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Ohio Administrative Code

Rule 5160-19-03 Comprehensive maternal care program.

Effective: November 18, 2022

The "comprehensive maternal care (CMC)program" is a maternal and infant support program that utilizes acomprehensive care coordination and service model incorporating supportiveservices for expectant and postpartum medicaid eligible individuals to reduceadverse birth and infant outcomes.

(A) For purposes of Chapter 5160-19 of the Administrative Code, the following definitions apply:

(1) "Attribution" is the process through which the Ohio department of medicaid (ODM) or its designee assigns eligible individuals to a specific CMC entity.

(2) "CMC attributed medicaid individuals" are the eligible pregnant and postpartum Ohio medicaid recipients for whom an entity eligible under this rule has accountability for coordinating and ensuring the delivery of CMC program activities. All eligible individuals will be attributed except for:

(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 benefits as defined in rule 5160-1-08 of the Administrative Code except for those with exclusively dental or vision coverage.

(3) "Comprehensive maternal care entity" (CMC entity) is the primary entity which meets the criteria described in this rule and is responsible for meeting CMC program activities for attributed medicaid individuals. The following medicaid providers are eligible to participate and receive payment under

this rule:

(a) Professional medical groups as defined in Chapter 5160-1 of the Administrative Code.

(b) Federally qualified health centers (FQHC) and rural health clinics (RHC) as defined in Chapter 5160-28 of the Administrative Code.

(c) Clinics as defined in Chapter 5160-13 of the Administrative Code.

(d) Professional medical groups billing under hospital provider types.

(4) "Electronic pregnancy risk assessment form" (e-PRAF) is the electronic version of ODM form 10207 "pregnancy risk assessment form" (PRAF) that is submitted through the web portal designated by ODM.

(5) "Electronic report of pregnancy" (e-ROP) is the electronic version of ODM form 10257, "report of pregnancy" (ROP) that is submitted through the web portal designated by ODM.

(6) "Eligible provider" is as defined in rule 5160-1-17 of the Administrative Code.

(B) To be eligible and remain eligible for enrollment and participation as a CMC entity for payment in each program year, the CMC entity will:

(1) Have an active Ohio medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code;

(2) Have provided prenatal and perinatal services to at least one hundred fifty pregnant and postpartum individuals under the same tax identification number, as identified through ODM data sources; and

(3) Apply to become a CMC entity. ODM reserves the right to deny any enrollment application it determines is not in compliance with the activities in this rule. An applicant may seek reconsideration pursuant to rule 5160-70-02 of the Administrative Code if ODM has denied a CMC

program enrollment application.

(C) At the time of enrollment, the applicant attests that for the duration of its participation, it will do all of the following:

(1) Perform the activities identified in this rule.

(2) Have at least one practitioner from each of the following categories on staff or contracted with the entity:

(a) A practitioner with prescribing authority in the state of Ohio;

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

(c) A case manager to lead the care coordination relationship and serve as the primary point of contact for the attributed medicaid individual.

(3) Demonstrate organizational commitment to integration of physical and behavioral health care by meeting one of the following:

(a) Employ or have under contract one or more licensed behavioral health care clinicians;

(b) Have an integrated care agreement such as a contract or memorandum of understanding with a behavioral health care entity;

(c) Have an ownership or membership interest in a provider organization where primary and behavioral health care services are integrated within the facility structure or entity, and are readily available to attributed medicaid individuals; or

(d) Have accreditation by a national accrediting entity as an integrated primary care-behavioral health provider.

(4) Integrate services of community resources and other practitioners including non-physician

licensed or certified behavioral health practitioners described in rule 5160-8-05 of the Administrative Code.

(5) Conduct the following cultural competency activities to advance health equity:

(a) Ensure all clinical and professional staff who provide direct care to or interact with patients complete cultural competency training, meeting criteria established by ODM within six months of program enrollment and annually thereafter and for new employees within thirty calendar days of start date; and

(b) At least annually, assess the demographics of patients served, including race, ethnicity, and language, and adapt training needs for staff based on the results of the assessment.

(6) 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.

(7) Establish or adapt a patient and family advisory council to include members who reflect the demographics of the attributed medicaid individuals served.

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

(9) Review quarterly and annual reports as specified by ODM.

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

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

(12) Have the ability to submit prescriptions electronically.

(13) Ensure than an e-PRAF is submitted for every pregnant individual.

(D) Attribution.

(1) The following hierarchy will be used in attributing individuals to a CMC entity:

(a) The eligible individual's choice of provider identified through the completion of the PRAF or e-PRAF.

(b) Pregnancy or postpartum related claims data concerning the eligible individual.

(c) Primary care provider relationship.

(d) Other data concerning the eligible individual such as geographic location.

(2) All pregnant and postpartum medicaid individuals will be assigned to either of the following risk tiers:

(a) Pregnant or postpartum individuals who:

(i) Are determined to be progesterone eligible as evidenced on the PRAF;

(ii) Are at risk of pre-term birth based on having had a prior pre-term birth or a shortened cervix as evidenced by vital statistics data or claims history;

(iii) Live in an area determined to have the least access to critical services according to the most recent Ohio opportunity index (OOI); or

(iv) 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.

(b) Pregnant or postpartum individuals up to three months postpartum who do not qualify under the previous tier.

(3) At any time, the eligible individual may choose a specific CMC entity or request to be re-attributed to a different CMC entity by submitting a request to the MCO, ODM or its designee.

(4) Eligible individuals may opt-out of the CMC program and may opt-in at any time by making a request to the MCO, ODM, or its designee.

(E) It is the responsibility of the CMC entity, upon enrollment and on an annual basis, to attest that it will meet the following provisions:

(1) Risk stratification. It is the responsibility of the CMC entity to:

(a) 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

(b) Perform maternal depression screens and use screening 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.

(2) Enhanced access. It is the responsibility of the CMC entity to:

(a) Expedite the first prenatal visit by:

(i) Offering appointments within seven calendar days of the patients initial request; and

(ii) Establishing a process to reduce the gestational age at the first prenatal appointment with the overall goal of achieving the first appointment by the ninth week of gestation.

(b) 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;

(c) Within one business day of initial request, provide access to a maternal care provider with access to the patient's medical record; and

(d) 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.

(3) Patient engagement. It is the responsibility of the CMC entity to:

(a) Implement strategies to engage patients early in their care and encourage them to be active participants in their care delivery;

(b) Implement specialized outreach strategies for pregnant individuals who are attributed to, but have not been seen by, the CMC;

(c) Deliver services in a manner that addresses the social, cultural, and linguistic needs of patients with specific attention to populations with high rates of infant and maternal mortality;

(d) Implement procedures that acknowledge patient consent and choice regarding referrals for needed treatment, community, and other supports;

(e) Assure patient consents are obtained to support exchange of information in compliance with state and federal regulations; and

(f) Establish partnerships with primary care practitioners and payers in order to strengthen the referral process of the CMC entity.

(4) Team based care delivery. It is the responsibility of the CMC entity to:

(a) 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);

(b) Establish care team meetings and planned, formal communication (including sharing of care plan documentation) among team members for highest risk patients;

(c) Have a process during the individuals prenatal period to assemble a team of providers who will care for the individual and baby during the postpartum period;

(d) Have active relationships with providers and community resources based on patient population needs; and

(e) Provide various care management strategies in partnership with payers, ODM and other providers, as applicable.

(5) Care management plan. It is the responsibility of the CMC entity to:

(a) Create, maintain, and update care plans and 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

(b) Identify key activities that need action or follow up by care team members.

(6) Patient experience. It is the responsibility of the CMC entity to:

(a) Have a process to ensure continuity in relationships and care throughout the entire care process including:

(i) A plan to transition patients to appropriate providers and resources as they move through the care continuum; and

(ii) A process to complete a transfer of care (in person or by telephone) with the CMC entity, the patient and members of the care team, specifically the individuals primary care practitioner, pediatric primary care for the baby, behavioral health provider, and community partners as appropriate.

(b) Assess its approach to improving the 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;

(c) Use the collected information to identify and act on opportunities to improve patient experience and reduce disparities; and

(d) Report findings and opportunities for improvement to patients, patient and family advisory council, payers, and ODM.

(7) Follow-up after hospital discharge. It is the responsibility of the CMC entity to:

(a) Establish relationships with emergency departments (EDs) and hospitals from which it frequently sends and receives referrals and has an established process to ensure a reliable flow of information;

(b) Proactively and consistently obtain patient discharge summaries from hospitals and other facilities, and connect information from discharge summaries to broader entity systems for highest risk tier patients; and

(c) 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.

(8) Community integration. It is the responsibility of the CMC entity to:

(a) Identify local entities that can help address social and emotional needs of patients and integrate them into activities described in paragraph (F) of this rule, as appropriate;

(b) Participate directly or indirectly in state and local infant and maternal mortality efforts; and

(c) Integrate community services and supports into broader entity systems, including risk stratification, care management plan, and population health management.

(9) Population health management. It is the responsibility of the CMC entity to:

(a) Identify individuals in need of medical, behavioral, or community support services to drive best-evidence care using multifaceted outreach efforts;

(b) Track and follow up on referrals to medical, behavioral health, and community service providers and ensure no gaps in care;

(c) Actively review maternal and infant health outcome measures for the CMC entity, affiliated health system, etc.; and

(d) 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.

(F) It is the responsibility of the CMC entity to pass at least fifty percent of the following clinical quality measures, to be evaluated annually at the end of each performance period. Further details regarding these metrics can be found on the ODM website, www.medicaid.ohio.gov.

(1) Hepatitis B screening.

(2) Maternal primary care visit.

(3) HIV screening.

(4) TDAP vaccine.

(5) Tobacco cessation.

(6) Postpartum care.

(G) The CMC entity may qualify to access the following payments:

(1) The CMC per-member-per-month (PMPM) is a payment to support the CMC entity. Payment is in the form of a prospective PMPM payment that will be calculated for each attributed medicaid individual using ODM's risk tier file to categorize individuals in one of the two risk tiers. Specific information about this payment can be found on the ODM website, www.medicaid.ohio.gov.

(2) The CMC quality add-on payment is made to the CMC entities who meet quality outcomes. Specific information about this payment can be found on the ODM website, www.medicaid.ohio.gov.

(H) Penalties.

(1) It is the responsibility of the CMC entity to continue meeting all provisions as defined in this rule, including those contained in the described attestations. If these provisions are not met, payment under this rule is subject to termination.

(2) It is the responsibility of the CMC entity to continue meeting clinical quality measures defined in this rule. If any of these provisions are not met, a warning will be issued. After two consecutive warnings, payment under this rule will be terminated.

(3) A CMC entity may seek reconsideration pursuant to rule 5160-70-02 of the Administrative Code to challenge decisions by ODM to terminate payment described in this rule.