

2027 Episodes of Care Design Changes

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Date: September 30, 2026

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 2027 performance period beginning January 1, 2027.

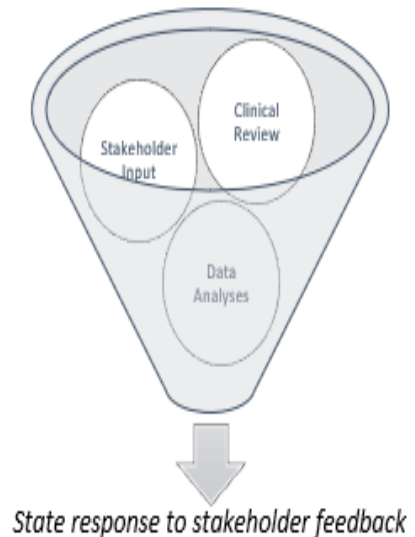
The state greatly appreciates the feedback received from stakeholders throughout the year, and especially those stakeholders who attended the Episodes of Care Annual Feedback Session on March 31, 2026. The virtual feedback session provides an opportunity for stakeholders from across Tennessee to comment 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 2026 performance year, including the feedback session, 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 2027 performance period. A summary of these changes is provided in the table starting on page ten.

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 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 on the program. These insights, along with stakeholder perspectives, are carefully considered when formulating a response and implementing any necessary design changes.



When Will Providers See These Changes Reflected in Their Reports?

The episode design changes in this memo will take effect on January 1, 2027, for the 2027 performance year. Providers will first see these changes in their August 2027 interim performance reports, which reflect the first quarter (January through March) of the 2027 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: As a provider's office with three locations in two separate counties as Franklin and Coffee counties, serving over 6 rural counties, it is hard when being held to the same standards as peers in a metropolitan area.

Response: The Episodes program was designed by a Technical Advisory Group (TAG) composed of clinicians from diverse specialties, provider types, and practice settings across Tennessee, including rural areas, ensuring that rural perspectives were reflected in episode development. TAG members determined the appropriate accountable provider for each episode and established standards intended to support high-quality, cost-effective care statewide. Program data has not shown rural-urban or regional patterns indicating that rural providers are disadvantaged relative to urban peers, and both rural and urban quarterbacks have been successful across all episodes. While we understand that providers may face challenges related to patient complexity or resource limitations, detailed provider reports are available to help identify areas of influence within each episode, and if a quarterback believes they are being held accountable inappropriately, we encourage contacting the MCO representative to review the specifics of the situation.

Comment: Don't penalize surgeons that complete procedures in rural areas because the hospital outpatient surgical center has contracted rates that are unfavorable to the episode. When this happens, the hospital gets their money, the Medicaid plan "loses" money, and the clinician pays back the Medicaid plan. Change your contracted rate with the facility. Don't penalize clinicians providing healthcare in the only surgical facility available to patients.

Response: TAG members concluded that holding quarterbacks accountable for total episode cost, including facility costs, is essential to promoting value and maintaining transparency across the program. Both rural and urban providers have performed well under this model. While facility rates may vary, the detailed episode reports can help quarterbacks identify specific cost drivers

and understand how facility selection contributes to episode spend. Providers can often reduce facility related costs by reviewing which facilities offer lower negotiated rates with their managed care organizations, coordinating care with facilities known for lower costs and strong quality performance, and encouraging patients to use in network, cost effective sites of care. If a quarterback believes accountability is being applied incorrectly, they are encouraged to contact their managed care organization to review the issue, discuss cost drivers and relevant risk factors, and determine whether a reconsideration request is appropriate.

Internal Program Review: TennCare's clinical team reviewed whether Sickle Cell Disease should be excluded from all episodes.

Response: The state will add Sickle Cell Disease as a global clinical exclusion. Members with Sickle Cell Disease experience a distinct and highly complex clinical pathway that is not comparable to typical episode journeys. To ensure fair provider comparisons and maintain consistency with the program's clinical exclusion standards, episodes involving members with Sickle Cell Disease will be excluded from all episode types going forward.

Episode-Specific Feedback

Acute Seizure

Internal Program Review: TennCare’s clinical team reviewed whether Sickle Cell Disease should be excluded from all episodes.

Response: The state has reviewed quality metrics for the Acute Seizure episode and is implementing changes to ensure the metrics more accurately reflect clinical best practices and the intended patient population. Specifically, the informational quality metric “Brain MRI utilization in newly diagnosed seizure” will be moved to a gain-sharing quality metric to better capture value and alignment across all seizure types. Additionally, the existing gain-sharing quality metric “Brain MRI utilization in newly diagnosed focal epilepsy” will be moved to an informational only quality metric. This adjustment reflects feedback and ensures the metric aligns more appropriately with episode intent.

Internal Program Review: TennCare’s clinical team reviewed the quality metric “Prolonged EEG monitoring utilization in newly diagnosed seizure” due to low utilization and potential misalignment with coding practices.

Response: The state has reviewed the data for this quality metric and found that nearly half of EEG studies are claimed using CPT 95812 (extended EEG, 41–60 minutes), which is not currently captured in the quality metric definition. To address this, the state will update the metric to measure the percentage of valid episodes with newly diagnosed seizure in which EEG monitoring of 41 minutes or more was conducted during the episode window (higher rate indicative of better performance). CPT 95812, Electroencephalogram (EEG) extended monitoring; 41–60 minutes, will be added to the configuration file to ensure these encounters are appropriately captured. This update will improve accuracy and better reflect provider practice patterns.

Back/Neck Pain

Comment: Our practice has been penalized for not ordering imaging. If there is recent imaging, we request it from the provider rather than reorder it. This saves money for TennCare, but the scoring does not reflect our use of imaging.

Response: The state would like to clarify that quarterbacks do not incur any financial penalty or risk-sharing responsibility for electing not to repeat imaging that has already been completed. The only quality metric tied to gain-sharing for this episode is the Difference in Average Morphine Equivalent Dose (MED) per day; the imaging-related metrics referenced (absence of spine X-ray and absence of spine MRI) are informational only and do not affect gain-sharing or risk-sharing determinations. These informational only metrics are included solely to measure imaging patterns and do not influence payment adjustments. The state recognizes that imaging decisions vary based on clinical circumstances, and obtaining existing studies in lieu of ordering duplicative imaging is consistent with clinical best practice. For this reason, the episode design does not penalize providers for avoiding unnecessary repeat imaging.

Pediatric Pneumonia

Internal Program Review: TennCare's clinical review of pediatric pneumonia data indicated that the quality metrics "Utilization of narrow-spectrum antibiotics" and "Utilization of macrolides in patients under 6 years old" should be further evaluated to ensure providers are not disadvantaged when clinically appropriate medications are prescribed for atypical or clinically complicated pneumonia.

Response: The state will update quality metric "Utilization of macrolides in patients under 6 years old" to exclude instances when a macrolide is appropriately used to treat complicated pneumonia – i.e., when there is a diagnosis of mycoplasma pneumoniae, legionella pneumophila, chlamydia pneumoniae, or pneumococcal pneumonia.

The state will also update quality metric “Utilization of narrow spectrum antibiotics” to exclude instances when a broad-spectrum antibiotic is appropriately used to treat complicated pneumonia – i.e., when there is a diagnosis of mycoplasma pneumoniae, legionella pneumophila, chlamydia pneumoniae, pneumococcal pneumonia, or haemophilus influenzae.

These updates strengthen alignment with evidence-based clinical guidelines so that providers can deliver appropriate care for complicated pneumonia without incurring unintended negative impacts on quality metric performance.

Perinatal

Comment: Providers have expressed concerns regarding the upcoming maternity unbundling coding changes and how these adjustments may affect the perinatal episode and provider performance.

Response: The 2027 Perinatal episode performance period will be temporarily paused to support the transition from bundled to unbundled maternity services coding. Providers will continue to receive quarterly reports; however, no gain-sharing or risk-sharing payments will be issued for this episode in 2027.

Summary of Changes

Providers will first see these changes in their August 2027 interim performance reports, which reflect the first quarter (January through March) of the 2027 performance period.

Table 1: Summary of Changes Taking Effect in 2027

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.
All Episodes	Add Sick Cell Disease to the list of global clinical exclusions.
Acute Seizure	The quality metric “Brain MRI utilization for newly diagnosed focal epilepsy” has been reclassified as an informational only quality metric.
Acute Seizure	The quality metric “Brain MRI utilization in newly diagnosed seizure” has been reclassified as a gain-sharing quality metric.
Acute Seizure	The state has updated the inclusion criteria for the quality metric ‘Prolonged EEG Monitoring Utilization in Newly Diagnosed Seizure’ to include EEG monitoring lasting at least 41 minutes.
Acute Seizure	The state will add CPT 95812: Electroencephalogram (EEG) extended monitoring; 41–60 minutes to the configuration file trigger logic.
Pediatric Pneumonia	The quality metric “Utilization of Macrolides in Patients Under 6 Years Old” will exclude instances when a macrolide is appropriately used to treat complicated pneumonia – i.e., when there is a diagnosis of mycoplasma pneumoniae, legionella pneumophila, chlamydia pneumoniae, or pneumococcal pneumonia.
Pediatric Pneumonia	The quality metric “Utilization of narrow spectrum antibiotics” will exclude instances when a broad-spectrum antibiotic is appropriately used to treat complicated pneumonia – i.e., when there is a diagnosis of mycoplasma pneumoniae, legionella pneumophila, chlamydia pneumoniae, pneumococcal pneumonia, or haemophilus influenzae.
Perinatal	Temporary pause of the Perinatal episode performance period for the 2027 performance year.