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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 22-0038

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 15, 2023

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

Re: Ohio State Plan Amendment (SPA) Transmittal Number 22-0038

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 22-0038. This amendment implements the Comprehensive Maternal Care (CMC) program, which is a comprehensive care coordination and service model incorporating supportive care for expectant and postpartum individuals.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Ohio Medicaid SPA 22-0038 was approved on March 15, 2023, with an effective date of January 1, 2023.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at christine.davidson@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tiffany Williams, ODM
Deborah Benson, CMCS
Angela Cimino, CMCS
Justin Myrowitz, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-038

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Sections 1905(a)(25) and 1905(t)of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 240,000
b. FFY 2024 $ 368,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A Item 25c, pages 1 through 7 (new)
Attachment 4.19-B item 25c, pages 1 through 5 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT

Coverage & Limitations and Payment for Services: Implementation of Comprehensive Maternal Care Program

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
December 29, 2022

15. RETURN TO

Tiffany Williams
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
December 29, 2023

17. DATE APPROVED
03/15/2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

Comprehensive Maternal Care (CMC) program. The Ohio Comprehensive Maternal Care program (CMC program) is a Patient Centered Medical Home (PCMH) program that utilizes a team-based care delivery model led by medical professionals to comprehensively manage the health needs of all eligible expectant and postpartum mothers to reduce adverse maternal and infant outcomes. Participation in this program is voluntary.

This is a pregnancy related service and is therefore exempt from comparability limits at 42 CFR 440.250(p).

Key definitions:

- A **Comprehensive Maternal Care (CMC) entity** is the primary entity responsible for meeting the program activities and outcomes for attributed Medicaid individuals.
- The **electronic pregnancy risk assessment form**(e-PRAF) is the electronic version of ODM's pregnancy risk assessment form (PRAF) that is submitted through the web portal designated by ODM.
- The **electronic report of pregnancy** (e-ROP) is the electronic version of ODM's notification of pregnancy form (NOP) that is submitted through the web portal designated by ODM.

CMC entities that have enrolled in this program provide primary care case management services under authorities of §1905(t) and 1905(a)(25) of the Social Security Act, which includes location, coordination, and monitoring of health care services. The State ensures that it will comply with the applicable beneficiary protections in §1905(t)(3) as described below, including providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies. Eligible CMC entities enrolled in the CMC program receive per-member-per-month (PMPM) payments for meeting the CMC program activity requirements. In addition, CMC entities may become eligible to receive add-on payments for demonstrating excellence in their peer group for meeting quality goals.

Program Goals

The CMC program supports expectant and postpartum Medicaid-eligible individuals by managing their health needs and is intended to improve health outcomes and reduce adverse maternal and infant outcomes. An enrolled CMC entity will receive PMPM payments and may have access to quality add-on payments contingent upon meeting quality outcomes. The measures being used to assess performance include nine (9) activity requirements and six (6) clinical quality measures.

Additionally, the program will be monitored and evaluated as described in Attachment 4.19-B, Item 25c, in the section entitled "Monitoring and Reporting." Evaluation includes process and outcome measures based on a combination of qualitative and quantitative factors, including but not limited to claims, CMC program reporting and survey data. Eligible providers may participate in the CMC program via a provider agreement for participation in Medicaid. Medicaid beneficiaries are free to choose from any qualified provider. Entities that enroll in the CMC program continue to provide services and submit claims in accordance with fee-for-service requirements.

Provider Qualifications

Enrolled CMC entities participating in the CMC program serve as primary care case managers for attributed Medicaid individuals and must meet all of the qualifications set forth in this section.

Only the following types of entities may participate in the Ohio CMC program as a primary care case manager:

i. Professional medical groups;

ii. Federally qualified health centers (FQHCs) and rural health clinics (RHC); Clinics; or

iii. Professional medical groups billing under hospital provider types

Members will be attributed only to CMC entities with providers of the following types:

i. A practitioner with prescribing authority in the state of Ohio:
   a. Medical doctor (MD) or doctor of osteopathy (DO)
   b. Advanced practice registered nurses: Clinical nurse specialist (CNS), Certified Nurse Midwife (CNW) or certified nurse practitioner (CNP)
   c. Physician assistant.

ii. A registered nurse (RN) or licensed practical nurse (LPN); and

iii. A case manager to lead the care coordination relationship and serve as the primary point of contact for the attributed Medicaid individual.

To be eligible for enrollment in the CMC program for payment beginning each program year, the CMC entity must:

i. Have provided, within the past twelve months, prenatal and perinatal services to at least 150 pregnant and postpartum individuals under the same tax identification number, as identified through ODM data sources; and
ii. At the time of enrollment, attest that for the duration of its participation, it will do all of the following:

   a. Perform the activities required under the CMC program

   b. Have at least one practitioner from each of the following categories – a practitioner with prescribing authority in the state of Ohio; an RN or LPN; and a case manager to lead the care coordination relationship and serve as primary point of contact -- on staff or contracted with the entity

c. Demonstrate organizational commitment to integration of physical and behavioral health care

d. Integrate services of community resources and other practitioners including non-physician licensed or certified behavioral health practitioners

e. Conduct cultural competency activities to advance health equity

f. In the delivery of the CMC program activities, ensure appropriate measures are taken to protect the safety and confidentiality of attributed Medicaid individuals in accordance with all state and federal regulations

g. Establish or adapt a patient and family advisory council to include members who reflect the demographics of the attributed Medicaid individuals served and participate in ODM-led patient survey or assessment activities

h. Participate in learning activities as determined by ODM or its designee and share data with ODM and contracted managed care organizations (MCOs)

i. Review quarterly and annual reports as specified by ODM

j. Actively use an electronic health record (EHR) in clinical services

k. Have the ability to share, receive, and use electronic data from a variety of sources with other health care providers, ODM, and the MCOs

l. Have the ability to submit prescriptions electronically

m. Ensure than an e-PRAF is submitted for every pregnant individual

CMC entity responsibilities

It is the responsibility of the CMC entity, upon enrollment and on an annual basis, to attest that it will meet conduct the following activities:

- Risk stratification. The CMC entity will:
  - i Use risk stratification information from multiple sources (including payers, e-PRAF, screenings tools, electronic health records, and patient history) to risk stratify patients and integrate this information into clinical records and care plans; and
  - ii Perform maternal depression screens and use tools such as social determinants of health, screenings, brief intervention, and referral to treatment (SBIRT) at routine intervals to identify patients in need of, and connect them to, community services and supports.

- Enhanced access. The CMC entity will:
  - i Expedite the first prenatal visit by offering appointments within seven calendar days of the patient's initial request and by establishing a process to improve the gestational age of the first prenatal appointment with the overall goal of achieving the first appointment by the ninth week of gestation.
  - ii Offer at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include e-visits, telehealth, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, or weekends;
  - iii Within one business day of initial request, provide access to a maternal care provider with access to the patient's medical record; and
  - iv Make patient clinical information available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the entity when the office is closed.

- Patient Engagement. The CMC entity will:
  - i Implement strategies to engage patients early in their care and encourage them to be active participants in their care delivery;
  - ii Implement specialized outreach strategies for pregnant individuals who are attributed to, but have not been seen by, the CMC entity;
  - iii Deliver services in a manner that addresses the social, cultural, and linguistic needs of patients with specific attention to populations who experience high rates of infant and maternal mortality;
  - iv Implement procedures that acknowledge patient consent and choice regarding referrals for needed treatment, community and other supports;
  - v Assure patient consents are obtained to support exchange of information in compliance with state and federal regulations; and
  - vi Establish partnerships with primary care practitioners and payers in order to strengthen the referral process of the CMC entity.

- Team based care delivery. The CMC entity will:

i Define care team members, roles and qualifications with specific input from the patient regarding team composition (e.g., obstetricians, primary care, behavioral health, pediatricians, doulas, midwives, community workers, care managers, payers and community partners, as applicable);
ii Establish care team meetings and planned, formal communication (including sharing of care plan documentation) among team members for highest risk patients;
iii Have a process during the individual's prenatal period to assemble a team of providers who will care for the individual and baby during the postpartum period;
iv Have active relationships with providers and community resources based on patient population needs; and
v Provide various care management strategies in partnership with payers, ODM and other providers, as applicable.

- Care management plan. The CMC entity will:
  i Create, maintain, and update care plans/clinical documentation such as progress notes for the highest risk pregnant individuals which includes necessary key elements including integrated behavioral health elements, as applicable; and
  ii Identify key activities that need action/follow up by care team members.

- Patient experience. The CMC entity will:
  i Have a process to ensure continuity in relationships and care throughout the entire care process including:
    a. a plan to transition patients to appropriate providers and resources as they move through the care continuum; and
    b. a process to complete a transfer of care for the postpartum individual (in person or by telephone) with the CMC entity, the patient and members of the care team, specifically the individual's primary care practitioner or Comprehensive Primary Care (CPC) entity, behavioral health provider, and community partners as appropriate.
  ii Assess its approach to patient experience at least once annually through quantitative and qualitative means, including the patient and family advisory council, covering such topics as access to care, cultural competence, holistic care, and effective communication;
  iii Use the collected information to identify and act on opportunities to improve patient experience and reduce disparities; and
  iv Report findings and opportunities for improvement to patients, patient and family advisory council, payers, and ODM.

- Follow-up after hospital discharge. The CMC entity will:
  i Establish relationships with emergency departments and hospitals from which it frequently sends and receives referrals and has an established process to ensure a reliable flow of information;
  ii Proactively and consistently obtain patient discharge summaries from hospitals and other facilities, and connects information from discharge summaries to broader entity systems for highest risk tier patients; and

iii Track patients receiving care at hospitals and EDs, proactively contact patients for appropriate follow-up care given the cause of admission within an appropriate period following a hospital admission or emergency department visit.

- Community integration. The CMC entity will:
  - i Identify local entities that can help address social and emotional needs of patients and integrate them into activities, as appropriate;
  - ii Participate directly or indirectly in state and local infant and maternal mortality efforts; and
  - iii Integrate community services and supports into broader entity systems, including risk stratification, care management plan, and population health management.

- Population health management. The CMC entity will:
  - i Identify individuals in need of medical, behavioral, or community support services to drive best-evidence care using multifaceted outreach efforts;
  - ii Track and follow up on referrals to medical, behavioral health, and community service providers and ensure no gaps in care;
  - iii Actively review maternal and infant health outcome measures, including comprehensive primary care reports and any other relevant reports as applicable, for the CMC entity, affiliated health system, etc.; and
  - iv Have a planned strategy to improve maternal and infant health outcomes segmented by high-risk subpopulations, including a planned strategy to reduce disparities in outcomes.

Assurances

The following beneficiary protections in §1905(t) apply to this program:

- Services are provided according to the provisions of 1905(t) of the Social Security Act (the Act);

- §1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment;

- §1905(t)(3)(B), which restricts enrollment to nearby providers, does not apply to this program because there is no enrollment of new Medicaid beneficiaries as part of this program;

- §1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner;

- §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment;

- Sections 1905(t)(3)(E) and 1905(t)(3)9(F) refer to 1932 of the Act, which allows the Centers for Medicare and Medicaid Services to enforce this provision without applying the general 42 CFR Part 438 regulations.

- §1903(d)(1) provides for protections against fraud and abuse;

- Any marketing and/or other activities will not result in selective recruitment and enrollment of individuals with more favorable health status, pursuant to Section 1905(t)(3)(D) of the Act, prohibiting discrimination based on health status, marketing activities included; and

- The state will notify Medicaid beneficiaries of the CMC program. The notification will include a description of the attribution process, calculation of payments, how personal information will be used and of payment incentives, and will be made publicly available, including to those beneficiaries who are attributed to an enrolled CMC entity.

Enrolled CMC entities are those that meet all eligibility criteria outlined above, have applied via the ODM designated portal, and have had their application accepted by ODM. At the end of each performance year, in order to continue participation in Ohio's CMC program, an enrolled CMC entity must re-attest to meeting all activity requirements, data sharing with ODM and designees and participation in learning activities and must be meeting other program requirements.

Comprehensive Maternal Care (CMC) Program, Payment Adjustment.

Payment for the CMC program can include two types of payments for enrolled CMC entities: (1) per-member-per-month payments; and (2) quality add-on payments. All enrolled CMC entities are eligible for PMPM payments, and some may be eligible for quality add-on payments. All payments are distributed to enrolled CMC entities by ODM or its designee.

Definitions and key calculations applicable to all payment

- A **Comprehensive Maternal Care (CMC) entity** is the primary entity responsible for meeting the program activities and outcomes for attributed Medicaid individuals.
- The **electronic pregnancy risk assessment form** (e-PRAF) is the electronic version of ODM's pregnancy risk assessment form (PRAF) that is submitted through the web portal designated by ODM.
- The **electronic report of pregnancy** (e-ROP) is the electronic version of ODM's notification of pregnancy form (NOP) that is submitted through the web portal designated by ODM.
- The **Performance period** is the 12-month calendar year period of participation in the CMC program by an enrolled CMC entity. An enrolled CMC entity's first performance period begins January 1st after their enrollment in the program.

Attribution:

i Member exclusions: All Medicaid beneficiaries who are pregnant or postpartum are included in the attribution process, except for the following excluded populations:

a. Individuals who are currently receiving another care coordination service that substantially duplicates those activities provided under this program.

b. Individuals with a limited Medicaid benefit plan other than presumptive eligibility for pregnant individuals.

c. Individuals dually enrolled in Ohio Medicaid and Medicare.

d. Individuals with third party liability medical coverage except for those with exclusively third-party dental or vision coverage.

ii Methodology: ODM will attribute all non-excluded members to a CMC entity that meets the provider type requirements described under "Provider Qualifications" in Attachment 3.1-A, item 25c. Attribution of Medicaid-covered individuals occurs monthly using retrospective data. Eligible Medicaid-covered individuals will only be attributed to one entity at a time, and only one enrolled CMC entity will receive PMPM payments for CMC services per attributed beneficiary. Attribution will be done using a hierarchical process as follows:

a. The Medicaid-covered individual's choice of provider identified through the completion of the PRAF or the e-PRAF or when communicated directly via contact with ODM or its designee);
b. Medicaid-covered individuals who do not express member choice explicitly will be attributed to an entity based on pregnancy or postpartum claims history;

c. For Medicaid-covered individuals who do not express member choice and do not have sufficient claims history, partial claims history and non-claims factors including primary care provider relationship or geographic proximity will be used for attribution.

Risk scoring:

i Methodology: ODM will score all members attributed to a CMC entity based on health status using an evidence-based proprietary risk scoring methodology. Risk scoring will be done using 12 months of available Medicaid data plus at least three months of run-out. If this much data is not available, ODM will use the data available to conduct risk scoring. Individuals without Medicaid history will be assigned to the healthiest risk status, and will be reassigned once there is sufficient claims data to update the risk status.

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

Clinical quality measures required for PMPM and quality add-on payments

An enrolled CMC entity must meet all of the activity requirements described in Attachment 3.1-A, in addition to clinical quality measures described below, in order to receive any PMPM or quality add-on payments. Enrolled CMC entities must meet the required clinical quality measure thresholds for each program year (calendar year) in which they participate.

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

Effective January 1st of each program year, the clinical quality measures and thresholds are in effect for that performance year, and can be found at the following link: https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/maternal-and-infant-support. Quality metrics are only applicable to an enrolled CMC entity if the patient volume in the metric denominator is sufficient for the measured metric to be statistically valid. Clinical quality metrics will be evaluated for each enrolled CMC entity at the end of each performance period using claims from the performance period for all members attributed to the enrolled CMC entity.

Clinical quality metrics: The set of clinical quality metrics includes adult health measures, behavioral health measures, infant measures, and individuals' health measures. Specific information regarding these requirements can be found at the link to the Payment Innovation website referenced in the paragraph above. An enrolled CMC entity must pass at least 50% of applicable metrics. Clinical quality metrics are evaluated annually based on performance through the performance period plus at least three months of claims run-out.

Per-member-per-month (PMPM) payments

Definition: The PMPM payment is a prospective payment that is both paid and risk-adjusted quarterly, and that supports the activities required by the CMC program. The unit of service is quarterly. PMPM payments begin in the first month of an enrolled CMC entity's first performance period. Payment for CMC services under Ohio's CMC program will not duplicate payments made for the same services under other program authorities or under Ohio's CPC program for this same purpose. ODM offers guidance to providers on this restriction, and throughout the development of this program, ODM carefully reviews existing and new services to ensure that CMC participants are not receiving similar services through other Medicaid funded programs. Enrolled CMC entities must meet the effective program requirements in order to receive PMPM payments. Failing an activity requirement results in PMPM payment suspension. Failing to pass 50% of applicable clinical quality metrics results in a warning; two consecutive warnings result in PMPM payment suspension. A payment suspension will be lifted once an enrolled CMC entity passes all activity requirements and 50% of applicable clinical quality and efficiency metrics.

Risk tiers: Members attributed to enrolled CMC entities are placed in the following risk tiers with associated PMPMs for each tier:

i Pregnant or postpartum individuals who ($40.00 PMPM):
   a. Are determined to be progesterone eligible as evidenced on the PRAF;
   b. Are at risk of pre-term birth based on having had a prior pre-term birth or shortened cervix as evidenced by vital statistics data or claims history
   c. Live in an area determined to have the least access to critical services according to the most recent Ohio opportunity index (OOI); or
   d. Are considered medically complex as evidenced by claim history indicating substance use disorder, asthma, diabetes, lupus, chronic kidney disease, advanced maternal age (individuals over forty years of age) or cardiovascular disease.

ii Pregnant or postpartum individuals up to three months postpartum who do not qualify under the previous tier ($15.00 PMPM).

PMPM amounts may be updated no more frequently than annually.

Calculation: The quarterly PMPM payment for an enrolled CMC entity is calculated as follows:

Quarterly PMPM payment for an enrolled CMC entity:

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

Quality add-on payments

a. Timing of payments: quality add-on payments will be made after the end of the performance period when all necessary data is received in final form.

b. Payments made by ODM: The quality add-on amount paid to enrolled CMC entities includes members based on member months.

Quality add-on payment for enrolled CMC entities demonstrating maternal care excellence:

This payment will be a lump sum amount calculated and paid annually, after the end of the performance period when all necessary data is received in final form. Payments will be made to the CMC entities with the highest performance compared to peers on specific metrics linked to improved maternal outcomes. These metrics may include reducing time to the first prenatal visit, improving well care visit rates such as dental exams, improvements in tobacco cessation rates, and reductions in racial disparities across quality metrics. CMC entities can earn up to three points of up to $8,000 per point, with one point each awarded for:

A. Participation in Perinatal Quality Improvement Collaborative OR implementing patient safety practices or bundles;
B. Integration and support of community partners; and
C. Integration of information from patient feedback processes

Performance metric thresholds will be posted to ODM's website at https://medicaid.ohio.gov/ no later than the December 31st preceding the performance year.

For quality add-on payments to eligible CMC entities, the pool available for CMC providers to share for each performance year is capped at $1,000,000. If the sum of all calculated payments for enrolled CMC entities with the highest quality across all Ohio CMC entities during a performance year exceeds $1,000,000, each entity's payment is scaled down proportionally until total outlays equal $1,000,000.

Monitoring and Reporting

ODM will collect data from and monitor enrolled CMC entities in the following ways: 1) Upon enrollment, enrolled CMC entities will attest they will meet activity requirements as specified in the "Entity Characteristics" section. The CMC entities will re-attest to meeting CMC program activity requirements one year after enrollment and annually thereafter; 2) the state, or its designee, will monitor enrolled CMC entities to verify and document that activity requirements are being met.

In addition, ODM will provide enrolled CMC entities with quarterly progress reports which include clinical quality metrics.

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

Ohio will:

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