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Date: September 30, 2025
Subject: Updates to TennCare's Episodes of Care Program

Introduction

This memorandum describes stakeholder feedback, state responses, and a summary of changes to the Episodes of Care program for the 2026 performance period beginning January 1, 2026.

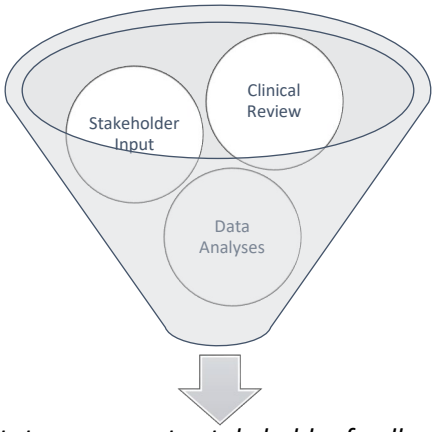
The state greatly appreciates the feedback received from stakeholders throughout the year, and especially those stakeholders who attended the Episodes of Care Annual Feedback Session on May 1, 2025. The virtual feedback session provides an opportunity for stakeholders from across Tennessee to comment on what is working well and what could be improved in the clinical design of all 48 episodes of care. Members of the public are given the opportunity to share their feedback live during the event, as well as submit their feedback in advance via email or an online form.

This memo reflects the feedback that TennCare received throughout the 2025 performance year and is organized by episode type in alphabetical order. After careful review of all comments, the state is making nine changes to the design of the Episodes of Care Program for the 2026 performance period. A summary of these changes is provided in the table on page nine.

Episodes of Care Feedback Process

What Does the State Do with Your Feedback?

The state highly values stakeholder feedback and evaluates proposed changes to the Episodes of Care Program on an ongoing basis, with concentrated efforts occurring during the summer months after the Annual Feedback Session. Upon receiving stakeholder input, the state conducts data analyses and solicits clinical input to better understand each feedback item and its potential impact to the program. These insights, along with stakeholder perspectives, are carefully considered when formulating a response and implementing any necessary design changes.



State response to stakeholder feedback

When Will Providers See These Changes Reflected in Their Reports?

The episode design changes in this memo will take effect on January 1, 2026, for the 2026 performance year. Providers will first see these changes in their August 2026 interim performance reports, which reflect the first quarter (January through March) of the 2026 performance period.

Episodes of Care Program Basics

How are episodes designed?

Every episode was designed with recommendations from Tennessee clinicians, who formed a Technical Advisory Group (TAG). These design recommendations included the episode trigger, the type of accountable provider, the included claims, episode duration, exclusions, risk factors, and quality metrics. For every episode, clinicians' feedback and recommendations were incorporated into the design prior to implementation.

TAGs were composed of Tennessee clinicians with relevant expertise who volunteered their time to make recommendations on the clinical aspects of the episode's design. Members were selected through a nomination process. TAGs met in person multiple times as part of the episode design process.

How does the Episodes of Care program make fair comparisons across episodes?

Episodes are designed with exclusions in place for episodes that cannot be fairly compared. Some exclusions are business exclusions (e.g., incomplete data, dual eligibility), clinical exclusions (e.g., active cancer management, triplet pregnancy), patient exclusions (e.g., left against medical advice, death), and high-cost outlier exclusions (i.e., the risk-adjusted cost for an episode makes it an outlier relative to other valid episodes). After all exclusions have been applied, a set of valid episodes remain that are used to determine financial accountability.

The Episodes of Care program also includes other components to make fair comparisons among providers. Risk adjustment is a method used to scale the episode spend up or down to account for higher patient costs based on comorbidities or other factors shown in the data to be significantly higher cost. This adjustment is calculated based on the comorbidities coded in the patient's claims. Quarterbacks are held accountable for their risk-adjusted episode spend.

Who determines the risk factors for each episode?

TAG members recommended a clinically appropriate list of risk factors for each episode. After the conclusion of the TAG, this list of risk factors was sent to the MCOs. The MCOs test each risk factor, in addition to other diagnoses that are identified in their models, for statistical significance based on their data. The risk factors that are statistically significant in terms of episode spend for each MCO are used as risk factors for that episode type.

For more information about the Episodes of Care program, including FAQs, up-to-date program results and more, visit TennCare's Website or email payment.reform@tn.gov.

General Episodes Feedback

Comment: Are the configuration file codes reviewed and updated for each episode?

Response: Yes. The state reviews and makes necessary changes to the configuration file of each episode type annually. The state also reviews all configuration files on a regular basis to update codes, including removal of invalidated codes and the addition of new or revised codes related to configuration file maintenance.

Comment: Non-compliant patients are unable to be engaged, no matter how many resources provided to them.

Response: While patient non-compliance can be a challenge, the Episodes of Care Program incentivizes providers to positively influence patient behavior by rewarding providers with gainsharing payments for high-quality, cost-effective care. The Episodes of Care Program also accounts for patient behavior through clinical and business exclusions that minimize provider risk for decisions made by the patient. For example, an episode is excluded if a patient has a discharge status of "left against medical advice or discontinued care" on any inpatient or outpatient claim during the episode window.

Comment: What determines whether a patient encounter is included or excluded?

Response: Exclusions are generally applied where fair comparisons cannot be made. Providers are not held accountable for excluded episodes. There are several exclusions applied to all episodes (e.g., business exclusions, clinical exclusions, overlapping episode exclusions, etc.), as well as multiple episode-specific exclusions. After all exclusions are applied, a set of valid episodes remain that are used to evaluate performance. An updated list of exclusions can be found in the technical documents of each episode, including the Executive Summary and Detailed Business Requirements (DBR). Stakeholders may access Executive Summaries through TennCare's Website.

Comment: Clinician groups who independently contract with hospitals to provide emergency services have no control over the facility costs attributed to their episodes, particularly in rural areas where there are few alternative facilities to choose from. Does the Episodes Program provide an exception for this type of situation?

Response: Each episode was designed by a TAG composed of clinicians from diverse specialties and practice settings, including rural areas. TAGs determined the appropriate accountable provider for each episode, and the decision to hold quarterbacks accountable for total episode cost—including facility costs—was considered a source of value for the program. While we recognize that some providers may have limited control over certain costs, provider reports are available to help bring insight and influence cost and quality within the episode.

Comment: How does TennCare monitor and account for external changes to episode costs, such as legislatively mandated provider rate increases, to ensure that providers are not inadvertently pushed over preset program thresholds?

Response: The state and the MCOs evaluate and calculate thresholds on an annual basis. The state continuously monitors program data and provider performance to ensure fairness while maintaining financial accountability and incentivizing high-quality, cost-effective care. In the past, the state has made additional thresholding changes when unforeseen circumstances have significantly disadvantaged a category of providers or disproportionately influenced provider performance in a particular episode.

Episode-Specific Feedback

Acute Seizure

Comment: Gainsharing Quality Metric 1 'Brain MRI Utilization in Focal Epilepsy' has consistently experienced low pass rates and should be reviewed for clinical appropriateness.

Response: The state will narrow the parameters of gainsharing Quality Metric 1 to better align with the standard of care. Because an MRI is rarely recommended when a patient with known focal epilepsy experiences a seizure, the state will incorporate language into Quality Metric 1 to exclude patients with a recent history of seizure diagnosis. The updated metric will target 'Brain MRI utilization in *newly diagnosed* focal epilepsy' and capture the "Percentage of valid episodes with *newly diagnosed* focal epilepsy in which brain MRI was conducted during the episode window (higher rate indicative of better performance)."

Asthma Acute Exacerbation

Comment: Why is the Asthma Medication Ratio (AMR) still utilized in the Asthma Episode when there is data to suggest that it is not a reliable indication of asthma control?

Response: The Asthma Medication Ratio (AMR) is a Healthcare Effectiveness Data and Information Set (HEDIS) measure that is not used in the Asthma Acute Exacerbation episode. While Quality Metric 2, 'Appropriate medications within the trigger and post-trigger window', is aimed at medication management in the Asthma episode, it specifically captures the percent of patients who receive "an administration of or filled prescription for oral corticosteroids and/or injectable corticosteroids within the trigger or post-trigger window." The focus on oral or injectable corticosteroids differentiates this metric from the AMR. As written, Quality Metric 2 still reflects the appropriate standard of care for acute asthma exacerbation and serves as a source of value to the Episodes of Care program.

Attention Deficit and Hyperactivity Disorder (ADHD)

Comment: Change how the Episodes of Care Program incorporates therapy costs into the behavioral health episodes to reflect care pathways with higher therapy utilization.

Response: The state will change the method for calculating Adjusted Therapy Cost (Care Category 2) in the ADHD episode. Instead of incorporating the unadjusted cost of therapy into the ADHD total episode cost, the new method will capture each quarterback's average cost-per-session of therapy relative to their therapy-providing peers. This change ensures that therapy providers are not disadvantaged for offering evidence-based care and supports fair comparisons between therapy and non-therapy quarterbacks.

Oppositional Defiant Disorder (ODD)

Comment: Change how the Episodes of Care Program incorporates therapy costs into the behavioral health episodes to reflect care pathways with higher therapy utilization.

Response: The state will change the method for calculating Adjusted Therapy Cost (Care Category 2) in the ODD episode. Instead of incorporating the unadjusted cost of therapy into the ODD total episode cost, the new method will capture each quarterback's average cost-per-session of therapy relative to their therapy-providing peers. This change ensures that therapy providers are not disadvantaged for offering evidence-based care and supports fair comparisons between therapy and non-therapy quarterbacks.

Perinatal

Comment: Remove the informational quality metric 'Screening for gestational diabetes'.

Response: The state will remove informational quality metric 'Screening for gestational diabetes' from the Perinatal Episode. Quarterbacks have sustained high performance for screening for gestational diabetes since this metric was first designed and implemented, and this quality metric is no longer a significant source of value for the program. This is part of the state's efforts to continuously improve the program.

Comment: Remove the informational quality metric 'C-section'.

Response: The state will remove the informational quality metric 'C-section' from the Perinatal Episode since the quality metric tied to gainsharing, 'Primary C-section', is a more precise metric for evaluating quality in the Perinatal episode. This is part of the state's efforts to continuously improve the program.

Comment: Consider creating a new quality metric in the Perinatal Episode aimed at promoting RSV Vaccination during pregnancy.

Response: The state will add two new informational only quality metrics to the Perinatal episode aimed at promoting RSV Vaccination during pregnancy: 'RSV Vaccine Counseling' and 'RSV Vaccine Administration'. By including one metric for counseling and one for administration, this change aims to capture a range of provider interventions for promoting RSV Vaccination during the episode.

Respiratory Infection

Comment: Add a clinical exclusion for sickle cell disease to the Respiratory Infection Episode.

Response: The state will exclude all respiratory infection episodes involving a patient with sickle cell disease. The journey of a patient with this condition is unique, because a respiratory infection may complicate a patient's sickle cell disease, leading to more complex care.

Skin and Soft Tissue Infection (SSTI)

Comment: The Skin and Soft Tissue Infection (SSTI) episode should differentiate between infections managed in the primary care setting and those requiring more specialized orthopedic interventions, which are inherently more complex and more expensive to treat.

Response: There are currently several exclusions within the SSTI episode that enable fair comparisons between providers in different settings and a variety of specialties. SSTI episodes requiring orthopedic intervention are likely to be excluded based on the patient's immediate inpatient stay or 'admission within 24 hours' exclusion. There are also numerous diagnosis codes that fall within the existing 'Complicated SSTI' exclusion. MCOs include additional complications as part of their risk adjustment methodology.

Urinary Tract Infection (UTI) – Inpatient

Comment: Because hospitals incur substantial costs from members delaying or foregoing treatment of Urinary Tract Infections (UTIs) in the primary care setting, the state should consider reclassifying this episode as informational-only.

Response: The state will continue financial accountability within the UTI Inpatient episode. The UTI TAG recommended two episode types (inpatient and outpatient) to reflect the patient care journey for urinary tract infections, which the state implemented.

Summary of Changes Taking Effect in 2026

Providers will first see these changes in their August 2026 interim performance reports, which reflect the first quarter (January through March) of the 2026 performance period.

Episode Type(s) Impacted	Change to Episode Design
All Episodes	Removal of invalidated codes and the addition of new or revised codes related to configuration file maintenance.
Acute Seizure	Quality Metric 1 updated to focus on newly diagnosed epilepsy, excluding patients with a recent seizure history.
ADHD	Therapy costs adjusted to reflect quarterbacks' average cost-per-session relative to peers, supporting fair comparisons.
ODD	Therapy costs adjusted to reflect quarterbacks' average cost-per-session relative to peers, supporting fair comparisons.
Perinatal	Informational only quality metric 'Screening for Gestational Diabetes' retired.
Perinatal	Informational only quality metric 'C-Section' retired.
Perinatal	Added new informational only quality metric 'RSV Vaccine Administration'.
Perinatal	Added new informational only quality metric 'RSV Vaccine Counseling'.
Respiratory Infection	Added clinical exclusion for patients with sickle cell disease.