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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 26-0008

This file contains the following documents in the order listed:

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



Medicaid and CHIP Operations Group

June 16, 2026

Scott R. Partika, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) - 26-0008

Dear Director Partika:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) OH-26-0008. This amendment proposes to update the Comprehensive Maternal Care (CMC) Program Updates for Program Year 2026. PY 2026 updates include updating the Pregnancy Risk Assessment Form name to Perinatal Risk Assessment Form to account for additional submissions in the postpartum period, shifting performance requirements to the monitoring and reporting section of the state plan, and clarifying that ODM may recoup payments from entities that do not meet other program requirements.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations, including Sections 1905(a)(25) and 1905(t) of the Social Security Act. This letter informs you that Ohio's Medicaid SPA TN 26-0008 was approved on June 16, 2026, with an effective date of January 1, 2026.

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 Keri Rosenbloom Toback at (312) 353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

A black rectangular box redacting the signature of Nicole McKnight.

Nicole McKnight
Acting Director, Division of Program Operations

Enclosures

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Robert Bromwell, CMCS
Justin Myrowitz, CMCS
Angela Cimino, CMCS
Christine Davidson, CMCS

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 6 — 0 0 0 8

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, 2026

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 2026 \$ 0
b. FFY 2027 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, Item 25c, pages 1 and 5
Attachment 4.19-B, Item 25c, pages 1,3, 4 and 5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if Applicable)

Attachment 3.1-A, Item 25c, page 1 (TN 25-003)
Attachment 3.1-A, Item 25c, page 5 (TN 22-038)
Attachment 4.19-B, Item 25c, page 1, 4 and 5 (TN 22-038)
Attachment 4.19-B, Item 25c, page 3 (TN 25-003)

9. SUBJECT OF AMENDMENT

Comprehensive Maternal Care (CMC) Program Updates for Program Year 2026

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 Signature]

12. TYPED NAME

SCOTT PARTIKA

13. TITLE

STATE MEDICAID DIRECTOR

14. DATE SUBMITTED

March 24, 2026

15. RETURN TO

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

FOR CMS USE ONLY

16. DATE RECEIVED

March 24, 2026

17. DATE APPROVED

June 16, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

January 1, 2026

19. [Redacted]

20. TYPED NAME OF APPROVING OFFICIAL

Nicole McKnight

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 perinatal risk assessment form**(e-PRAF) is the electronic version of ODM's perinatal 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.

- 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. 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, CMC staff, and provider 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.
 - v Demonstrate a means of assessing and improving staff and provider satisfaction at least once annually.
 - 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

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 perinatal risk assessment form** (e-PRAF) is the electronic version of ODM's perinatal 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;

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.

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:

Quarterly PMPM payment for an enrolled CMC practice

= [(number of patients on the practice's panel attributed to standard risk tier
* PMPM amount for standard risk tier)
+ (number of patients on the practice's panel attributed to enhanced risk tier
* PMPM amount for enhanced risk tier)] * 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. 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 performance 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.

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 during a performance year results in a warning. After two consecutive program years of not meeting at least 50% of applicable metrics, payment and participation in the program will be terminated. ODM may recoup payments if it is discovered that an enrolled entity has failed to meet other program requirements.

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.