

## Definitions and Calculations Applicable to Payment Methodologies

- **CPC practices** are identified by Medicaid Billing ID. These practices may have any number of practitioners that bill under the Medicaid Billing ID.
- **CPC entities** are comprised of one CPC practice enrolled individually, or two or more CPC practices aggregated by a convener practice to form a CPC partnership.
- **Performance period** is the 12-month calendar year period of participation in the CPC program. Each performance period begins January 1<sup>st</sup> for all CPC entities enrolled in the program.
- **Baseline year** is the 12-month period two years preceding the start of the performance year. For example, the baseline year for performance period 2017 is calendar year 2015.
- **Attribution:**
  - Member exclusions: All Medicaid members are included in the CPC program and are therefore included in the attribution process, with the following exceptions:
    - Dual-eligible members;
    - Members with limited benefits;
    - Members with third-party liability coverage (except dental or vision);
    - Other members that are excluded for administrative reasons (e.g., foster care members)
  - Methodology: ODM will attribute all non-excluded fee-for-service and managed care members to a primary care practice. Attribution of members occurs quarterly using retrospective data. Members will only be attributed to one primary care practice. Attribution will be performed using the following hierarchical process:
    - Member choice when expressed (i.e., communicated explicitly via contact with ODM through the Medicaid hotline or via the member's managed care plan);
    - For members that do not explicitly choose a primary care provider, the member will be attributed to the primary care practice with which they have the most preventive care claims in the preceding 18 months;
    - For members that do not choose a primary care provider and that do not have any preventive care claims with a primary care provider in the preceding 18 months, geographic proximity and other relevant factors (e.g., age) will be used to attribute the member to a primary care practice.
- **Risk scoring:**
  - Methodology: ODM will generate a risk score for all members attributed to a primary care practice using 3M's Clinical Risk Grouper (CRG) methodology. This methodology uses 24 months of claims history to generate a score.
  - Relationship to payment: The risk score is used both to determine per member per month (PMPM) payment amounts distributed to CPC practices on a quarterly basis, and as an adjustment in the calculation of shared savings payments on an annual basis. The relationship to both payment streams is described in more detail below.

### Quality and efficiency metrics required for PMPM and shared savings payments

CPC practices must meet all of the activity requirements as attested to upon enrollment, in addition to passing clinical quality and efficiency metric requirements, in order to receive either PMPM or shared savings payments. All clinical quality and efficiency metrics are assigned

specific numeric thresholds by ODM, which are updated for each performance period. CPC entities will be assessed for each clinical quality and efficiency metric for which they meet the minimum number of members required to be statistically valid (i.e., 30 members in the denominator of clinical quality metrics). CPC entities must pass 50% or more of the clinical quality metrics, and 50% or more of the efficiency metrics, for which they are assessed. Passing will be determined by comparing CPC entity performance for the metric with the ODM established thresholds for the performance period. Clinical quality and efficiency metrics will be evaluated for each CPC entity at the end of each performance period using fee-for-service claims and managed care encounters for the entire performance period for all members attributed to the CPC entity.

- **Clinical quality metrics:** The full set of clinical quality metrics are listed under the “CPC Requirements” tab of the Payment Innovation section of the ODM website, located at <https://www.medicaid.ohio.gov/Provider/PaymentInnovation/CPC>. The clinical quality metrics measure performance across multiple population health groupings, including adult health, behavioral health, pediatric health, and women’s health. CPC entities must pass at least fifty percent of the metrics for which they have a statistically adequate number of members in the denominator.
- **Efficiency metrics:** Efficiency metrics measure health system utilization to determine the efficiency of member care. The full set of efficiency metrics are listed under the “CPC Requirements” tab of the Payment Innovation section of the ODM website, located at <https://www.medicaid.ohio.gov/Provider/PaymentInnovation/CPC>. CPC entities must pass at least fifty percent of the efficiency metrics for the performance period.
- **Thresholds:** ODM will notify CPC practices of the full set of metrics and associated thresholds prior to the beginning of the performance period.