Ohio Administrative Code

Rule 5160-19-04 Episode based payments.

Effective: December 31, 2020

(A) Excluding calendar years 2020 and 2021, all medicaid managed care plans, providers under contract with medicaid managed care plans, and medicaid providers who participate in the medicaid fee-for-service program will participate in episode-based payments. This participation is limited to those episodes in which the provider renders services.

(B) Definitions.

(1) An "episode" is a defined group of related medicaid covered services provided to a specific patient over a specific period of time. The characteristics of an episode will vary according to the medical condition for which a recipient has been treated. Detailed descriptions and definitions for each episode are found in the Ohio medicaid payment innovation website located at www.medicaid.ohio.gov.

(a) "Episode type" means a diagnosis, health care intervention, or condition which characterizes the episode.

(b) For each episode type there are specific parameters that define the episode including:

(i) "Episode trigger" means those diagnosis or procedures and corresponding claim types and care settings that characterize a potential episode.

(ii) "Pre-trigger window" means the time period prior to an applicable trigger event and includes all relevant care for the patient.

(iii) "Trigger window" means the duration of the potential trigger event and includes all care provided.

(iv) "Post trigger window" means the time period following the trigger event and includes all

relevant care and any complications that might occur.

(v) "Episode level exclusions" means patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted.

(vi) "Potential risk factors" means those patient characteristics, comorbidities, diagnosis or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode.

(vii) "Quality metrics" means measures determined by the department that will be used to evaluate the quality of care delivered during a specific episode.

(2) "Performance period" means a twelve-month period, beginning on the first day of a calendar year, for which the department will measure episode performance of all providers delivering services during the course of a specific episode. For an episode to be included within the performance period, the end date for the episode it has to fall within the performance period. Due to the COVID-19 emergency, there will be no performance period during which the department measures episode performance for calendar years 2020 and 2021.

(3) "Principal accountable provider (PAP)" means the provider that is held accountable for both the quality and cost of care delivered to a patient for an entire episode. The department designates a PAP based on factors such as decision-making responsibilities, influence over other providers, and episode expenditures.

(4) "Thresholds" are the upper and lower incentive benchmarks for an episode of care.

(a) "Acceptable" means the specific dollar value for each specific episode such that a provider with an average risk-adjusted reimbursement above the dollar value incurs a negative incentive payment.

(b) "Commendable" means the specific dollar value for each specific episode such that a provider with an average risk-adjusted reimbursement below the dollar value is eligible for a positive incentive payment if all quality metrics linked to the incentive payment are met.

(c) "Positive incentive limit" means a level set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(C) Through the use of episode-based payments, the department provides incentive payments to recognize the quality, efficiency, and economy of services provided in the course of an episode.

(D) Episode definitions and appropriate quality measures are based on evidence-based practices derived from peer-reviewed medical literature, historical provider performance, clinical information furnished by providers of the care, and services typically rendered during the episodes of care.

(E) Any medicaid covered services provided in the delivery of care for an episode may be included in the calculation of the average risk-adjusted episode reimbursement. The services considered need not be limited solely to those provided by the PAP.

(F) For each PAP, the department calculates the average risk-adjusted episode reimbursement for each episode that occurs within the performance period. The average risk-adjusted episode reimbursement is specific to the episode type, and is derived in the following manner:

(1) All episodes ending within a performance period are identified for each potential PAP and the total reimbursement for each episode is calculated based on related covered services delivered during the duration of each episode.

(2) The department excludes certain episodes in measuring a PAP's performance.

(a) Business exclusions are non-clinical reasons for excluding an episode. Business exclusions for each episode are found within the episode definitions at the Ohio medicaid payment innovation website.

(b) Clinical exclusions include characteristics of the patient or episode. Clinical exclusions for each episode are found within the episode definitions at the Ohio medicaid payment innovation website.

(3) For the episodes that remain after business exclusions and clinical exclusions are applied, the

department excludes costs that are not attributable to the episode cost of care for the medicaid recipient.

(4) After the excluded episodes and costs are removed from the episodes assessed for the performance year, the department applies any risk adjustments necessary to enable comparison of a PAP's performance relative to the performance of other providers in a way that takes patient health risk factors and other health complications into sufficient consideration. Risk adjustments are specific to each episode as described at the Ohio medicaid payment innovation website.

(5) The average risk-adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by the department.

(G) Incentive payments to a PAP are based upon episodes that end within a performance period. Incentive payments may be positive or negative and are calculated and made retrospectively after the end of the performance period. Incentive payments are based on the aggregate of valid, paid claims across a PAP's episodes and are not relatable to any individual provider's claim for payment. A PAP has to have a minimum volume of episodes during the course of a performance period in order to be eligible for a positive or negative incentive payment. Due to the COVID-19 emergency, and in accordance with paragraph (B)(2) of this rule, PAPs will not be eligible for incentive payments for services provided during calendar years 2020 and 2021.

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specific period of time. For each PAP, the average risk-adjusted episode reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition.

(2) If the PAP's average risk-adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by the department for each episode type have been met, the department will make a positive incentive payment to the PAP. This incentive payment will be based on the difference between the PAP's average risk-adjusted episode reimbursement and the commendable threshold.

(3) If the PAP's average risk-adjusted episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative incentive payment. This negative incentive payment will be based on the difference between the PAP's average risk-adjusted episode reimbursement and the acceptable threshold.

(4) If the average risk-adjusted episode reimbursement is between the acceptable and commendable thresholds, the PAP will not receive a positive incentive payment or incur a negative incentive payment.

(H) Threshold determination.

Thresholds are determined by taking into consideration several factors, including the potential to improve patient access, and the level and type of practice pattern changes essential for performance improvement.

(1) The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects a PAP's unacceptable variation from typical performance without clinical justification.

(2) The commendable threshold is set such that outperforming the commendable threshold represents efficient, quality care.

(I) For each episode type, the department applies quality metrics to evaluate the quality of care delivered during the episode and applies these metrics to providers that are eligible for positive incentive payments in order to avoid the risk of incentivizing care delivery at a cost that could compromise quality. Included are quality metrics reflecting certain standards which support the delivery of adequate care during the course of the episode.

(J) Incentive payments are separate from, and do not alter, the reimbursement methodology for medicaid covered services set forth in department rules located in agency 5160 of the Administrative Code.

(K) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient.

(L) Nothing in this rule prevents the department from engaging in any retrospective review or other program integrity activity.

(M) PAPs cannot make use of hearing rights under Chapter 119. of the Revised Code to challenge a decision made by the department; however, reconsideration rights as stated in rules 5160-70-01 and 5160-70-02 of the Administrative Code may be utilized.