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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 25-0003

This file contains the following documents in the order listed:

1) Approval Letter
2) Form CMS 179
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

May 16, 2025

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) 25-0003

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0003. This amendment updates Ohio's Comprehensive Maternal Care Program under the state plan for calendar year 2025.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Ohio's Medicaid SPA TN 25-0003 was approved on May 16, 2025, effective January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Ohio State Plan.

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

Sincerely,

[redacted]

Shantrina Roberts, Acting Director
Division of Program Operations

Enclosures

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tamara Edwards, ODM
Robert Bromwell, 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: 25 — 0003

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, 2025

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 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, Item 25c, pages 1, 3 and 6
Attachment 4.19-B, Item 25c, page 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A, Item 25c, pages 1, 3 and 6 (TN 22-038)
Attachment 4.19-B, Item 25c, page 3 (TN 22-038)

9. SUBJECT OF AMENDMENT

Comprehensive Maternal Care (CMC) Program Updates for Program Year 2025

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
February 24, 2025

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
February 24, 2025

17. DATE APPROVED
May 16, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Shantrina Roberts

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

22. REMARKS

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 activity requirements and 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.

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 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 that an e-PRAF is submitted for every pregnant individual

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.
  - iv Allow patients to have a doula of their choice at any pregnancy related service or appointment. Patients that procure or request the assistance of a doula as part of their prenatal, birth or postpartum care will be supported by the practice in receiving doula services.

- 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;

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 Enhanced Risk: Pregnant or postpartum individuals who ($40.00 PMPM):
   a. 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
   b. Live in an area determined to have the least access to critical services according to the most recent Ohio opportunity index (OOI); or
   c. 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 Standard Risk: 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:

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