

Episodes of Care FAQs: What You Need to Know

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Have a question you would like us to answer?

Please submit additional questions and comments to payment.reform@tn.gov

Episodes of Care basics

Q: WHEN WERE EPISODES OF CARE STARTED IN TENNESSEE?

The first episodes were designed in 2013, and episode performance reports were first available for quarterbacks in 2014. These were the preview reports for total joint replacement, perinatal, and asthma acute exacerbation.

The Tennessee Health Care Innovation Initiative was launched in February 2013 to change the way health care is paid for in Tennessee. The goal of the initiative is to move from paying for volume to paying for value by rewarding health care providers for delivering high-quality, cost-effective care. There are three strategies in this initiative: Primary Care Transformation, Episodes of Care, and Long-Term Services and Supports. This document focuses on Episodes of Care.

Q: WHAT ARE EPISODES OF CARE?

A: The Episodes of Care program rewards high-quality care, encourages provider coordination, and disincentivizes ineffective and/or inappropriate care. An episode of care includes all the relevant health care services a patient receives during a specified period for the treatment of a physical or behavioral health condition. For each episode of care, a quarterback is defined and held accountable for the quality and cost of care delivered during the entire episode.

For example, the asthma acute exacerbation episode includes all asthma care from the initial presentation in an emergency department or hospital to 30 days afterwards. The total cost of care associated with a single episode is called the episode spend.

Q: WHAT IS A QUARTERBACK?

A: The quarterback is the provider who has the most impact on the overall cost and quality of a patient's treatment within an episode. Every episode has a designated quarterback, which is identified at the Tax Identification Number (TIN) level. The quarterback is the only provider eligible for risk-sharing or gain-sharing payments.

Besides delivering and coordinating care to the patient during the episode of care, the quarterback receives quarterly reports showing how their performance on quality and cost metrics compares to other TennCare quarterbacks for that same episode across the state.

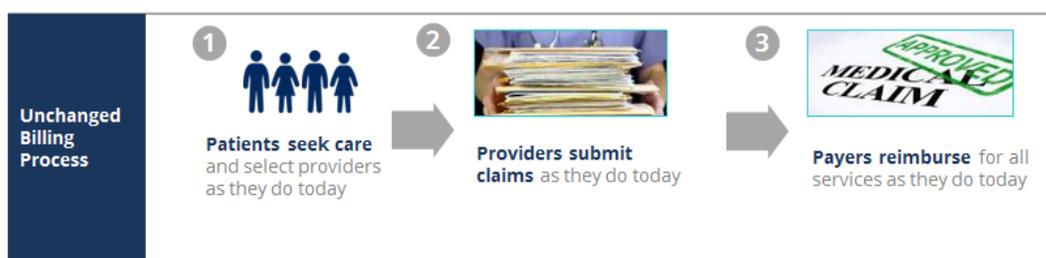
Q: WHO CAN BE A QUARTERBACK?

A: Quarterbacks can be professionals (individual physicians or groups of individual physicians) or facilities. For some episodes, the quarterback is the facility (for example, the hospital where the patient was treated for an asthma attack). For other types of episodes, the quarterback is the professional delivering care (for example, the surgeon who performed the patient's total joint replacement). In every case, it is the business entity that is being held accountable (i.e., incentives and payments are determined at the Tax Identification Number level). For example, for episodes with a professional quarterback, the quarterback may be a large multispecialty group or an individual practitioner delivering care.

Q: DOES THE EPISODES OF CARE PROGRAM CHANGE MY REIMBURSEMENT PROCESS?

A: No. Quarterbacks will continue to deliver care, submit claims, and receive reimbursement as they do today. Rather than focus on volume of care, the Episodes of Care program rewards high-quality and better health outcomes, while encouraging care providers to use resources efficiently. The only possible change in payment for the quarterback occurs after the episode is completed and the cost and quality metrics are reported:

- The quarterback may get a reward payment if the average risk-adjusted episode spend is below a commendable level for the episode and quality metrics meet the state's guidelines.
- The quarterback may owe money if the average risk-adjusted episode spend for the episode exceeds an acceptable level.



Q: WHICH EPISODES ARE INCLUDED IN THE PROGRAM?

A: There are a total of 48 specific episodes currently being implemented (a total of 55 specific episodes have been designed). You can find the full list of episodes here: <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html>.

Q: WHERE CAN I FIND THE MOST RECENT RESULTS?

A: Every year, TennCare publishes the Episodes of Care final results for both cost savings and quality improvements. Please visit <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html> to see the most recent program results.

Episodes of Care design

Q: WHO PROVIDES INPUT ON THE DESIGN OF EPISODES?

A: Every episode is designed with recommendations from Tennessee clinicians, who form a Technical Advisory Group (TAG), defined below. These design recommendations include the episode trigger, the type of quarterback for the episode, included spend, episode duration, exclusions, risk factors, and quality metrics. For every episode that has been designed in Tennessee, the clinicians' recommendations were incorporated into the episode design before implementation.

Once an episode is implemented, the state conducts an annual feedback session to provide an opportunity for stakeholders to comment on what is working well and how to improve the clinical design. The program has made over 100 program improvements to date based on stakeholder feedback.

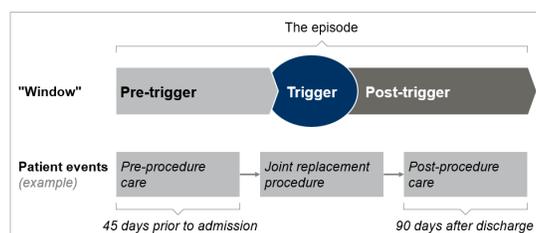
Q: WHAT IS A TECHNICAL ADVISORY GROUP (TAG)?

A: Technical Advisory Groups (TAGs) are composed of Tennessee clinicians with expertise in relevant specialties who volunteer their time to make recommendations on the clinical design of episodes. Members are selected through a nomination process. TAGs meet in person multiple times as part of the episode design process. Many of the TAG participants are also providers in Episodes of Care.

Q: WHAT IS THE TIMELINE OF AN EPISODE?

A: An episode of care has three basic parts: the episode trigger, the pre-trigger services, and the post-trigger services.

- The episode **trigger** is the procedure or diagnosis. For example, the total joint replacement episode is triggered by the joint replacement procedure.
- **Pre-trigger services** are the related labs, diagnostic tests, medications, therapy, and other related costs that the patient receives during a specified time before the episode trigger. For example, the total joint replacement episode includes all costs related to the joint replacement procedure in the 45 days leading up to the procedure, such as the initial assessment of the patient x-rays of the joint, pre-procedure bloodwork, etc. If the episode is triggered by an emergency, such as congestive heart failure, there may not be related pre-trigger services included in that episode.
- **Post-trigger services** are the related follow-up care that a patient receives after the trigger event. For example, the total joint replacement episode ends 90 days after discharge.



Q: ARE ALL COSTS INCLUDED IN AN EPISODE?

A: No. Only the services, tests, medications, etc. that are related to the episode are included in the episode. If a patient receives unrelated care at the same time as the episode, the costs of the unrelated care are not included in the episode. The costs that are included vary for each episode and are outlined in the configuration file and Detailed Business Requirements documents for each individual episode. Click [HERE](#) to view these documents in the [Searchable Episodes Table](#).

Fairness, risk adjustment, and exclusions

Q: HOW DOES THE EPISODES OF CARE PROGRAM FAIRLY COMPARE EPISODES?

A: The Episodes of Care program includes many components to make fair comparisons among providers, including the following:

- **Risk adjustment** is a method used to scale the spend for medical services up or down so that the spend becomes comparable across quarterbacks no matter how complex their patients are. This adjustment is done on the basis of the comorbidities coded by providers. For example, an expectant mother with diabetes (a comorbidity) may need more complex care, which may result in a more expensive episode. Therefore, with risk-adjustment, the spend for this episode gets scaled to be fairly compared with an otherwise healthy expectant mother.
- Episode design also factors in several **exclusions** for episodes where fair comparisons cannot be made. There are several exclusions applied to all episodes (e.g., business exclusions, clinical exclusions, overlapping episode exclusions). After all exclusions have been applied, a set of valid episodes remain that are used for performance evaluations to make fair comparisons across providers.

Q: HOW DO THE MCOS PERFORM RISK ADJUSTMENT?

A: An episode's risk-adjusted spend is the episode spend divided by a risk weight for the specific episode. The risk weight adjusts the cost of that episode. Each risk factor has an individual risk weight that is published on each MCO's website. An episode's risk weight is the sum of all individual risk weights for the risk factors that apply to that patient population or episode. If the episode's risk weight is above 1.0, the episode spend will be adjusted down. If the episode's risk weight is below 1.0, the episode spend will be adjusted up. Quarterbacks are accountable for their risk-adjusted episode spend.

Q: WHO DETERMINES THE RISK FACTORS FOR EACH EPISODE?

A: Technical Advisory Group (TAG) members recommend a clinically appropriate list of risk factors for each episode. After the conclusion of the TAG, the list of risk factors is sent to the Managed Care Organizations (MCOs). The MCOs test each risk factor, in addition to other diagnoses that are identified in their model, for statistical significance based on their own data. The risk factors that are statistically significant in terms of episode spend are included in the risk adjustment factors for that episode for that MCO.

Q: HOW ARE RISK FACTORS CAPTURED IN EPISODES OF CARE?

A: In general, risk factors identified during the episode or found in claims up to 12 months prior to the start of an episode are included in the risk adjustment calculation. For example, if an ADHD episode started on January 1, 2017, the episode would include risk factors from January 1, 2016 through December 31, 2016, along with any risk factors identified in the ADHD episode.

Q: WHAT ARE THE TYPES OF EPISODE EXCLUSIONS?

A: Episodes can be excluded or accountability for the episode waived for several reasons. Providers are not held accountable for any episodes that are excluded or for which accountability is waived.

Reasons for episode exclusion:

- **Business exclusions:** An episode is excluded if the patient has inconsistent Medicaid enrollment, third-party liability, dual eligibility, or if the episode occurred in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- **Clinical exclusions:** An episode is excluded if the patient has one of the specified clinical conditions for an episode type that would lead to a different care pathway.
- **Patient exclusions:** An episode is excluded if the patient does not meet the age criteria for the episode, passes away during the episode window, or has a discharge status of 'left against medical advice or discontinued care' during the episode.
- **High-cost outlier:** An episode is excluded if the risk-adjusted episode spend is greater than the high outlier threshold.
- **Overlapping episode exclusion:** Overlapping episodes are excluded to avoid duplicative accountability for a provider treating the same patient for two or more episodes at overlapping times. If episodes overlap (same quarterback, same patient, shared costs), one episode will be counted as valid and all other overlapping episodes will be excluded, based on rules provided in the Detailed Business Requirements.
- **COVID-19 Exclusion:** The state has implemented a program-wide exclusion for COVID-19. An episode is excluded if the patient has a diagnosis code related to COVID-19 (U071) or pneumonia due to COVID-19 (J1282) at any time during the episode window.

Reasons for waived accountability:

- **Maternal Fetal medicine (MFM) exclusion:** An episode where the quarterback is identified to be an MFM is excluded. **This is for the perinatal episode only.**
- **Low-volume exclusion:** Accountability for episodes is waived if the quarterback has less than five valid episodes for that year. The low-volume exclusion is determined on an individual quarterback basis and is reassessed each year.

Q: HOW ARE RISK FACTORS DIFFERENT FROM EXCLUSIONS?

A: Unlike exclusions, risk factors do not cause an episode to be excluded. Instead, risk factors are used to adjust the episode spend in order to make fair comparisons among episodes.

Thresholding and payments

Q: AS A QUARTERBACK, HOW CAN I RECEIVE GAIN-SHARING PAYMENTS?

A: Quarterbacks receive gain-sharing payments (i.e., reward payments) for an episode if they meet the requirements for both the commendable cost and quality thresholds. A quarterback meets the cost threshold when the quarterback's risk-adjusted episode spend is below the commendable threshold set by each MCO. A quarterback meets the quality threshold when performance meets a predetermined threshold on all of the quality metrics linked to gain-sharing.

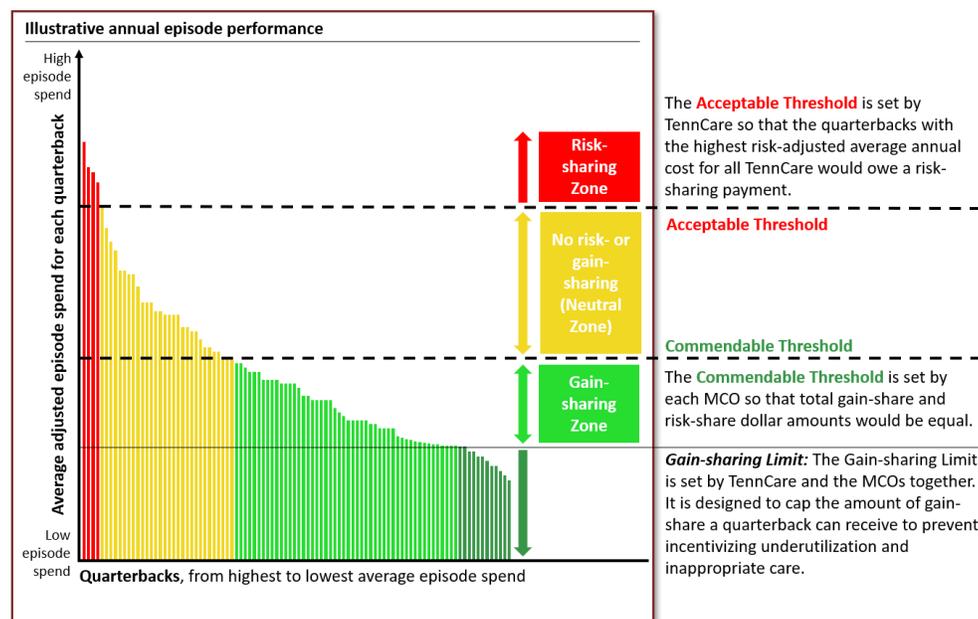
Q: HOW DOES COST THRESHOLDING WORK?

A: Cost thresholds determine whether a quarterback receives a gain-sharing payment (i.e., reward), owes a risk-sharing payment, or has no additional payment. There are two key cost thresholds in the Episodes of Care program: the acceptable threshold and the commendable threshold.

The acceptable thresholds are set by the state annually at approximately the 90th percentile for each episode type. The acceptable threshold is a single statewide dollar amount for each episode type. If a quarterback's average risk-adjusted episode spend is above the acceptable threshold, the quarterback will owe a risk-sharing payment to the MCO.

Each MCO sets their own commendable thresholds. If a quarterback passes all quality metrics linked to gain-sharing payments for that episode type and has an average risk-adjusted episode spend lower than the commendable threshold, the quarterback will be eligible for a gain-sharing payment.

Finally, a gain-sharing limit is set by TennCare and the MCOs. It is designed to cap the amount of gain-share a quarterback can receive to prevent incentivizing underutilization and inappropriate care.



Q: HOW IS QUALITY INCORPORATED INTO GAIN-SHARING PAYMENTS?

A: Each episode of care has associated quality metrics (recommended by the Technical Advisory Group) that are either linked to gain-sharing or reported for information only. To be eligible for gain-sharing payments, quarterbacks must meet the commendable cost threshold and all quality metrics linked to gain-sharing. These quality metrics are set each year by the state to reflect the most current data and changes resulting from stakeholder feedback.

Q: AS A QUARTERBACK, HOW ARE GAIN-SHARING AND RISK-SHARING PAYMENTS CALCULATED?

A: A quarterback's average episode spend is calculated for each MCO. If a quarterback's average risk-adjusted episode spend is above the acceptable threshold, the quarterback will owe a risk-sharing payment to the MCO. If a quarterback's average risk-adjusted episode spend is below the commendable threshold and all quality metrics linked to gain-sharing are met, the quarterback will receive a gain-sharing payment (i.e., reward payment) from the MCO.

Please see below for an example calculation of a risk-sharing and a gain-sharing payment. If a quarterback's total risk-sharing payment to the MCO is \$100 or less, the quarterback will not be required to make a payment back to the MCO.

To understand why you owe a risk-sharing payment or receive a gain-sharing payment, review your quarterly performance report and contact your MCOs for any questions on your performance report or to discuss how to identify opportunities to improve.

Risk-sharing calculation

Acceptable Threshold	-	Provider Average Cost	X	Number of Valid Episodes	X	Risk-sharing factor	=	Total risk-sharing payment
\$1,000	-	\$1,150	X	5	X	50%	=	\$375

Gain-sharing calculation

Commendable Threshold	-	Provider Average Cost	X	Number of Valid Episodes	X	Risk-sharing factor	=	Total gain-sharing payment
\$500	-	\$300	X	5	X	50%	=	\$500

Q: IS THERE A LIMIT ON THE AMOUNT A QUARTERBACK MAY OWE TO AN MCO IN RISK-SHARING PAYMENTS?

A: Yes. If a quarterback owes a risk-sharing payment, that payment cannot exceed 25% of the amount paid to the quarterback for their episodes in the performance period. If a quarterback is accountable for multiple episode types in the performance period, the MCO performs this calculation in aggregate across all episode types in the performance period.

Q: WHERE CAN I FIND MORE INFORMATION ON COST AND QUALITY THRESHOLDS?

A: Additional information on cost and quality thresholds, including the values for the acceptable cost threshold and quality thresholds by episode for this performance year, is available on TennCare's Episode of Care website: <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html>

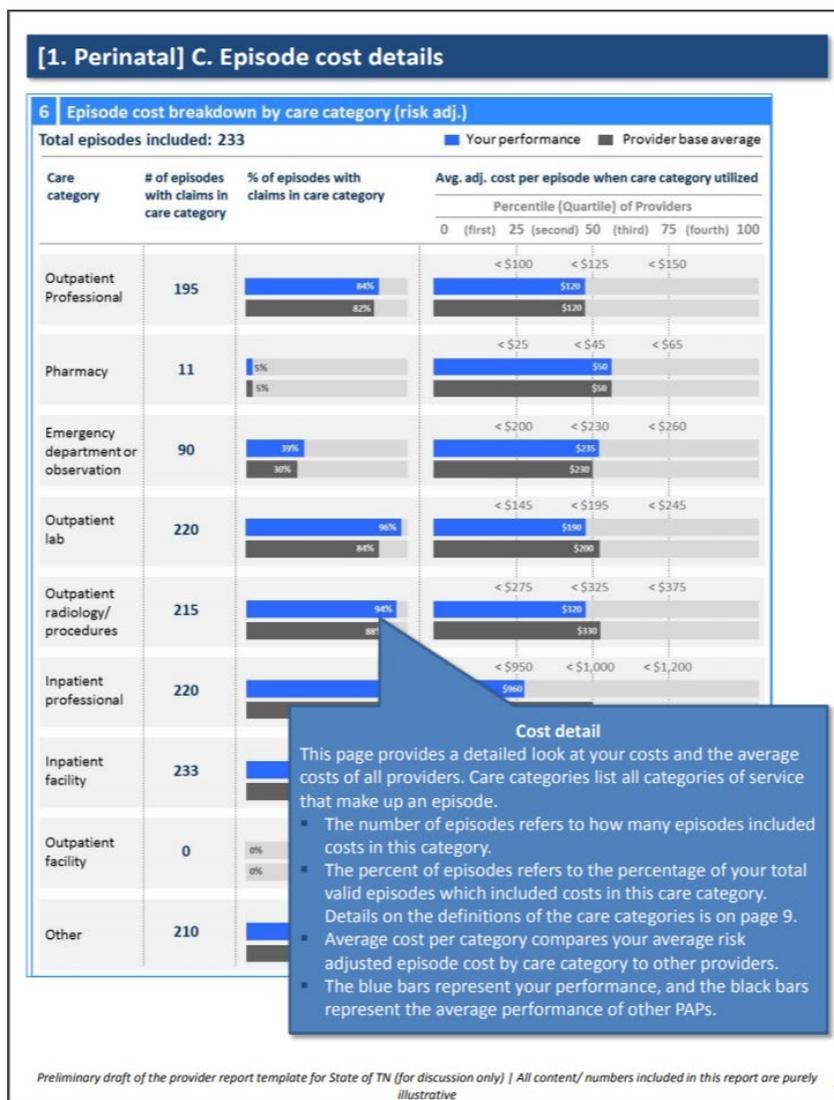
Episodes of Care provider reports

Q: WHAT ARE EPISODES OF CARE PROVIDER REPORTS?

A: Episode of Care provider reports are published every quarter by the Managed Care Organizations (MCOs) and consist of actionable information about both the cost and quality for each episode. The provider report consists of a summary performance document and a detailed patient-level spreadsheet. This information allows quarterbacks to compare their performance to their peers. Provider reports contain data previously not available to providers.

For example, the summary performance document contains a breakdown of each category of costs, called "care categories." This section provides quarterbacks insight into the total costs paid by category (e.g., pharmacy, outpatient professional) for the episode of care. The example image below is from the Guide to Reading Your Episode of Care Report available on the TennCare website:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/Howtoguide.pdf>



Q: WHERE ARE QUARTERBACKS' EPISODE OF CARE PROVIDER REPORTS LOCATED?

A: Each MCO creates a separate provider report for their members. Episode of Care provider reports are available through online portals specific to each MCO.



Wellpoint (formerly Amerigroup) report platform: <https://www.availity.com/>



BlueCare report platform: <https://www.availity.com/>



UnitedHealthcare report platform: <https://www.uhcprovider.com/>

Q: WHO SHOULD I REACH OUT TO ABOUT QUESTIONS RELATED TO A QUARTERBACK'S EPISODE OF CARE PROVIDER REPORT OR COMMERCIAL EPISODES OF CARE?

A: For questions regarding provider report(s), please contact the relevant MCO provider support team:



Wellpoint (formerly Amerigroup) phone number: 800-454-3730

Wellpoint (formerly Amerigroup) episodes of care website:
<https://www.provider.wellpoint.com/tennessee-provider/patient-care/episodes-of-care>



BlueCare phone number: 800-924-7141 (Option 4)

BlueCare episodes of care website:
<https://bluecare.bcbst.com/providers/quality-care/thcii.html>



United Healthcare phone number: 615-493-9532

UnitedHealthcare episodes of care website:
<https://www.uhcprovider.com/en/health-plans-by-state/tennessee-health-plans/tn-comm-plan-home/tn-episodes-care.html>

For questions on commercial episodes of care:



For any questions about Cigna's commercial episodes of care program, please contact Cigna at 615-595-3663 or email Megan.Higdon@Cigna.com



For any questions about BlueCross BlueShield Tennessee's commercial episodes of care program, please contact Darlene Smith at 615-760-8754 or email Darlene_Smith@bcbst.com

Opioids and Episodes of Care

Q: HOW DOES THE EPISODES OF CARE PROGRAM INCENTIVIZE NON-OPIOID PAIN RELIEF SERVICES?

A: Prescribing opioid-sparing pain relief services may increase a quarterback's average episode spend. A quarterback may qualify for an adjustment in risk-sharing payments attributable to the increased cost of opioid-sparing pain relief services if the following conditions are met:

1. The health care provider is required to make an Episodes of Care risk-sharing payment to an MCO;
2. Some portion of the episode spend were due to pain relief services;
3. The opioid-sparing pain relief services provided to the patient were more expensive than an alternative pain relief service; and
4. The provider can demonstrate that the pain relief services provided to the patient had the effect of reducing opioid use by the patient relative to an alternative pain relief service routinely used by other providers in the episode.

Eligible quarterbacks should follow the existing Reconsideration Process through the Managed Care Organizations (MCOs).

Q: DOES THE EPISODES OF CARE PROGRAM INCLUDE MEASURES RELATED TO A PATIENT'S DAILY OPIOID INTAKE?

A: Yes. Several episodes (e.g., back and neck pain, knee arthroscopy) have quality metrics that measure opioid use. The quality metrics review the average morphine equivalent dose (MED) per day across various time frames (e.g., prior to the episode trigger, after the episode trigger).

Q: DO EPISODES OF CARE INCLUDE THE COSTS OF MEDICATION ASSISTED TREATMENT (MAT) IN THE PERINATAL EPISODE?

A: No. Costs for medication assisted treatment (MAT) related to the treatment of opioid use disorder is excluded from the perinatal episode spend, beginning with the 2019 performance year. For more information, please see the perinatal Detailed Business Requirements and Configuration File located in the Searchable Episodes Table on TennCare's website: <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/searchable-episodes-table.html>

How to learn more

Q: WHAT ADDITIONAL RESOURCES ARE AVAILABLE ON EPISODES OF CARE?

A: TennCare's website contains additional information about the Episodes program. Visit <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html> to find the following information and more:

- Annual Episodes of Care thresholds and final results
- Memos about program changes, updates, and improvements
- Information about how the program is designed and how to read provider reports
- Key documents for each type of episode, located in an easy-to-reference Searchable Episodes Table

Q: HOW CAN I RECEIVE REGULAR UPDATES ABOUT THE EPISODES OF CARE PROGRAM?

A: Sign up for the Episodes of Care newsletter to receive important news and information about the program. To subscribe, visit TennCare's Episodes of Care website or go to: https://stateofennessee.formstack.com/forms/episodes_newsletter_subscribe

Q: HOW CAN I PROVIDE FEEDBACK ON THE EPISODES OF CARE PROGRAM?

A: Every year, TennCare hosts a feedback session designed to allow stakeholders to provide feedback on the program. Sign up for our newsletter to receive important information about when the feedback session is held.

You can also send questions or feedback about the program at any time by writing to Payment.Reform@tn.gov

Glossary of Terms

<i>Comorbidity</i>	Any other relevant condition accompanying the main diagnosis that triggered the episode. Comorbidities are one way the episode design identifies patient complexity. For example, in the context of the ODD episode, comorbidities are all behavioral health conditions other than ODD. In the context of risk-adjustment, comorbidities refer to all coded conditions that have a risk-adjustment weight attached to them.
<i>Episode of Care</i>	Episodes of Care cover acute or specialist-driven health care delivered during a specified time period to treat a physical or behavioral health condition. Episodes are triggered by looking back at claims data and identifying an episode trigger, as well as all of the care explicitly related to that physical or behavioral health condition.
<i>Episode spend</i>	The episode spend is the total cost of care for treating the patient during an episode of care. Episode spend is based on claims paid to providers by the Managed Care Organizations for all the services provided as part of an episode.
<i>Gain-sharing</i>	Gain-sharing is the term for a payment that rewards providers for reducing spend and meeting quality metric thresholds. If providers lower their episode spend while maintaining quality, they can share any savings they have made on the spend for delivering the episodes. In the context of the TennCare episodes program, gain-sharing payments constitute 50 percent of the spend below the “commendable” threshold for spend.
<i>Patient Journey</i>	A patient journey is the series of events a patient experiences during the treatment of a health condition over a specified period of time. Mapping physician visits, hospital admissions, ED visits, and prescriptions along a journey can highlight and visualize the impact of care improvements on patient experience.
<i>Quality metric</i>	Quality metrics are tools that measure health care processes, outcomes, patient perceptions, organizational structures, and/or systems associated with providing high-quality health care and/or one or more health care quality goals. These goals include effective, safe, efficient, patient-centered, equitable, and timely care. Every episode has quality metrics. Some quality metrics are linked to gain-sharing payments, meaning gain-sharing payments are only paid if a provider meets the threshold for the quality metric. Others are tracked only for informational purposes.

Quarterback	The “quarterback,” or principal accountable provider (PAP), is the provider who is in the best position to influence quality and spend outcomes. Quarterbacks can be individual clinicians, groups of clinicians, or facilities, depending on the episode type. Often, they are the provider that made the initial diagnosis and submitted the claim relating to the episode. The quarterback is the party financially accountable within episodes and is therefore responsible for achieving quality and spend outcomes and is eligible for gainsharing or risk-sharing payments.
Readmission	A readmission is a repeated admission within the same episode (a defined number of days after the episode started). Readmission rates have increasingly been used as an outcome measure in health services research and as a benchmark of the quality of health systems.
Retrospective payment model	A retrospective payment model is one that looks back at claims data after the care has been provided and payments have been made. Depending on provider performance in the episode, the payment to the quarterback may be adjusted through gain-sharing payments by the MCO to the quarterback or risk-sharing payments owed to the MCO by the quarterback after the quarterback has already billed and been paid by the MCO. Gain- and risk-sharing payments are calculated based on a full performance year and are paid annually.
Risk adjustment	Risk-adjustment is a method used to scale the spend for medical services up or down so that the spend becomes comparable across providers no matter how complex their patients are. This adjustment is done on the basis of the comorbidities coded by providers. For example, an expectant mother with diabetes (a comorbidity) may need more complex care, which may result in a more expensive episode. Therefore, with risk-adjustment, the spend for this episode gets scaled down to the equivalent of an otherwise healthy expectant mother.