_month

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- Set Practice 6-Month Attribution Flag for TCOC to 1 (and 0 otherwise) if member_panel_tcoc is equal to 1 and the cpc_practice_medicaid_id parameter is equal to practice_medicaid_id_6_month
- Set Member Date of Birth to member_dob
- Set Member Age to member_age
- Set Member Gender to member_gender
- Set Risk Band to risk_tier
- Set Risk Tiers to:

  - 1 if CDPS raw risk score is <= 1.0
  - 2 if CDPS raw risk score 1.0 < Risk Score <= 2.5
  - 3 if CDPS raw risk score is > 2.5, 0 otherwise

    - Set Spend Percentile Within Practice to spend_percentile_within_practice
    - Set Member Attribution Status: Currently in Panel Flag to 1 (and 0 otherwise) if quarter_id from the Quarterly Attribution Bridge Table (O.05) is equal to 4 and cpc_practice_medicaid_id is equal to practice_medicaid_id on the Quarterly Attribution Bridge Table (O.05)
    - Set Member Attribution Status: Newly Attributed in Current Quarter to 1 (and 0 otherwise) if Member Attribution Status: Currently in Panel Flag is equal to 1 and if quarter_id from the Quarterly Attribution Bridge Table (O.05) is equal to 3 and cpc_practice_medicaid_id is <u>not</u> equal to practice_medicaid_id on the Quarterly Attribution Bridge Table (O.05)

      Note: this flag is intended to identify when the member's attributed practice in the fourth (current) quarter of the rolling period differs from the member's attributed practice in the third quarter of the rolling period

- Set Member Attribution Status: 6 or More Months in Panel Flag to 1 if the cpc_practice_medicaid_id parameter is equal to practice_medicaid_id_6_month and 0 otherwise
- Set PCP Medicaid ID to practitioner_medicaid_id_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set PCP Medicaid ID to *null*
- Set PCP Name to practitioner_name_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel

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Flag is equal to 0, set PCP Name to *null*

- Set Practice Medicaid ID to practice_medicaid_id_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set Practice Medicaid ID to *null*
- Set Practice Name to practice_name_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set Practice Name to *null*
- Set Payer to payer_practice_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set Payer to *null*
- Set Payer Detail to payer_practice_detail_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set Payer Detail to *null*
- Set Attribution Method to attribution_method_6_month
  - However, if Member Attribution Status: 6 or More Months in Panel Flag is equal to 0, set Attribution Method to *null*
- Set W30-First 15 Months Den Flag to w30a_den_flag
- Set W30-First 15 Months Num Flag to w30a_num_flag
- Set W30-15 to 30 Months Den Flag to w30b_den_flag
- Set W30-15 to 30 Months Num Flag to w30b_num_flag
- Set WCV-3-11 years Den Flag to wcv11_den_flag
- Set WCV-3-11 years Num Flag to wcv11_num_flag
- Set WCV-12-17 years Den Flag to wcv17_den_flag
- Set WCV-12-17 years Num Flag to wcv17_num_flag
- Set WCV-18-21 years Den Flag to wcv21_den_flag
- Set WCV-18-21 years Num Flag to wcv21_num_flag
- Set WCC Den Flag to wcc_den_flag

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- Set WCC Num Flag to wcc_num_flag
- Set PPC_Prenatal Den Flag to ppc_prenatal_den_flag
- Set PPC_Prenatal Num Flag to ppc_prenatal_num_flag
- Set LBW Den Flag to lbw_den_flag
- Set LBW Num Flag to lbw_num_flag
- Set PPC_Postpartum Den Flag to ppc_postpartum_den_flag
- Set PPC_Postpartum Num Flag to ppc_postpartum_num_flag
- Set CCS Den Flag to ccs_den_flag
- Set CCS Num Flag to ccs_num_flag
- Set CBP Den Flag to cbp_den_flag
- Set CBP Num Flag to cbp_num_flag
- Set SPC Den Flag to spc_den_flag
- Set SPC Num Flag to spc_num_flag
- Set AMR Den Flag to amr_den_flag
- Set AMR Num Flag to amr_num_flag
- Set FUH Den Count to fuh_den_count
- Set FUH Num Count to fuh_num_count
- Set IET Den Count to iet_den_count
- Set IET Count to iet_num_count
- Set TCI Den Flag to tci_den_flag
- Set TCI Num Flag to tci_num_flag
- Set AMB - Count of Avoidable ER Visits to amb_er_visit_count
- Set AHRQ PQI 90 - Count of IP Admits to pqi_90_ip_admit_count
- Set MPT - Count of BH Related Admits to mpt_bh_related_ip_admit_count
- Set PDL Antidiabetics, Insulin, Lantus only Num Flag to pdl_ail_num_flag
- Set PDL Antidiabetics, Insulin, Lantus only Den Flag to pdl_ail_den_flag
- Set PDL Antidiabetics, DPPIV Inhibitors Num Flag to pdl_adi_num_flag
- Set PDL Antidiabetics, DPPIV Inhibitors Den Flag to pdl_adi_den_flag
- Set PDL Asthma Num Flag to pdl_asth_num_flag
- Set PDL Den Flag to pdl_asth_den_flag
- Set PDL COPD Num Flag to pdl_copd_num_flag
- Set PDL COPD Den Flag to pdl_copd_den_flag
- Set 3 or More ED Flag to 3_or_more_ed_flag

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- Set 1 or More IP Admit Flag to 1_or_more_ip_admit_flag
- Set No PCP Visit Flag to no_pcp_visit_flag
- Set Total Spend (Post Exclusions) $ to the sum of tcoc_unadjusted_month from the Monthly Member Table (O.02) plus (+) rolling_period_pmpm_payment from the Rolling Period Member Table (O.03)
- Set PMPM Payment $ to rolling_period_pmpm_payment
- Set Hospital Inpatient Care $ to hospital_inpatient_care_spend
- Set ED Care $ to ed_care_spend
- Set Hospital Outpatient Care $ to hospital_outpatient_care_spend
- Set Office and Clinic Care $ to office_and_clinic_care_spend
- Set Institutional Care $ to institutional_care_spend
- Set Home and Community-Based Care $ to home_and_community_based_care_spend
- Set Prescription Drugs $ to prescription_drugs_spend
- Set Specialty Pharmaceuticals $ to specialty_pharmaceuticals_spend
- Set Lab and Pathology $ to lab_and_pathology_spend
- Set Radiology $ to radiology_spend
- Set Ancillary Services $ to ancillary_services_spend
- Set DME and Supplies $ to dme_and_supplies_spend
- Set Physical Occupational and Speech Therapies $ to physical_occupational_and_speech_therapies_spend
- Set Others $ to others_spend
- Set Monthly TCOC $ for each member to the [sum of tcoc_unadjusted_month from the Monthly Member Table (O.02) plus (+) the sum of monthly_pmpm_payment where valid_attribution_month_tcoc is equal to 1 for the month] divided by (÷) the sum of valid_attribution_month_tcoc
- Set Monthly Risk-Adjusted TCOC $ to member_ra_tcoc
- Set LSC Kids Numerator Flag to lsc_cpck_num_flag
- Set LSC Kids Denominator Flag to lsc_cpck_den_flag
- Set CIS Kids Numerator Flag to cis_cpck_num_flag
- Set CIS Kids Denominator Flag to cis_cpck_den_flag
- Set IMA Kids Numerator Flag to ima_cpck_num_flag
- Set IMA Kids Denominator Flag to ima_cpck_den_flag
- Set TCI Kids Numerator Flag to tci_cpck_num_flag
- Set TCI Kids Denominator Flag to tci_cpck_den_flag
- Set TFC Numerator Flag to tfc_num_flag

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- Set TFC Denominator Flag to tfc_den_flag
- Set Partnership ID 6 month to partnership_medicaid_id_6_month
    - However, if Member Attribution Status - 6 or More Months in Partnership Flag is equal to 0 set Partnership ID 6 month to null
- Set Partnership Name to partnership_name_6_month
    - However, if Member Attribution Status - 6 or More Months in Partnership Flag is equal to 0, set Partnership Name to null
- Set Partnership 6-Month Attribution Flag for Measure to member_panel_partnership_metrics
- Set Performance Year to performance_yearSet Member Attribution Status - 6 or More Months in Partnership Flag to member_attribution status
- Set Partnership 6-Month Attribution Flag for TCOC to partnership_member_panel_tcocMember Attribution Status - 6 or More Months in Partnership Flag
- Set BPD Den Flag to bpd_den_flag
- Set BPD Num Flag to bpd_num_flag
- Set EED Den Flag to eed_den_flag
- Set EED Num Flag to eed_num_flag
- Set OED Num Flag to oed_num_flag
- Set OED Den Flag to oed_den_flag
- Set CHL Num Flag to chl_num_flag
- Set CHL Den Flag to chl_den_flag
- Set WCC Supplemental Num Flag to wcc_supp_num_flag
- Set CBP Supplemental Num Flag to cbp_supp_num_flag
- Set GSD Num Flag to gsd_num_flag
- Set GSD Den Flag to gsd_den_flag
- Set GSD Supplemental Num Flag to gsd_supp_den_flag
- Set FUM _7- 6-17 years Num Count to fum_7_6_num_count
- Set FUM _30- 6-17 years Num Count to fum_30_6_num_count
- Set FUM _7- 18-64 years Num Count to fum_7_18_num_count
- Set FUM _30- 18-64 years Num Count to fum_30_18_num_count
- Set FUM _7- 65 years Num Count to fum_7_65_num_count
- Set FUM _30- 65 years Num Count to fum_30_65_num_count
- Set FUM _7- Total Num Count to fum_7_num_count

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- Set FUM _30- Total Num Count to fum_30_num_count
- Set FUM _7- 6-17 years Den Count to fum_7_6_den_count
- Set FUM _30- 6-17 years Den Count to fum_30_6_den_count
- Set FUM _7- 18-64 years Den Count to fum_7_18_den_count
- Set FUM _30- 18-64 years Den Count to fum_30_18_den_count
- Set FUM _7- 65 years Den Count to fum_7_65_den_count
- Set FUM _30- 65 years Den Count to fum_30_65_den_count
- Set FUM _7- Total Den Count to fum_7_den_count
- Set FUM _30- Total Den Count to fum_30_den_count
- Set FUA _7- 13-17 years Num Count to fua_7_13_num_count
- Set FUA _30- 13-17 years Num Count to fua_30_13_num_count
- Set FUA _7- 18 years Num Count to fua_7_18_num_count
- Set FUA _30- 18 years Num Count to fua_30_18_num_count
- Set FUA _7- Total Num Count to fua_7_num_count
- Set FUA _30- Total Num Count to fua_30_num_count
- Set FUA _7- 13-17 years Den Count to fua_7_13_den_count
- Set FUA _30- 13-17 years Den Count to fua_30_13_den_count
- Set FUA _7- 18 years Den Count to fua_7_18_den_count
- Set FUA _30- 18 years Den Count to fua_30_18_den_count
- Set FUA _7- Total Den Count to fua_7_den_count
- Set FUA _30- Total Den Count to fua_30_den_count
- Set COL_E Num Flag to col_e_num_flag
- Set COL_E Den Flag to col_e_den_flag
- Set POD Num Flag to pod_num_flag
- Set POD Den Flag to pod_den_flag

5.10.9 File K

File K (ODF.09) is the member-level summary CSV file created for ODM, and contains all members enrolled in Ohio CPC and their associated information during a 12-month rolling period. It is shared with ODM after the CPC Practice Reports are delivered to practices.

File K (ODF.09) is created by combining (via a union) each of the individual File I (ODF.07) output data files created for each of the enrolled Ohio CPC practices.

The resulting output data file contains at least one and at most four rows per member, with each row per member representing the quarter(s) they were attributed to a given Ohio CPC practice over the 12-month rolling period.

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Starting with APM versions of PY2024 files, retired metrics are removed from files K,L,and S as well as other files.

5.10.10 File L

File L (ODF.10) contains summarized data at the practice-level for all Ohio CPC practices and is shared with ODM after the CPC Practice Reports are delivered to practices.

Starting with APM versions of PY2024 files, retired metrics will be removed from files K, L, and S as well as other files.

- Set the following fields on File L (ODF.10) using the corresponding fields from the Rolling Period Practice Table (O.04) unless otherwise noted:
    - Set Reporting Year to reporting_year
    - Set Reporting Quarter to reporting_quarter
    - Set Performance Period ID to 1
    - Set Performance Period Start Date to rolling_period_start_date
    - Set Performance Period End Date to rolling_period_end_date
    - Set Reporting Practice Medicaid ID to reporting_practice_medicaid_id
    - Set Reporting Practice Name to reporting_practice_name
- Set the current_quarter_members_panel_total parameter for each practice to the set of distinct member_medicaid_id on the Monthly Member Table (O.02) where practice_medicaid_id is equal to reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04) and valid_attribution_month_metrics is equal to 1 when month_id on the Monthly Member Table (O.02) is equal to 12
- Set the previous_quarter_members_panel_total parameter for each practice to the set of distinct member_medicaid_id on the Monthly Member Table (O.02) where practice_medicaid_id is equal to reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04) and valid_attribution_month_metrics is equal to 1 when month_id on the Monthly Member Table (O.02) is equal to 9
- Set Avg Monthly Members - Total Medicaid to the count of distinct members in current_quarter_members_panel_total
- Set # of Members Gained Since The Previous Quarter - Total Medicaid to the count of distinct members in current_quarter_members_panel_total who are not in previous_quarter_members_panel_total
- Set # of Members Lost Since The Previous Quarter - Total Medicaid to the count of distinct members in previous_quarter_members_panel_total who are not in current_quarter_members_panel_total

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- Set Avg Risk Score - Total Medicaid to sum of time_weighted_risk_score on the Rolling Period Member Table (O.03) divided by (÷) the sum of tcoc_eligible_months, and where practice_medicaid_id_6_month on the Rolling Period Member Table (O.03) is equal to reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04)
- Set Monthly Members - Total Medicaid - Risk Tier 1 to the count of distinct member_medicaid_id on the Rolling Period Member Table (O.03) where cdps_health_status is equal to (+) 1
- Set Monthly Members - Total Medicaid - Risk Tier 2 to the count of distinct member_medicaid_id on the Rolling Period Member Table (O.03) where cdps_health_status is equal to (=) 2
- Set Monthly Members - Total Medicaid - Risk Tier 3 to the count of distinct member_medicaid_id on the Rolling Period Member Table (O.03) where cdps_health_status is equal to (=) 3
- Calculate the average monthly members, members gained/lost, average risk score, and monthly members by risk tier for each of the seven MCOs and FFS as follows:
    - For each payer, apply an additional filtering step to the logic above for calculating: Avg Monthly Members - Total Medicaid, # of Members Gained Since The Previous Quarter - Total Medicaid, # of Members Lost Since The Previous Quarter - Total Medicaid, Avg Risk Score - Total Medicaid, Monthly Members - Total Medicaid - Risk Tier 1, Monthly Members - Total Medicaid - Risk Tier 2, and Monthly Members - Total Medicaid - Risk Tier 3
    - For the average monthly members and members gained/lost fields, filter by payer_detail on the Monthly Member Table (O.02)
    - For the average risk score and risk tier fields, filter by payer_detail_6_month on the Rolling Period Member Table (O.03)
  - Use the logic describe above, plus the associated filter by payer, to calculate the following fields on File L (ODF.10):
  - Avg Monthly Members - Ohio FFS,
  - # of Members Gained Since The Previous Quarter - Ohio FFS,
  - # of Members Lost Since The Previous Quarter - Ohio FFS,
  - Avg Risk Score - Ohio FFS,
  - Monthly Members - Ohio FFS - Risk Tier 1,

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  - Monthly Members - Ohio FFS - Risk Tier 2,
  - Monthly Members - Ohio FFS - Risk Tier 3
  - Avg Monthly Members - Buckeye,
  - # of Members Gained Since The Previous Quarter - Buckeye,
  - # of Members Lost Since The Previous Quarter - Buckeye,
  - Avg Risk Score - Buckeye,
  - Monthly Members - Buckeye - Risk Tier 1,
  - Monthly Members - Buckeye - Risk Tier 2,
  - Monthly Members - Buckeye - Risk Tier 3
  - Avg Monthly Members - CareSource,
  - # of Members Gained Since The Previous Quarter - CareSource,
  - # of Members Lost Since The Previous Quarter - CareSource,
  - Avg Risk Score - CareSource,
  - Monthly Members - CareSource - Risk Tier 1,
  - Monthly Members - CareSource - Risk Tier 2,
  - Monthly Members - CareSource - Risk Tier 3
  - Avg Monthly Members - Molina,
  - # of Members Gained Since The Previous Quarter - Molina,
  - # of Members Lost Since The Previous Quarter - Molina,
  - Avg Risk Score - Molina,
  - Monthly Members - Molina - Risk Tier 1,
  - Monthly Members - Molina - Risk Tier 2,
  - Monthly Members - Molina - Risk Tier 3
  - Avg Monthly Members - UnitedHealthCare,
  - # of Members Gained Since The Previous Quarter - UnitedHealthCare,
  - # of Members Lost Since The Previous Quarter - UnitedHealthCare,
  - Avg Risk Score - UnitedHealthCare,
  - Monthly Members - UnitedHealthCare - Risk Tier 1,
  - Monthly Members - UnitedHealthCare - Risk Tier 2,
  - Monthly Members - UnitedHealthCare - Risk Tier 3
- Set W30-First 15 Months Score to w30a_rate
- Set W30-First 15 Months Pass Fail to w30a_pass
- Set W30-First 15 Months Threshold to w30a_threshold

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- Set W30-First 15 Months Numerator to w30a_num
- Set W30-First 15 Months Denominator to w30a_den
- Set W30-15 to 30 Months Score to w30b_rate
- Set W30-15 to 30 Months Pass Fail to w30b_pass
- Set W30-15 to 30 Months Threshold to w30b_threshold
- Set W30-15 to 30 Months Numerator to w30b_num
- Set W30-15 to 30 Months Denominator to w30b_den
- Set WCV-3-11 years Score to wcv11_rate
- Set WCV-3-11 years Pass Fail to wcv11_pass
- Set WCV-3-11 years Threshold to wcv11_threshold
- Set WCV-3-11 years Numerator to wcv11_num
- Set WCV-3-11 years Denominator to wcv11_den
- Set WCV-12-17 years Score to wcv17_rate
- Set WCV-12-17 years Pass Fail to wcv17_pass
- Set WCV-12-17 years Threshold to wcv17_threshold
- Set WCV-12-17 years Numerator to wcv17_num
- Set WCV-12-17 years Denominator to wcv17_den
- Set WCV-18-21 years Score to wcv21_rate
- Set WCV-18-21 years Pass Fail to wcv21_pass
- Set WCV-18-21 years Threshold to wcv21_threshold
- Set WCV-18-21 years Numerator to wcv21_num
- Set WCV-18-21 years Denominator to wcv21_den
- Set WCC Score to wcc_rate
- Set WCC Pass Fail to wcc_pass
- Set WCC Threshold to wcc_threshold
- Set WCC Den to wcc_den
- Set WCC Num to wcc_num
- Set PPC_Prenatal Score to ppc_prenatal_rate
- Set PPC_Prenatal Pass Fail to ppc_prenatal_pass
- Set PPC_Prenatal Threshold to ppc_prenatal_threshold
- Set PPC_Prenatal Den to ppc_prenatal_den
- Set PPC_Prenatal Num to ppc_prenatal_num
- Set LBW Score to lbw_rate

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- Set LBW Pass Fail to lbw_pass
- Set LBW Threshold to lbw_threshold
- Set LBW Den to lbw_den
- Set LBW Num to lbw_num
- Set PPC_Postpartum Score to ppc_postpartum_rate
- Set PPC_Postpartum Pass Fail to ppc_postpartum_pass
- Set PPC_Postpartum Threshold to ppc_postpartum_threshold
- Set PPC_Postpartum Den to ppc_postpartum_den
- Set PPC_Postpartum Num to ppc_postpartum_num
- Set CCS Score to ccs_rate
- Set CCS Pass Fail to ccs_pass
- Set CCS Threshold to ccs_threshold
- Set CCS Den to ccs_den
- Set CCS Num to ccs_num
- Set CBP Score to cbp_rate
- Set CBP Pass Fail to cbp_pass
- Set CBP Threshold to cbp_threshold
- Set CBP Den to cbp_den
- Set CBP Num to cbp_num
- Set SPC Score to spc_rate
- Set SPC Pass Fail to spc_pass
- Set SPC Threshold to spc_threshold
- Set SPC Den to spc_den
- Set SPC Num to spc_num
- Set AMR Score to amr_rate
- Set AMR Pass Fail to amr_pass
- Set AMR Threshold to amr_threshold
- Set AMR Den to amr_den
- Set AMR Num to amr_num
- Set FUH Score to fuh_rate
- Set FUH Pass Fail to fuh_pass
- Set FUH Threshold to fuh_threshold
- Set FUH Den to fuh_den

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- Set FUH Num to fuh_num
- Set IET Score to iet_rate
- Set IET Pass Fail to iet_pass
- Set IET Threshold to iet_threshold
- Set IET Den to iet_den
- Set IET Num to iet_num
- Set TCI Score to tci_rate
- Set TCI Pass Fail to tci_pass
- Set TCI Threshold to tci_threshold
- Set TCI Den to tci_den
- Set TCI Num to tci_num
- Set AMB Score to amb_rate
- Set AMB Den to amb_den
- Set AMB Num to amb_num
- Set AMB - Pass Fail to amb_pass
- Set AMB - Threshold to amb_threshold
- Set AMB - Count of Avoidable ER Visits per 1,000 to amb_rate
- Set AHRQ PQI 90 - Pass Fail to pqi_90_pass
- Set AHRQ PQI 90 - Threshold to pqi_90_threshold
- Set AHRQ PQI 90 - Count of IP Admits per 1,000 to pqi_90_rate
- Set MPT - Pass Fail to mpt_pass
- Set MPT - Threshold to mpt_threshold
- Set MPT - Count of BH-Related IP Admits per 1,000 to mpt_rate
- Set Adherence Ratio Antidiabetics, Insulin, Lantus only Score to pdl_ail_rate
- Set Adherence Ratio Antidiabetics, Insulin, Lantus only Pass Fail to pdl_ail_pass
- Set Adherence Ratio Antidiabetics, Insulin, Lantus only Threshold to pdl_ail_threshold
- Set Adherence Ratio Antidiabetics, Insulin, Lantus only Numerator to pdl_ail_num
- Set Adherence Ratio Antidiabetics, Insulin, Lantus only Denominator to pdl_ail_den
- Set Adherence Ratio Antidiabetics, DPPIV Inhibitors Score to pdl_adi_rate
- Set Adherence Ratio Antidiabetics, DPPIV Inhibitors Pass Fail to pdl_adi_pass
- Set Adherence Ratio Antidiabetics, DPPIV Inhibitors Threshold to pdl_adi_threshold
- Set Adherence Ratio Antidiabetics, DPPIV Inhibitors Numerator to pdl_adi_num
- Set Adherence Ratio Antidiabetics, DPPIV Inhibitors Denominator to pdl_adi_den

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- Set Adherence Ratio Asthma Score to pdl_asth_rate
- Set Adherence Ratio Asthma Pass Fail to pdl_asth_pass
- Set Adherence Ratio Asthma Threshold to pdl_asth_threshold
- Set Adherence Ratio Asthma Numerator to pdl_asth_num
- Set Adherence Ratio Asthma Denominator to pdl_asth_den
- Set Adherence Ratio COPD Score to pdl_copd_rate
- Set Adherence Ratio COPD Pass Fail to pdl_copd_pass
- Set Adherence Ratio COPD Threshold to pdl_copd_threshold
- Set Adherence Ratio COPD Numerator to pdl_copd_num
- Set Adherence Ratio COPD Denominator to pdl_copd_den
- Set Members with 3 or More ED Visits to members_with_3_or_more_ed_visits
- Set Members with 1 or More IP Admissions to members_with_1_or_more_ip_admissions
- Set Members With No PCP Visit to members_with_no_pcp_visit_
- Set TCOC Threshold to target_ra_tcoc_pmpm_final on the Practice Baseline Total Cost of Care Table (O.06) where <u>all</u> the following criteria are true:
    - baseline_practice_medicaid_id on the Practice Baseline Total Cost of Care Table (O.06) is equal to performance_practice_medicaid_id on the Practice Shared Savings Table (O.07)
    - performance_rolling_period_start_date on the Practice Shared Savings Table (O.07) is equal to baseline_rolling_period_start_date on the Practice Baseline Total Cost of Care Table (O.06) plus (+) 24 months
    - performance_rolling_period_end_date on the Practice Shared Savings Table (O.07) is equal to baseline_rolling_period_end_date on the Practice Baseline Total Cost of Care Table (O.06) plus (+) 24 months Set Total Cost of Care PMPM $ (without adj for PCMH PMPM payment) to practice_ra_tcoc_pmpm
- Set Net Total Cost of Care PMPM $ (net of PCMH PMPM payment) to
- Set Hospital Inpatient Care $ to hospital_inpatient_care_spend

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- Set ED Care $ to ed_care_spend
- Set Hospital Outpatient Care $ to hospital_outpatient_care_spend
- Set Office and Clinic Care $ to office_and_clinic_care_spend
- Set Institutional Care $ to institutional_care_spend
- Set Home and Community-Based Care $ to home_and_community_based_care_spend
- Set Prescription Drugs $ to prescription_drug_spend
- Set Specialty Pharma $ to specialty_pharma_spend
- Set Lab and Pathology $ to lab_and_pathology_spend
- Set Radiology $ to radiology_spend
- Set Ancillary Services $ to ancillary_services_spend
- Set DME and Supplies $ to dme_and_supplies_spend
- Set PT/OT/ST $ to pt_ot_st_spend
- Set Others $ to others_spend
- Set Performance Year to the year of the rolling_period_end_date
- Set CPC Kids to 'Yes' if the Reporting Practice Medicaid ID equals Medicaid_Id from the Ohio CPC Practices List (I.S.08) where the is_CPC_kids is equal to 'Y'
- Set LSC Kids Score to lsc_cpck_rate
- Set LSC Kids Pass Fail to lsc_cpck_pass
- Set LSC Kids Threshold to lsc_cpck_threshold
- Set LSC Kids Num Count to lsc_cpck_num
- Set LSC Kids Den Count to lsc_cpck_den
- Set CIS Kids Score to cis_cpck_rate
- Set CIS Kids Pass Fail to cis_cpck_pass
- Set CIS Kids Threshold to cis_cpck_threshold
- Set CIS Kids Num Count to cis_cpck_num
- Set CIS Kids Den Count to cis_cpck_den
- Set IMA Kids Score to ima_cpck_rate
- Set IMA Kids Pass Fail to ima_cpck_pass
- Set IMA Kids Threshold to ima_cpck_threshold
- Set IMA Kids Num Count to ima_cpck_num
- Set IMA Kids Den Count to ima_cpck_den
- Set TCI Kids Score to tci_cpck_rate
- Set TCI Kids Pass Fail to tci_cpck_pass
- Set TCI Kids Threshold to tci_cpck_threshold

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- Set TCI Kids Num Count to tci_cpck_num
- Set TCI Kids Den Count to tci_cpck_den
- Set TFC Score to tfc_cpck_rate
- Set TFC Pass Fail to tfc_cpck_pass
- Set TFC Threshold to tfc_cpck_threshold
- Set TFC Num Count to tfc_cpck_num
- Set TFC Den Count to tfc_cpck_den
- Set AHRQ PQI 90 Num Count to pqi_90_count
- Set AHRQ PQI 90 Den Count to pqi_90_den_member_months
- Set MPT – Count of BH-Related IP Admits Num Count to mpt_count
- Set MPT- Count of BH-Related IP Admits Den Count to mpt_den_member_months
- Set Practice Partnership ID the Practice_Partnership_ID if the Reporting Practice Medicaid ID equals Medicaid_Id from the Ohio CPC Practices List (I.S.08)
    - Avg Monthly Members - Amerihealth,
    - # of Members Gained Since The Previous Quarter - Amerihealth,
    - # of Members Lost Since The Previous Quarter - Amerihealth,
    - Avg Risk Score - Amerihealth,
    - Monthly Members - Amerihealth - Risk Tier 1,
    - Monthly Members - Amerihealth - Risk Tier 2,
    - Monthly Members - Amerihealth- Risk Tier 3
    - Avg Monthly Members - Anthem,
    - # of Members Gained Since The Previous Quarter - Anthem
    - # of Members Lost Since The Previous Quarter - Anthem,
    - Avg Risk Score - Anthem,
    - Monthly Members - Anthem - Risk Tier 1,
    - Monthly Members - Anthem - Risk Tier 2,

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  - Monthly Members - Anthem - Risk Tier 3
  - Avg Monthly Members - Humana,
  - # of Members Gained Since The Previous Quarter - Humana,
  - # of Members Lost Since The Previous Quarter - Humana,
  - Avg Risk Score - Humana,
  - Monthly Members - Humana - Risk Tier 1,
  - Monthly Members - Humana - Risk Tier 2,
  - Monthly Members – Humana - Risk Tier 3

- Set BPD Score bpd_rate
- Set BPD Pass Fail to bpd_pass
- Set BPD_Threshold to bpd_threshold
- Set BPD Numerator to bpd_num
- Set BPD Denominator to bpd_den
- Set EED Score to eed_rate
- Set EED Pass Fail to eed_pass
- Set EED Threshold to eed_cpck_threshold
- Set EED Numerator to eed_cpck_num
- Set EED Denominator to eed_den
- Set OED Score to oed_rate
- Set OED Pass Fail to oed_pass
- Set OED Threshold to oed_threshold
- Set OED Numerator to oed_num
- Set OED Denominator to oed_den
- Set CHL Score to chl_rate
- Set CHL Pass Fail to chl_pass
- Set CHL Threshold to chl_threshold
- Set CHL Numerator to chl_num
- Set CHL Denominator to chl_den
- Set WCC Supplemental Score to wcc_supp_rate

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- Set WCC Supplemental Pass Fail to wcc_supp_pass
- Set WCC Supplemental Numerator to wcc_supp_num
- Set CBP Supplemental Score to cbp_supp_rate
- Set CBP Supplemental Pass Fail to cbp_supp_pass
- Set CBP Supplemental Numerator to cbp_supp_num
- Set GSD Score to gsd_rate
- Set GSD Pass Fail to gsd_pass
- Set GSD Threshold to gsd_threshold
- Set GSD Numerator to gsd_num
- Set GSD Denominator to gsd_den
- Set GSD Supplemental Score to gsd_supp_rate
- Set GSD Supplemental Pass Fail to gsd_supp_pass
- Set GSD Supplemental Numerator to gsd_supp_num
- Set FUM_7- 6-17 years Score to fum_7_6 _score
- Set FUM_30- 6-17 years Score to fum_30_6_ score
- Set FUM_7- 18-64 years Score to fum_7_18_ score
- Set FUM_30- 18-64 years Score to fum_30_18_ score
- Set FUM_7- 65 years Score to fum_7_65 _score
- Set FUM_30- 65 years Score to fum_30_65_years _ score
- Set FUM_7- Total Score to fum_7_years _ score
- Set FUM_30- Total Score to fum_30_years _ score
- Set FUM_7- 6-17 years Pass Fail to fum_7_6_pass
- Set FUM_30- 6-17 years Pass Fail to fum_30_6_pass
- Set FUM_7- 18-64 years Pass Fail to fum_7_18_pass
- Set FUM_30- 18-64 years Pass Fail to fum_30_18_pass
- Set FUM_7- 65 years Pass Fail to fum_765_pass
- Set FUM_30- 65 years Pass Fail to fum_30_65_pass
- Set FUM_7- Total Pass Fail to fum_7_pass
- Set FUM_30- Total Pass Fail to fum_30_pass
- Set FUM_7- 6-17 years Threshold to fum_7_6_threshold
- Set FUM_30- 6-17 years Threshold to fum_30_6_threshold
- Set FUM_7- 18-64 years Threshold to fum_7_18_threshold
- Set FUM_30- 18-64 years Threshold to fum_30_18_threshold

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- Set FUM_7- 65 years Threshold to fum_7_65_threshold
- Set FUM_30- 65 years Threshold to fum_30_65_threshold
- Set FUM_7- Total Threshold to fum_7_threshold
- Set FUM_30- Total Threshold to fum_30_threshold
- Set FUM_7- 6-17 years Numerator to fum_7_6_num
- Set FUM_30- 6-17 years Numerator to fum_30_6_num
- Set FUM_7- 18-64 years Numerator to fum_7_18_num
- Set FUM_30- 18-64 years Numerator to fum_30_18_num
- Set FUM_7- 65 years Numerator to fum_7_56_num
- Set FUM_30- 65 years Numerator to fum_30_65_num
- Set FUM_7- Total Numerator to fum_7_num
- Set FUM_30- Total Numerator to fum_30_num
- Set FUM_7- 6-17 years Denominator to fum_7_6_denom
- Set FUM_30- 6-17 years Denominator to fum_30_6_denom
- Set FUM_7- 18-64 years Denominator to fum_7_18_denom
- Set FUM_30- 18-64 years Denominator to fum_30_18_denom
- Set FUM_7- 65 years Denominator to fum_7_65_denom
- Set FUM_30- 65 years Denominator to fum_30_65_denom
- Set FUM_7- Total Denominator to fum_7_denom
- Set FUM_30- Total Denominator to fum_30_denom
- Set FUA_7- 13-17 years Score to fua_7_13 _score
- Set FUA_30- 13-17 years Score to fua_30_13 _score
- Set FUA_7- 18 years Score to fua_7_18 _score
- Set FUA_30- 18 years Score to fua_30_18 _score
- Set FUA_7- Total Score to fua_7 _score
- Set FUA_30- Total Score to fua_30 _score
- Set FUA_7- 13-17 years Pass Fail to fua_7_13_pass
- Set FUA_30- 13-17 years Pass Fail to fua_30_13_pass
- Set FUA_7- 18 years Pass Fail to fua_7_18_pass
- Set FUA_30- 18 years Pass Fail to fua_30_13_pass
- Set FUA_7- Total Pass Fail to fua_7_pass
- Set FUA_30- Total Pass Fail to fua_30_pass
- Set FUA_7- 13-17 years Threshold to fua_7_13_threshold

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- Set FUA_30- 13-17 years Threshold to fua_30_13_threshold
- Set FUA_7- 18 years Threshold to fua_7_18_threshold
- Set FUA_30- 18 years Threshold to fua_30_18_threshold
- Set FUA_7- Total Threshold to fua_7_threshold
- Set FUA_30- Total Threshold to fua_30_threshold
- Set FUA_7- 13-17 years Numerator to fua_7_13_num
- Set FUA_30- 13-17 years Numerator to fua_30_13_num
- Set FUA_7- 18 years Numerator to fua_7_18_num
- Set FUA_30- 18 years Numerator to fua_30_18_num
- Set FUA_7- Total Numerator to fua_7_num
- Set FUA_30- Total Numerator to fua_30_num
- Set FUA_7- 13-17 years Denominator to fua_7_13_denom
- Set FUA_30- 13-17 years Denominator to fua_30_13_denom
- Set FUA_7- 18 years Denominator to fua_7_18_denom
- Set FUA_30- 18 years Denominator to fua_30_18_denom
- Set FUA_7- Total Denominator to fua_7_denom
- Set FUA_30- Total Denominator to fua_30_denom
- Set COL_E Score to col_e_rate
- Set COL_E Pass Fail to col_e_pass
- Set COL_E Threshold to col_e_threshold
- Set COL_E Numerator to col_e_num
- Set COL_E Denominator to col_e_den
- Set POD Score to pod_rate
- Set POD Pass Fail to pod_pass
- Set POD Threshold to pod_threshold
- Set POD Numerator to pod_num
- Set POD Denominator to pod_den
-

File L (ODF.10) MCO Version

File L (ODF.10) contains summarized data at the practice level for all Ohio CPC practices and is shared with ODM after the CPC Practice Reports are delivered to practices. Each MCO will receive a version with retired metrics removed and summary columns for that MCO, with the summary columns for other MCOs removed. Member-level data will remain aggregated for the entire practice.

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5.10.11 File S

File S contains all information included in File L, provider-level CSV but is reported at the Partnership level instead of at the practice level.

- Set fields in File S using corresponding fields from Partnership level source data, for example:
    - Reporting Year
    - Reporting Quarter
    - Performance Period ID
    - Performance Period Start Date
    - Performance Period End Date
    - Partnership ID
    - Partnership Name
- Set Partnership Total Cost of Care PMPM $ (without adj for PCMH PMPM payment) equal to unadj_tcoc divided by (÷) time_weighted_risk_score for the partnership member panel.
- Reference *Calculate Practice-level Total Cost of Care*, for more information on calculating PMPM.
- Set Partnership Net Total Cost of Care PMPM $ (net of PCMH PMPM payment) equal to (unadj_tcoc plus (+) cpc_pmpm_payment) divided by (÷) time_weighted_risk_score, aggregated at the Partnership level.
- Reference *Calculate Practice-level Total Cost of Care*, for more information on calculating PMPM.

5.10.11.1 File S MCO Version

File S contains summarized data at the partnership level for all Ohio CPC partnerships and is shared with ODM. Each MCO will receive a version with retired metrics removed and summary columns for that MCO, with the summary columns for the other MCOs removed. Member-level data will remain aggregated for the entire partnership.

5.10.12 File O

File O (ODF.13) is the member-level provider report CSV data file intended for receipt by Medicaid MCOs. One copy of File O (ODF.13) is created for each MCO.

File O (ODF.13) is identical to File I (ODF.09), however File O (ODF.13) contains only members belonging to the MCO receiving File O (ODF.13), so that MCOs only receive a File O (ODF.13) containing their members. File O (ODF.13) does not contain fields for retired metrics.

Create file File O (ODF.13), for each MCO by segmenting File I (ODF.07) where Payer Detail on File I (ODF.07) is equal to the name of the MCO that will receive the file.

5.10.13 Files G3 and G4

File G3 (ODF.14), **and** File G4 (ODF.15) are the shared savings payment files required by ODM to process shared savings payments. File G3 (ODF.14) is the shared savings relative to peer payment file, whereby shared savings payments are issued by ODM directly to practices with the lowest TCOC, as described in Section 3.8.2. File G4 (ODF.15) is the shared savings relative to self payment file for FFS members, whereby shared savings payments are issued directly to practices that were eligible for payment based on self-improvement, as described in Section 3.8.2.

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5.10.13.1 Create File G3 – shared savings payment file for practices with lowest TCOC

- Use the Practice Shared Savings Payments Table (O.08) to update the following fields in File G3:
  - Set Payee ID to practice_npi from the Attribution Output Table (O.01)
  - **Note:** NPI must be the primary NPI associated with the practice's Billing Medicaid ID. If no NPI exists, populate with Medicaid ID.
  - Set Payee Type to “P”
  - Set Reason to “8700”
  - Set Fund Code to the concatenation of “4602” and fund_code from the Practice Shared Savings Payments Table (O.08)
  - For example, if fund_code is equal to “REG” then Fund Code should be set to “4602REG”
  - Set Payout Amount to total_ss_peers_dollar from the Practice Shared Savings Payments Table (O.08) for each Payee ID and Fund Code
  - Set Process Type to “R”
  - Set Issue Date to the following:
    - The date that annual reports were delivered, if delivered in the reporting year (the year prior to the performance_year in the Practice Shared Savings Payments Table (O.08)), OR
    - December 31st of the reporting year if reports were delivered after the end of the reporting year. For example, if performance_year is equal to “2025” then set Issue Date “12/31/2025”
  - Set Provider Type to “MCD”
  - Set Associated FFY to blank (no value)

5.10.13.2 Create File G4 – shared savings payment file for self-improvement for FFS

- Use the Practice Shared Savings Payments Table (O.08) to update the following fields in File G4:
  - Set Payee ID to practice_npi from the Attribution Output Table (O.01)

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Note: NPI must be the primary NPI associated with the practice's Billing Medicaid ID. If no NPI exists, populate with Medicaid ID.

- Set Payee Type to "P"
- Set Reason to "8700"
- Set Fund Code to the concatenation of "4602" and fund_code from the Practice Shared Savings Payments Table (O.08)
- For example, if fund_code is equal to "REG" then Fund Code should be set to "4602REG"
- Set Payout Amount to ffs_ss_self_dollar from the Practice Shared Savings Payments Table (O.08) for each Payee ID and Fund Code
- Set Process Type to "R"
- Set Issue Date to the following:

  – The date that annual reports were delivered, if delivered in the reporting year (the year prior to the performance_year in the Practice Shared Savings Payments Table (O.08)), OR

  – December 31st of the reporting year, if reports were delivered after the end of the reporting year**.** For example, if performance_year is equal to "2025" then set Issue Date "12/31/2025"

- Set Provider Type to "MCD"

5.10.14 File G5

File G5 (ODF.16) are the shared savings payment files required by Medicaid MCOs to make their portion of shared savings payments to practices that were eligible for payment based on self-improvement. The G5 file includes seven (7) tables – one for each MCO. Set Associated FFY to Blank.

5.10.14.1 Create File G5 – shared savings payment file for self-improvement for MCOs

- Begin by creating seven (7) empty tables, one for each MCO (i.e., Buckeye, CareSource, Molina, United, Amerihealth, Anthem, and Humana). For each MCO table begin by populating the following:
  - Set Performance Year to the year (YYYY) of the performance_period_start_date parameter
  - Populate the Practice Medicaid ID field with a list of all practices in

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reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04)

- For each one of the seven (7) MCO tables, and where Practice Medicaid ID is equal to reporting_practice_medicaid_id in the Rolling Period Practice Table (O.04), populate the following fields:
    - Set Passed Quality Metrics to 1 (0 otherwise) if quality_metrics_pass_rate from the Rolling Period Practice Table (O.04) is greater than or equal to (≥) 0.5
    - Set Passed Efficiency Metrics to 1 (0 otherwise) if efficiency_metrics_pass_rate from the Rolling Period Practice Table (O.04) is greater than or equal to (≥) 0.5
    - Set Member Months to practice_member_months_tcoc from the Rolling Period Practice Table (O.04)
    - Set Time-Weighted Risk Score to practice_time_weighted_risk_score from the Rolling Period Practice Table (O.04)
    - Set Unadjusted TCOC PMPM to practice_unadj_tcoc_pmpm from the Rolling Period Practice Table (O.04)
    - Set Risk Score to Time-Weighted Risk Score divided by (÷) Member Months
  - For each one of the seven (7) MCO tables, and where Practice Medicaid ID is equal to baseline_practice_medicaid_id in the Practice Baseline Total Cost of Care Table (O.06), populate the following fields:
    - Set Programmatic Adjustment Factor to program_adjustment_factor from the Practice Baseline Total Cost of Care Table (O.06)
    - Set Baseline Time-Weighted Risk Score to baseline_practice_time_weighted

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_risk_score from the Practice Baseline Total Cost of Care Table (O.06)

- Set Baseline Unadjusted TCOC PMPM to baseline_practice_unadj_tcoc_pmpm from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Risk Score to baseline_practice_time_weighted_risk_score divided by (÷) baseline_practice_member_months_tcoc from the Practice Baseline Total Cost of Care Table (O.06)

  - For each one of the seven (7) MCO tables, and where Practice Medicaid ID is equal to performance_practice_medicaid_id in the Practice Shared Savings Table (O.07), populate the following fields:
    - Set Eligible for TCOC to shared_savings_eligible from the Practice Shared Savings Table (O.07)
    - Set Risk-Adjusted TCOC Decile to tcoc_decile from the Practice Shared Savings Table (O.07)
  - For each Practice Medicaid ID on the Practice Shared Savings Payments Table (O.08), populate the MCO Specific Time-Weighted Risk Score.

Note: This field should reflect the practice-level MCO specific time-weighted risk score, thus should be pulled as a singular value from one of the fund code rows in Table O.08.

  - Set MCO Specific Time-Weighted Risk Score to:
  - buckeye_time_weighted_risk_score for the Buckeye MCO Table
  - caresource_time_weighted_risk_score for the CareSource MCO Table
  - molina_time_weighted_risk_score for the Molina MCO Table
  - united_time_weighted_risk_score for the United MCO Table
  - amerihealth_time_weighted_risk_score for the Amerihealth MCO Table
  - anthem_time_weighted_risk_score for the Anthem MCO Table
  - humana_time_weighted_risk_score for the Humana MCO Table

- Group by Practice Medicaid ID on the Practice Shared Savings Payments Table (O.08) and populate the Shared Savings Payment Relative to Self fields
- Set Shared Savings Payment Relative to Self to:

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- buckeye_ss_self_dollar for the Buckeye MCO Table
- caresource_ss_self_dollar for the CareSource MCO Table
- molina_ss_self_dollar for the Molina MCO Table
- united_ss_self_dollar for the United MCO Table
- amerihealth_ss_self_dollar for the Amerihealth MCO Table
- anthem_ss_self_dollar for the Anthem MCO Table
- humana_ss_self_dollar for the Humana MCO Table

5.10.15 File G6: CPC for Kids Bonus Payment

File G6 is the CPC for Kids Bonus Payment file. To generate File G6, Gainwell first must receive File B from ODM, which contains the CPC for Kids Bonus payment recipients.

- GWT then populates the fields below based on Table O.09, which populated bonus payment fund codes:
  - Set Payee ID to the practice NPI associated with the reason and fund code combination

  Note: NPI must be the primary NPI associated with the practice's Billing Medicaid ID. If no NPI exists, use Medicaid ID

  - Set Payee Type to ‘P’
  - Set Reason Code to 8702
  - Set Fund Code to a concatenation of ‘4603’ (ex: 4603REG)
  - Set Payout Amount to the amount associated with the reason and fund code for the practice
  - Set Process Type to ‘R’
  - Set Issue Date to null
  - Set Provider Type to MCD
  - Set Associated FFY **to** null

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5.10.16 File T: Shared Savings Internal Calculations Table

Shared Savings Internal Calculations Table (ODF.17) is the shared savings internal calculations table used to obtain the shared savings relative to self and relative to peers information at the practice level. A supplemental file is created to provide the distribution of Shared Savings earned to the practices within a partnership.

5.10.16.1 Create File ODF.17 – Shared Savings Internal Calculations Table- Practice Level

- Begin by populating the Shared Savings Internal Calculations Table (ODF.17) for the given program year.
- Set Performance Year to the year (YYYY) of the performance_period_start_date parameter
- Set Performance Period Start Date to the first day of 12-month rolling period representing the Ohio CPC program year (e.g., 1/1/2025 for a program year of 1/1/2025 to 12/31/2025)
- Set Performance Period End Date to the last day of 12-month rolling period representing the Ohio CPC program year (e.g., 12/31/2025 for a program year of 1/1/2025 to 12/31/2025)
- Populate the Practice Medicaid ID field with a list of all practices in reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04)
- Set Practice Name to practice_name from the Rolling Period Practice Table (O.04) where Practice Medicaid ID is equal to reporting_practice_medicaid_id
- Populate the baseline year fields for each practice by matching Practice Medicaid ID to baseline_practice_medicaid_id in the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Total Unadjusted TCOC to baseline_practice_unadj_tcoc from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Member Months to baseline_practice_member_months_tcoc from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Unadjusted TCOC PMPM to baseline_practice_unadj_tcoc_pmpm from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Time-Weighted Risk Score to baseline_practice_time_weighted_risk_score from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Risk-Adjusted TCOC PMPM to Baseline Total Unadjusted TCOC divided by (÷) Baseline Time-Weighted Risk Score
- Set Programmatic Adjustment Factor to program_adjustment_factor from the Practice Baseline Total Cost of Care Table (O.06)
- Set Baseline Total Unadjusted TCOC with Adjustment Factor as follows:
    - equal to

Baseline Total Unadjusted TCOC times

(×) [1 plus (+) Programmatic Adjustment Factor] times

(×) [1 plus (+) Programmatic Adjustment Factor]

$$\text{Baseline Total Unadjusted TCOC with Adjustment Factor} = \text{Baseline Total Unadjusted TCOC} \times [1 + \text{Programmatic Adjustment Factor}]$$

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$\times$ [1 + Programmatic Adjustment Factor]

- Set Baseline Risk-Adjusted TCOC PMPM with Adjustment Factor equal to target_ra_tcoc_pmpm_final from the Practice Baseline Total Cost of Care Table (O.06)
- Group by practice_medicaid_id on the Rolling Period Practice Table (O.04) and set the Quarterly PMPMs equal to the sum of practice_cpc_pmpm_payment across all four (4) quarters, ensuring that:
    - Practice Medicaid ID is equal to practice_medicaid_id from the Rolling Period Practice Table (O.04)
    - Performance Period Start Date is equal to rolling_period_start_date from the Rolling Period Practice Table (O.04)
    - Performance Period End Date is equal to rolling_period_end_date from the Rolling Period Practice Table (O.04)
- Populate the program year fields for each practice by matching Practice Medicaid ID to: performance_practice_medicaid_id in the Practice Shared Savings Table (O.07) or reporting_practice_medicaid_id in the Rolling Period Practice Table (O.04)
- Set Total Unadjusted TCOC to practice_unadj_tcoc from the Rolling Period Practice Table (O.04)
- Set Member Months to practice_member_months_tcoc from the Rolling Period Practice Table (O.04)
- Set Unadjusted TCOC PMPM to practice_unadj_tcoc_pmpm from the Rolling Period Practice Table (O.04)
- Set Time-Weighted Risk Score to practice_time_weighted_risk_score from the Rolling Period Practice Table (O.04)
- Set Eligible for TCOC to shared_savings_eligible from the Practice Shared Savings Table (O.07)
- Set Unadjusted TCOC PMPM with Quarterly PMPMs equal to [Total Unadjusted TCOC plus (+) Quarterly PMPMs] divided by (÷) Member Months
- Set Risk-Adjusted TCOC PMPM to Total Unadjusted TCOC divided by (÷) Time-Weighted Risk Score
- Set Risk-Adjusted TCOC PMPM with Quarterly PMPMs equal to [Total Unadjusted TCOC plus (+) Quarterly PMPMs] divided by (÷) Time-Weighted Risk Score
- Calculate the shared savings related fields by matching Practice Medicaid ID to performance_practice_medicaid_id in the Practice Shared Savings Table (O.07)
- Set Shared Savings TCOC Target with Adjustment Factor and Minimum Savings Rate to 0.99 times (×) Baseline Risk-Adjusted TCOC PMPM with Adjustment Factor
- Set Savings Rate to savings_rate from the Practice Shared Savings Table (O.07)

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- Set Savings Flag to 1 (0 otherwise) if shared_savings_self_amount from the Practice Shared Savings Table (O.07) is greater than zero (> 0) to flag practices that have a non-zero shared savings relative to self amount
- Set Panel Size Flag to 1 (0 otherwise) if Member Months is greater than or equal to (≥) 60,000
- Set Gain Rate to gain_sharing_rate from the Practice Shared Savings Table (O.07)
- Set Shared Savings Payment Relative to Self to shared_savings_self_amount from the Practice Shared Savings Table (O.07)
- Set Risk-Adjusted TCOC Decile to tcoc_decile from the Practice Shared Savings Table (O.07)
- Set Shared Savings Payment Relative to Peers to shared_savings_peers_amount from the Practice Shared Savings Table (O.07)
- Set Total Shared Savings to shared_savings_total_amount from the Practice Shared Savings Table (O.07)

5.10.16.2 Create File ODF.17 – Shared Savings Internal Calculations Table- Partnership Level

- Begin by populating the Shared Savings Internal Calculations Table (ODF.17) for the given program year
    - Set Performance Year to the year (YYYY) of the performance_period_start_date parameter
    - Set Performance Period Start Date to the first day of 12-month rolling period representing the Ohio CPC program year (e.g., 1/1/2025 for a program year of 1/1/2025 to 12/31/2025)
    - Set Performance Period End Date to the last day of 12-month rolling period representing the Ohio CPC program year (e.g., 12/31/2025 for a program year of 1/1/2025 to 12/31/2025)
    - Populate the Practice Medicaid ID field with a list of all practices in reporting_practice_medicaid_id from the Rolling Period Practice Table (O.04)
    - Set Practice Name to practice_name from the Rolling Period Practice Table (O.04) where Practice Medicaid ID is

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equal to reporting_practice_medicaid_id

- Populate the Partnership ID field with a list of all partnerships in Practice_partnership_id from the Rolling Period Partnership Table (O.04)
- Populate the baseline year fields for each partnership by matching Partnership ID to baseline_partnership_id in the Partnership Baseline Total Cost of Care Table (O.06)
- Set baseline_adj_tcoc equal to baseline_unadj_tcoc from the Entity Baseline Total Cost of Care Table (O.06) times (×)[1 plus (+) program_adjustment_factor] times (×)
  [1 plus (+) program_adjustment_factor] Set is_partnership_entity flag to 'Y' if Partnership ID matches the Practice_partnership_ID field on Rolling Period Partnership Table (O.04)
- Populate is_partnership_main_practice with 'Y' if the practice within the partnership has been designated as the Convener practice during Enrollment.
- Set gain_sharing_rate to equal gain_sharing_rate from the Entity Shared Savings Table (O.07c)
- Set shared_savings_eligible to equal shared_savings_eligible from the Entity Shared Savings Table (O.07a)
- Set savings_rate to equal savings_rate from the Entity Shared Savings Table (O.07a)
- Set shared_savings_self_earned to equal

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shared_savings_self_earned from the Entity Savings Table (O.07a)

- Set Practice_TWRS to the sum of member_risk_score where valid_attribution_month_tcoc = 1 and practice_medicaid_id in Monthly Member Table (O.02) is equal to performance_practice_medicaid_id in the Entity Shared Savings Table (O.07c).
- Set Entity_TWRS to the sum (+) of practice_twrs for each practice within the Partnership.
- Set Proportion_TWRS equal to practice_twrs divided by (÷) entity_twrs on the Practice Partnerships Shared Savings Table (O.07c)
- Set practice_shared_savings_self_amount to equal practice_shared_savings_self_amount from the Entity Shared Savings Table (O.07c)
- Set partnership_shared_savings_self_amount to equal shared_savings_self_amount from the Entity Shared Savings Table (O.07a)
- Set practice_shared_savings_peers to equal practice_shared_savings_peers from the Entity Shared Savings Table (O.07c)
- Set partnership_shared_savings_peers to equal shared_savings_peers from the Entity Shared Savings Table (O.07a)
- Set partnership_shared_savings_total to equal shared_savings_total

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from theEntity Shared Savings Table (O.07a)

5.10.17 File P: Member-Level Provider Enrollment File

File P represents the annual member level enrollment file which is shared with ODM for purposes of determining the practices eligible to enroll in the Ohio CPC Program for the upcoming year.

- The Enrollment File P includes all members from the June Attribution of the current year. Additional filters are applied as detailed in the figure below:

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Filters to Generate File P (Attribution for Enrollment)

Utilization flag filter	Invalid practices filter	Exclusions filter
▪ Removes members who did NOT have any claims within the last 24 month	▪ Removes invalid practices and any members attributed to invalid practices	▪ Removes members that are excluded from the CPC program for any reason
▪ Set utilization_flag to 1 (and 0 otherwise) if the member had at least one of any type of claim with their attributed practice within the 24 months (730 days) prior to the attribution_date, that is, where both of the following are true: – billing_provider_id on the claim matches practice_medicaid_id for the member on the Attribution Output Table (O.01) – header_to_date_of_service on the claim is greater than or equal to (≥) 730 days prior to the attribution_date and less than or equal to (≤) the attribution_date	▪ Set valid_practice to 1 if the specialty type and provider type of the practice_medicaid_id for each member on the Attribution Output Table (O.01) matches one of the valid specialty type and practice type combinations, as specified on the cpc_pcp_attribution codelist, and 0 otherwise	▪ Exclusions include TPL, limited benefits, program eligibility, duals, foster child and transition status (Detailed in Section 5.2.2 of the DBR) ▪ The field ExclAny can be used to remove members with any of the standard member exclusions listed above **Note:** The foster child flag is no longer being counted and will equal 0.

Filters to Generate File P (Attribution for Enrollment)

Utilization flag filter	Invalid practices filter	Exclusions filter
▪ Removes members who did NOT have any claims within the last 24 month	▪ Removes invalid practices and any members attributed to invalid practices	▪ Removes members that are excluded from the CPC program for any reason
▪ Set utilization_flag to 1 (and 0 otherwise) if the member had at least one of any type of claim with their attributed practice within the 24 months (730 days) prior to the attribution_date, that is, where both of the following are true: – billing_provider_id on the claim matches practice_medicaid_id for the member on the Attribution Output Table (O.01) – header_to_date_of_service on the claim is greater than or equal to (≥) 730 days prior to the attribution_date and less than or equal to (≤) the attribution_date	▪ Set valid_practice to 1 if the specialty type and provider type of the practice_medicaid_id for each member on the Attribution Output Table (O.01) matches one of the valid specialty type and practice type combinations, as specified on the cpc_pcp_attribution codelist, and 0 otherwise	▪ Exclusions include TPL, limited benefits, program eligibility, duals, foster child and transition status (Detailed in Section 5.2.2 of the DBR) ▪ The field ExclAny can be used to remove members with any of the standard member exclusions listed above **Note:** The foster child flag is no longer being counted and will equal 0.

Figure 3. Filters to Generate File P

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- The structure of File P is one row per member.
- Begin with all members on the Attribution Output Table (O.01)
- Update the File P output data file using the following fields from the Attribution Output Table (O.01), unless otherwise noted, for the corresponding quarter:
    - Set Payer to payer
    - Set Practice Medicaid ID to practice_medicaid_id
    - Set Rendering Provider Medicaid ID to practitioner_medicaid_id
    - Set Member Medicaid ID to member_medicaid_id
    - Set Member First Name to member_first_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set Member Last Name to member_last_name from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set Member Date of Birth to member_dob
    - Set Member City to ADR_CITY from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set Member State to member_state from the Member Extract (I.C.01) where member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)
    - Set Member Zip Code to ADR_ZIP_CODE from the Member Extract (I.C.01) where

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member_medicaid_id from the Attribution Output Table (O.01) equals member_id from the Member Extract (I.C.01)

- Set Practice City to ADR_MAIL_CITY1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id from the Attribution Output Table (O.01)
- Set Practice State to ADR_MAIL_STATE1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id from the Attribution Output Table (O.01)
- Set Practice Zip Code to ADR_MAIL_ZIP1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id from the Attribution Output Table (O.01)
- Set Rendering Provider City to ADR_MAIL_CITY1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals Rendering_Provider_Medicaid_ID from the Attribution Output Table (O.01)
- Set Rendering Provider State to ADR_MAIL_STATE1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals Rendering_Provider_Medicaid_ID from the Attribution Output Table (O.01)
- Set Rendering Provider Zip Code to ADR_MAIL_ZIP1 from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals

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Rendering_Provider_Medicaid_ID from the Attribution Output Table (O.01)

5.10.18 File P Summary: Provider-Level Enrollment Summary File

File P Summary represents the annual practice-level enrollment file (aggregated from File P) which is shared with ODM for purposes of determining the practices eligible to enroll in the Ohio CPC Program for the upcoming year.

The structure of File P Summary is one row per practice and is NOT limited to any participating CPC practice list.

- Update the File P Summary output data file as follows:
- Set Practice Medicaid ID to practice_medicaid_id
- Set Practice Name to practice_name
- Set Practice Tax ID to NUM_TAX_ID from the Provider Extract (I.C.02) where provider_id from the Provider Extract (I.C.02) equals practice_medicaid_id
- Set Practice NPI to practice_npi
- Set Practice CPC ID to CPC_ID if the Practice Medicaid ID equals Medicaid_Id from the Ohio CPC Practices List (I.S.08)
- Set Convenor CPC ID to Convenor_ID if the Practice Medicaid ID equals Medicaid_Id from the Ohio CPC Practices List (I.S.08)
- Set Total Attributed member count to the sum of attributed members by practice
- Set Total Attributed Pediatric member count to sum of members < 21 years of age by practice
- Set Currently enrolled in CPC Flag(Y/N) is based on the current Ohio CPC Practice List; the practice currently enrolled in CPC (Y/N).

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- Set Meets CPC Partnership Program Criteria (Y/N) whether or not the practice has at least 150 valid attributed members
- Set Meets CPC Individual Program Criteria(Y/N) whether the practice has at least 500 attributed members
- Set Meets CPC for Kids program Criteria(Y/N) whether the practice has at least 150 attributed pediatric members
- Set Practice Meets at least 50% QM for Last 2 Years – if the practice was in the CPC program, set to 'Y' if the practice passed at least 1 of the past 2 years; 'N' if they were in CPC both years and failed both years; NA if they were not in the program both years
- Set Partnership Meets at least 50% QM for Last 2 Years - if the practice was in the CPC program as part of a partnership, set to 'Y' if the partnership passed at least 1 of the past 2 years; 'N' if they were in a CPC partnership both years and failed both years; NA if they were not in a partnership in the program both years
- Set Practice Meets at least 50% Eff Metrics for Last 2 Years - if the practice was in the CPC program, set to 'Y' if the practice passed at least 1 of the past 2 years; 'N' if they were in CPC both years and failed both years; NA if they were not in the program both years
- Set Partnership Meets at least 50% Eff Metrics for Last 2 Years - if the practice was in the CPC program as part of a partnership, set to 'Y' if the partnership passed at least 1 of the past 2 years; 'N' if they were in a CPC partnership both years and failed both years;

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NA if they were not in a partnership in the program both years

- Set Practice Meets at least 50% applicable pediatric QM for Last 2 Years – if the practice was in the CPC program and participating in the CPC for Kids program, set to 'Y' if they passed at least 1 of the last 2 years; 'N' if the practice was in the CPC program and participating in the CPC for Kids program and failed both years; NA if they were not in the CPC for Kids program both years
- Set Partnership Meets at least 50% applicable pediatric QM for Last 2 Years - if the practice was in the CPC program as part of a partnership participating in the CPC for Kids program, set to 'Y' if the partnership passed at least 1 of the past 2 years; 'N' if they were in a CPC partnership participating in CPC for Kids both years and failed both years; NA if they were not in a partnership participating in CPC for Kids in the program both years
- Set Practice Passes at least one of the applicable CPC for Kids QMs for last 2 years to 'Y' if the practice was in the CPC for Kids program and passed at least 1 CPC for Kids metric; 'N' if they were in CPC for Kids and did not pass at least 1 CPC for Kids metrics for both years; NA if they were not in the CPC for Kids program both years.
- Set Partnership Passes at least one of the applicable CPC for Kids QMs for last 2 years to 'Y' if the practice was in a partnership that was in the CPC for Kids program and passed at least 1 CPC for Kids metric; 'N' if they were in a

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partnership participating in CPC for Kids and the partnership did not pass at least 1 CPC for Kids metrics for both years; NA if they were not in the CPC for Kids program both years.

- Set Practice Meets Activity Requirements - if the practice was in the CPC program, set to 'Y' if the practice passed at least 1 of the past 2 years; 'N' if they were in CPC both years and failed both years; NA if they were not in the program both years
- Set Partnership Meets Activity Requirements- if the practice was in a partnership that was in the CPC program, set to 'Y' if the partnership passed at least 1 of the past 2 years; 'N' if they were in CPC both years and failed both years; NA if they were not in the program both years

5.10.19 GAR File: Layout and Cases

The AP_AR file is created in special cases and is not part of the quarterly Attribution file package. It is generated any time a reconciliation of PMPM payments is required. The AP_AR file is required by ODM to process quarterly PMPM payment reconciliation. Examples of cases that warrant generation of the AP_AR file include, but are not limited to:

- Practice is terminated from the program and a take back is needed
- Payment adjustments are needed for previous payments

5.10.19.1 Create GAR File – the recoupment upload

- Set Payee ID to the NPI for FFS or the MCO Payer ID (this ID matches what was originally issued in Files G1 and G2)
- Set Payee Type to "P"
- Set AR Reason to 8422 (CPC Regular FFS), 8423 (CPC Regular MCO), 8424 (for CPC for Kids FFS), 8425 (CPC for Kids MCO)
- Set Fund Code to 4502 (CPC Regular FFS), 4402 (CPC for Kids FFS), 4572 (CPC Regular MCO), 4472 (CPC for Kids MCO)
- Set Associated FFYQ to the Year/Quarter that is being taken back
- Set Setup Amount to the amount to recover (matches the amount paid in G1/G2)
- Set Effective Date to null

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- Set Recoupment Type to “A”
- Set Recoupment Percent to 1
- Set Recoupment Amount to null
- Set Pay Terms to STD F
- Set AR Number to CP<YY><Quarter ID><NPI/Payer ID>
- Set External Invoice ID to MCD
- Set Provider Type to MD
- Set Business Area to MD

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6 PREVIEW REPORTS

6.1 Purpose

The first reports issued for a given program year are Preview reports. Preview reports are the first reports issued for a program year, using the certified HEDIS metrics list, the CPC participating practice list, and the known changes for that program year. The purpose of Preview reports is to give providers who are joining the CPC program for the program year in a different capacity than the proceeding program year as listed in the following section, a chance to view their data, understand how to use the files they receive, and prepare for their new or updated participation in the CPC program.

6.1.1 Preview Rolling Period

The rolling period used for Preview reports corresponds to the rolling period used for the Performance report from the previous program year. See the table below for an example.

Table 26. Preview Rolling Period Example

Report	Program year	Rolling Period
Q1 2026 Performance	2025	10/1/2024–9/30/2025
Q1 2026 Preview	2026	10/1/2024–9/30/2025
Q2 20265 Performance	20254	1/1/2025–12/31/20254
Q2 2026 Preview	2026	1/1/2025–12/31/2025

6.2 Distribution

Preview reports are not distributed to MCOs. Preview reports are distributed to:

- Practices who are new to the CPC program year
- Practices who are in partnerships that are new to the CPC program
- Practices who were previously participating in a CPC partnership and are now an individual entity.
- Practices who were previously individual entities who are now participating in a partnership
- Practices within a partnership where the partnership has changed composition (i.e., gained or lost participating practices)

Files distributed to providers are:

- Summary PDF File J**:** described in section 5.10.7.
- Member-level File I: described in section 5.10.8.

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7 APPENDICES

Appendices to the Ohio CPC DBR are contained in separate files containing the following sections:

- Appendix A: Ohio CPC Quality and Efficiency Metrics Specifications
- Appendix B: Service Care Categories
- Appendix C: Reconciliation
- Appendix D: Ohio CPC Configuration File (contained in a file separate from the other appendices)

7.1 Appendix A: Ohio CPC Quality and Efficiency Metrics Specifications

This section provides details on metrics that are defined or modified by the Ohio Department of Medicaid used in Ohio CPC reporting.

7.1.1 BH IP Admits / 1,000 Annualized Members (HEDIS MPT)

The Behavioral Health Admissions per 1,000 Member Months metric is defined using the standard HEDIS® specifications for the Mental Health Utilization (MPT) measure. However, the standard specifications output the results of the metric as a percentage of all members receiving the given service. For purposes of Ohio CPC, the specifications are modified to count the number of events of the given service. The event count is then used to calculate the rate of events per 1,000 annualized members.

7.1.2 Tobacco Use: Screening and Cessation (NQF 0028)

Specifications for the Tobacco Use: Screening and Cessation metric (NQF 0028) use the standard specifications for the measure, which can be found at:

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health - Claims (cms.gov)

The metric is defined as follows:

Denominator

- All patients aged 18 years and older with either:
- At least two visits [nqf_28_tobacco_visits_em value set] during the measurement year
- At least one preventive visit [nqf_28_tobacco_visits_general value set] during the measurement year

Numerator

- Patients who were screened for tobacco use at least once during the two-year measurement period identified by the AND who received tobacco cessation counseling intervention if identified as a tobacco user [nqf_28_tobacco_screen_cessation value set].

  Note: This value set contains codes to identify numerator compliant members along the following three dimensions:

- CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

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- CPT II 1036F: Current Tobacco non-user
- CPT Category I codes: Smoking and tobacco-use cessation counseling if the patient screened positive for smoking/tobacco use and counseling was provided
    - 99406: Smoking/tobacco counseling 3–10 minutes
    - 99407: Smoking/tobacco counseling greater than 10 minutes

Denominator Exclusions

- Members are excluded from the denominator if there is evidence of documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy), any time within the measurement year or year prior to the measurement year, as defined by the [nqf_28_tobacco_exclusion value set].

7.1.3 Live Births Weighing Less than 2,500 Grams (ODM)

7.1.3.1 Description

Live Births Weighing Less than 2,500 grams is an ODM measure that utilizes baby birthweight data from the Centers for Disease Control and Prevention (CDC).

- ODM is responsible for providing the low birthweight data, which is represented by the input file Low Birthweight Data (I.M.01).

  Note: There is one quarter lag between when the low birthweight data is made available and the quarter during which the Ohio CPC Practice Reports are generated. For example, for a 12-month rolling period of 1/1/2024 to 12/31/2024 utilizes low birthweight data captures the timeframe 10/1/2017 to 9/30/2024.

  Note: The Low Birthweight Data (I.M.01) input file contains the year and month of the baby's birth. The baby's birth_date on the input file for purposes of Ohio CPC is constructed by concatenating idob_MO, idob_YR, and "1" with hyphens in between. For example, idob_MO of "5" and idob_YR of "2024" would result in a birth_date of "201824-5-1".

7.1.3.2 Numerator

- Ohio Medicaid members who had a live birth during the performance period where the birth weight of the baby is less than or equal to (≤) 2,500 grams.

7.1.3.3 Denominator

- Ohio Medicaid members who had a live birth during the performance period.

7.1.3.4 Steps to update the Rolling Period Member Table (O.03)

- If the mother_id appears more than once in the input file, determine the birth date(s) of the previous and next babies associated with the mother and exclude any records where the number of months between births is less than or equal to (≤) 3
- For the given mother_id, set the next_birth_date parameter as the baby_birth_date of the second baby_id following the birth of the baby on the record

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- For the given mother_id, set the previous_birth_date parameter as the baby_birth_date of the baby_id born prior to the birth of the baby on the record
- Exclude all members from the Low Birthweight Data (I.M.01) input file where the number of months between the baby_birth_date of the baby and the previous_birth_date parameter for the record is less than or equal to (≤) 3 and where the number of months between the baby_birth_date of the baby and the next_birth_date parameter for the record is less than or equal to (≤) 3
- Set lbw_den_flag on the Rolling Period Member Table (O.03) equal to 1 (and 0 otherwise) if <u>all</u> the following criteria are true:
    - mother_id on the Low Birthweight Data (I.M.01) input file is equal to member_medicaid_id on the Rolling Period Member Table (O.03)
    - baby_birth_date on the Low Birthweight Data (I.M.01) input file is greater than or equal to (≥) 3 months prior to the rolling_period_start_date from the Rolling Period Member Table (O.03)
    - baby_birth_date on the Low Birthweight Data (I.M.01) input file is less than or equal to (≤) 3 months prior to the rolling_period_end_date from the Rolling Period Member Table (O.03)
- Set lbw_num_flag on the Rolling Period Member Table (O.03) equal to 1 (and 0 otherwise) if <u>all</u> the following criteria are true:
    - mother_id on the Low Birthweight Data (I.M.01) input file is equal to member_medicaid_id on the Rolling Period Member Table (O.03)
    - baby_birth_date on the Low Birthweight Data (I.M.01) input file is greater than or equal to (≥) 3 months prior to the rolling_period_start_date from the Rolling Period Member Table (O.03)
    - baby_birth_date on the Low Birthweight Data (I.M.01) input file

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is less than or equal to (≤) 3 months prior to the rolling_period_end_date from the Rolling Period Member Table (O.03)

- baby_birth_weight is less than or equal to (≤) 2500

7.1.4 IP Admits for ACSC / 1,000 Annualized Members (AHRQ PQI 90)

7.1.4.1 Description

Prevention Quality Indicators (PQI) overall composite, ages 18 years and older, expressed within Ohio CPC as a rate per 1,000 annualized members.

Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.

7.1.4.2 Source

AHRQ QI ICD-10-CM/PCS Specification v2025 Prevention Quality Indicator 90 (PQI 90)
http://qualityindicators.ahrq.gov/

.

7.1.4.3 Numerator

- Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:
  - PQI #1 Diabetes Short-Term Complications Admission Rate
  - PQI #3 Diabetes Long-Term Complications Admission Rate
  - PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
  - PQI #7 Hypertension Admission Rate
  - PQI #8 Heart Failure Admission Rate
  - PQI #11 Bacterial Pneumonia Admission Rate
  - PQI #12 Urinary Tract Infection Admission Rate

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  - PQI #14 Uncontrolled Diabetes Admission Rate
  - PQI #15 Asthma in Younger Adults Admission Rate
  - PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

- Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

  Note: technical specifications on each PQI are listed below.

7.1.4.4 Denominator

- Population ages 18 years and older. Denominators should be defined for all PQIs as all members with at least one month of eligibility during the measurement timeframe.
- For Ohio CPC, the denominator is expressed as a rate per 1,000 annualized members.

  Note: The AHRQ PQI #90 specifications contain reference to the metropolitan area or county; metropolitan area or county should be ignored for purposes of Ohio CPC.

7.1.4.5 Measure Timeframe Parameters

Table 27. Measure Timeframe Parameters

Timeframe Parameter	Timeframe Value
Measurement Year	The rolling 12-month period representing an Ohio CPC reporting or performance period
Age for Denominator	Age 18 as of the date of the discharge
Continuous Enrollment	None
Anchor Date	Use the date of the discharge as the anchor date

7.1.4.6 Note on Major Diagnostic Categories (MDCs)

This measure requires the use of Major Diagnostic Categories (MDCs) for the numerator of the PQI #16 measure. Specifically, PQI 16 excludes “MDC 14 (pregnancy, childbirth, and puerperium)” from the numerator. Identify MDC 14 using the [PQI_MDC14 value set]. Only make this exclusion for the numerator of the PQI #16 measure, and not any other PQI measure.

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7.1.5 PQI #1 Diabetes Short-Term Complications Admission Rate

7.1.5.1 Description

- Hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric hospitalizations, and transfers from other institutions.

7.1.5.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) [PQI_ACDIASD value set].

7.1.5.3 Numerator Exclusions

- Exclude discharges:
  - Transfer from a hospital (different facility)
  - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999).

7.1.5.4 Denominator

- Population ages 18 years and older.

7.1.6 PQI #3 Diabetes Long-Term Complications Admission Rate

7.1.6.1 Description

- Hospitalizations for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 population, ages 18 years and older. Excludes obstetric hospitalizations and transfers from other institutions.

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7.1.6.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) [PQI_ACDIALD value set]

7.1.6.3 Numerator Exclusions

- Exclude discharges:
  - Transfer from a hospital (different facility)
  - Transfer from an SNF or ICF
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999)

7.1.6.4 Denominator

- Population ages 18 years and older.

7.1.7 PQI #5 Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate

7.1.7.1 Description

- Hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma, ages 40 years and older. Excludes hospitalizations with cystic fibrosis and anomalies of the respiratory system, obstetric hospitalizations, and transfers from other institutions.

7.1.7.2 Numerator

- Hospital discharges, for patients ages 40 years and older, with <u>at least one of the following:</u>
  - A principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis) [PQI_ACCOPDD value set]
  - A principal ICD-10-CM diagnosis code for asthma [PQI_ACSASTD value set]; or

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7.1.7.3 Numerator Exclusions

- Exclude cases:
  - With any-listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system [PQI_RESPAN value set]
  - Transfer from a hospital (different facility)
  - Transfer from an SNF or ICF
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing),principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999)

7.1.7.4 Denominator

- Population ages 40 years and older.

7.1.8 PQI #7 Hypertension Admission Rate

7.1.8.1 Description

- Hospitalizations with a principal diagnosis of hypertension, ages 18 years and older. Excludes hospitalizations with stage 1-4 or unspecified chronic kidney disease combined with dialysis access procedure, hospitalizations for cardiac procedure, obstetric hospitalizations, and transfers from other institutions

7.1.8.2 Numerator

- Hospital discharges for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for hypertension [PQI_ACSHYPD value set].

7.1.8.3 Numerator Exclusions

- Exclude cases:
  - With any-listed ICD-10-PCS procedure codes for cardiac procedure [PQI_ACSCARP value set]

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- With any-listed ICD-10-CM diagnosis codes of Stage I-IV kidney disease [PQI_ACSHY2D value set], only if accompanied by any-listed ICD-10-PCS procedure codes for dialysis access [PQI_ACSHYPP value set]
- Transfer from a hospital (different facility)
- Transfer from an SNF or ICFs/IID
- Transfer from another health care facility
- With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing),principal diagnosis (DX1=missing), or county (PSTCO=missing)
- With an ungroupable DRG (DRG=999)

7.1.8.4 Denominator

- Population ages 18 years and older.

7.1.9 PQI #8 Heart Failure Admission Rate

7.1.9.1 Description

- Hospitalizations with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes hospitalizations with cardiac procedure, obstetric hospitalizations, and transfers from other institutions.

7.1.9.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for heart failure [PQI_ACSCHFD value set].

  Note: ICD-10-CM diagnosis codes were not provided in version 5.5 of the Prevention Quality Indicators Technical Specifications for PQI 08, as of the time of the launch of the Ohio CPC program. An ICD-9 to ICD-10 cross-walking methodology was used to identify relevant ICD-10 codes and were provided for the value set. AHRQ has since released ICD-10-CM codes in version > 6.0 of the PQI Technical Specifications, although the codes obtained through cross-walking are still used for purposes of continuity.

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7.1.9.3 Numerator Exclusions

- Exclude cases:
  - With any-listed ICD-10-PCS procedure codes for cardiac procedure [PQI_ACSCARP value set]
  - Transfer from a hospital (different facility)
  - Transfer from an SNF or ICF
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999)

7.1.9.4 Denominator

- Population ages 18 years and older.

7.1.10 PQI #11 Bacterial Pneumonia Admission Rate

7.1.10.1 Description

- Hospitalizations with a principal diagnosis of community-acquired bacterial pneumonia, ages 18 years and older. Excludes hospitalizations with sickle cell or hemoglobin-S disease, other indications of immunocompromised state, obstetric hospitalizations, and transfers from other institutions.

7.1.10.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for community-acquired bacterial pneumonia [PQI_ACSBACD value set].

Numerator Exclusions

- Exclude discharges:
  - With any-listed ICD-10-CM diagnosis codes for sickle cell or HB-S disease [PQI_ACSBA2D value set]
  - With any-listed ICD-10-CM diagnosis codes or any-listed ICD-

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10-PCS procedure codes for immuno-compromised state [PQI_IMMUNID value set] or [PQI_IMMUNIP value set]

- Transfer from a hospital (different facility)
- Transfer from an SNF or ICF
- Transfer from another health care facility
- With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
- With an ungroupable DRG (DRG=999)

7.1.10.3 Denominator

- Population ages 18 years and older.

7.1.11 PQI #12 Urinary Tract Infection Admission Rate

7.1.11.1 Description

- Hospitalizations with a principal diagnosis of urinary tract infection, ages 18 years and older. Excludes hospitalizations with a kidney or urinary tract disorder, other indications of immunocompromised state, obstetric hospitalizations, and transfers from other institutions.

7.1.11.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for urinary tract infection [PQI_ACSUTID value set].

7.1.11.3 Numerator Exclusions

- Exclude cases:
  - With any-listed ICD-10-CM diagnosis codes for kidney or urinary tract disorder [PQI_KIDNEY value set]
  - With any-listed ICD-10-CM diagnosis codes or any-listed ICD-10-PCS procedure codes for immuno-compromised state [PQI_IMMUNID value set] or [PQI_IMMUNIP value set]

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- Transfer from a hospital (different facility)
- Transfer from an SNF or ICF
- Transfer from another health care facility
- With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
- With an ungroupable DRG (DRG=999)

7.1.11.4 Denominator

- Population ages 18 years and older.

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7.1.12 PQI #14 Uncontrolled Diabetes Admission Rate

7.1.12.1 Description

- Hospitalizations for a principal diagnosis of uncontrolled diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 years and older. Excludes obstetric hospitalizations, and transfers from other institutions.

7.1.12.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication [PQI_ACDIAUD value set].

7.1.12.3 Numerator Exclusions

- Exclude discharges:
  - Transfer from a hospital (different facility)
  - Transfer from an SNF or ICF
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999)

7.1.12.4 Denominator

- Population ages 18 years and older.

7.1.13 PQI #15 Asthma in Younger Adults Admission Rate

7.1.13.1 Description

- Hospitalizations for a principal diagnosis of asthma, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric hospitalizations, and transfers from other institutions.

7.1.13.2 Numerator

- Hospital discharges, for patients ages 18 through 39 years, with a principal ICD-10-CM diagnosis code for asthma [PQI_ACSASTD value set].

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7.1.13.3 Numerator Exclusions

- Exclude discharges:
  - With any-listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system [PQI_RESPAN value set]
  - Transfer from a hospital (different facility)
  - Transfer from an SNF or ICF
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
  - With an ungroupable DRG (DRG=999)

7.1.13.4 Denominator

- Population ages 18 through 39 years.

7.1.14 PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

7.1.14.1 Description

- Hospitalizations for diabetes and a procedure of lower-extremity amputation (except toe amputations), ages 18 years and older. Excludes traumatic lower-extremity amputation hospitalizations, obstetric hospitalizations, and transfers from other institutions.

7.1.14.2 Numerator

- Hospital discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for lower-extremity amputation [PQI_ACSLEAP value set] and any-listed ICD-10-CM diagnosis codes for diabetes [PQI_ACSLEAD value set].

7.1.14.3 Numerator Exclusions

- Exclude discharges:
  - With any-listed ICD-10-CM diagnosis codes for traumatic amputation of the lower extremity [PQI_ACLEA2D value set]

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- MDC 14 (pregnancy, childbirth, and puerperium) [PQI_MDC14 value set]
- Transfer from a hospital (different facility)
- Transfer from an SNF or ICF
- Transfer from another health care facility
- With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)
- With an ungroupable DRG (DRG=999)

7.1.14.4 Denominator

- Population ages 18 years and older.

7.1.15 Tobacco Use: Screening and Cessation Ages 12-17, Modified (NQF 0028)

Specifications for the Tobacco Use: Screening and Cessation metric (NQF 0028) use the standard specifications for the measure, which can be found at:

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

The metric is defined as follows:

7.1.15.1 Denominator

- All patients aged 12-17 years and older with either:
  - At least two visits [nqf_28_tobacco_visits_em value set] during the measurement year
  - At least one preventive visit [nqf_28_tobacco_visits_general value set] during the measurement year

7.1.15.2 Numerator

- Patients who were screened for tobacco use at least once during the two-year measurement period identified by the AND who received tobacco cessation counseling intervention if identified as a tobacco user [nqf_28_tobacco_screen_cessation value set].

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Note: This value set contains codes to identify numerator compliant members along the following three dimensions:

- CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
- CPT II 1036F: Current Tobacco non-user
- CPT Category I codes: Smoking and tobacco-use cessation counseling if the patient screened positive for smoking/tobacco use and counseling was provided
    - 99406: Smoking/tobacco counseling 3-10 minutes
    - 99407: Smoking/tobacco counseling greater than 10 minutes

7.1.15.3 Denominator Exclusions

- Members are excluded from the denominator if there is evidence of documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy), any time within the measurement year or year prior to the measurement year, as defined by the [nqf_28_tobacco_exclusion value set].

7.1.16 Preferred Drug List (ODM)

The Preferred Drug List was introduced by ODM as an information only metric for PY2021. Specifications for the Preferred Drug List metric are defined by ODM as:

The ratio of members with UPDL prescriptions with a "preferred" NDC to members with one or more (i.e., "preferred" or "non-preferred" NDC) UPDL prescriptions during the measurement year (MY), calculated for the following UPDL drug categories, by CPC:

7.1.16.1 CPC Adherence UPDL Category (Category)

- Antidiabetics, Insulin
- Antidiabetics, Non-Insulin
- Asthma
- COPD

Preferred Adherence Ratio, = <u># of members with UPDL preferred prescriptions</u>

by Category # of members with UPDL prescriptions (preferred or non-preferred)

Adherence Ratio Numerator: The number of unduplicated members with one or more prescriptions with a "preferred" NDC on the UPDL, during the measurement year, by Category.

Adherence Ratio Denominator: The number of unduplicated members with one or more prescriptions (i.e., "preferred" or "non-preferred" NDC) on the UPDL, during the measurement year, by Category.

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7.1.17 Metric Implementation Notes

The following section describes configuration elements specific to Ohio CPC. These represent parameters or decisions that are made needed for the implementation of the quality and efficiency metrics to be consistent with that of Ohio CPC.

Ohio CPC counts eligibility on the first day of the month for purposes of clinical quality and efficiency metrics.

Any optional exclusions as part of the clinical quality metrics are run for the Ohio CPC metrics.

- For quality and efficiency metrics that require identification of a practitioner associated with the claim, the following fields are used to identify providers (in order, with subsequent fields used only if the prior field is blank):
    - Prior to Program year 2020:
        - Rendering provider on the claim
        - Attending provider on the claim
        - Billing provider on the claim
    - Beginning Program year 2020:
        - Billing provider on the claim
- For specifications that call for the identification of eligible practitioner and provider types, the definitions below were determined by the Ohio Department of Medicaid. These provider definitions can be found in the following codelists in the Ohio CPC Configuration File:
    - Eye Care Professional: eyecare_provider_type and eyecare_specialty
    - Mental Health Provider: mhp_provider_type and mhp_specialty
    - OB/GYN and other prenatal care practitioner: obgyn_provider_type and obgyn_specialty
- Primary Care Physician: pcp_provider_type and pcp_specialtyContinuous enrollment criteria, if applicable to the metric, are applied for purposes of Ohio CPC.
- The member must be enrolled in Medicaid (with any MCO or FFS, members may be enrolled in multiple MCOs and/or FFS during this period) during the continuous enrollment timeframe and parameters as defined by each metric.
- Where allowable continuous enrollment gaps are used, the allowable gap in continuous enrollment is up to 45 days.
- Ohio CPC clinical quality and efficiency metrics based on HEDIS® specifications should adhere to the "Collecting Data for Measures with Multiple Numerator Events" in the HEDIS General Guidelines for Data Collection and Reporting, measures requiring more than one event to satisfy

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the numerator must only include events at least 14 days apart when only assessing administrative data or when combining administrative and medical record data.

7.1.18 eCQM Supplemental Data Calculation Methodology

Electronic Quality Clinical Metrics (eCQMs) will be introduced to CPC reporting for Program year 2025. Starting during Program year 2025, providers can start submitting eCQM supplemental data.

Information regarding eCQM supplemental data is provided as part of the Program year 2025 training documentation to facilitate the data sharing process as providers prepare for introduction of the programmatic change.

7.1.18.1 eCQM Supplemental Data Metrics Calculation Process

After the eCQM (Electronic Quality Clinical Measures) supplemental data is successfully loaded into the respective tables, then the eCQM supplemental data metrics are calculated. This process utilizes the base populations derived from certified HEDIS (Healthcare Effectiveness Data and Information Set) measures as the denominator. The detailed steps for this process are outlined below:

1. Base Population Identification
    - Source of Base Population: For each eCQM supplemental data metric, the base population is identified using the denominator from the corresponding certified HEDIS measure. This population represents all members who qualify for the measure based on predefined criteria, such as age, diagnosis, and treatment history.
    - Population Filtering: The identified base population is filtered to include only those members who meet the specific criteria for the eCQM supplemental data under consideration.
2. eCQM Supplemental Data Verification
    - Data Matching: For each member in the base population, the system checks whether chart data has been supplied by a provider. This chart data is submitted through quarterly eCQM supplemental data files and is matched against the member records in the base population.
    - Presence of eCQM Supplemental Data: If eCQM supplemental data for a member is present, it

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proceeds to the next validation step. If no data is found, the member criteria for meeting the metric numerator is unchanged from the non-eCQM supplemental data numerator.

3. Rate Calculation
4. eCQM Supplemental Data Rate Augmentation
   - The eCQM supplemental data process involves integrating the eCQM supplemental data into the existing metrics, allowing members who were initially excluded from the numerator to be counted as compliant, provided they are valid attributed members for the reporting period, and they otherwise qualify for the metric per NCQA certified specifications. The aggregation of data will apply existing rules of member level aggregation for practices and partnerships.
5. Reporting
   - Data Validation: Before finalizing the eCQM supplemental data rates, all calculations are validated to ensure accuracy. There validation process has three parts:
     1. Validation of the eCQM supplemental data: during the data load into the data base, eCQM origin is validated (identifying where the files came from). After the data is loaded, time frame and value range are confirmed.
     2. Validation of the eCQM supplemental data -CPC linkage: validating the member and time period reflected in the eCQM supplemental data matches CPC attribution for the same time period.
     3. Validation of results: if eCQM supplemental data is received that matches the first two validation steps, they are included in the appropriate eCQM supplemental data metric.
   - Output Generation: The final eCQM supplemental rates are then generated and prepared for reporting. These rates can be included in various reports, dashboards, or data submissions,

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depending on the specific requirements of the stakeholders or regulatory bodies.

7.1.18.2 CPC Reporting Process

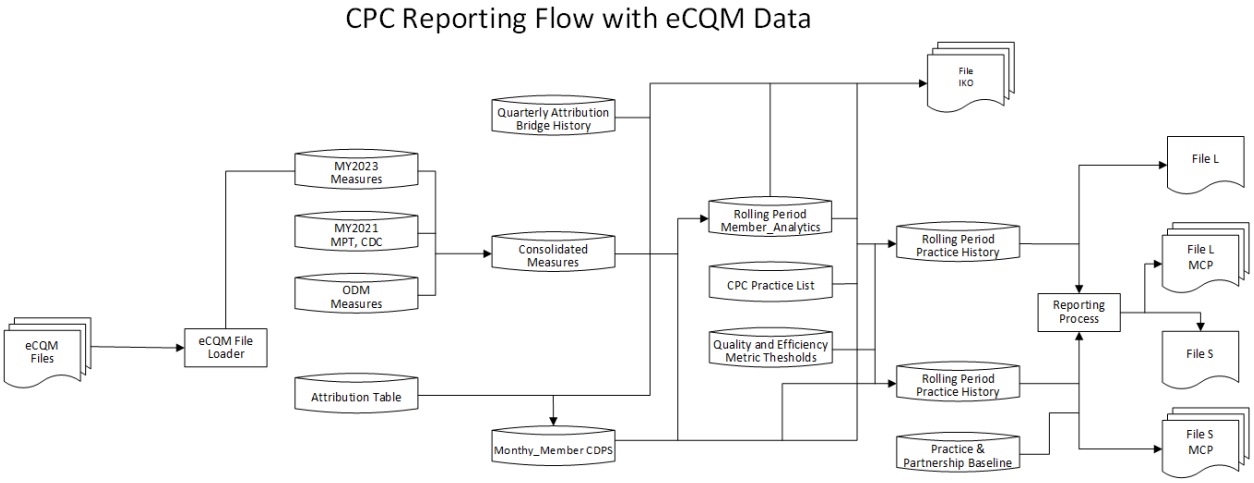

Figure 4: CPC Reporting Flow with eCQM Data

The image above demonstrates the steps for data flow to generate eCQM supplemental data metrics:

eCQM supplemental data files are ingested by GWT into the eCQM supplemental data file loader

As measures are generated for a particular program year, the eCQM supplemental data is applied as described previously. Members can only be *added* to a metric numerator due to eCQM supplemental data. A member will *never* be removed from a metric numerator due to eCQM supplemental data.

After applicable metrics are augmented with eCQM supplemental data, the CPC reporting algorithm continues. Metric data is then merged with member risk and member spend data to populate the Rolling_Period_Member_Analytics table for the entire Medicaid population.

The applicable CPC Practice List and metric thresholds are added and the member-level data is aggregated on the Rolling_Period_Practice_Hist table.

Output files are generated and the QA process for verifying output files is completed.

7.2 Appendix B: Service Care Categories

7.2.1 Service Category Description

There are sixteen service categories defined as part of the Ohio CPC program, which represent a combination of care type and service location:

Table 28. Service Category Descriptions

Service category	Description
Hospital inpatient care	All facility and professional services provided in hospital inpatient setting (inc. behavioral health (BH)), including:

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Service category	Description
	Core services such as treatment and procedures, accommodation, E&M Other services such as medication, durable medical equipment (DME) and supplies, lab and pathology, radiology and other services
ED care	All facility and professional services provided in ED setting, including: Core services such as treatment and procedures, accommodation, E&M Other services such as medication, DME and supplies, lab and pathology, radiology and other services
Hospital outpatient care	Core services such as treatment and procedures, accommodation, E&M provided in hospitals on outpatient basis, including ambulatory surgical centers (ASCs) and hospital outpatient (inc. BH). Other services not included as they are a potential source of value to track separately
Office and clinic care	Core services such as treatment and procedures, E&M provided in a clinic or office setting (inc. BH). Other services not included as they are a potential source of value to track separately
Institutional care	All facility and professional services provided skilled nursing facility setting, including: Core services such as treatment and procedures, accommodation, E&M Other services such as medication, DME and supplies, lab and pathology, radiology and other services
Home and community-based care	All facility and professional services provided in home, community, and residential-BH settings, including: Core services such as treatment and procedures, accommodation, E&M Other services such as medication, DME and supplies, lab and pathology, radiology and other services
Specialty pharma	Medication and pharmaceuticals billed through a current procedural terminology (CPT) code, on a professional or a facility claim; typically covered by medical benefits. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.
Retail prescriptions	Medication and pharmaceuticals billed on a pharmacy claim by a retail pharmacy; typically covered by pharmacy benefits. Only in pharmacy setting.
DME and supplies	Durable medical equipment and supplies, billed on a professional or facility claim. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.
Lab and pathology	Lab tests and pathology services, billed on a professional or facility claim. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.

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Service category	Description
Radiology	Radiology imaging services, billed on a professional or facility claim. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.
Ancillary services	Ancillary services such as employment, personal care, respite, crisis management, education, home health etc. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.
Other types of care	Vision, dental, and any uncategorized services, billed on a professional or facility claim. Only in hospital outpatient (inc. BH), ASC, office & clinic, and not specified setting.
Treatment and evaluation at other sites	Core services such as treatment and procedures, accommodation, E&M provided in pharmacy and other setting; includes both facility and professional services. Other services not included as they are a potential source of value to track separately
Physical, occupational, speech therapy	Physical, occupational, and speech therapies (PT/OT/ST), billed on a professional or facility claim. Only in hospital outpatient (inc. BH), ASC, office & clinic, and other setting.
Ambulance and transportation	Transportation services rendered in any settings and any services rendered in an ambulance.

7.2.2 Output Fields

The service category logic results in four fields which are added to each claim detail line:

- Claim form
- Service location
- Care type
- Service category

Possible values and abbreviations for each field are listed in the table below:

Table 29. Detail Claim Line Output Fields

Description	Abbreviation
Claim form	-
Facility claim	UB-04
Professional claim	CMS-1500
Pharmacy claim	NCPDP
Service location	-
Hospital inpatient	HI
Hospital inpatient-BH	HI-BH
Ambulatory surgical centers	ASC
Hospital outpatient	HO

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Description	Abbreviation
Hospital outpatient-BH	HO-BH
Ambulance	AMB
Emergency department	ED
Office and clinic	OC
Office and clinic-BH	OC-BH
Skilled nursing facility	SNF
Community	COMM
Residential-BH	RES-BH
Home	HOME
Pharmacy	RX
Other	OTHER
Uncategorized	UNCAT
Care type	-
Anesthesia	ANE
Surgery	SUR
Medicine	MED
Facility services	FAC
Evaluation and management	E&M
Physical, occupational, speech therapy	PTOTST
Medication and pharmaceuticals	PHAR
DME and supplies	DME
Laboratory and pathology	LAB
CT, MRI, radioisotope imaging	CTMRI
X-ray, ultrasound, and other imaging	XUS
Ancillary services	ANC
Vision	VIS
Transportation	TRANS
Dental	DEN
Other	Other
Uncategorized	UNCAT
Service category	-
Hospital inpatient care	HI

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Description	Abbreviation
ED care	ED
Hospital outpatient care	HO
Office and clinic care	OC
Institutional care	INST
Home and community-based care	HC
Specialty pharma	SPH
Retail prescriptions	RPH
DME and supplies	DME
Lab and pathology	LAB
Radiology	RAD
Ancillary services	ANC
Other types of care	OCARE
Treatment and evaluation at other sites	OLOC
Physical, occupational, speech therapy	PTOTST
Ambulance and transportation	AMB

7.2.3 Claim Forms

Claim form classification is based on the form on which the claim was filed, which include:

- Professional: CMS-1500 or electronic equivalent
- Facility: UB-04 or electronic equivalent
- Pharmacy: Pharmacy claim form (NCPDP) or electronic equivalent

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7.2.4 Service Locations

Service location assignment logic differs for each claim form. The methodology for each claim form is defined as follows:

- For all pharmacy claim forms, Service location is set to “Pharmacy”.
- For all facility claim forms, Service location is set based on the following logic. Service location is defined on the entire claim level for facility claims. The logic should be applied in a hierarchical manner in order listed:
    - Residential BH:
        - Claims with *Type of Bill* field starting with a value listed in the srv_cat_community_bh_tob codelist
        - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_community_bh_revenue codelist
    - Skilled nursing facility:
        - Claims with *Type of Bill* field starting with a value listed in the srv_cat_snf_tob codelist
        - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_snf_revenue codelist
    - Community:
        - Claims with Type of Bill field starting with a value listed in the srv_cat_community_tob codelist
        - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_community_revenue codelist
    - Hospital inpatient:
        - Claims with *Type of Bill* field starting with a value listed in the srv_cat_hospital inpatient_tob codelist
        - Home:
        - Claims with *Type of Bill* field starting with a value listed in the srv_cat_home_tob codelist
        - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_home_revenue codelist
    - ED:
        - Claims with *Type of Bill* field starting with a value listed in the srv_cat_ed_tob codelist
        - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_ed_revenue codelist or with *Detail Procedure Code* field with a value listed in the srv_cat_ed_cpt_or_hcpcs codelist. The claim must also have *Type of Bill* field starting with a value listed in the srv_cat_ed_ambulance_tob codelist

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- Ambulance
  - Claims with at least one detail line with *Revenue Code* field with a value listed in the srv_cat_ambulance_revenue codelist. The claim must also have *Type of Bill* field starting with a value listed in the srv_cat_ed_ambulance_tob codelist
- Ambulatory surgical center
  - Claims with *Type of Bill* field starting with a value listed in the srv_cat_asc_tob codelist
- Hospital outpatient
  - Claims with *Type of Bill* field starting with a value listed in the srv_cat_hospital_outpatient_tob codelist
- Office and clinic
  - Claims with *Type of Bill* field starting with a value listed in the srv_cat_office_and_clinic_tob codelist
- Office and clinic BH
  - Claims with *Type of Bill* field starting with a value listed in the srv_cat_office_and_clinic_bh_tob codelist
- Other location
  - Claims with Type of Bill field starting with a value listed in the srv_cat_other_tob codelist
- Uncategorized location
  - Any facility claims yet to be categorized

- For all professional claim forms, Service location is set based on the following logic. Service location is defined on individual claim detail line level for professional claim detail lines. The logic should be applied in a hierarchical manner:
  - ED:
    - Professional claim detail lines with *Detail Procedure Code* field with values listed in the srv_cat_ed_cpt_or_hcpcs codelist
    - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_ed_pos codelistHospital inpatient
    - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_hospital_inpatient_pos codelist
  - Hospital inpatient BH
    - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_hospital_inpatient_bh_pos codelist
  - Ambulatory surgical center
    - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_asc_pos codelist
  - Hospital outpatient

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  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_hospital_outpatient_pos codelist
    - Hospital outpatient BH
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_hospital_outpatient_bh_pos codelist
    - Ambulance
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_ambulance_pos codelist
    - Office and clinic
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_office_and_clinic_pos codelist
    - Office and clinic BH
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_office_and_clinic_bh_pos codelist
    - Skilled nursing facility
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_snf_pos codelist
    - Community
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_community_pos codelist
    - Residential BH
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_community_bh_pos codelist
    - Home
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_home_pos codelist
    - Pharmacy
  - Professional claim detail lines with *Place of Service* field with values listed in the srv_cat_pharmacy_pos codelist
    - Other location
  - Professional claim detail lines with Place of Service field with values listed in the srv_cat_other_pos codelist
    - Uncategorized location
  - All other professional claim detail lines yet to be categorized
- The above logic uses standard *Type of Bill* and *Place of Service* values, defined by the National Uniform Billing Committee and the CMS, respectively. During the ETL process, whether the client uses the standard values for these fields must be confirmed for this logic to work properly. If the

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client uses a client-specific value set to populate these fields, then a mapping logic should be obtained from or developed with the client before applying this logic.

7.2.5 Care Types

Care type assignment logic differs for each claim form. Methodology for each claim form is defined as following:

- Pharmacy claim form: Care type is set to “Medication and pharmaceuticals”.
- Facility claims paid on header level or facility claim detail lines without a CPT or HCPCS code: Care type is set to “Facility services”
- Facility and professional claim paid on detail level with a CPT or HCPCS code: Each detail lines are categorized based on the CPT or HCPCS code of the Detail Procedure Code.
- For all facility and professional claims categorized on detail line level, the categorization scheme is specified using the CCS single categorization, multi-level CCS categorization code level 1 (CL1) and code level 2 (CL2), based on the *Detail Procedure Code*. The categorization is conducted in five hierarchical steps:
    - Step 1: Categorization based on CCS single (may be in combination with other categorization)
    - Step 2: For remaining codes after previous step, categorization based on multi-level CCS code levels 1 and 2
    - Step 3: For remaining codes after previous step, categorization of dental codes
    - Step 4: For remaining codes after previous step, categorization of codes in multi-level CCS code level 1 57 Temporary and any other codes
    - Step 5: Recategorization of CT, MRI, Radioisotope imaging and Medicine from X-ray, ultrasound, and other imaging and Acupuncture and osteopathic procedure codes

7.2.5.1 Categorization Based on CCS Single and Multi-level

CPT or HCPCS codes categorized by H-CUP as the following are classified into the specified care type (*note: CL1 and CL2 refer to the multi-level CCS level 1 and level 2 categories*):

Table 30. Care Type Categorization Based on Single and Multi-level CCS Categories

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Care Type	Code Classification by H-CUP
Physical, occupational, speech therapy	CCS single 212 Diagnostic physical therapy CCS single 213 Physical therapy exercises, manipulation, and other procedures CCS single 215 Other physical therapy and rehabilitation CCS single 227 Other diagnostic procedures (interview, evaluation, consultation), of which CL2 5332 Special Otorhinolaryngologic Services and Procedures
Ancillary services	CCS single 237 Ancillary services, of which CL1 52 Evaluation and management CL2 5308 Education and Training for Patient Self-Management CL2 5321 Non-Face-to-Face Nonphysician Services
Medicine	CL2 5505 Nuclear Medicine Procedures, of which CCS single 12 Other therapeutic endocrine procedures CCS single 163 Other non-OR therapeutic procedures on musculoskeletal system CCS single 211 Therapeutic radiology CCS single 237 Ancillary Services
Medication and pharmaceuticals	CCS single 240 Medications (Injections, infusions and other forms)
Vision	CCS single 241 Visual aids and other optical supplies
Transportation	CCS single 239 Transportation - patient, provider, equipment
Other	CCS single 237 Ancillary services, of which CL2 is 5333 Special Services, Procedures and Reports

7.2.5.2 Categorization Based on Multi-level CCS Levels 1 and 2

Of the remaining codes, CPT or HCPCS codes categorized by H-CUP as the following are further categorized into the specified care type (*note: CL1 and CL2 refer to the multi-level CCS level 1 and level 2 categories*):

Table 31. Care Type Categorization Based on Multi-level CCS Levels 1 and 2

Care Type	Code Classification by H-CUP
Anesthesia	CL1 50 Anesthesia
Surgery	CL1 56 Surgery
Evaluation and management	CL1 52 Evaluation and management
Physical, occupational, speech therapy	CL2 5327 Physical Medicine and Rehabilitation Evaluations CL2 5303 Biofeedback Services and Procedures
Medication and pharmaceuticals	CL2 5101 Chemotherapy Drugs CL2 5102 Drugs Administered Other Than Oral Method

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Care Type	Code Classification by H-CUP
DME and supplies	CL2 5103 Durable Medical Equipment (DME) CL2 5104 Enteral And Parenteral Therapy CL2 5105 Medical And Surgical Supplies CL2 5106 Orthotic Procedures CL2 5107 Prosthetic Procedures
Laboratory and pathology	CL1 54 Pathology and laboratory
X-ray, ultrasound and other imaging	CL2 5501 Bone/Joint Studies CL2 5502 Breast, Mammography CL2 5503 Diagnostic Radiology (Diagnostic Imaging) Procedures CL2 5504 Diagnostic Ultrasound Procedures CL2 5505 Nuclear Medicine Procedures CL2 5507 Radiologic Guidance
Medicine	CL1 53 Medicine, except for (already classified above) CL2 5327 Physical Medicine and Rehabilitation Evaluations CL2 5303 Biofeedback Services and Procedure CL2 5301 Acupuncture Procedures CL2 5324 Osteopathic Manipulative Treatment Procedures CL2 5506 Radiation Oncology Treatment

7.2.5.3 Categorization of Dental Codes

American Dental Association maintains a separate code list for dental procedures. All these codes start with letter “D”. All claim detail lines with procedure codes starting with D are classified into care type “Dental”.

7.2.5.4 Categorization of any Remaining Codes

All remaining codes at this point are CPT or HCPCS codes categorized into the multi-level CCS code level 1 57 Temporary and other. Many of these are codes for emerging technology, codes specific to state Medicaid agencies or private payers, or codes relevant to metrics results and measurements. These codes are classified based on their CCS single categories. CCS single categories and how codes map to different care types is specified in the Configuration file under “Care type for temporary and other codes”.

7.2.5.5 Recategorization of Select Imaging and Nontraditional Procedure Codes

Codes meeting the following criteria are recategorized to the respective care type:

Table 32. Care Type Categorization for Imaging and Nontraditional Procedure Codes

Previous Care Type	Updated Care Type	Codes
Physical, occupational, speech therapy	Other	Any codes categorized as: CL2 5301 Acupuncture Procedures CL2 5324 Osteopathic Manipulative Treatment Procedures

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Previous Care Type	Updated Care Type	Codes
X-ray, ultrasound and other imaging	CT, MRI, radioisotope	Of the codes categorized to "X-ray, ultrasound and other imaging" in Section 3.3.2: CCS single 177 CCS single 178 CCS single 179 CCS single 180 CCS single 198 CCS single 207 CCS single 208 CCS single 209 CCS single 210

7.2.6 Service Categories

Once each claim detail line has a Service location and a Care type assigned, all spend can be mapped into a matrix of Service location and Care type. Sixteen service categories are specified as the following:

The following specifications are applied hierarchically, in order listed:

Table 33. Service Category Specifications

Service Category	Specification
Ambulance and transportation	Any spend in Service location Ambulance OR any spend for Care type Transportation
Hospital inpatient care	Any remaining spend in Service locations Hospital inpatient and Hospital inpatient – BH
ED care	Any remaining spend in Service location Emergency department
Institutional care	Any remaining spend in Service location Skilled nursing facility
Home and community-based care	Any remaining spend in Service locations Community, Residential-BH, and Home
Hospital outpatient care	Spend in Service locations Ambulatory surgical centers, Hospital outpatient, and Hospital outpatient-BH for Care types Anesthesia, Surgery, Medicine, Facility services, and Evaluation & management
Office and clinic care	Spend in Service locations Office and clinic and Office and clinic-BH for Care types Anesthesia, Surgery, Medicine, Facility services, and Evaluation & management
Treatment and evaluation at other sites	Spend in Service locations Pharmacy and Other for Care types Anesthesia, Surgery, Medicine, Facility services, and Evaluation & management
Physical, occupational, speech therapy	Spend for Care type Physical, occupational, speech therapy in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, Uncategorized and Other.

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Service Category	Specification
Specialty pharma	Spend for Care type Medication and pharmaceuticals in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Uncategorized and Other.
Retail prescriptions	Spend for Care type Medication and pharmaceuticals in Service locations Pharmacy
DME and supplies	Spend for Care type DME and supplies in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, Uncategorized and Other.
Lab and pathology	Spend for Care type Laboratory and pathology in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, Uncategorized and Other.
Radiology	Spend for Care types CT, MRI, radioisotope imaging and X-ray, ultrasound, and other imaging in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, Uncategorized and Other.
Ancillary services	Spend for Care type Ancillary services in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, Uncategorized and Other.
Other types of care	Spend for Care types Vision, Dental, Other and Uncategorized in Service locations Ambulatory surgical centers, Hospital outpatient, Hospital outpatient-BH, Office and clinic, Office and clinic-BH, Pharmacy, and Other.

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7.3 Appendix C: Reconciliation

The following section details the cases used for APM PY2025 in the QA test process for reconciling the values between the File J PDF, and the CSV files (I,K,L,O,S).

7.3.1 File L/File S

For quality and Efficiency metrics in File L (practice aggregate file for ODM and MCOs) and File S (partnership aggregate for ODM and MCOs), check that the numerator divided by the denominator value is equal to the metric rate.

Table 34. File L/File S Columns Tested

NUMERATOR	DENOMINATOR	SCORE
W30a Num	W30a Den	W30a Score
W30b Num	W30b Den	W30b Score
WCV11 Num	WCV11 Den	WCV11 Score
WCV17 Num	WCV17 Den	WCV17 Score
WCV21 Num	WCV21 Den	WCV21 Score
WCC Num	WCC Den	WCC Score
PPC_Prenatal Num	PPC_Prenatal Den	PPC_Prenatal Score
LBW Num	LBW Den	LBW Score
PPC_Postpartum Num	PPC_Postpartum Den	PPC_Postpartum Score
CCS Num	CCS Den	CCS Score
CBP Num	CBP Den	CBP Score
SPC Num	SPC Den	SPC Score
MMA Num	MMA Den	MMA Score
AMR Num	AMR Den	AMR Score
FUH Num	FUH Den	FUH Score
IET Num	IET Den	IET Score
TCI Num	TCI Den	TCI Score
AMB Num	AMB Den	AMB Score
LSC Kids Num Count	LSC Kids Den Count	LSC Kids Score
CIS Kids Num Count	CIS Kids Den Count	CIS Kids Score
IMA Kids Num Count	IMA Kids Den Count	IMA Kids Score
TCI Kids Num Count	TCI Kids Den Count	TCI Kids Score
TFC Kids Num Count	TFC Kids Den Count	TFC Kids Score
AHRQ PQI 90 Num Count	AHRQ PQI 90 Den Count	AHRQ PQI - Count of IP Admits per 1
MPT - Count of BH-Related IP Admits Num Count	MPT - Count of BH-Related IP Admits Den Count	MPT - Count of BH-Related IP Admits per 1

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NUMERATOR	DENOMINATOR	SCORE
Adherence Ratio Antidiabetics, Insulin, Lantus only Numerator	Adherence Ratio Antidiabetics, Insulin, Lantus only Denominator	Adherence Ratio Antidiabetics, Insulin, Lantus only Score
Adherence Ratio Antidiabetics, DPPIV Inhibitors Numerator	Adherence Ratio Antidiabetics, DPPIV Inhibitors Denominator	Adherence Ratio Antidiabetics, DPPIV Inhibitors Score
Adherence Ratio Asthma Numerator	Adherence Ratio Asthma Denominator	Adherence Ratio Asthma Score
Adherence Ratio COPD Numerator	Adherence Ratio COPD Denominator	Adherence Ratio COPD Score
CHL Numerator	CHL Denominator	CHL Score
BPD Numerator	BDP Denominator	BPD Score
EED Numerator	EED Denominator	EED Score
OED Numerator	OED Denominator	OED Score
WCC Supplemental Numerator	-	WCC Supplemental Score
CBP Supplemental Numerator	-	CBP Supplemental Score
GSD Numerator	GSD Denominator	GSD Score
GSD Supplemental Numerator	-	GSD Supplemental Score
FUM _7- 6-17 years Numerator	FUM _7- 6-17 years Denominator	FUM _7- 6-17 years Score
FUM _30- 6-17 years Numerator	FUM _30- 6-17 years Denominator	FUM _30- 6-17 years Score
FUM _7- 18-64 years Numerator	FUM _7- 18-64 years Denominator	FUM _7- 18-64 years Score
FUM _30- 18-64 years Numerator	FUM _30- 18-64 years Denominator	FUM _30- 18-64 years Score
FUM _7- 65 years Numerator	FUM _7- 65 years Denominator	FUM _7- 65 years Score
FUM _30- 65 years Numerator	FUM _30- 65 years Denominator	FUM _30- 65 years Score

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NUMERATOR	DENOMINATOR	SCORE
FUM _7- Total Numerator	FUM _7- Total Denominator	FUM _7- Total Score
FUM _30- Total Numerator	FUM _30- Total Denominator	FUM _30- Total Score
FUA _7- 13-17 years Numerator	FUA _7- 13-17 years Denominator	FUA _7- 13-17 years Score
FUA _30- 13-17 years Numerator	FUA _30- 13-17 years Denominator	FUA _30- 13-17 years Score
FUA _7- 18 years Numerator	FUA _7- 18 years Denominator	FUA _7- 18 years Score
FUA _30- 18 years Numerator	FUA _30- 18 years Denominator	FUA _30- 18 years Score
FUA _7- Total Numerator	FUA _7- Total Denominator	FUA _7- Total Score
FUA _30- Total Numerator	FUA _30- Total Denominator	FUA _30- Total Score
COL_E Numerator	COL_E Denominator	COL_E Score
POD Numerator	POD Denominator	POD Score

7.3.2 Member level File K to Aggregate File L/File S

- Check that Quality and Efficiency metric numerators and denominators in File L/File S can be derived from File K. To do this, count the number of 'YES' values in the File K column with a given provider ID, using only members who have 'Practice 6-Month Attribution Flag for Measure' = 'YES', as well as the Practice Medicaid ID populated
    - For Partnerships, use **unique** members who have the 'Partnership 6-Month Attribution Flag for Measure = 'YES'', as well as the Partnership ID 6 month populated
- Check that metric numerator, denominator rates align with File J for applicable areas for entity.

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Here are the mappings of File K columns to File L columns.

Table 35. File K to File L Column Mapping

File K Column	File L/File S Column
W30-First 15 Months Num Flag	W30-First 15 Months Numerator
W30-First 15 Months Den Flag	W30-First 15 Months Denominator
W30-First 15 to 30 Months Num Flag	W30-First 15 to 30 Months Numerator
W30-First 15 to 30 Months Den Flag	W30-First 15 to 30 Months Denominator
WCV-3-11 years Num Flag	WCV-3-11 years Numerator
WCV-3-11 years Den Flag	WCV-3-11 years Denominator
WCV-12-17 years Num Flag	WCV-12-17 years Numerator
WCV-12-17 years Den Flag	WCV-12-17 years Denominator
WCV-18-21 years Num Flag	WCV-18-21 years Numerator
WCV-18-21 years Den Flag	WCV-18-21 years Denominator
WCC Den Flag	WCC Den
WCC Num Flag	WCC Num
PPC_Prenatal Den Flag	PPC_Prenatal Den
PPC_Prenatal Num Flag	PPC_Prenatal Num
LBW Den Flag	LBW Den
LBW Num Flag	LBW Num
PPC_Postpartum Den Flag	PPC_Postpartum Den
PPC_Postpartum Num Flag	PPC_Postpartum Num
CCS Den Flag	CCS Den
CCS Num Flag	CCS Num
CBP Den Flag	CBP Den
CBP Num Flag	CBP Num
SPC Den Flag	SPC Den
SPC Num Flag	SPC Num
AMR Den Flag	AMR Den
AMR Num Flag	AMR Num
FUH Den Flag	FUH Den
FUH Num Flag	FUH Num
IET Den Flag	IET Den
IET Num Flag	IET Num
TCI Den Flag	TCI Den
TCI Num Flag	TCI Num

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File K Column	File L/File S Column
LSC Kids Numerator Flag	LSC Kids Num Count
LSC Kids Denominator Flag	LSC Kids Den Count
CIS Kids Numerator Flag	CIS Kids Num Count
CIS Kids Denominator Flag	CIS Kids Den Count
IMA Kids Numerator Flag	IMA Kids Num Count
IMA Kids Denominator Flag	IMA Kids Den Count
TCI Kids Numerator Flag	TCI Kids Num Count
TCI Kids Denominator Flag	TCI Kids Den Count
TFC Kids Numerator Flag	TFC Kids Num Count
TFC Kids Denominator Flag	TFC Kids Den Count
PDL Antidiabetics, Insulin, Lantus only Num Flag	Adherence Ratio Antidiabetics, Insulin, Lantus only Numerator
PDL Antidiabetics, Insulin, Lantus only Den Flag	Adherence Ratio Antidiabetics, Insulin, Lantus only Denominator
PDL Antidiabetics, DPPIV Inhibitors Num Flag	Adherence Ratio Antidiabetics, DPPIV Inhibitors Numerator
PDL Antidiabetics, DPPIV Inhibitors Den Flag	Adherence Ratio Antidiabetics, DPPIV Inhibitors Denominator
PDL Asthma Num Flag	Adherence Ratio Asthma Numerator
PDL Asthma Den Flag	Adherence Ratio Asthma Denominator
PDL COPD Num Flag	Adherence Ratio COPD Numerator
PDL COPD Den Flag	Adherence Ratio COPD Denominator
CHL Num Flag	CHL Numerator
CHL Den Flag	CHL Denominator
OED Num Flag	OED Numerator
OED Den Flag	OED Denominator
BPD Num Flag	BPD Numerator
BPD Den Flag	BPD Denominator
EED Num Flag	EED Numerator
EED Den Flag	EED Denominator
WCC Supp Num Flag	WCC Supplemental Numerator
CBP Supp Num Flag	CBP Supplemental Numerator
GSD Num Flag	GSD Numerator
GSD Den Flag	GSD Denominator
GSD Supplemental Num Flag	GSD Supplemental Numerator

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File K Column	File L/File S Column
FUM _7- 6-17 years Num Count	FUM _7- 6-17 years Numerator
FUM _30- 6-17 years Num Count	FUM _30- 6-17 years Numerator
FUM _7- 18-64 years Num Count	FUM _7- 18-64 years Numerator
FUM _30- 18-64 years Num Count	FUM _30- 18-64 years Numerator
FUM _7- 65 years Num Count	FUM _7- 65 years Numerator
FUM _30- 65 years Num Count	FUM _30- 65 years Numerator
FUM _7- Total Num Count	FUM _7- Total Numerator
FUM _30- Total Num Count	FUM _30- Total Numerator
FUM _7- 6-17 years Den Count	FUM _7- 6-17 years Denominator
FUM _30- 6-17 years Den Count	FUM _30- 6-17 years Denominator
FUM _7- 18-64 years Den Count	FUM _7- 18-64 years Denominator
FUM _30- 18-64 years Den Count	FUM _30- 18-64 years Denominator
FUM _7- 65 years Den Count	FUM _7- 65 years Denominator
FUM _30- 65 years Den Count	FUM _30- 65 years Denominator
FUM _7- Total Den Count	FUM _7- Total Denominator
FUM _30- Total Den Count	FUM _30- Total Denominator
FUA _7- 13-17 years Num Count	FUA _7- 13-17 years Numerator
FUA _30- 13-17 years Num Count	FUA _30- 13-17 years Numerator
FUA _7- 18 years Num Count	FUA _7- 18 years Numerator
FUA _30- 18 years Num Count	FUA _30- 18 years Numerator
FUA _7- Total Num Count	FUA _7- Total Numerator
FUA _30- Total Num Count	FUA _30- Total Numerator
FUA _7- 13-17 years Den Count	FUA _7- 13-17 years Denominator
FUA _30- 13-17 years Den Count	FUA _30- 13-17 years Denominator
FUA _7- 18 years Den Count	FUA _7- 18 years Denominator
FUA _30- 18 years Den Count	FUA _30- 18 years Denominator
FUA _7- Total Den Count	FUA _7- Total Denominator
FUA _30- Total Den Count	FUA _30- Total Denominator
COL_E Num Flag	COL_E Numerator
COL_E Den Flag	COL_E Denominator
POD Num Flag	POD Numerator
POD Den Flag	POD Denominator

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Check that additional columns in File L/File S can be derived from File K. To do this, count or add the values in the File K column with a given provider ID, using only members who have 'Practice 6-Month Attribution Flag for TCOC' = 'YES'.

- For Partnerships, use **unique** members who have the 'Partnership 6-Month Attribution Flag for TCOC = 'YES''

Here are the mappings of File K columns to File L/File S columns. Where the 'value' column is 'sum', the sum of the File K values should equal the File L value. Where 'value' does not equal 'sum', the count of the members with the given 'value' should equal the File L value.

Table 36. File L to File K Column Mapping with Values

File L/File S Column	File K Column	Value
Avg Monthly Members - Total Medicaid	Measure Eligible Months	Sum / 12
# of Members Gained Since The Previous Quarter - Total Medicaid	Member Attribution Status: Newly Attributed in Current Quarter	Sum where flag = 'YES'
Monthly Members - Total Medicaid - Risk Tier 1	Risk Tiers	Sum where Risk Tier = 1
Monthly Members - Total Medicaid - Risk Tier 2	Risk Tiers	Sum where Risk Tier = 2
Monthly Members - Total Medicaid - Risk Tier 3	Risk Tiers	Sum where Risk Tier = 3
Members with 3 or More ED Visits	3 or More ED Flag	Sum where flag = 'YES'
Members with 1 or More IP Admissions	1 or More IP Admit Flag	Sum where flag = 'YES'
Members With No PCP Visit	No PCP Visit Flag	Sum where flag = 'YES'
Hospital Inpatient Care $	Hospital Inpatient Care $	Sum
ED Care $	ED Care $	Sum
Hospital Outpatient Care $	Hospital Outpatient Care $	Sum
Office and Clinic Care $	Office and Clinic Care $	Sum
Institutional Care $	Institutional Care $	Sum

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File L/File S Column	File K Column	Value
Home and Community-Based Care $	Home and Community-Based Care $	Sum
Prescription Drugs $	Prescription Drugs $	Sum
Specialty Pharma $	Specialty Pharmaceuticals $	Sum
Lab and Pathology $	Lab and Pathology $	Sum
Radiology $	Radiology $	Sum
Ancillary Services $	Ancillary Services $	Sum
DME and Supplies $	DME and Supplies $	Sum
PT/OT/ST $	Physical Occupational and Speech Therapies $	Sum
Others $	Others $	Sum

7.3.3 File O

- Check metric numerator, denominator and rate alignment with File K and File J MCO section when grouped by 'Payer Detail'

7.3.4 File J Checks

For File J, checks are done to ensure the following are in alignment for aggregate files L and/or S. For partnership File J reports, check that the PMPM payment quoted on the partnership-level "CPC Performance Summary" page is the sum of the PMPM payments quoted on the practice-level "CPC Performance Summary" pages.

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7.3.4.1 Summary Payment Page

Oct 2024 - Sep 2025

CPC Performance Summary

Your payment eligibility

	PMPM	Shared savings[1]
Your payment eligibility	Congratulations! You are eligible for the PMPM payment	Eligibility for this payment will be reflected on your annual report for performance year 2026
Your payment amount	**$30,173.72** *PMPM Payment for Q1 2026 paid February 2026*	**Total Cost of Care (Relative to self) Risk-adj. PMPM** N/A - Not scored in this period 2026 performance year **Total Cost of Care (Relative to peers) Risk-adj. PMPM** N/A - Not scored in this period 2026 performance year

Requirements for payments

Requirement categories	Found on pages	PMPM payment		Shared savings payment[1]	
		Reporting period performance	Goal	Reporting period performance	2026 Goal
Activity requirements	N/A[2]	N/A[2]	100%	N/A[2]	100%
Clinical quality measures	4	68%	≥ 50%	68%	≥ 50%
Efficiency measures	3	100%	≥ 50%	100%	≥ 50%
CPC for kids[3]	7	0.00%	≥33.33%	0.00%	≥33.33%
CPC for kids clinical quality[3]	7	33%	≥50%	33%	≥50%
Total Cost of Care (Relative to self) Risk-adj. PMPM	2	Not scored for this payment stream		$ 372.97	$189.63[1]

Figure 5. Example Summary Payment Page

File C for attribution payment amount and File L for the Quality Metrics, Efficiency Metrics, and Total Cost of Care.

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Summary Performance Page

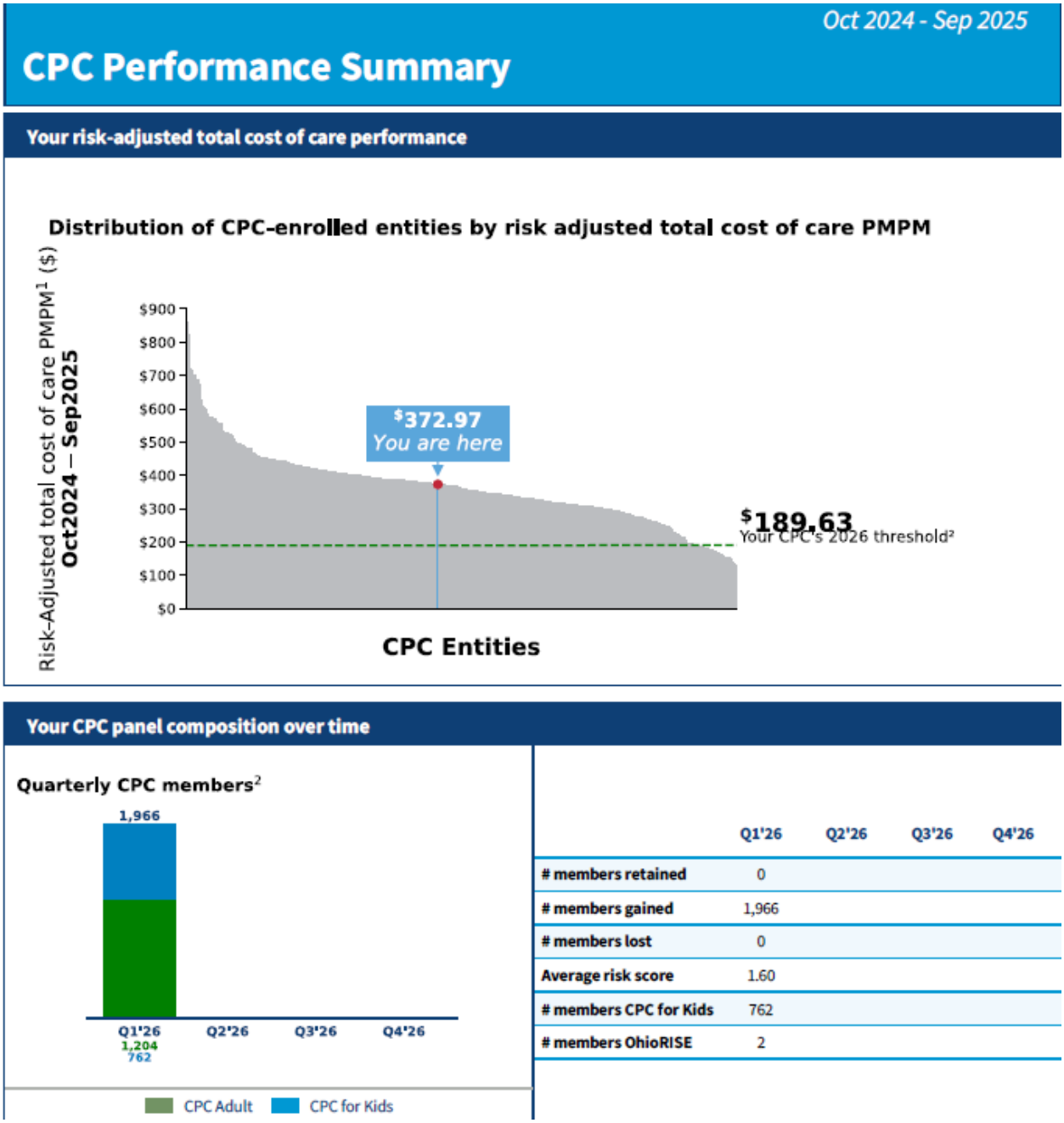

Figure 6. Summary Performance Page

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Check the risk adjusted cost PMPM (found in the “you are here” box) against the value or (in the case of a partnership) sum of values in the 'Net Total Cost of Care PMPM $ (net of PCMH PMPM payment)' column of File L. For partnerships, the value is found by taking the average of the practice values weighted by the practices’ 'Avg Monthly Members - Total Medicaid' value.

Check the bar graph value on the left side of the ‘'Your CPC panel composition over time’ panel. Because historical data is not kept in the csv files, only the right most (most recent) bar can be checked.

The total member count (top, black number) is checked against the ‘Avg Monthly Members – Total Medicaid’ value in File L.

The CPC Adult count (middle, green number) is checked against the count of members in File K who are in the practice/partnership, have ‘Practice 6-Month Attribution Flag for Measure’ = ‘YES’, and ‘Member Age’ ≥ 21 yrs.

The CPC Kid count (bottom, blue number) is checked against the count of members in File K who are in the practice/partnership, have ‘Practice 6-Month Attribution Flag for Measure’ = ‘YES’, and ‘Member Age’<21 yrs.

Check the table values on the right side of the ‘'Your CPC panel composition over time’ panel. Because historical data is not kept in the csv files, only the right most (most recent) column can be checked.

The ‘# members retained’ value is checked against the count of members in File K who are in the practice/partnership, have ‘Practice 6-Month Attribution Flag for Measure’ = ‘YES’, and have ‘Member Attribution Status: 6 or More Months in Panel Flag’ = ‘YES’.

The ‘# members gained’ value is checked against the count of members in File K who are in the practice/partnership, have ‘Practice 6-Month Attribution Flag for Measure’ = ‘YES’, and have ‘Member Attribution Status: Newly Attributed in Current Quarter’= ‘YES’

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Measure Summary Page

Oct 2024 - Sep 2025

CPC Performance Summary **Measure Summary**

Total cost of care performance tied to payment

Total Cost of Care	Risk-Adjusted Total Cost of Care PMPM	Met total cost of care	$372.97 Your Performance	≤ $ 234.68 Threshold 2025	≤ $ 189.63 Threshold 2026

Efficiency measures tied to payment [1] **Meeting 4/4 efficiency measures**

EFFICIENCY	Your Performance	Threshold 2025	Threshold 2026
Ambulatory Care [2]	71.07	≤81.71	≤81.71
Inpatient Admissions for Ambulatory Care Sensitive Conditions/1,000 Member Months	0.94	≤2.00	≤2.00
Mental Health Utilization (Inpatient) [3]	1.33	≤1.94	≤1.94
Preferred Drug List Adherence			
Antidiabetics, DPPIV Inhibitors	N/A	≥75.00%	≥75.00%
Antidiabetics, Insulin, Lantus only	97.62%	≥85.00%	≥85.00%
Asthma	99.71%	≥95.00%	≥95.00%
COPD	98.90%	≥95.00%	≥95.00%
			Meeting 4/4 efficiency metrics

Enough individuals to be evaluated[4]
Not enough individuals to be evaluated
Oct 2024 - Sep 2025 performance meeting threshold
Oct 2024 - Sep 2025 performance not meeting threshold

Figure 7: Example Efficiency Measures Tied to Payment Page

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Oct 2024 - Sep 2025

CPC Performance Summary — Measure Summary

Clinical quality measures tied to payment [1]	Total meeting 13/19 quality measures		
WOMEN'S HEALTH	Your Performance	Threshold 2025	Threshold 2026
HEDIS MY 2025 Prenatal and Postpartum Care: Timeliness of Prenatal Care - Adjusted, Unaudited HEDIS Rate	71.43%	≥80.21%	≥81.21%
Live Births Weighing Less than 2,500 grams [2]	2.86%	≤9.20%	≤9.20%
HEDIS MY 2025 Prenatal and Postpartum Care: Postpartum Care - Adjusted, Unaudited HEDIS Rate	71.43%	≥69.12%	≥70.12%
HEDIS MY 2025 Cervical Cancer Screening - Adjusted, Unaudited HEDIS Rate	55.60%	≥52.47%	≥53.47%
HEDIS MY 2025 Chlamydia Screening in Women - Adjusted, Unaudited HEDIS Rate	35.96%	≥44.31%	≥45.31%
		Meeting 3/5 quality measures	
ADULT HEALTH			
HEDIS MY 2025 Controlling High Blood Pressure - Adjusted, Unaudited HEDIS Rate	60.54%	≥47.71%	≥48.71%
HEDIS MY 2025 Statin Therapy for Patients with Cardiovascular Disease - Adjusted, Unaudited HEDIS Rate: Received Statin Therapy	76.74%	≥80.75%	≥81.75%
HEDIS MY 2025 Asthma Medication Ratio - Adjusted, Unaudited HEDIS Rate	N/A	≥56.91%	≥57.91%
HEDIS MY 2025 Blood Pressure Control for Patients with Diabetes - Adjusted, Unaudited HEDIS Rate	49.66%	≥18.82%	≥19.82%
HEDIS MY 2025 Eye Exam for Patients with Diabetes - Adjusted, Unaudited HEDIS Rate	79.19%	≥43.01%	≥44.01%
HEDIS MY 2025 Glycemic Status Assessment for Patients With Diabetes - Adjusted, Unaudited HEDIS Rate	53.69%	≤0.00%	≤56.81%
		Meeting 3/5 quality measures	

Enough individuals to be evaluated[3]
Not enough individuals to be evaluated
Oct 2024 - Sep 2025 performance meeting threshold
Oct 2024 - Sep 2025 performance not meeting threshold

Figure 8. Example Women's and Adult Health Clinical Quality Measures Tied to Payment Page

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Check the two columns of thresholds on the right side of the page against values in a excel spreadsheet. Both the values and directions must be equal. For the value, 'equal' is defined as:

abs(value_excel – value_pdf) <= 1e-3

Check the efficiency and clinical quality metrics in the colorful column of the pdf against the values in File L calculated by numerator / denominator. 'Equal' is defined as:

abs((value_pdf – value_csv) / (value_pdf + 1e-6)) <= 5e-3 (ie 0.5%)

Here is the mapping of pdf measure names to File L columns.

Table 37. PDF Measure Names to File L Column Mapping

Metric in PDF	File L Denominator	File L Numerator
Asthma Medication Ratio	AMR Den	AMR Num
Health-Related Inpatient Admissions / 1,000 Member Months	MPT - Count of BH-Related IP Admits Den Count	MPT - Count of BH-Related IP Admits Num Count
Lead Screening for Children	LSC Kids Den Count	LSC Kids Num Count
Tobacco Cessation for Ages 12-17	TCI Kids Den Count	TCI Kids Num Count
Cervical Cancer Screening	CCS Den	CCS Num
Child and Adolescent Well-Care Visits 3-11 years	WCV11_Den	WCV11_Num
Child and Adolescent Well-Care Visits 12-17 years	WCV17_Den	WCV17_Num
Child and Adolescent Well-Care Visits 18-21 years	WCV21_Den	WCV21_Num
Children Immunization Status (combination 3)	CIS Kids Den Count	CIS Kids Num Count
Controlling High Blood Pressure	CBP Den	CBP Num
Emergency Department Visits / 1,000 Member Months	AMB Den	AMB Num
Preferred Drug List Adherence	N/A	N/A
Antidiabetics, Insulin, Lantus only	Adherence Ratio Antidiabetics, Insulin, Lantus only Denominator	Adherence Ratio Antidiabetics, Insulin, Lantus only Numerator
Antidiabetics, DPPIV inhibitors	Adherence Ratio Antidiabetics, DPPIV Inhibitors Numerator	Adherence Ratio Antidiabetics, DPPIV Inhibitors Denominator
Asthma	Adherence Ratio Asthma Numerator	Adherence Ratio Asthma Denominator
COPD	Adherence Ratio COPD Numerator	Adherence Ratio COPD Denominator

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Metric in PDF	File L Denominator	File L Numerator
Topical Fluoride for Children	TFC Kids Den Count	TFC Kids Num Count
Follow-Up After Hospitalization for Mental Illness within 7 Days	FUH Den	FUH Num
Live Births Weighing Less than 2,500 Grams	LBW Den	LBW Num
Immunizations for Adolescents (combination 2)	IMA Kids Den Count	IMA Kids Num Count
Initiation of Alcohol and Other Drug Dependence Treatment	IET Den	IET Num
Inpatient Admissions for Ambulatory Care Sensitive Conditions/1,000 Member Months	AHRQ PQI 90 Den Count	AHRQ PQI 90 Num Count
Well-Child Visits in the First 30 Months of Life First 15 Months	W30- First 15 Months Denominator	W30- First 15 Months Numerator
Well-Child Visits in the First 30 Months of Life 15 to 30 Months	W30-15 to 30 Months Denominator	W30-15 to 30 Months Numerator
Postpartum Care	PPC_Postpartum Den	PPC_Postpartum Num
Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy	SPC Den	SPC Num
Tobacco Use: Screening and Cessation Intervention	TCI Den	TCI Num
Weight Assessment and Counseling for Children/Adolescents: BMI Percentile	WCC Den	WCC Num
Timeliness of Prenatal Care	PPC_Prenatal Den	PPC_Prenatal Num
Chlamydia Screening in Women	CHL Denominator	CHL Numerator
Oral Evaluation, Dental Services	OED Denominator	OED Numerator
Glycemic Status Assessment for Patients with Diabetes: >9.0%	GSD Numerator	GSD Denominator
Blood Pressure Control for Patients with Diabetes	BDP Denominator	BPD Numerator
Eye Exam for Patients with Diabetes	EED Denominator	EED Numerator
eCQM Supplemental Data- Weight Assessment and Counseling for Children/Adolescents: BMI Percentile	-	WCC Supplemental Numerator
eCQM Supplemental Data- Controlling High Blood Pressure	-	CBP Supplemental Numerator
eCQM Supplemental Data- Glycemic Status Assessment for Patients with Diabetes	-	GSD Supplemental Numerator
7 Day Follow-Up After Emergency Department Visit for Substance Use – Total	FUA_7-Total Denominator	FUA_7-Total Numerator

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Metric in PDF	File L Denominator	File L Numerator
7 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 13-17 years	FUA_7-13-17 years Denominator	FUA_7-13-17 years Numerator
7 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 18+ years	FUA_7-18 Plus years Denominator	FUA_7-18 Plus years Numerator
30 Day Follow-Up After Emergency Department Visit for Substance Use – Total	FUA_30-Total Denominator	FUA_30-Total Numerator
30 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 13-17 years	FUA_30-13-17 years Denominator	FUA_30-13-17 years Numerator
30 Day Follow-Up After Emergency Department Visit for Substance Use – Ages 18 Plus	FUA_30-18 Plus years Denominator	FUA_30-18 Plus years Numerator
7 Day Follow-Up After Emergency Department Visit for Mental Illness – Total	FUM_7-Total Denominator	FUM_7-Total Numerator
7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years	FUM_7-6-17 years Denominator	FUM_7-6-17 years Numerator
7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years	FUM_7-18-64 years Denominator	FUM_7-18-64 years Numerator
7 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 65+ years	FUM_7-65 Plus years Denominator	FUM_7-65 Plus years Numerator
30 Day Follow-Up After Emergency Department Visit for Mental Illness – Total	FUM_30-Total Denominator	FUM_30-Total Numerator
30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 6-17 years	FUM_30-6-17 years Denominator	FUM_30-6-17 years Numerator
30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 18-64 years	FUM_30-18-64 years Denominator	FUM_30-18-64 years Numerator
30 Day Follow-Up After Emergency Department Visit for Mental Illness – Ages 65+ years	FUM_30-65 Plus years Denominator	FUM_30-65 Plus years Numerator

Check that the values in the statement “Meeting X/Y efficiency measures” has correct values for X and Y given the score and thresholds reported in the pdf.

Check that the values in the statement “Meeting X/Y quality measures” has correct values for X and Y given the scores and thresholds reported in the pdf.

Check the ‘Risk-Adjusted Total Cost of Care PMPM’ value at the top of the chart against the “You are here” cost on the previous page.

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Measures Tied to Payment Page

Measures Details *Oct 2024 - Sep 2025*

WOMEN'S HEALTH **APPENDIX - B**

Clinical Quality Measures Tied to Payment

Clinical quality measure performance	Definition	Your rolling 12-month performance							
		Q1 Preview	Q2 Preview	Q3 Perf.	Q4 Perf.	Q1 Perf.	Q2 Perf.	Annual	
71.43% HEDIS MY 2025 Prenatal and Postpartum Care: Timeliness of Prenatal Care; 25 / 35 members; Threshold: 81.21 %	The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.	71.43% Oct '24 - Sep '25	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	Threshold 81.21%
2.86% Live Births Weighing Less than 2,500 grams[1]; 1 / 35 members; Threshold: 9.20 %	The percentage of live births that weigh less than 2,500 grams.	2.86% Oct '24 - Sep '25	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	Threshold 9.20%
71.43% HEDIS MY 2025 Prenatal and Postpartum Care: Postpartum Care; 25 / 35 members; Threshold: 70.12 %	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	71.43% Oct '24 - Sep '25	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	Threshold 70.12%
55.60% HEDIS MY 2025 Cervical Cancer Screening; 268 / 482 members; Threshold: 53.47 %	The percentage of women 21-64 years of age who were screened for cervical cancer.	55.60% Oct '24 - Sep '25	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	Threshold 53.47%
35.96% HEDIS MY 2025 Chlamydia Screening in Women; 32 / 89 members; Threshold: 45.31 %	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	35.96% Oct '24 - Sep '25	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	0.00% Jan '99 - Dec '99	Threshold 45.31%

Enough individuals to be evaluated[1] | Performance meeting threshold | Performance not meeting threshold | Informational only

Not enough individuals to be evaluated | 75th percentile for CPC-enrolled practices | Threshold target direction

Figure 9. Example Appendix B Page

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Check the thresholds values along the left side of the page (underneath the large, bold score values) against values recorded in an excel spreadsheet.

Check the thresholds values along the right side of the page (the dotted lines in the bar graphs) against values recorded in an excel spreadsheet.

Check the large, bold score values on the left side of the page against the value in File L calculated from numerator / denominator.

Check the members counts under the large, bold score values along the left side of the page, against the numerator and denominator values in File L.

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Payment Calculation Page

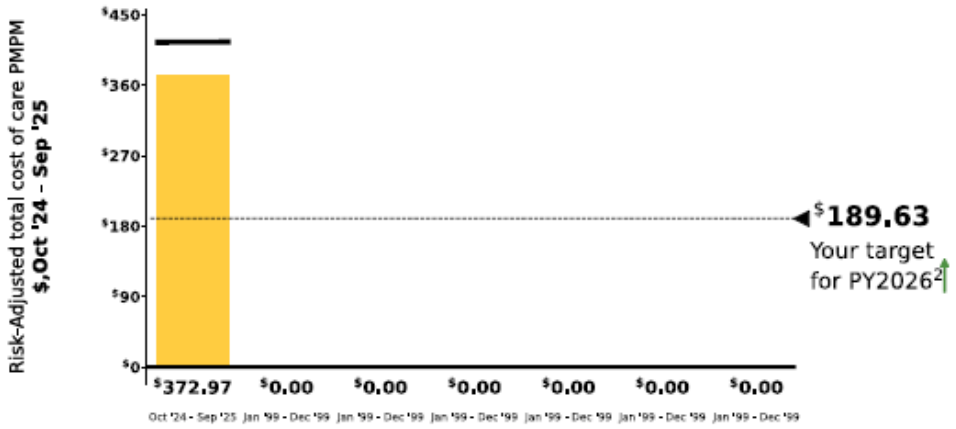
Oct 2024 - Sep 2025

Cost of Care Performance

Appendix - C

Total cost of care performance tied to payment

Performance of your CPC practice - Informational only



Shared savings payment calculation [1]

Component	Your practice	Description
A. Total cost of care performance	----	Risk-adjusted total cost of care for the performance period per member per month (PMPM).
B. Target total cost of care	----	Risk-adjusted baseline total cost of care PMPM, further adjusted for programmatic changes over time.
C. Savings percentage	----	Savings as a percentage of Target TCOC, calculated as (Target TCOC (B.) - TCOC performance (A.)) / Target TCOC (B.).
D. Gain sharing rate	----	Percent of savings to be distributed as shared savings payment, determined by baseline performance. Only CPC entities with Savings percentage 1% can be eligible for shared savings
E. Panel Size (Member Months)	----	Total member months for members attributed to the CPC entity for at least 6 months in the performance period.
F. Baseline TCOC with Adjustment Factor	----	The Total Cost of Care after applying programmatic adjustment factors for a given baseline year.
G. Shared savings payment based on self-improvement	----	Shared savings payment calculated as (Non-risk adjusted Target TCOC (F. * Savings percentage (C.) * Gain sharing rate (D.)).
H. Shared savings payment for practices with lowest total cost of care	----	Bonus payment for the decile of CPC entities with the lowest TCOC performance, calculated as (Pre-determined PMPM bonus payment * Panel size variable (E.)/12).
Potential total shared savings	----	**Shared savings payment calculated as (Shared savings based on self - improvement (G.) + Shared savings payment for practices with lowest TCOC (H.)).**

Performance meeting threshold Performance not meeting threshold 75th percentile for CPC-enrolled practices Eligible for shared savings

Figure 10. Example Appendix C Payment Calculation Page

No Quarterly Checks

This page will reconcile to File T for Annual Performance Reports.

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Care Categories Page

Ohio Department of Medicaid

Quarterly CPC Practice - PY2026

MERCY MEDICAL PARTNERS NORTHERN REGION LLC (0057671)

Measures Impacting Total Cost of Care: Care Categories

Oct 2024 - Sep 2025

Appendix - D

Care categories

Categories		Number and percentage of individuals	Spend per individual with a claim	Percentage of total spend[1]
Hospital and Emergency Department	Hospital Inpatient Care	193 60%	$11	20%
	Emergency Department Care	778 60%	$80	71%
	Hospital Outpatient Care	1,290 93%	$76	96%
Office and Clinic	Office and Clinic Care	1,030 6%	$35	3%
Supportive and Institutional Care	Institutional Care	13 0%	$38	40%
	Home and Community-Based Care	286 31%	$52	9%
Pharmaceuticals	Prescription Drugs	1,413 57%	$62	62%
	Specialty Pharmaceuticals	76 50%	$41	41%
Diagnostics	Lab and Pathology	684 29%	$77	31%
	Radiology	589 81%	$82	83%
Others	Ancillary Services	4 0%	$49	0%
	Durable Medical Equipment and Supplies	18 0%	$75	0%
	Physical, Occupational, and Speech Therapies	138 79%	$67	56%
	Others	306 7%	$95	79%

Your Oct 2024 - Sep 2025 performance percentile

0 25th 50th 75th 100th

Oct 2024 - Sep 2025 percentiles

Figure 11. Example Appendix D Care Categories Page

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Check all values in the care categories table (# members, % members, average spend, and % of total spend) against data in File K.

- # members is found by counting the number of members in the practice/partnership who have 'Practice 6-Month Attribution Flag for Measure' = ‘YES’ and have spend in the care category > $0.
- % members is found by # members / total members * 100. Total members is the count of members in the practice/partnership who have 'Practice 6-Month Attribution Flag for Measure' = ‘YES’. The pdf value and the File K value are considered equal if:

  abs(value_pdf – value_csv) <= 5%

- Average spend is the mean of spend in the care category of members in the practice/parentship who have spend in th care category > $0 and have 'Practice 6-Month Attribution Flag for Measure' = ‘YES’.
- % of total spend is average spend / total spend * 100. Total spend is the sum of all non-zero spends in the care category for members in the practice/partnership who have 'Practice 6-Month Attribution Flag for Measure' = ‘YES’. . The pdf value and the File K value are considered equal if:

  abs(value_pdf – value_csv) <= 5%

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Spend by Panel Composition Page

Measures Impacting Total Cost of Care: Spend by Panel Composition

Oct 2024 - Sep 2025
Appendix - D

Risk bands (Oct 2024 - Sep 2025 performance)

Risk band	Members[1]	Total spend (%)	Total spend PMPM ($)	RA[2] total spend PMPM($)
LOW	917	13	$178	$246
MEDIUM	594	28	$554	$345
HIGH	394	54	$1,569	$351

Top spenders (Oct 2024 - Sep 2025 performance)

Spend Percentile	Members[1]	Total spend (%)	Total spend PMPM ($)	RA[2] total spend PMPM($)
TOP 1%	39	15	$4,714	$5,000
2 - 5%	78	20	$2,990	$1,641
6 - 15%	193	28	$1,702	$777
16 - 25%	193	15	$940	$405
26 - 100%	1,432	19	$161	$22

Figure 12. Example Appendix D Spend by Panel Composition Page

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Check the values for the three risk band rows against File K.

Lowest, medium, and highest risk members are members in the practice/partnership with 'Practice 6-Month Attribution Flag for Measure' = ‘YES’ and which have 'Risk Tiers' = ‘1’, ‘2’, and ‘3’ respectively.

Members is simply the number of members in the lowest/medium/highest cohort.

Total spend (%) is 100 * cohort_spend / total_spend. Cohort spend is the spend of members in the lowest/medium/highest cohort and total is the total spend for all members regardless of the ‘Risk Tiers’ value. Spend is found using columns ‘Total Spend (Post Exclusions) $.’ Equal means abs(File K_value – pdf_value) <= 0.5%

Total Spend PMPM ($) is cohort_spend / cohort_member_months. Cohort_spend is the same as in Total spend (%). Cohort_member_months is the sum of ‘Measure Eligible Months’ for members in the lowers/medium/highest cohort. Equal means abs(File K_value – pdf_value) <= $1

Spend by care category (%) is 100 * cohort_care_category_spend / cohort_spend. Cohort_spend is the same as above. Cohort_care_category_spend is the spend value of members within the cohort which is in the care category. For this the following columns are used for their respective care category: 'Hospital Inpatient Care $', 'ED Care $', 'Hospital Outpatient Care $', 'Office and Clinic Care $', 'Prescription Drugs $', 'Others $'.

Because low percent categories often don’t get values printed in the pdf and no textual hint as to which category the percentages belong, there is a process required to compare the File K value to them. The spend percentages for each care category are calculated from File K and stored in a list in the order of care categories in the pdf (csv_value_list). The values from the pdf are then scraped from the page (pdf_value_list). Then the lowest percent value is removed from csv_value_list until the length of the list is equal to the length of pdf_value_list. The two lists are then compared. Elements are considered equal when abs(File K_value – pdf_value) <= 0.5%.

This check does the same for the top spenders cohorts (Top 1%, 2-5%, 6-15%, 16-25%, 26-100%) that check_spend_panel_risk_band does for the risk cohorts. 'Spend Percentile Within Practice' is used to determine a member’s spend percentile.

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Efficiency by Panel Composition Page

Measures Impacting Total Cost of Care: Efficiency by Panel Composition

Oct 2024 - Sep 2025
Appendix - D

Risk bands (Oct 2024 - Sep 2025 performance)

Risk band	Members[1]	Members ≥ 3 ED Visits	Spend PMPM if ≥ 3 visits	Members ≥ 1 IP admission	Spend PMPM if ≥ 1 admission	Members no PCP visit	Spend PMPM if no PCP visit
LOW	917	45	$558	21	$2,481	312	$19
MEDIUM	594	88	$496	45	$1,053	65	$46
HIGH	394	112	$517	60	$698	21	$28

Top spenders (Oct 2024 - Sep 2025 performance)

Spend Percentile	Members[1]	Members ≥ 3 ED Visits	Spend PMPM if ≥ 3 visits	Members ≥ 1 IP admission	Spend PMPM if ≥ 1 admission	Members no PCP visit	Spend PMPM if no PCP visit
Top 1%	39	6	$3,817	12	$4,412	0	$0
2 - 5%	78	23	$1,589	25	$1,633	3	$1,838
6 - 15%	193	49	$761	45	$817	5	$606
16 - 25%	193	47	$400	23	$419	4	$463
26 - 100%	1,432	125	$122	24	$185	393	$2

Figure 13. Example Appendix D Efficiency by Panel Composition Page

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This page is the first of the Payer-Level Detail Pages. It has two additional panels: “Your CPC panel composition…” and “Total cost of care performance tied to payment…” The “Efficiency measures tied to payment” panel undergoes all the same tests that the Payer-Level Detail Pages do, and so will not be repeated here.

Oct 2024 - Sep 2025

CPC Performance Summary

Appendix - E

PANEL COMPOSITION

Your CPC panel composition in Q1 2026

Measure	Ohio FFS	Ameri-Health	Anthem	Buckeye	CareSource	Humana	Molina	United Healthcare	Total Medicaid[1]
Average monthly members	93	173	308	649	234	215	163	131	1,966
Average risk score	2.27	1.18	1.24	1.93	1.60	1.39	1.61	1.29	1.60

TOTAL COST OF CARE

Total cost of care performance tied to payment (Oct 2024 - Sep 2025 performance)

Risk-adjusted Total Cost of Care PMPM	$ 1228.75	$ 471.93	$ 313.86	$ 258.25	$ 251.31	$ 558.57	$ 380.33	$ 447.34	$ 372.97	Threshold ≤ $ 189.63

Efficiency measures tied to payment (Oct 2024 - Sep 2025 performance)

EFFICIENCY

Measure	Ohio FFS	Ameri-Health	Anthem	Buckeye	CareSource	Humana	Molina	United Healthcare	Total Medicaid	Threshold PY 2026
Ambulatory Care [2]	8.16	7.24	7.42	7.94	6.82	5.22	4.53	8.34	71.07	≤81.71
Inpatient Admissions for Ambulatory Care Sensitive Conditions/1,000 Member Months	0.22	0.25	0.06	0.04	0.14	0.05	0.0	0.17	0.94	≤2.00
Mental Health Utilization (Inpatient) [3]	0.2	0.32	0.07	0.13	0.04	0.11	0.12	0.24	1.33	≤1.94
PREFERRED DRUG LIST ADHERENCE										
Antidiabetics, DPPIV Inhibitors	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	≥75.00 %
Antidiabetics, Insulin, Lantus only	100.0%	100.0%	100.0%	100.0%	66.67%	100.0%	100.0%	100.0%	97.62 %	≥85.00 %
Asthma	100.0%	100.0%	100.0%	100.0%	100.0%	97.67%	100.0%	100.0%	99.71 %	≥95.00 %
COPD	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.67%	98.90 %	≥95.00 %

Meeting 4 / 4 Efficiency Measures

Measures impacting total cost of care: 0% to 20% 21% to 40% 41% to 60% 61% to 80% 81% to 100%

Oct 2024 - Sep 2025 performance meeting threshold Oct 2024 - Sep 2025 performance not meeting threshold

Figure 14. Example Appendix E Payer-Level Detail Page

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Check the top two panels of the first payer-level detail pages. These are ‘Average monthly members’, ‘average risk score’, and ‘risk-adjusted total cost of care PMPM’ for each payer against File K.

Values are calculated using members who are in the practice/partnership, which have 'Practice 6-Month Attribution Flag for Measure' = ‘YES’ and which have 'Payer Detail' = 'FFS', 'BUCKEYE', 'CARESOURCE', 'MOLINA',, 'UNITED', ‘AMERIHEALTH’, ‘ANTHEM’, ‘HUMANA” or any value for the respective payers.

Average monthly members is calculated as total_member_months / 12. Total member months is the sum of 'Measure Eligible Months' for members in the cohort.

Risk-adjusted total cost of care PMPM is calculated by total_RA_spend / total_member_months. Total_RA_spend is found as the sum of 'Total Spend (Post Exclusions) $' for members in the cohort.

Check the measure scores against File K when stratified by payer. It’s based on File K column ‘Payer Detail.’

Scores are calculated from File K using the calculation indicated earlier in the document.

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Payer-Level Detail Page

Oct 2024 - Sep 2025

CPC Performance Summary **Appendix - E**

PAYER-LEVEL DETAIL

Clinical quality measures tied to payment (Oct 2024 - Sep 2025 performance) [1]

WOMEN'S HEALTH

Measure	Ohio FFS	Ameri-Health	Anthem	Buckeye	CareSource	Humana	Molina	United Healthcare	Total Medicaid[2]	Threshold PY 2026
HEDIS MY 2025 Prenatal and Postpartum Care: Timeliness of Prenatal Care	0.0%	100.0%	60.0%	66.67%	80.0%	60.0%	100.0%	80.0%	71.43%	≥81.21%
Live Births Weighing Less than 2,500 grams [3]	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.86%	≤9.20%
HEDIS MY 2025 Prenatal and Postpartum Care: Postpartum Care	0.0%	100.0%	20.0%	83.33%	80.0%	80.0%	100.0%	60.0%	71.43%	≥70.12%
HEDIS MY 2025 Cervical Cancer Screening	33.33%	51.85%	57.38%	65.92%	50.85%	39.29%	58.62%	46.43%	55.60%	≥53.47%
HEDIS MY 2025 Chlamydia Screening in Women	0.0%	30.0%	11.11%	37.5%	53.85%	45.45%	40.0%	25.0%	35.96%	≥45.31%

Meeting 3 / 5 Quality Measures

Enough individuals to be evaluated [4] Not enough individuals to be evaluated

Measures impacting total cost of care: 0% to 20% 21% to 40% 41% to 60% 61% to 80% 81% to 100%

Oct 2024 - Sep 2025 performance meeting threshold Oct 2024 - Sep 2025 performance not meeting threshold

Figure 15. Example Appendix Payer-Level Detail Page

Check measure score values against file K.

Check measure thresholds and directions on the right side of the page against an .xlsx spread sheet.

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