200.100 Episode Definition/Scope of Services  7-1-16

This section describes, for each episode type, the rules for determining the specific services as derived from paid claims included in a particular episode.

A. **Episode subtypes:** Episode types may be divided into two or more subtypes distinguished by more specific diagnostic criteria or other clinical information.

B. **Episode triggers:** Services, diagnoses or procedures that may initiate an episode as defined for each episode type.

C. **Episode duration:** The time before and after an episode trigger during which medical claims may be included in an episode.

D. **Episode services:** Criteria used to determine which medical claims are included or excluded in an episode when delivered within the episode duration. Services excluded across all episode types are nursing home claims, EPSDT claims and managed care claims and fees.

200.300 Exclusions  7-1-16

There are two types of exclusions. Global Exclusions are either policy related or clinically pertinent medical conditions that will exclude a beneficiary from all Episodes of Care.

Global Exclusions (applied to all Episodes of Care):

A. Medicaid and Medicare dual eligibility

B. Beneficiaries with non-continuous Medicaid enrollment for the duration of the episode

C. Beneficiaries with Third Party Liability

D. Beneficiaries with one or more of the following:
   1. End-Stage Renal Disease
   2. Clinically pertinent metabolic, nutritional, immunity disorders
   3. Clinically pertinent disorders of blood and blood forming organs
   4. Clinically pertinent cancers
   5. Active chemotherapy treatments
   6. Clinically pertinent organ transplants
   7. Leukemia
   8. Cystic Fibrosis

E. Beneficiaries leaving against medical advice

F. Beneficiaries expiring during the episode duration

G. Beneficiaries admitted to hospice care

H. Episodes that are a result from trauma

The second type of exclusions, referred to as Episode-Specific Exclusions, are at the episode type level. These exclusions are determined through consultation with providers and are identified as a significant impact on a particular episode. Episode-Specific Exclusions are identified for each episode of care.
200.400 Adjustments

This section describes, for each episode type, adjustments to the reimbursement amount attributable to a PAP for the purpose of calculating performance and determining incentive payments.

Across all episode types, the reimbursement amount attributable to a PAP for facility claims for acute inpatient hospitalizations is adjusted to a per diem rate of $850.

200.500 Quality Measures

This section describes, for each episode type, the specified data and measures which Medicaid will track and evaluate to ensure provision of high-quality care for each episode type. Quality measures may be determined from paid claims data or provider portal entry.

A. Quality measures “to pass”: Measures for which a PAP must meet or exceed a minimum threshold in order to qualify for a positive (gain-share) incentive payment for that episode type.

B. Quality measures “to track”: Measures for which a PAP’s performance is not linked to receive incentive payments. Performance on these measures may result in a program integrity review.

200.600 Reimbursement Thresholds

This section describes, for each episode type, the specific values used to calculate positive (gain-share) or negative (risk-share) incentive payments. This includes an acceptable threshold, a commendable threshold, a gain-sharing limit and a risk-sharing percentage.

200.700 Minimum Case Volume

This section describes, for each episode type, the minimum case volume required for a PAP to qualify for positive (gain-share) or negative (risk-share) incentive payments. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive (gain-share) or negative (risk-share) incentive payments for that episode type.