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# Rulemaking Hearing Rule(s) Filing Form

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

<b>Agency/Board/Commission:</b>	Tennessee Department of Finance and Administration
<b>Division:</b>	Bureau of TennCare
<b>Contact Person:</b>	George Woods
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**Revision Type (check all that apply):**

- Amendment
- New
- Repeal

**Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)**

Chapter Number	Chapter Title
1200-13-5	Hospitalization Program
Rule Number	Rule Title
1200-13-5-.01	Definitions
1200-13-5-.02	Determination of Reimbursable Cost
1200-13-5-.03	Approval of the Department Required for Participants Cost Report Required
1200-13-5-.04	Cost Report Required
1200-13-5-.05	Billing Procedure
1200-13-5-.06	Application of Prospective Payment Method
1200-13-5-.07	Provider Exempted from Prospective Payment System
1200-13-5-.08	Prospective Payment Methodology
1200-13-5-.09	Minimum Occupancy Adjustment
1200-13-5-.10	Resident and Intern Adjustment
1200-13-5-.11	High Medicaid Volume Incentive
1200-13-5-.12	Other Adjustment to the Prospective Rate
1200-13-5-.13	New Providers
1200-13-5-.14	Lower of Cost or Charges Limit
1200-13-5-.15	Rate Notification and Effective Date
1200-13-5-.16	Method for Paying Providers which are Exempt from Prospective System
1200-13-5-.17	Audit

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Rule Chapter 1200-13-5 Hospitalization Program is deleted in its entirety and replaced with a new Rule Chapter 1200-13-05 which shall read as follows:

Chapter 1200-13-05  
Hospital Rate Variation Corridors

Table of Contents

1200-13-05-.01	Definitions
1200-13-05-.02	Implementation of Contract Amendments for Existing Contracts between Hospitals and MCOs
1200-13-05-.03	Implementation of New Contracts between Hospitals and MCOs Entered into after July 1, 2013
1200-13-05-.04	Exclusion of Any Hospital from TennCare Networks
1200-13-05-.05	Out-of-Network Reimbursement
1200-13-05-.06	Agreements between Hospitals and MCOs for Limited Services
1200-13-05-.07	Changes to Hospital Rates Negotiated Between MCOs and Hospitals after September 30, 2015
1200-13-05-.08	Categorization of New Services Added after July 1, 2015

1200-13-05-.01 Definitions.

- (1) Bureau of TennCare (Bureau). The administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.
- (2) Existing Contracts. The contracts that were in place between a Tennessee hospital and a TennCare MCO as of July 1, 2013.
- (3) Hospital. A general or specialty acute care facility licensed as a hospital by the Tennessee Department of Health pursuant to T.C.A. § 68-11-206, excluding hospitals that are categorized as Rehabilitation, Research, Long Term Acute or Psychiatric on the 2013 Joint Annual Report of Hospitals.
- (4) Inpatient Services. Routine, nonspecialized services that are provided at many or most hospitals in the state to patients admitted to the hospital as inpatients.
- (5) MCO (Managed Care Organization). An appropriately licensed Health Maintenance Organization (HMO) contracted with the Bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and behavioral benefits to TennCare enrollee-members through a network of qualified providers.
- (6) Medicare. A hospital's fee-for-service reimbursement under Title XVIII including that hospital's adjustment for DSH, wage index, etc., and excluding only Indirect Medical Education (IME), pass through payments, and any Medicare payment adjustments for Sequestration, Value Based Purchasing, Readmissions and Hospital Acquired Conditions.
- (7) Medicare Severity Diagnosis Related Groups (MS-DRG). The Medicare statistical system of classifying any inpatient stay into groups for the purpose of payment.
- (8) New Contract. Any initial contract between an MCO and a hospital that did not exist on July 1, 2013. Contracts in place on July 1, 2013, that have been materially altered since July 1, 2013, are not new contracts.
- (9) Outpatient Services. Services that are provided by a hospital to patients in the outpatient department of the hospital and patients receiving outpatient observation services.
- (10) Rate Corridors. Upper and lower limits established by the state's actuary and approved by the Bureau, in

consultation with the Tennessee Hospital Association (THA), for payments by MCOs to hospitals for services provided to TennCare enrollees. The Rate Corridors are based on a hospital's Medicare reimbursement that existed in FFY 2011 and used to determine the parameters of TennCare rates for contracts between Tennessee hospitals and TennCare MCOs after July 1, 2013. The determination of whether a hospital's TennCare rates are within the prescribed Rate Corridors shall be made on the basis of reimbursement from all TennCare MCOs with which the hospital has a contract. The Rate Corridors, which were calculated by the State's actuary as the budget neutral corridors, are as follows:

- (a) For inpatient services, the minimum level is 53.8% and the maximum level is 80% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level is 93.2% and the maximum level is 104% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level is 32% and the maximum level is 83% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum level is 4% and the maximum level is 174% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level is 49% and the maximum level is 164% of the hospital's Medicare for 2011.
- (11) Specialized Services. Services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma.
- (12) TennCare. The TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.
- (13) TennCare Actuary. The actuarial firm selected by the Bureau to assist the Bureau in establishing the capitation rates for TennCare MCOs each year.
- (14) Total TennCare Rates. Payment rates for each hospital in the aggregate from all MCOs with which the hospital has network contracts.
- (15) Year 1 Corridors. The initial upper and lower limits established by the Bureau in consultation with THA based on a hospital's Medicare reimbursement that existed in FFY 2011 and that were used to implement rate variation limitations in contracts between Tennessee hospitals and TennCare MCOs from July 1, 2012 until July 1, 2013. The Year 1 Corridors are as follows:
- (a) For inpatient services, the minimum level was 40% and the maximum level was 90% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level was 90% and the maximum level was 125% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level was 30% and the maximum level was 80% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum level was 4% and the maximum level was 180% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level was 30% and the maximum level was 160% of the hospital's Medicare for 2011.

1200-13-05-.02 Implementation of Contract Amendments for Existing Contracts between Hospitals and MCOs.

These contracts set rates for a period of two years effective July 1, 2013, and provided for rate amendments to be negotiated and implemented on July 1, 2015.

- (1) For hospitals that had existing contracts with MCOs in place on July 1, 2013, and the MCO and hospital had negotiated contract amendments to bring rates for total TennCare into the Rate Corridors and the rates in the contracts have not been adjusted since July 1, 2013, the MCOs will reissue those amendments with a new effective date of July 1, 2015.
- (2) In the case of a hospital that had contracts with MCOs in place on July 1, 2013, which contracts included amendments implementing rates within the Rate Corridors, and where the rates in the contracts have been adjusted since July 1, 2013, the Bureau shall evaluate the rates in the current contracts to determine if the total TennCare rates for the hospital are within the Rate Corridors. If the rate adjustments cause the total TennCare reimbursement for the hospital to be outside of the Rate Corridors, the affected MCOs shall implement contract amendments approved by the Bureau in consultation with the TennCare Actuary to bring the hospital rates into the Rate Corridors effective July 1, 2015.
- (3) In the case of a hospital with contracts in existence on July 1, 2013, which contracts include rates outside of the Rate Corridors, the affected MCOs shall implement contract amendments to bring total TennCare rates into the Rate Corridors with an effective date of July 1, 2015. The Bureau shall verify that the new contract rates in conjunction with contracts between the hospital and all other MCOs bring the hospital's total TennCare rates within the Rate Corridors.

1200-13-05-.03 Implementation of New Contracts between Hospitals and MCOs Entered into after July 1, 2013.

These contracts have not yet been in effect for a period of time sufficient to negotiate rate amendments for a July 1, 2015, implementation date. In the case of a hospital that entered into a contract with an MCO after July 1, 2013, including a hospital that entered into a contract with an MCO with rates within Year 1 Corridors effective January 1, 2015, the affected MCOs shall implement contract amendments that bring the hospital rates within the Rate Corridors no later than September 30, 2015.

1200-13-05-.04 Exclusion of Any Hospital from TennCare Networks.

A hospital that does not accept a contract amendment required by this Rule shall be excluded effective October 1, 2015, from participation in the TennCare MCO network to which the contract amendment applies.

1200-13-05-.05 Out-of-Network Reimbursement.

Out-of-Network payments to all hospitals shall be governed by TennCare Medicaid Rule 1200-13-13-.08(2)(a)-(c) and TennCare Standard Rule 1200-13-14-.08(2)(a)-(c).

1200-13-05-.06 Agreements between Hospitals and MCOs for Limited Services.

Rates for a single case agreement negotiated between the MCOs and hospitals that are not in network with the MCOs to ensure access to services for TennCare enrollees may not exceed the ceiling or be below the floor of the Rate Corridors appropriate for those services.

1200-13-05-.07 Changes to Hospital Rates Negotiated between MCOs and Hospitals after September 30, 2015.

To ensure that each hospital's total TennCare reimbursement remains within the Rate Corridors, proposed rate changes after September 30, 2015, shall be evaluated by the Bureau to determine if the proposed rate change will move the hospital's total TennCare rates outside of the Rate Corridors. If the evaluation indicates the change will put the hospital outside of the Rate Corridors, the Bureau shall provide the adjustments necessary to ensure that the contract is compliant with the limits of the Rate Corridors. TennCare rates between a hospital and an MCO may not be modified after September 30, 2015, without approval from the Bureau.

1200-13-05-.08 Categorization of New Services Added after July 1, 2015.

MS-DRG classifications serve as the basis for identifying services as inpatient or specialized. MS-DRG classifications may change and new MS-DRG classifications may be added from time to time. New or modified MS-DRG classifications shall be evaluated for assignment to appropriate inpatient or specialized categories by the Bureau in consultation with THA and the TennCare Actuary.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-2803.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 09/09/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/02/15

Rulemaking Hearing(s) conducted on: (add more dates). 08/26/15



Date: 9/9/2015

Signature: [Handwritten Signature]

Name of Officer: Darin J. Gordon

Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: September 9, 2015

Notary Public Signature: [Handwritten Signature]

My commission expires on: January 8, 2019

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]  
Herbert H. Slatery III  
Attorney General and Reporter  
9/16/2015 Date

**Department of State Use Only**

Filed with the Department of State on: 9/21/15

Effective on: 12/20/15

[Handwritten Signature]  
Tre Hargett  
Secretary of State

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PUBLICATIONS

## Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no public comments on this rule chapter.

**Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The rule chapter is not anticipated to have an effect on small businesses.

### **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The rule chapter is not anticipated to have an impact on local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The Rule Chapter replaces an emergency rule chapter that was adopted to ensure full implementation of hospital payment rate variation corridors set out in Chapter 276 of the Public Acts of 2015. The rule chapter defines the specific activities required of the TennCare MCOs and the hospitals participating in TennCare to fully implement the rate variation corridors.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Rule Chapter is lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-2803.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The entities most directly affected by this Rule Chapter are the hospital providers. The governmental entity most directly affected by this Rule Chapter is the Bureau of TennCare, Tennessee Department of Finance and Administration

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rule Chapter was approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of this Rule Chapter is not anticipated to have an effect on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

John G. (Gabe) Roberts  
General Counsel

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

John G. (Gabe) Roberts  
General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road  
Nashville, TN 37243  
(615) 507-6838  
gabe.roberts@tn.gov donna.tidwell@tn.gov

(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

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GW10115232

**RULES  
OF  
TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT  
DIVISION OF MEDICAID**

**CHAPTER 1200-13-5  
HOSPITALIZATION PROGRAM**

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**1200-13-5-.01 DEFINITIONS.** The following definitions shall apply to rules 1200-13-5-.02 through 1200-13-5-.15 inclusive, unless otherwise indicated:

- (1) *Capital Costs* means those costs which are required or allowed by Title XVIII principles to be included in all depreciation columns on line 72 of worksheet B of HCFA form 2552-81(11-81). Capital costs shall not include costs associated with non-reimbursable cost centers.
- (2) *Medical Education Costs* means those costs associated with a nursing school or intern resident services in an approved residency program which are required or allowed by Title XVIII principles to be included in columns 18 and 19 of line 72 on worksheet B of HCFA form 2552-81(11-81). Medical education costs shall not include costs associated with non-reimbursable cost centers, nor shall they include costs for routine in-service training.
- (3) *Hospital Based Physician Costs* means physician costs applicable to Medicaid beneficiaries which are required or allowed by Title XVIII principles to be included on line 12 of Column 5f of Part 1 of worksheet D-3 of HCFA form 2552-81(11-81). Such costs shall not be allowable for services provided on or after October 1, 1983.
- (4) *Utilization Ratio* means the ratio of inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee to total inpatient days.
- (5) *Medicaid Day* means any part of a day including the day of admission in which a person determined eligible for Medicaid by the State of Tennessee is admitted as an inpatient with the intention of remaining overnight. The day of discharge is not counted as a day. If admission and discharge occur on the same day, the day is considered one inpatient day.
- (6) *Approved Residency Program* means: (1) intern or resident in training teaching program approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association; or, (2) in the case of a hospital or osteopathic hospital with an intern or resident in training program in the field of dentistry, under a teaching program approved by the Council on Dental Education of the American Dental Association.
- (7) *Operating Component* means those costs, applicable to inpatient services only, which are required or allowed by Title XVIII principles to be included on line 10 of Part 1 of schedule E-5 of HCFA form 2552-81(11-81);

less the portion, which is attributable to patients determined eligible for Medicaid by the State of Tennessee, of depreciation, medical education costs, and hospital-based physician costs, plus an allowance for the inpatient routine nursing salary differential which was repealed by Medicare on October 1, 1982.

(8) *Pass Through Component* means the share which is attributable to patients determined eligible for Medicaid by the State of Tennessee of actual capital costs and actual medical education costs. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass through component.

(9) *Title XVIII principles* means, except where indicated otherwise, those Medicare principles which are applicable to hospitals, which were in effect on October 1, 1982, and which are described at 42 CFR, 405.

(10) *Base Year Cost Report* means the cost report for the next to the last 12 month cost reporting period preceding the first cost reporting period subject to prospective payment.

EXAMPLE:

*Ist Year Subject to*

*Prospective Payment* \_\_\_\_\_ *Base Year*

1/1/84 to 12/31/84 \_\_\_\_\_ 1/1/82 to 12/31/82

7/1/84 to 6/30/85 \_\_\_\_\_ 7/1/82 to 6/30/83

If a hospital's cost reporting period ending on or after September 30, 1982 was for less than 12 months, the cost report for the most recent 12 month cost reporting period ending before September 30, 1982 will be used. The Commissioner of the Department of Health and Environment reserve the right to rebase the reimbursement system described in Chapter 12-13-5 of the Rules of the Department of Health and Environment at such time deemed necessary.

(11) *Department* means the Tennessee Department of Health and Environment.

*Authority:* T.C.A. § 4-5-202, 12-4-301, 71-5-105 and 71-5-109, Public Chapter 913 of the Acts of 1992. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed January 13, 1987; effective February 27, 1987. Amendment filed September 25, 1992; effective November 9, 1992.

**1200-13-5-.02 DETERMINATION OF REIMBURSABLE COST.** The Comptroller of the Treasury in accordance with the Department's rules and regulations shall make the determination of reimbursable per diem cost for hospitals.

*Authority:* T.C.A. §§ 14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.03 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPANTS.** Only those institutions or distinct parts thereof certified by the Department in accordance with the General Rule 1200-13-1-.05(2) as rendering hospital care and contracting with Medicaid may participate and be reimbursed as providers under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

*Authority:* T.C.A. §§ 14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.04 COST REPORTS REQUIRED.**

(1) In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's Fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, as per rule 1200-13-5-.13, to submit to the Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance

with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise by these rules. All covered services are to be in accordance with the Medicaid Program definition of covered services.

- ~~(2) Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1992 and described at 42 CFR 405 shall be subject to the sanctions specified in T.C.A. §71-5-130.~~
- ~~(3) To be eligible to receive payment, contracting hospitals shall use uniform hospital statistics and classification of accounts as published by the American Hospital Association for all accounting records, or any other acceptable accounting methods approved by the Department of Health in consultation with the Comptroller and the Tennessee Hospital Association. Any contracting hospital that does not adopt the uniform classification of accounts, or that does not submit certified statements when required by the Department of Health will be subject to the sanctions specified in T.C.A. §71-5-130.~~
- ~~(4) After a period of five years following the implementation of the TennCare Program on January 1, 1994, amended or corrected hospital cost reports with claims for reimbursement for services prior to January 1, 1994 shall not be accepted.~~

~~Authority: T.C.A. §§14-23-105, 14-23-109, 71-5-105, 71-5-109 and 4-5-202. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed April 14, 1989; effective May 8, 1989. Amendment filed October 14, 1998; effective December 28, 1998.~~

~~**1200-13-5-.05 BILLING PROCEDURE.** Institutions or distinct parts thereof rendering hospital care shall bill the Department or other agency or organization designated by the Department on the forms and in the manner designated. No provider shall charge for Medicaid patients more than is charged for private paying patients for equivalent accommodations and services.~~

~~Authority: T.C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.~~

~~**1200-13-5-.06 APPLICATION OF PROSPECTIVE PAYMENT METHOD.** With respect to cost reporting periods on or after the effective date of this rule, all Medicaid providers of hospital care, except those exempted by the provisions of rule 1200-13-5-.07 shall be paid for inpatient services by a prospective method as set out in rules 1200-13-5-.08 through 1200-13-5-.15 inclusive.~~

~~Authority: T.C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.~~

~~**1200-13-5-.07 PROVIDERS EXEMPTED FROM PROSPECTIVE PAYMENT SYSTEM.** The prospective payment system shall not apply to:~~

- ~~(1) Long term care facilities (hospitals which have an average length of stay of more than 25 days).~~
  - ~~(2) Hospitals which elect not to submit a cost report which have less than \$100,000 annually, based on the State of Tennessee's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee; the annual total charges does not include charges associated with transplants covered by Tennessee Medicaid and are reimbursed in accordance with rule 1200-13-1-.06(18)(f)2.~~
- ~~Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered item billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed \$100,000 in total Tennessee Medicaid charges annually:~~
- ~~(a) In state hospitals or out of state hospitals in contiguous medical marketing areas, will be treated as new providers as specified in rule 1200-13-5-.13.~~

~~—(b)— All other hospitals will be reimbursed as specified in rule 1200-13-5-.16(6).~~

~~—(3)— Outpatient services~~

~~*Authority:* T.C.A. §§12-4-301, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and 4-5-202. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed May 8, 1991; effective June 22, 1991.~~

#### ~~1200-13-5-.08 PROSPECTIVE PAYMENT METHODOLOGY.~~

~~(1)— The prospective payment will be made as a rate per inpatient day. Each facility's reimbursable inpatient costs will be determined in accordance with Title XVIII principles, from a base year cost reporting period. Costs will be separated into an operating component and a pass-through component. A trending factor will be applied to the operating rate component only. The prospective rate will be the sum of the trended operating component and the untrended pass-through component, plus or minus adjustments for minimum occupancy, (effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty), resident and intern costs, Medicaid disproportionate share and other adjustments as provided in rule 1200-13-5-.12. Tennessee Medicaid costs will be determined by a computed utilization ratio from form HCFA-2552.~~

~~—(a)— Except for inpatient hospital days involving approved organ transplants, the first twenty (20) days per fiscal year will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only), and Medicaid disproportionate share adjustment (MDSA) components. For medically necessary days in excess of twenty (20) per fiscal year, reimbursement will be made at 60 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only) and MDSA components. Approved inpatient days involving organ transplants will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only) and MDSA components. Admission and stays involving organ transplants that span fiscal years will be reimbursed as if the entire stay had occurred during the first fiscal year.~~

~~—(2)— Adjustments to Base Period Costs. It may be necessary to adjust base year cost reports to make the base period costs comparable to inpatient costs incurred in the prospective period, such as costs to be incurred by hospitals required to enter the Social Security system beginning January 1, 1984. Therefore, hospitals submitting form HCFA 1008 to their Medicare intermediary should send a copy of this form to the Comptroller of the Treasury. For hospitals which do not submit form HCFA 1008, appropriate adjustments will be made based on the best available information.~~

~~—(3)— Pass Through Component.~~

~~(a)— Each facility's initial prospective rate will be based on the base year cost report and will include a pass through component consisting of the portion of capital costs and medical education costs which is attributable to patients determined eligible for Medicaid by the State of Tennessee. The pass through component may vary from year to year depending on each facility's actual capital costs and medical education costs and will not be computed until the facility's cost report is received. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass through component.~~

~~(b)— Additional capital costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1994. The cost basis of depreciable assets in a sale not considered bona fide is additionally limited to (5) the seller's cost basis less accumulated depreciation. The~~

— purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs.

(c) — The payment of return on equity will be determined by Medicare principles of cost reimbursement, 42 CFR 405, in effect on August 1, 1983 providing that, effective April 20, 1983, return on equity shall be adjusted to reflect 100% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

EXAMPLE

Base Year:	12/31/82
Base Year Cost Report Received	05/01/83
Initial Prospective Rate Determined	06/01/83
Beginning of Prospective Payment	01/01/84
12/31/83 Cost Report Received	05/01/84
12/31/83 Cost Report Rate	
Adjustment Completed	06/01/84

— In this example, the initial prospective rate continues until June 1, 1984. On June 1, 1984, the rate is adjusted (for service dates on or after June 1, 1984) for the Tennessee Medicaid share of the actual capital costs, medical education costs, hospital based physician costs, and return on equity (for proprietary providers only) reported on the December 31, 1983, cost report.

(d) — Beginning with fiscal years beginning July 1, 1987, and later, capital costs will be reduced by 3.5% for dates of services July 1, 1987 through September 30, 1987, by 7% for dates of service October 1, 1987 through December 31, 1987, by 12% for dates of service January 1, 1988 through September 30, 1988, and by 15% for dates of service October 1, 1988 through September 30, 1989, by 0% for dates of service October 1, 1989 through December 31, 1989, and by 15% for dates of service January 1, 1990 and later. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reduction in capital costs. Upon the effective date of these rules, hospitals will be reimbursed 100% of their capital costs.

(4) — Operating Component. — Each facility's initial prospective rate shall include an operating component which is computed from the base year cost report. The operating component will be trended forward each year. Trending to the new rebased year, (1988 cost reports or if not available the prior cost report) will be computed by utilizing the indexing rate recommended by the Prospective Payment Assessment Commission, applied from the end of the hospital's fiscal year to October 1, 1989.

— Thereafter the trending index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and as published in the *Tennessee Administrative Register*. The trending indexes above shall be applied from October 1, 1989, to the midpoint of the state's fiscal year, no earlier than December 31, 1990, and shall be effective the first of the state's fiscal year, no earlier than July 1, 1990. When necessary, indexes will be prorated to correspond to a provider's year end. Each provider will be notified of its new operating rate due to indexing within 30 days of the beginning of the state's fiscal year.

*Authority:* T.C.A. §§ 4-5-202, 12-4-301, 71-5-105 and 71-5-109; Public Chapter 913 of the Acts of 1992. *Administrative History.* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed February 21, 1986; effective March 23, 1986. Amendment filed September 12, 1986; effective October 27, 1986. Amendment filed May 29, 1987; effective July 13, 1987. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed August 8, 1990; effective September 22, 1990. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed September 25, 1992; effective November 9, 1992.

**1200-13-5-.09 MINIMUM OCCUPANCY ADJUSTMENT.** Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

- \_\_\_\_\_ Hospitals over 100 beds — 70%
- \_\_\_\_\_ Hospitals with 100 beds or fewer — 60%

The adjustments will be computed as follows and will be made at the same time as the pass through adjustment as set out in rule 1200-13-5-15:

$$\text{ACC} = \text{TCC} \times \frac{\text{TBD}}{\text{ABD}(Y)}$$

- \_\_\_\_\_ ACC = allowable capital costs
- \_\_\_\_\_ TCC = total capital costs
- \_\_\_\_\_ TBD = total bed days used during the period
- \_\_\_\_\_ ABD = total bed days available during the period
- \_\_\_\_\_ Y = .6 for hospitals with 100 beds or fewer
- \_\_\_\_\_ .7 for hospitals over 100 beds

All references to beds means staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use, such as being closed for reasons including but not limited to, painting, maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine, at least monthly, its number of staffed beds. A schedule showing the number of staffed and unstaffed beds, along with the reasons for being unstaffed, must be submitted with the cost report. This schedule is subject to audit in accordance with rule 1200-13-5-17. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of cost report period. Effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty.

*Authority: T.C.A. §§4-5-202, 12-4-301, 14-23-105, 14-23-109, 71-5-105, and 71-5-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed August 8, 1990; effective September 22, 1990.*

**1200-13-5-10 RESIDENT AND INTERN COST ADJUSTMENT.**

- (1) On the basis of the ratio of full time equivalent residents and interns to total beds, a resident and intern cost adjustment shall be granted to teaching facilities having an approved residency program. Such facilities will be given this adjustment independent of the Medicaid disproportionate share adjustment. The resident and intern cost adjustment shall not be subject to trending. The cost adjustment shall be calculated using the following formula but shall not exceed 10%, and will be made at the same time as the pass through adjustment.

$$RI = 1.89 \times \left[ \left( 1 + \frac{\text{interns and residents}}{\text{beds}} \right) - 1 \right]$$

- (2) For purposes of this adjustment, hospitals are to report only full time equivalent interns and residents on form HCFA 1008, Part 1. For years when form 1008 is no longer in effect, hospitals must submit their number of full time equivalent interns and residents with their cost report. The number of full time equivalent interns and residents is the sum of: (a) interns and residents employed 35 hours or more per week, and (b) one half of the total number of interns and residents working less than 35 hours per week regardless of the number of hours worked.

*EXAMPLE assuming no high Medicaid volume incentive or minimum occupancy adjustment.*

	Year 1	Year 2	Year 3
1. Operating Component Prior to Trending	\$250.00	\$277.50	\$299.70
2. Pass Through Component	25.00	30.00	35.00
3. Basis for RI adjustment	275.00	307.50	334.70
4. RI Adjustment at 8% (line 3 x .08)	22.00	24.60	26.78
5. Trend Factor for Operating Component	11%	8%	7%
6. Trended Operating Component (line 1 x line 5 + 100%)	277.50	299.70	320.69

~~7. Prospective Rate (line 2 + line 4 + line 6) \$324.50 \$354.30 \$382.46~~

*Authority. T.C.A. §§ 4-5-202, 14-23-10, 5, 14-23-109, 71-5-105 and 71-5-109. Administrative History. Original rule filed June 26, 1985, effective July 26, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed December 30, 1986, effective February 13, 1987. Amendment filed December 8, 1989; effective January 22, 1990.*

**~~1200-13-5-11 MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT (MDSA).~~**

- ~~(1) In accordance with the Medicaid State Plan, hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio over 8% will be provided a payment incentive. The Medicaid disproportionate share adjustment shall not be subject to trending and shall be based on cost reports with fiscal year ending 6/30/86 and later. The incentive will be the higher of (a) or (b) but shall not exceed 17% and (a) + (c) or (b) + (c) shall not exceed 22%:~~
- ~~(a) The prospective rate will be adjusted upward by 3% for each 1% increment in the utilization rate above 8%.~~
  - ~~(b) The prospective rate will be adjusted upward by 3% for each increment of 1,000 reimbursed inpatient Medicaid days over 3,000.~~
  - ~~(c) The prospective rate will be adjusted upward by 5% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this incentive.~~

~~Also, in order to receive incentive (c), the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~

- ~~(2) In accordance with the Medicaid State Plan, acute care hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid, or a utilization ratio over 14% will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34% and (a) + (c) or (b) + (c) shall not exceed 44%:~~
- ~~(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14%;~~
  - ~~(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but less than 4,000.~~
  - ~~(c) The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this adjustment.~~

~~Also, in order to receive adjustment (c), the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~

- ~~(d) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. If no inpatient charity care is reported there will be no disproportionate share payment. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~

- ~~(e) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a quarterly basis established in June of each year. The quarterly payment will be prospective based on the disproportionate share adjustment established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established on paid claims from June-May fiscal year plus expected improvement based on a historical basis for the upcoming fiscal year July-June.~~
- ~~(3) In accordance with the Medicaid State Plan, acute care hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34% and (a) + (c) or (b) + (c) shall not exceed 44%.~~
- ~~(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.~~
- ~~(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but less than 4,000.~~
- ~~(c) The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this adjustment.~~
- ~~Also, in order to receive this adjustment (c) the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~
- ~~(d) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~
- ~~(e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominately individuals under 18 years of age or who did not offer nonemergency obstetric services as of December 21, 1987.~~
- ~~(4) In accordance with the Medicaid State Plan, acute care hospitals that do not qualify under the criteria in (3) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:~~
- ~~(a) The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.~~
- ~~(b) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~

- ~~(c) Low income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:~~
- ~~1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,~~
  - ~~2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.~~
- ~~(d) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominately individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.~~
- ~~(5) Any hospital designated as a perinatal center by statute or regulation and with a service plan approved by the Department of Health Maternal and Child Health Section or any hospital providing without charge services to high risk, multi-handicapped persons under age 21 who are enrolled in the Department's Children's Special Services program shall, because of the extraordinary risk and expertise involved in treatment of these individuals, be eligible to receive an adjustment not to exceed the uncompensated cost for perinatal services and services to handicapped children at each hospital for the state fiscal year. The total uncompensated care for each of the qualified providers will be divided by the total anticipated Medicaid days for the same period in order to determine the amount to be added to the disproportionate share adjustment calculated in paragraphs (3) and (4) above. This new adjustment will be multiplied by the total anticipated Medicaid days for the period. This adjustment will be added to and not subject to any limits that are included in paragraphs (3) and (4) above.~~
- ~~(6) Beginning July 1, 1991, any acute care hospital qualifying for a disproportionate share adjustment under the qualifying criteria listed in paragraphs (3) and (4) above and having at least 1,000 projected Medicaid days and having a Medicaid utilization ratio that exceeds the industry average utilization ratio which is computed by dividing the available hospital days by the Medicaid industry days will be eligible for an additional enhanced disproportionate share adjustment based on the following:~~
- ~~(a) The prospective rate will be adjusted upward by an amount equal to the difference of the hospital's Medicaid utilization ratio and the industry average utilization ratio multiplied by a factor of 9.45.~~
  - ~~(b) The enhanced MDSA payment will be based on the enhanced disproportionate share adjustment calculated in subparagraph (a) above multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July through June.~~
  - ~~(c) The sum of the MDSA payment calculated in (3), (4), and the enhanced payment computed in this paragraph (6) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments converted to cost based on the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~
- ~~(7) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the~~

- determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
- (8) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July June. This will be estimated based on projections from historical experience and the addition of any expected improvements.
- (9) Effective October 1, 1992, hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a Medicaid utilization ratio over 7.94% or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c), and the sum of (a), (b), or (c), whichever is higher, plus (f) cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this rule Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this rule charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services.
- (a) The prospective rate will be adjusted upward by a factor of 27.169 times the difference between the actual utilization rate and a 7.94% utilization rate.
- (b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.
- (c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.
- (d) Low income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:
1. Total Medical inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and
  2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.
- (e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.
- (f) Any hospital whose charity exceeds 6% of the industry's total charity will receive an additional payment. This payment will be equal to their percentage of the industry's charity times a factor of 4.05 times the value of their charity.

- ~~(g) Any hospital that has a Medical utilization rate of 23% or greater and 23,000 Medicaid days or more will qualify for an additional MDSA payment. Hospitals qualifying will be allowed payment in excess of 40% of charity. Instead of a 40% limit these hospitals will receive up to a 75% limit. Any hospital qualifying for this enhancement whose ratio of charity to total revenues exceed 30% will be capped at a total MDSA payment of \$42,750,000. Any hospital whose ratio is less than or equal to 30%, will be capped at \$37,750,000.~~
- ~~(h) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.~~
- ~~(i) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements.~~
- ~~(j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on subparagraph (g) of these regulations, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.~~
- (10) Effective July 1, 1993, only those hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or having a Medicaid utilization ratio over 8.55% or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of the amount determined by subparagraphs (a), (b), or (c), whichever is higher, and added to subparagraph (f). That total cannot exceed 40% of inpatient and outpatient "charity" charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this rule Medicaid days Will not include days reimbursed by the Primary Care Network. For the purpose of this rule "charity", unless otherwise specified, will be defined as inpatient and outpatient "charity" charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. "Charity" will include charges for both instate and out-of-state services.
- ~~(a) The prospective rate will be adjusted upward by a factor of 27.169 times the difference between the actual utilization rate and a 8.55% utilization rate.~~
- ~~(b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.~~
- ~~(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.~~
- ~~(d) Low income Utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics, The sum of:~~
- ~~1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from either the state and local governments in a cost reporting period, divided by the total amount of revenues of the hospitals for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and~~
  - ~~2. The total amount of the hospital's charges for inpatient hospital services attributable to "charity care" (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to "charity care" shall not include contractual allowances and discounts (other than for indigent patient not eligible for Medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.~~

- (e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.
- (f) Any hospital whose "Charity" exceeds 6% of the industry's total "charity" will receive an additional payment. This payment will be equal to their percentage of the industry's "charity" times a factor of 3.0 times the value of their "charity".
- (g) Any hospital that has Medicaid Utilization rate of 24% or greater and 25,000 Medicaid days or more will qualify for an additional MDSA payment. Qualifying hospitals will be allowed payment in excess of 40% "charity". Instead of a 40% limit these hospitals will receive up to a 91% limit. Any hospital qualifying for this enhancement whose ratio of "charity" to total revenues exceeds 30% will be capped at a total MDSA payment of \$60,000,000. Any hospital whose ratio is less than or equal to 30%, will be capped at \$50,000,000.
- (h) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
- (i) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is still unavailable, the latest report on file will be used.
- (j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on subparagraph (g) of these regulations, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.

*Authority:* T.C.A. §§71-5-105, 71-5-109, 12-4-301, and 4-5-202; *Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (PL 102-234).* *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed December 31, 1986; effective February 14, 1987. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 18, 1991; effective November 2, 1991. Amendment filed January 20, 1993; effective March 6, 1993. Amendment filed October 22, 1993; effective January 5, 1994.

#### **1200-13-5-.12 OTHER ADJUSTMENTS TO THE PROSPECTIVE RATE.**

- (1) Adjustments to the prospective rate shall be made for the following reasons:
  - (a) a mathematical mistake in computing the rate;
  - (b) additional individual capital expenditures for which there is an approved certificate of need such as the purchase of major equipment or addition of new beds, which would have an impact of 5% on the facility's total prospective rate, or a \$25,000 effect on Tennessee Medicaid reimbursement.
  - (c) a significant change in case mix resulting in a 5% change in the facility's total prospective rate, or a \$25,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio.

- (2) Providers who are seeking a rate adjustment due to additional costs and who wish to have such an adjustment effective at the same time as the additional costs are actually incurred must submit request for such adjustment to the Medicaid agency at least 45 days prior to the time the additional costs will be incurred. The effective date of such rate adjustments shall be the first day of the month following 45 days from the date of receipt of the adjustment request.

Requests for adjustment must include detailed cost information identifying the appropriate operating and pass-through components.

*Authority:* T. C.A. §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

#### ~~1200-13-5-.13 NEW PROVIDERS, CHANGES IN OWNERSHIP, AND CHANGES IN FISCAL YEAR END.~~

~~New providers entering the Program will be required to submit a budgeted cost report from which an interim prospective rate will be set. Each new provider must submit, in accordance with rule 1200-13-5-.04 an actual cost report covering the first full year of actual operations, at which point a final prospective rate, with a retroactive adjustment, will be set. A change of ownership does not constitute a new provider. Any change in ownership or fiscal year end should be reported to the Office of the Comptroller of the Treasury and the Department.~~

*Authority:* T. C.A. §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed April 30, 1987, effective June 14, 1987.

~~1200-13-5-.14 LOWER OF COST OR CHARGES LIMIT.~~ In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first fiscal year under prospective payment. Carry forwards of unreimbursed costs will not be recognized once a provider's initial fiscal year under the prospective payment method has begun.

*Authority:* T. C.A. §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

#### ~~1200-13-5-.15 RATE NOTIFICATION AND EFFECTIVE DATES.~~

- (1) Beginning 30 days after the effective date of this regulation, each provider will be notified of their initial prospective rate at least 30 days prior to the beginning of their first fiscal year under prospective payment. For those providers whose first fiscal year under prospective payment begins earlier than 30 days after the effective date of this rule, every attempt will be made to provide for a reasonable notice to them. The initial prospective rate shall apply to services provided on or after the first day of the provider's first fiscal year subject to prospective payment. Payment for services rendered prior to the first day of the provider's first fiscal year subject to prospective payment and submitted for payment after such date shall be paid at the rate in effect during the period the service was rendered. Providers must split bill for services spanning their first prospective year and the prior year.
- (2) Within 30 days after the receipt of each provider's cost report, each provider will be notified of their new prospective rate due to the normal pass-through adjustment. This rate shall be effective by the first day of the next month one month subsequent to the date of receipt of the provider's cost report. Providers must split bill for services spanning the effective date of the rate change.
- (3) Within 30 days before the beginning of each fiscal year subsequent to the initial prospective year, each provider will be notified of their new prospective rate due to the normal operating rate adjustment. This rate shall apply to services provided on or after the beginning of the new fiscal year. Providers must split bill for services spanning the effective date of the rate change.
- (4) Providers will be notified of special rate adjustment described in rule 1200-13-5-.12 no later than 45 days after the receipt of the appropriate data. Such rate change shall be effective as specified in

rule 1200-13-5-.12(2). Provider must split bill for services spanning the effective date of the rate change.

(5) Subsequent years' adjustments for high Medicaid volume, minimum occupancy, and resident and intern costs shall be completed at the same time and become effective at the same time as the pass-through adjustment described in rule 1200-13-5-.14(2).

(6) Delays in setting rates may be encountered if it becomes necessary to request additional information from a provider due to errors or omissions on cost reports. Cost reports are due as specified by Medicare regulations in effect on October 1, 1982.

(7) In cases of a change in ownership or fiscal year end, the operating component will be adjusted when the next trend is due under the old fiscal year end in order to avoid overlap or duplication of the period trended. This trend will be to the midpoint of the time between the old fiscal year end and the new fiscal year end and will be effective for dates of service beginning on the day after the old fiscal year end. The next trend will be from the midpoint of that period to the midpoint of the new fiscal year and will be effective for dates of service beginning on the first day of the new fiscal year. The rates should be computed at least 30 days prior to the effective date of the rate. Examples are found at subparagraphs (a) and (b) below.

(a) Assume that a provider has a former fiscal year end of June 30 and changes to a December 31 year end. The provider notifies us of the change before June 1, 1984. The provider's rate has already been indexed to the midpoint of the year July 1, 1983 to June 30, 1984, that midpoint being January 1, 1984. That rate was effective for services on or after July 1, 1983. Next, we will index from the midpoint of the former fiscal year, that midpoint being January 1, 1984, to the midpoint of the time between the provider's former year end of June 30, 1984, and the new fiscal year end of December 31, 1984, that midpoint being October 1, 1984. The effective date of this rate will be for services on or after July 1, 1984. Next, we will trend from the point where we left off (October 1, 1984) to the midpoint of the provider's new fiscal year end of December 31, 1985, that midpoint being July 1, 1985, with a corresponding effective date of services on or after January 1, 1985. Normal annual indexing takes place thereafter.

(b) Notification made subsequent to Comptroller's indexing based on the former fiscal year end. Assume the same facts in the first example except that the provider notifies us of their fiscal year end change sometime after June 1, 1984. The provider's rate has already been indexed to the midpoint of the year July 1, 1984 to June 30, 1985, that midpoint being January 1, 1985. That rate was effective for services on or after July 1, 1984. Next, we will index from the midpoint of the former fiscal year, that midpoint being January 1, 1985, to the midpoint of the time between the provider's former year end of June 30, 1985, and the new fiscal year end of December 31, 1985, that midpoint being October 1, 1985. The effective date of this rate will be for services on or after July 1, 1985. Next, we will trend from the point where we left off (October 1, 1985) to the midpoint of being July 1, 1986, with a corresponding effective date of service on or after January 1, 1985. Normal annual indexing takes place thereafter. This procedure will be followed to avoid overlapping of the periods trended even if the provider changed fiscal year end in 1984.

*Authority:* T.C.A. §§14-23-105, 14-23-109 and 4-5-202. *Administrative History:* Original rule filed June 26, 1995, effective July 26, 1985. Amendment filed March 25, 1987, effective May 9, 1987.

#### **1200-13-5-.16 METHOD FOR PAYING PROVIDERS WHICH ARE EXEMPT FROM PROSPECTIVE SYSTEM.**

(1) The Comptroller of the Treasury, will determine, in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described at 42 CFR 405, per diem reimbursable costs for those Medicaid providers of hospital services exempted from the prospective system set out in rules 1200-13-5-.06 through 1200-13-5-.15 inclusive, except those hospitals described in

~~item (3) of rule 1200-13-5-.07 which shall be reimbursed as described in that item. The maximum limit of such reimbursable costs shall be the lesser of: (a) the reasonable cost of covered services; or (b) the customary charges to the general public for such services. Provided, however, that such providers which are public hospitals rendering services free or at nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accord with provisions of 42 CFR 405 in effect on October 1, 1983. Covered services means covered services as defined by the Department. Each provider's per diem reimbursable cost will be based on the provider's cost report which is to be filled out and submitted in accordance with rule 1200-13-5-04.~~

~~(2) *Interim Rate.* The Comptroller of the Treasury, will establish interim per diem reimbursable rates for providers exempted from the prospective payment system. The interim rate remains in effect until the provider's actual reimbursable cost based on the provider's cost report, is established. Interim rates shall be based on prior cost report data and shall be subject to revision upon further review, audit, and/or subsequent finding of the Comptroller of the Treasury. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.~~

~~(3) *Approval of Initial Settlement.* When a provider's cost report is received, it is reviewed and compared with:~~

~~(a) The amount of charges for covered services provided to Medicaid beneficiaries by the provider during the provider's fiscal period.~~

~~(b) The amount of interim payments paid by the Department to the provider for the provider's fiscal period.~~

~~(c) The number of inpatient days approved for the provider by the Department during the provider's fiscal period.~~

~~On the basis of the comparison and review, the Comptroller of the Treasury will make an initial determination of the cost settlement due to the provider or the state for the designated period. Approval of the initial settlement will be subject to further review, audit and/or subsequent finding of the Comptroller of the Treasury. On the basis of the initial settlement, the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment made to the provider during the fiscal year.~~

~~(4) *Approval of Final Cost Settlement.* After the necessary final review and/or auditing has been performed by the Comptroller of the Treasury, the Comptroller will advise the Department of the final cost settlement approved. On the basis of the approved final settlement the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment made to the provider during the fiscal year.~~

~~(5) *Inpatient Routine Operating Per Diem Cost Limitation.* In the event that data is not available to compute the inpatient routine operating per diem cost limitation for all or any part of a provider's fiscal year, the Comptroller of the Treasury will use each provider's per diem cost limitation in effect prior to the provider's first fiscal year subject to prospective payment which will be appropriately trended by the actual hospital market index as published by the Health Care Financing Administration in the Federal Register or by Data Resources, Inc., or their successors.~~

~~(6) *Out of State Reimbursement Rate.* Hospitals which meet the criteria as set forth in rule 1200-13-5-.07(2), shall be reimbursed at the lesser of:~~

~~(a) the reasonable cost of covered services;~~

~~(b) the customary charges to the general public for such services, or~~

~~(c) the Medicaid reimbursement rate as established by the hospital's respective state. Covered services are those defined by the Tennessee Department of Health. Reimbursement by Tennessee Medicaid shall be considered as payment in full for covered services and no additional billings shall be made to the patient for these services.~~

~~Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109 and 4-5-202. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed May 8, 1991; effective June 22, 1991~~

**1200-13-5-.17 AUDIT.**

~~(1) All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Department or their designated representative. Cost report data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions.~~

~~(2) Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay." Medical audit exceptions may result in a direct recoupment rather than a rate change.~~

~~(3) The Department will provide for all costs of auditing which may be required.~~

~~Authority: T.C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.~~

~~1200-13-5-.18 TERMINATION OF MEDICAID HOSPITALIZATION PROGRAM. For hospitalization services provided prior to January 1, 1994, the rules as set out at rule chapter 1200-13-5 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except that Tennessee Medicaid will continue to pay Medicare premiums, deductibles and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.~~

~~Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. Administrative History: Original rule filed March 18, 1994; effective June 1, 1994.~~

Hospital Rate Variation Corridors

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1200-13-05-.01 Definitions.

(1) Bureau of TennCare (Bureau). The administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

- (2) Existing Contracts. The contracts that were in place between a Tennessee hospital and a TennCare MCO as of July 1, 2013.
- (3) Hospital. A general or specialty acute care facility licensed as a hospital by the Tennessee Department of Health pursuant to T.C.A. § 68-11-206, excluding hospitals that are categorized as Rehabilitation, Research, Long Term Acute or Psychiatric on the 2013 Joint Annual Report of Hospitals.
- (4) Inpatient Services. Routine, nonspecialized services that are provided at many or most hospitals in the state to patients admitted to the hospital as inpatients.
- (5) MCO (Managed Care Organization). An appropriately licensed Health Maintenance Organization (HMO) contracted with the Bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and behavioral benefits to TennCare enrollee-members through a network of qualified providers.
- (6) Medicare. A hospital's fee-for-service reimbursement under Title XVIII including that hospital's adjustment for DSH, wage index, etc., and excluding only Indirect Medical Education (IME), pass through payments, and any Medicare payment adjustments for Sequestration, Value Based Purchasing, Readmissions and Hospital Acquired Conditions.
- (7) Medicare Severity Diagnosis Related Groups (MS-DRG). The Medicare statistical system of classifying any inpatient stay into groups for the purpose of payment.
- (8) New Contract. Any initial contract between an MCO and a hospital that did not exist on July 1, 2013. Contracts in place on July 1, 2013, that have been materially altered since July 1, 2013, are not new contracts.
- (9) Outpatient Services. Services that are provided by a hospital to patients in the outpatient department of the hospital and patients receiving outpatient observation services.
- (10) Rate Corridors. Upper and lower limits established by the state's actuary and approved by the Bureau, in consultation with the Tennessee Hospital Association (THA), for payments by MCOs to hospitals for services provided to TennCare enrollees. The Rate Corridors are based on a hospital's Medicare reimbursement that existed in FFY 2011 and used to determine the parameters of TennCare rates for contracts between Tennessee hospitals and TennCare MCOs after July 1, 2013. The determination of whether a hospital's TennCare rates are within the prescribed Rate Corridors shall be made on the basis of reimbursement from all TennCare MCOs with which the hospital has a contract. The Rate Corridors, which were calculated by the State's actuary as the budget neutral corridors, are as follows:
  - (a) For inpatient services, the minimum level is 53.8% and the maximum level is 80% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level is 93.2% and the maximum level is 104% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level is 32% and the maximum level is 83% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum is 4% and the maximum level is 174% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level is 49% and the maximum level is 164% of the hospital's Medicare for 2011.
- (11) Specialized Services. Services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma.

- (12) TennCare. The TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.
- (13) TennCare Actuary. The actuarial firm selected by the Bureau to assist the Bureau in establishing the capitation rates for TennCare MCOs each year.
- (14) Total TennCare Rates. Payment rates for each hospital in the aggregate from all MCOs with which the hospital has network contracts.
- (15) Year 1 Corridors. The initial upper and lower limits established by the Bureau in consultation with THA based on a hospital's Medicare reimbursement that existed in FFY 2011 and that were used to implement rate variation limitations in contracts between Tennessee hospitals and TennCare MCOs from July 1, 2012 until July 1, 2013. The Year 1 Corridors are as follows:
  - (a) For inpatient services, the minimum level was 40% and the maximum level was 90% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level was 90% and the maximum level was 125% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level was 30% and the maximum level was 80% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum was 4% and the maximum level was 180% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level was 30% and the maximum level was 160% of the hospital's Medicare for 2011.

1200-13-05-.02 Implementation of Contract Amendments for Existing Contracts between Hospitals and MCOs.

These contracts set rates for a period of two years effective July 1, 2013, and provided for rate amendments to be negotiated and implemented on July 1, 2015.

- (1) For hospitals that had existing contracts with MCOs in place on July 1, 2013, and the MCO and hospital had negotiated contract amendments to bring rates for total TennCare into the Rate Corridors and the rates in the contracts have not been adjusted since July 1, 2013, the MCOs will reissue those amendments with a new effective date of July 1, 2015.
- (2) In the case of a hospital that had contracts with MCOs in place on July 1, 2013, which contracts included amendments implementing rates within the Rate Corridors, and where the rates in the contracts have been adjusted since July 1, 2013, the Bureau shall evaluate the rates in the current contracts to determine if the total TennCare rates for the hospital are within the Rate Corridors. If the rate adjustments cause the total TennCare reimbursement for the hospital to be outside of the Rate Corridors, the affected MCOs shall implement contract amendments approved by the Bureau in consultation with the TennCare Actuary to bring the hospital rates into the Rate Corridors effective July 1, 2015.
- (3) In the case of a hospital with contracts in existence on July 1, 2013, which contracts include rates outside of the Rate Corridors, the affected MCOs shall implement contract amendments to bring total TennCare rates into the Rate Corridors with an effective date of July 1, 2015. The Bureau shall verify that the new contract rates in conjunction with contracts between the hospital and all other MCOs bring the hospital's total TennCare rates within the Rate Corridors.

1200-13-05-.03 Implementation of New Contracts between Hospitals and MCOs Entered into after July 1, 2013.

These contracts have not yet been in effect for a period of time sufficient to negotiate rate amendments for a July 1, 2015, implementation date. In the case of a hospital that entered into a contract with an MCO

after July 1, 2013, including a hospital that entered into a contract with an MCO with rates within Year 1 Corridors effective January 1, 2015, the affected MCOs shall implement contract amendments that bring the hospital rates within the Rate Corridors no later than September 30, 2015.

1200-13-05-.04 Exclusion of Any Hospital from TennCare Networks.

A hospital that does not accept a contract amendment required by this Rule shall be excluded effective October 1, 2015, from participation in the TennCare MCO network to which the contract amendment applies.

1200-13-05-.05 Out-of-Network Reimbursement.

Out-of-Network payments to all hospitals shall be governed by TennCare Medicaid Rule 1200-13-13-.08(2)(a)-(c) and TennCare Standard Rule 1200-13-14-.08(2)(a)-(c).

1200-13-05-.06 Agreements between Hospitals and MCOs for Limited Services.

Rates for a single case agreement negotiated between the MCOs and hospitals that are not in network with the MCO to ensure access to services for TennCare enrollees may not exceed the ceiling or be below the floor of the Rate Corridors appropriate for those services.

1200-13-05.07 Changes to Hospital Rates Negotiated between MCOs and Hospitals after September 30, 2015.

To ensure that each hospital's total TennCare reimbursement remains within the Rate Corridors, proposed rate changes after September 30, 2015, shall be evaluated by the Bureau to determine if the proposed rate change will move the hospital's total TennCare rates outside of the Rate Corridors. If the evaluation indicates the change will put the hospital outside of the Rate Corridors, the Bureau shall provide the adjustments necessary to ensure that the contract is compliant with the limits of the Rate Corridors. TennCare rates between a hospital and an MCO may not be modified after September 30, 2015, without approval from the Bureau.

1200-13-05-.08 Categorization of New Services Added after July 1, 2015.

MS-DRG classifications serve as the basis for identifying services as inpatient or specialized. MS-DRG classifications may change and new MS-DRG classifications may be added from time to time. New or modified MS-DRG classifications shall be evaluated for assignment to appropriate inpatient or specialized categories by the Bureau in consultation with THA and the TennCare Actuary.

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**RULES  
OF  
TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT  
DIVISION OF MEDICAID**

**CHAPTER 1200-13-5  
HOSPITALIZATION PROGRAM**

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**1200-13-5-.01 DEFINITIONS.** The following definitions shall apply to rules 1200-13-5-.02 through 1200-13-5-.15 inclusive, unless otherwise indicated.

- (1) *Capital Costs* means those costs which are required or allowed by Title XVIII principles to be included in all depreciation columns on line 72 of worksheet B of HCFA form 2552-81(11-81). Capital costs shall not include costs associated with non-reimbursable cost centers.
- (2) *Medical Education Costs* means those costs associated with a nursing school or intern-resident services in an approved residency program which are required or allowed by Title XVIII principles to be included in columns 18 and 19 of line 72 on worksheet B of HCFA form 2552-81(11-81). Medical education costs shall not include costs associated with non-reimbursable cost centers, nor shall they include costs for routine in-service training.
- (3) *Hospital Based Physician Costs* means physician costs applicable to Medicaid beneficiaries which are required or allowed by Title XVIII principles to be included on line 12 of Column 5f of Part 1 of worksheet D-3 of HCFA form 2552-81(11-81). Such costs shall not be allowable for services provided on or after October 1, 1983.
- (4) *Utilization Ratio* means the ratio of inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee to total inpatient days.
- (5) *Medicaid Day* means any part of a day including the day of admission in which a person determined eligible for Medicaid by the State of Tennessee is admitted as an inpatient with the intention of remaining overnight. The day of discharge is not counted as a day. If admission and discharge occur on the same day, the day is considered one inpatient day.
- (6) *Approved Residency Program* means: (1) intern or resident in training teaching program approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association; or, (2) in the case of a hospital or osteopathic hospital with an intern or resident in training program in the field of dentistry, under a teaching program approved by the Council on Dental Education of the American Dental Association.
- (7) *Operating Component* means those costs, applicable to inpatient services only, which are required or allowed by Title XVIII principles to be included on line 10 of Part 1 of schedule E-5 of HCFA form 2552-81(11-81);

less the portion, which is attributable to patients determined eligible for Medicaid by the State of Tennessee, of depreciation, medical education costs, and hospital based physician costs, plus an allowance for the inpatient routine nursing salary differential which was repealed by Medicare on October 1, 1982.

(8) *Pass Through Component* means the share which is attributable to patients determined eligible for Medicaid by the State of Tennessee of actual capital costs and actual medical education costs. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass through component.

(9) *Title XVIII principles* means, except where indicated otherwise, those Medicare principles which are applicable to hospitals, which were in effect on October 1, 1982, and which are described at 42 CFR, 405.

(10) *Base Year Cost Report* means the cost report for the next to the last 12 month cost reporting period preceding the first cost reporting period subject to prospective payment.

EXAMPLE:

*Ist Year Subject to*

*Prospective Payment* \_\_\_\_\_ *Base Year*

1/1/84 to 12/31/84 \_\_\_\_\_ 1/1/82 to 12/31/82

7/1/84 to 6/30/85 \_\_\_\_\_ 7/1/82 to 6/30/83

If a hospital's cost reporting period ending on or after September 30, 1982 was for less than 12 months, the cost report for the most recent 12 month cost reporting period ending before September 30, 1982 will be used. The Commissioner of the Department of Health and Environment reserve the right to rebase the reimbursement system described in Chapter 12-13-5 of the Rules of the Department of Health and Environment at such time deemed necessary.

(11) *Department* means the Tennessee Department of Health and Environment.

*Authority:* T.C.A. § §4-5-202, 12-4-301, 71-5-105 and 71-5-109, Public Chapter 913 of the Acts of 1992.

*Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed January 13, 1987; effective February 27, 1987. Amendment filed September 25, 1992; effective November 9, 1992.

**1200-13-5-.02 DETERMINATION OF REIMBURSABLE COST.** The Comptroller of the Treasury in accordance with the Department's rules and regulations shall make the determination of reimbursable per diem cost for hospitals.

*Authority:* T.C.A. §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.03 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPANTS.** Only those institutions or distinct parts thereof certified by the Department in accordance with the General Rule 1200-13-1-.05(2) as rendering hospital care and contracting with Medicaid may participate and be reimbursed as providers under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

*Authority:* T.C.A. §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.04 COST REPORTS REQUIRED.**

(1) In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, as per rule 1200-13-5-.13, to submit to the Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance

with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise by these rules. All covered services are to be in accordance with the Medicaid Program definition of covered services.

(2) Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1992 and described at 42 CFR 405 shall be subject to the sanctions specified in *T.C.A.* §71-5-130.

(3) To be eligible to receive payment, contracting hospitals shall use uniform hospital statistics and classification of accounts as published by the American Hospital Association for all accounting records, or any other acceptable accounting methods approved by the Department of Health in consultation with the Comptroller and the Tennessee Hospital Association. Any contracting hospital that does not adopt the uniform classification of accounts, or that does not submit certified statements when required by the Department of Health will be subject to the sanctions specified in *T.C.A.* §71-5-130.

(4) After a period of five years following the implementation of the TennCare Program on January 1, 1994, amended or corrected hospital cost reports with claims for reimbursement for services prior to January 1, 1994 shall not be accepted.

*Authority:* *T.C.A.* §§14-23-105, 14-23-109, 71-5-105, 71-5-109 and 4-5-202. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed April 14, 1989; effective May 8, 1989. Amendment filed October 14, 1998; effective December 28, 1998.

**1200-13-5-.05 BILLING PROCEDURE.** Institutions or distinct parts thereof rendering hospital care shall bill the Department or other agency or organization designated by the Department on the forms and in the manner designated. No provider shall charge for Medicaid patients more than is charged for private paying patients for equivalent accommodations and services.

*Authority:* *T.C.A.* §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.06 APPLICATION OF PROSPECTIVE PAYMENT METHOD.** With respect to cost reporting periods on or after the effective date of this rule, all Medicaid providers of hospital care, except those exempted by the provisions of rule 1200-13-5-.07 shall be paid for inpatient services by a prospective method as set out in rules 1200-13-5-.08 through 1200-13-5-.15 inclusive.

*Authority:* *T.C.A.* §§14-23-105 and 14-23-109. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985.

**1200-13-5-.07 PROVIDERS EXEMPTED FROM PROSPECTIVE PAYMENT SYSTEM.** The prospective payment system shall not apply to:

(1) Long term care facilities (hospitals which have an average length of stay of more than 25 days).

(2) Hospitals which elect not to submit a cost report which have less than \$100,000 annually, based on the State of Tennessee's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee; the annual total charges does not include charges associated with transplants covered by Tennessee Medicaid and are reimbursed in accordance with rule 1200-13-1-.06(18)(f)2.

Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered item billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed \$100,000 in total Tennessee Medicaid charges annually:

(a) In state hospitals or out of state hospitals in contiguous medical marketing areas, will be treated as new providers as specified in rule 1200-13-5-.13.

~~—(b)— All other hospitals will be reimbursed as specified in rule 1200-13-5-16(6).~~

~~—(3)— Outpatient services~~

~~*Authority:* T.C.A. §§12-4-301, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and 4-5-202. *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed May 8, 1991; effective June 22, 1991.~~

#### ~~1200-13-5-.08 PROSPECTIVE PAYMENT METHODOLOGY.~~

~~(1) — The prospective payment will be made as a rate per inpatient day. Each facility's reimbursable inpatient costs will be determined in accordance with Title XVIII principles, from a base year cost reporting period. Costs will be separated into an operating component and a pass-through component. A trending factor will be applied to the operating rate component only. The prospective rate will be the sum of the trended operating component and the untrended pass-through component, plus or minus adjustments for minimum occupancy, (effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty), resident and intern costs, Medicaid disproportionate share and other adjustments as provided in rule 1200-13-5-.12. Tennessee Medicaid costs will be determined by a computed utilization ratio from form HCFA 2552.~~

~~—(a) — Except for inpatient hospital days involving approved organ transplants, the first twenty (20) days per fiscal year will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only), and Medicaid disproportionate share adjustment (MDSA) components. For medically necessary days in excess of twenty (20) per fiscal year, reimbursement will be made at 60 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only) and MDSA components. Approved inpatient days involving organ transplants will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only) and MDSA components. Admission and stays involving organ transplants that span fiscal years will be reimbursed as if the entire stay had occurred during the first fiscal year.~~

~~—(2) — Adjustments to Base Period Costs. It may be necessary to adjust base year cost reports to make the base period costs comparable to inpatient costs incurred in the prospective period, such as costs to be incurred by hospitals required to enter the Social Security system beginning January 1, 1984. Therefore, hospitals submitting form HCFA-1008 to their Medicare intermediary should send a copy of this form to the Comptroller of the Treasury. For hospitals which do not submit form HCFA-1008, appropriate adjustments will be made based on the best available information.~~

~~—(3) — Pass Through Component.~~

~~(a) — Each facility's initial prospective rate will be based on the base year cost report and will include a pass through component consisting of the portion of capital costs and medical education costs which is attributable to patients determined eligible for Medicaid by the State of Tennessee. The pass-through component may vary from year to year depending on each facility's actual capital costs and medical education costs and will not be computed until the facility's cost report is received. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass through component.~~

~~(b) — Additional capital costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1994. The cost basis of depreciable assets in a sale not considered bona fide is additionally limited to (5) the seller's cost basis less accumulated depreciation. The~~

— purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs.

- (e) The payment of return on equity will be determined by Medicare principles of cost reimbursement, 42 CFR 405, in effect on August 1, 1983 providing that, effective April 20, 1983, return on equity shall be adjusted to reflect 100% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

EXAMPLE

Base Year:	12/31/82
Base Year Cost Report Received	05/01/83
Initial Prospective Rate Determined	06/01/83
Beginning of Prospective Payment	01/01/84
12/31/83 Cost Report Received	05/01/84
12/31/83 Cost Report Rate	
Adjustment Completed	06/01/84

— In this example, the initial prospective rate continues until June 1, 1984. On June 1, 1984, the rate is adjusted (for service dates on or after June 1, 1984) for the Tennessee Medicaid share of the actual capital costs, medical education costs, hospital-based physician costs, and return on equity (for proprietary providers only) reported on the December 31, 1983, cost report.

- (d) Beginning with fiscal years beginning July 1, 1987, and later, capital costs will be reduced by 3.5% for dates of services July 1, 1987 through September 30, 1987, by 7% for dates of service October 1, 1987 through December 31, 1987, by 12% for dates of service January 1, 1988 through September 30, 1988, and by 15% for dates of service October 1, 1988 through September 30, 1989, by 0% for dates of service October 1, 1989 through December 31, 1989, and by 15% for dates of service January 1, 1990 and later. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reduction in capital costs. Upon the effective date of these rules, hospitals will be reimbursed 100% of their capital costs.

- (4) Operating Component. Each facility's initial prospective rate shall include an operating component which is computed from the base year cost report. The operating component will be trended forward each year. Trending to the new rebased year, (1988 cost reports or if not available the prior cost report) will be computed by utilizing the indexing rate recommended by the Prospective Payment Assessment Commission, applied from the end of the hospital's fiscal year to October 1, 1989.

— Thereafter the trending index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and as published in the *Tennessee Administrative Register*. The trending indexes above shall be applied from October 1, 1989, to the midpoint of the state's fiscal year, no earlier than December 31, 1990, and shall be effective the first of the state's fiscal year, no earlier than July 1, 1990. When necessary, indexes will be prorated to correspond to a provider's year end. Each provider will be notified of its new operating rate due to indexing within 30 days of the beginning of the state's fiscal year.

*Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71-5-109; Public Chapter 913 of the Acts of 1992. Administrative History. Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed February 21, 1986; effective March 23, 1986. Amendment filed September 12, 1986, effective October 27, 1986. Amendment filed May 29, 1987, effective July 13, 1987. Amendment filed June 2, 1988, effective July 17, 1988. Amendment filed August 8, 1990, effective September 22, 1990. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed September 25, 1992; effective November 9, 1992.*

**1200-13-5-.09 MINIMUM OCCUPANCY ADJUSTMENT.** Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

- ~~\_\_\_\_\_ Hospitals over 100 beds — 70%~~
- ~~\_\_\_\_\_ Hospitals with 100 beds or fewer — 60%~~

The adjustments will be computed as follows and will be made at the same time as the pass through adjustment as set out in rule 1200-13-5-.15.

~~\_\_\_\_\_~~ 
$$ACC = TCC \times \frac{TBD}{ABD(Y)}$$

- ~~\_\_\_\_\_ ACC = allowable capital costs~~
- ~~\_\_\_\_\_ TCC = total capital costs~~
- ~~\_\_\_\_\_ TBD = total bed days used during the period~~
- ~~\_\_\_\_\_ ABD = total bed days available during the period~~
- ~~\_\_\_\_\_ Y = .6 for hospitals with 100 beds or fewer~~
- ~~\_\_\_\_\_ .7 for hospitals over 100 beds~~

~~All references to beds means staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use, such as being closed for reasons including but not limited to, painting, maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine, at least monthly, its number of staffed beds. A schedule showing the number of staffed and unstaffed beds, along with the reasons for being unstaffed, must be submitted with the cost report. This schedule is subject to audit in accordance with rule 1200-13-5-.17. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of cost report period. Effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty.~~

~~Authority: T.C.A. §§4-5-202, 12-4-301, 14-23-105, 14-23-109, 71-5-105, and 71-5-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed August 8, 1990; effective September 22, 1990.~~

**1200-13-5-.10 RESIDENT AND INTERN COST ADJUSTMENT.**

- ~~\_\_\_\_\_ (1) On the basis of the ratio of full time equivalent residents and interns to total beds, a resident and intern cost adjustment shall be granted to teaching facilities having an approved residency program. Such facilities will be given this adjustment independent of the Medicaid disproportionate share adjustment. The resident and intern cost adjustment shall not be subject to trending. The cost adjustment shall be calculated using the following formula but shall not exceed 10%, and will be made at the same time as the pass through adjustment.~~

~~\_\_\_\_\_~~ 
$$RI = 1.89 \times \left[ \left( 1 + \frac{\text{interns and residents}}{\text{beds}} \right)^{.405} - 1 \right]$$

- ~~\_\_\_\_\_ (2) For purposes of this adjustment, hospitals are to report only full time equivalent interns and residents on form HCFA 1008, Part 1. For years when form 1008 is no longer in effect, hospitals must submit their number of full time equivalent interns and residents with their cost report. The number of full time equivalent interns and residents is the sum of: (a) interns and residents employed 35 hours or more per week, and (b) one half of the total number of interns and residents working less than 35 hours per week regardless of the number of hours worked.~~

~~\_\_\_\_\_ EXAMPLE assuming no high Medicaid volume incentive or minimum occupancy adjustment.~~

	Year 1	Year 2	Year 3
1. Operating Component Prior to Trending	\$250.00	\$277.50	\$299.70
2. Pass Through Component	25.00	30.00	35.00
3. Basis for RI adjustment	275.00	307.50	334.70
4. RI Adjustment at 8% (line 3 x .08)	22.00	24.60	26.78
5. Trend Factor for Operating Component	11%	8%	7%
6. Trended Operating Component (line 1 x line 5 + 100%)	277.50	299.70	320.69

7. Prospective Rate (line 2 + line 4 + line 6) ~~\_\_\_\_\_~~ \$324.50 ~~\_\_\_\_\_~~ \$354.30 ~~\_\_\_\_\_~~ \$382.46

*Authority. T.C.A. §§4-5-202, 14-23-10, 5, 14-23-109, 71-5-105 and 71-5-109. Administrative History. Original rule filed June 26, 1985, effective July 26, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed December 30, 1986, effective February 13, 1987. Amendment filed December 8, 1989; effective January 22, 1990.*

#### ~~1200-13-5-.11 MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT (MDSA).~~

- ~~(1) In accordance with the Medicaid State Plan, hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio over 8% will be provided a payment incentive. The Medicaid disproportionate share adjustment shall not be subject to trending and shall be based on cost reports with fiscal year ending 6/30/86 and later. The incentive will be the higher of (a) or (b) but shall not exceed 17% and (a) + (c) or (b) + (c) shall not exceed 22%:~~
- ~~(a) The prospective rate will be adjusted upward by 3% for each 1% increment in the utilization rate above 8%.~~
  - ~~(b) The prospective rate will be adjusted upward by 3% for each increment of 1,000 reimbursed inpatient Medicaid days over 3,000.~~
  - ~~(c) The prospective rate will be adjusted upward by 5% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this incentive.~~

~~Also, in order to receive incentive (c), the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~

- ~~(2) In accordance with the Medicaid State Plan, acute care hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid, or a utilization ratio over 14% will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34% and (a) + (c) or (b) + (c) shall not exceed 44%:~~
- ~~(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14%;~~
  - ~~(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but less than 4,000.~~
  - ~~(c) The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this adjustment.~~

~~Also, in order to receive adjustment (c), the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~

- ~~(d) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. If no inpatient charity care is reported there will be no disproportionate share payment. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~

- ~~(e) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a quarterly basis established in June of each year. The quarterly payment will be prospective based on the disproportionate share adjustment established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established on paid claims from June-May fiscal year plus expected improvement based on a historical basis for the upcoming fiscal year July June.~~
- ~~(3) In accordance with the Medicaid State Plan, acute care hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34% and (a) + (c) or (b) + (c) shall not exceed 44%.~~
- ~~(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.~~
- ~~(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but less than 4,000.~~
- ~~(c) The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this adjustment.~~
- ~~Also, in order to receive this adjustment (c) the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.~~
- ~~(d) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~
- ~~(e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominately individuals under 18 years of age or who did not offer nonemergency obstetric services as of December 21, 1987.~~
- ~~(4) In accordance with the Medicaid State Plan, acute care hospitals that do not qualify under the criteria in (3) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:~~
- ~~(a) The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.~~
- ~~(b) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~

- ~~(c) Low income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:~~
- ~~1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,~~
  - ~~2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.~~
- ~~(d) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominately individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.~~
- ~~(5) Any hospital designated as a perinatal center by statute or regulation and with a service plan approved by the Department of Health Maternal and Child Health Section or any hospital providing without charge services to high risk, multi handicapped persons under age 21 who are enrolled in the Department's Children's Special Services program shall, because of the extraordinary risk and expertise involved in treatment of these individuals, be eligible to receive an adjustment not to exceed the uncompensated cost for perinatal services and services to handicapped children at each hospital for the state fiscal year. The total uncompensated care for each of the qualified providers will be divided by the total anticipated Medicaid days for the same period in order to determine the amount to be added to the disproportionate share adjustment calculated in paragraphs (3) and (4) above. This new adjustment will be multiplied by the total anticipated Medicaid days for the period. This adjustment will be added to and not subject to any limits that are included in paragraphs (3) and (4) above.~~
- ~~(6) Beginning July 1, 1991, any acute care hospital qualifying for a disproportionate share adjustment under the qualifying criteria listed in paragraphs (3) and (4) above and having at least 1,000 projected Medicaid days and having a Medicaid utilization ratio that exceeds the industry average utilization ratio which is computed by dividing the available hospital days by the Medicaid industry days will be eligible for an additional enhanced disproportionate share adjustment based on the following:~~
- ~~(a) The prospective rate will be adjusted upward by an amount equal to the difference of the hospital's Medicaid utilization ratio and the industry average utilization ratio multiplied by a factor of 9.45.~~
  - ~~(b) The enhanced MDSA payment will be based on the enhanced disproportionate share adjustment calculated in subparagraph (a) above multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July through June.~~
  - ~~(c) The sum of the MDSA payment calculated in (3), (4), and the enhanced payment computed in this paragraph (6) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments converted to cost based on the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.~~
- ~~(7) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the~~

- ~~determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.~~
- ~~(8) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July June. This will be estimated based on projections from historical experience and the addition of any expected improvements.~~
- ~~(9) Effective October 1, 1992, hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a Medicaid utilization ratio over 7.94% or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c), and the sum of (a), (b), or (c), whichever is higher, plus (f) cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this rule Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this rule charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services.~~
- ~~(a) The prospective rate will be adjusted upward by a factor of 27.169 times the difference between the actual utilization rate and a 7.94% utilization rate.~~
- ~~(b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.~~
- ~~(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.~~
- ~~(d) Low income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:~~
- ~~1. Total Medical inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and~~
  - ~~2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.~~
- ~~(e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.~~
- ~~(f) Any hospital whose charity exceeds 6% of the industry's total charity will receive an additional payment. This payment will be equal to their percentage of the industry's charity times a factor of 4.05 times the value of their charity.~~

- ~~(g) Any hospital that has a Medical utilization rate of 23% or greater and 23,000 Medicaid days or more will qualify for an additional MDSA payment. Hospitals qualifying will be allowed payment in excess of 40% of charity. Instead of a 40% limit these hospitals will receive up to a 75% limit. Any hospital qualifying for this enhancement whose ratio of charity to total revenues exceed 30% will be capped at a total MDSA payment of \$42,750,000. Any hospital whose ratio is less than or equal to 30%, will be capped at \$37,750,000.~~
- ~~(h) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.~~
- ~~(i) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements.~~
- ~~(j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on subparagraph (g) of these regulations, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.~~
- (10) Effective July 1, 1993, only those hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or having a Medicaid utilization ratio over 8.55% or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of the amount determined by subparagraphs (a), (b), or (c), whichever is higher, and added to subparagraph (f). That total cannot exceed 40% of inpatient and outpatient "charity" charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this rule Medicaid days Will not include days reimbursed by the Primary Care Network. For the purpose of this rule "charity", unless otherwise specified, will be defined as inpatient and outpatient "charity" charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. "Charity" will include charges for both instate and out of state services.
- ~~(a) The prospective rate will be adjusted upward by a factor of 27.169 times the difference between the actual utilization rate and a 8.55% utilization rate.~~
- ~~(b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.~~
- ~~(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.~~
- ~~(d) Low income Utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics, The sum of:~~
- ~~1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from either the state and local governments in a cost reporting period, divided by the total amount of revenues of the hospitals for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and~~
  - ~~2. The total amount of the hospital's charges for inpatient hospital services attributable to "charity care" (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to "charity care" shall not include contractual allowances and discounts (other than for indigent patient not eligible for Medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.~~

- (e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.
- (f) Any hospital whose "Charity" exceeds 6% of the industry's total "charity" will receive an additional payment. This payment will be equal to their percentage of the industry's "charity" times a factor of 3.0 times the value of their "charity".
- (g) Any hospital that has Medicaid Utilization rate of 24% or greater and 25,000 Medicaid days or more will qualify for an additional MDSA payment. Qualifying hospitals will be allowed payment in excess of 40% "charity". Instead of a 40% limit these hospitals will receive up to a 91% limit. Any hospital qualifying for this enhancement whose ratio of "charity" to total revenues exceeds 30% will be capped at a total MDSA payment of \$60,000,000. Any hospital whose ratio is less than or equal to 30%, will be capped at \$50,000,000.
- (h) Each year a redetermination of the MDSA will be made at the same time the new pass-through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
- (i) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is still unavailable, the latest report on file will be used.
- (j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on subparagraph (g) of these regulations, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.

*Authority:* T.C.A. §§71-5-105, 71-5-109, 12-4-301, and 4-5-202; *Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (PL 102-234).* *Administrative History:* Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed December 31, 1986; effective February 14, 1987. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 18, 1991; effective November 2, 1991. Amendment filed January 20, 1993; effective March 6, 1993. Amendment filed October 22, 1993; effective January 5, 1994.

#### **1200-13-5-12 OTHER ADJUSTMENTS TO THE PROSPECTIVE RATE.**

- (1) Adjustments to the prospective rate shall be made for the following reasons:
  - (a) a mathematical mistake in computing the rate;
  - (b) additional individual capital expenditures for which there is an approved certificate of need such as the purchase of major equipment or addition of new beds, which would have an impact of 5% on the facility's total prospective rate, or a \$25,000 effect on Tennessee Medicaid reimbursement.
  - (c) a significant change in case mix resulting in a 5% change in the facility's total prospective rate, or a \$25,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio.

- (2) — Providers who are seeking a rate adjustment due to additional costs and who wish to have such an adjustment effective at the same time as the additional costs are actually incurred must submit request for such adjustment to the Medicaid agency at least 45 days prior to the time the additional costs will be incurred. The effective date of such rate adjustments shall be the first day of the month following 45 days from the date of receipt of the adjustment request.

Requests for adjustment must include detailed cost information identifying the appropriate operating and pass-through components.

*Authority: T. C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.*

**1200-13-5-.13 NEW PROVIDERS, CHANGES IN OWNERSHIP, AND CHANGES IN FISCAL YEAR END.**

New providers entering the Program will be required to submit a budgeted cost report from which an interim prospective rate will be set. Each new provider must submit, in accordance with rule 1200-13-5-.04 an actual cost report covering the first full year of actual operations, at which point a final prospective rate, with a retroactive adjustment, will be set. A change of ownership does not constitute a new provider. Any change in ownership or fiscal year end should be reported to the Office of the Comptroller of the Treasury and the Department.

*Authority: T. C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed April 30, 1987, effective June 14, 1987.*

**1200-13-5-.14 LOWER OF COST OR CHARGES LIMIT.** In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first fiscal year under prospective payment. Carry forwards of unreimbursed costs will not be recognized once a provider's initial fiscal year under the prospective payment method has begun.

*Authority: T. C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.*

**1200-13-5-.15 RATE NOTIFICATION AND EFFECTIVE DATES.**

- (1) — Beginning 30 days after the effective date of this regulation, each provider will be notified of their initial prospective rate at least 30 days prior to the beginning of their first fiscal year under prospective payment. For those providers whose first fiscal year under prospective payment begins earlier than 30 days after the effective date of this rule, every attempt will be made to provide for a reasonable notice to them. The initial prospective rate shall apply to services provided on or after the first day of the provider's first fiscal year subject to prospective payment. Payment for services rendered prior to the first day of the provider's first fiscal year subject to prospective payment and submitted for payment after such date shall be paid at the rate in effect during the period the service was rendered. Providers must split bill for services spanning their first prospective year and the prior year.

- (2) — Within 30 days after the receipt of each provider's cost report, each provider will be notified of their new prospective rate due to the normal pass-through adjustment. This rate shall be effective by the first day of the next month one month subsequent to the date of receipt of the provider's cost report. Providers must split bill for services spanning the effective date of the rate change.

- (3) — Within 30 days before the beginning of each fiscal year subsequent to the initial prospective year, each provider will be notified of their new prospective rate due to the normal operating rate adjustment. This rate shall apply to services provided on or after the beginning of the new fiscal year. Providers must split bill for services spanning the effective date of the rate change.

- (4) — Providers will be notified of special rate adjustment described in rule 1200-13-5-.12 no later than 45 days after the receipt of the appropriate data. Such rate change shall be effective as specified in

rule 1200-13-5-.12(2). Provider must split bill for services spanning the effective date of the rate change.

(5) Subsequent years' adjustments for high-Medicaid volume, minimum occupancy, and resident and intern costs shall be completed at the same time and become effective at the same time as the pass-through adjustment described in rule 1200-13-5-.14(2).

(6) Delays in setting rates may be encountered if it becomes necessary to request additional information from a provider due to errors or omissions on cost reports. Cost reports are due as specified by Medicare regulations in effect on October 1, 1982.

(7) In cases of a change in ownership or fiscal year end, the operating component will be adjusted when the next trend is due under the old fiscal year end in order to avoid overlap or duplication of the period trended. This trend will be to the midpoint of the time between the old fiscal year end and the new fiscal year end and will be effective for dates of service beginning on the day after the old fiscal year end. The next trend will be from the midpoint of that period to the midpoint of the new fiscal year and will be effective for dates of service beginning on the first day of the new fiscal year. The rates should be computed at least 30 days prior to the effective date of the rate. Examples are found at subparagraphs (a) and (b) below.

(a) Assume that a provider has a former fiscal year end of June 30 and changes to a December 31 year end. The provider notifies us of the change before June 1, 1984. The provider's rate has already been indexed to the midpoint of the year July 1, 1983 to June 30, 1984, that midpoint being January 1, 1984. That rate was effective for services on or after July 1, 1983. Next, we will index from the midpoint of the former fiscal year, that midpoint being January 1, 1984, to the midpoint of the time between the provider's former year end of June 30, 1984, and the new fiscal year end of December 31, 1984, that midpoint being October 1, 1984. The effective date of this rate will be for services on or after July 1, 1984. Next, we will trend from the point where we left off (October 1, 1984) to the midpoint of the provider's new fiscal year end of December 31, 1985, that midpoint being July 1, 1985, with a corresponding effective date of services on or after January 1, 1985. Normal annual indexing takes place thereafter.

(b) Notification made subsequent to Comptroller's indexing based on the former fiscal year end. Assume the same facts in the first example except that the provider notifies us of their fiscal year end change sometime after June 1, 1984. The provider's rate has already been indexed to the midpoint of the year July 1, 1984 to June 30, 1985, that midpoint being January 1, 1985. That rate was effective for services on or after July 1, 1984. Next, we will index from the midpoint of the former fiscal year, that midpoint being January 1, 1985, to the midpoint of the time between the provider's former year end of June 30, 1985, and the new fiscal year end of December 31, 1985, that midpoint being October 1, 1985. The effective date of this rate will be for services on or after July 1, 1985. Next, we will trend from the point where we left off (October 1, 1985) to the midpoint of being July 1, 1986, with a corresponding effective date of service on or after January 1, 1985. Normal annual indexing takes place thereafter. This procedure will be followed to avoid overlapping of the periods trended even if the provider changed fiscal year end in 1984.

*Authority: T.C.A. §§14-23-105, 14-23-109 and 4-5-202. Administrative History. Original rule filed June 26, 1995, effective July 26, 1985. Amendment filed March 25, 1987, effective May 9, 1987.*

#### **1200-13-5-.16 METHOD FOR PAYING PROVIDERS WHICH ARE EXEMPT FROM PROSPECTIVE SYSTEM.**

(1) The Comptroller of the Treasury, will determine, in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described at 42 CFR 405, per diem reimbursable costs for those Medicaid providers of hospital services exempted from the prospective system set out in rules 1200-13-5-.06 through 1200-13-5-.15 inclusive, except those hospitals described in

item (3) of rule 1200-13-5-.07 which shall be reimbursed as described in that item. The maximum limit of such reimbursable costs shall be the lesser of: (a) the reasonable cost of covered services; or (b) the customary charges to the general public for such services. Provided, however, that such providers which are public hospitals rendering services free or at nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accord with provisions of 42 CFR 405 in effect on October 1, 1983. Covered services means covered services as defined by the Department. Each provider's per diem reimbursable cost will be based on the provider's cost report which is to be filled out and submitted in accordance with rule 1200-13-5-04.

(2) ~~Interim Rate.~~ The Comptroller of the Treasury, will establish interim per diem reimbursable rates for providers exempted from the prospective payment system. The interim rate remains in effect until the provider's actual reimbursable cost based on the provider's cost report, is established. Interim rates shall be based on prior cost report data and shall be subject to revision upon further review, audit, and/or subsequent finding of the Comptroller of the Treasury. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.

(3) ~~Approval of Initial Settlement.~~ When a provider's cost report is received, it is reviewed and compared with:

(a) ~~The amount of charges for covered services provided to Medicaid beneficiaries by the provider during the provider's fiscal period.~~

(b) ~~The amount of interim payments paid by the Department to the provider for the provider's fiscal period.~~

(c) ~~The number of inpatient days approved for the provider by the Department during the provider's fiscal period.~~

~~On the basis of the comparison and review, the Comptroller of the Treasury will make an initial determination of the cost settlement due to the provider or the state for the designated period. Approval of the initial settlement will be subject to further review, audit and/or subsequent finding of the Comptroller of the Treasury. On the basis of the initial settlement, the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment made to the provider during the fiscal year.~~

(4) ~~Approval of Final Cost Settlement.~~ After the necessary final review and/or auditing has been performed by the Comptroller of the Treasury, the Comptroller will advise the Department of the final cost settlement approved. On the basis of the approved final settlement the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment made to the provider during the fiscal year.

(5) ~~Inpatient Routine Operating Per Diem Cost Limitation.~~ In the event that data is not available to compute the inpatient routine operating per diem cost limitation for all or any part of a provider's fiscal year, the Comptroller of the Treasury will use each provider's per diem cost limitation in effect prior to the provider's first fiscal year subject to prospective payment which will be appropriately trended by the actual hospital market index as published by the Health Care Financing Administration in the Federal Register or by Data Resources, Inc., or their successors.

(6) ~~Out of State Reimbursement Rate.~~ Hospitals which meet the criteria as set forth in rule 1200-13-5-.07(2), shall be reimbursed at the lesser of:

(a) the reasonable cost of covered services;

~~(b) the customary charges to the general public for such services, or~~

~~(c) the Medicaid reimbursement rate as established by the hospital's respective state. Covered services are those defined by the Tennessee Department of Health. Reimbursement by Tennessee Medicaid shall be considered as payment in full for covered services and no additional billings shall be made to the patient for these services.~~

~~Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109 and 4-5-202. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed May 8, 1991; effective June 22, 1991~~

#### ~~1200-13-5-.17 AUDIT.~~

~~(1) All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Department or their designated representative. Cost report data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions.~~

~~(2) Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay." Medical audit exceptions may result in a direct recoupment rather than a rate change.~~

~~(3) The Department will provide for all costs of auditing which may be required.~~

~~Authority: T.C.A. §§14-23-105 and 14-23-109. Administrative History: Original rule filed June 26, 1985; effective July 26, 1985.~~

~~1200-13-5-.18 TERMINATION OF MEDICAID HOSPITALIZATION PROGRAM. For hospitalization services provided prior to January 1, 1994, the rules as set out at rule chapter 1200-13-5 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except that Tennessee Medicaid will continue to pay Medicare premiums, deductibles and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.~~

~~Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. Administrative History: Original rule filed March 18, 1994; effective June 1, 1994.~~

### Hospital Rate Variation Corridors

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#### 1200-13-05-.01 Definitions.

(1) Bureau of TennCare (Bureau). The administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

- (2) Existing Contracts. The contracts that were in place between a Tennessee hospital and a TennCare MCO as of July 1, 2013.
- (3) Hospital. A general or specialty acute care facility licensed as a hospital by the Tennessee Department of Health pursuant to T.C.A. § 68-11-206, excluding hospitals that are categorized as Rehabilitation, Research, Long Term Acute or Psychiatric on the 2013 Joint Annual Report of Hospitals.
- (4) Inpatient Services. Routine, nonspecialized services that are provided at many or most hospitals in the state to patients admitted to the hospital as inpatients.
- (5) MCO (Managed Care Organization). An appropriately licensed Health Maintenance Organization (HMO) contracted with the Bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and behavioral benefits to TennCare enrollee-members through a network of qualified providers.
- (6) Medicare. A hospital's fee-for-service reimbursement under Title XVIII including that hospital's adjustment for DSH, wage index, etc., and excluding only Indirect Medical Education (IME), pass through payments, and any Medicare payment adjustments for Sequestration, Value Based Purchasing, Readmissions and Hospital Acquired Conditions.
- (7) Medicare Severity Diagnosis Related Groups (MS-DRG). The Medicare statistical system of classifying any inpatient stay into groups for the purpose of payment.
- (8) New Contract. Any initial contract between an MCO and a hospital that did not exist on July 1, 2013. Contracts in place on July 1, 2013, that have been materially altered since July 1, 2013, are not new contracts.
- (9) Outpatient Services. Services that are provided by a hospital to patients in the outpatient department of the hospital and patients receiving outpatient observation services.
- (10) Rate Corridors. Upper and lower limits established by the state's actuary and approved by the Bureau, in consultation with the Tennessee Hospital Association (THA), for payments by MCOs to hospitals for services provided to TennCare enrollees. The Rate Corridors are based on a hospital's Medicare reimbursement that existed in FFY 2011 and used to determine the parameters of TennCare rates for contracts between Tennessee hospitals and TennCare MCOs after July 1, 2013. The determination of whether a hospital's TennCare rates are within the prescribed Rate Corridors shall be made on the basis of reimbursement from all TennCare MCOs with which the hospital has a contract. The Rate Corridors, which were calculated by the State's actuary as the budget neutral corridors, are as follows:
  - (a) For inpatient services, the minimum level is 53.8% and the maximum level is 80% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level is 93.2% and the maximum level is 104% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level is 32% and the maximum level is 83% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum is 4% and the maximum level is 174% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level is 49% and the maximum level is 164% of the hospital's Medicare for 2011.
- (11) Specialized Services. Services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma.

- (12) TennCare. The TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.
- (13) TennCare Actuary. The actuarial firm selected by the Bureau to assist the Bureau in establishing the capitation rates for TennCare MCOs each year.
- (14) Total TennCare Rates. Payment rates for each hospital in the aggregate from all MCOs with which the hospital has network contracts.
- (15) Year 1 Corridors. The initial upper and lower limits established by the Bureau in consultation with THA based on a hospital's Medicare reimbursement that existed in FFY 2011 and that were used to implement rate variation limitations in contracts between Tennessee hospitals and TennCare MCOs from July 1, 2012 until July 1, 2013. The Year 1 Corridors are as follows:
- (a) For inpatient services, the minimum level was 40% and the maximum level was 90% of the hospital's Medicare for 2011.
  - (b) For outpatient services, the minimum level was 90% and the maximum level was 125% of the hospital's Medicare for 2011.
  - (c) For cardiac surgery, the minimum level was 30% and the maximum level was 80% of the hospital's Medicare for 2011.
  - (d) For specialized neonatal services the minimum was 4% and the maximum level was 180% of the hospital's Medicare for 2011.
  - (e) For other specialized services the minimum level was 30% and the maximum level was 160% of the hospital's Medicare for 2011.

1200-13-05-.02 Implementation of Contract Amendments for Existing Contracts between Hospitals and MCOs.

These contracts set rates for a period of two years effective July 1, 2013, and provided for rate amendments to be negotiated and implemented on July 1, 2015.

- (1) For hospitals that had existing contracts with MCOs in place on July 1, 2013, and the MCO and hospital had negotiated contract amendments to bring rates for total TennCare into the Rate Corridors and the rates in the contracts have not been adjusted since July 1, 2013, the MCOs will reissue those amendments with a new effective date of July 1, 2015.
- (2) In the case of a hospital that had contracts with MCOs in place on July 1, 2013, which contracts included amendments implementing rates within the Rate Corridors, and where the rates in the contracts have been adjusted since July 1, 2013, the Bureau shall evaluate the rates in the current contracts to determine if the total TennCare rates for the hospital are within the Rate Corridors. If the rate adjustments cause the total TennCare reimbursement for the hospital to be outside of the Rate Corridors, the affected MCOs shall implement contract amendments approved by the Bureau in consultation with the TennCare Actuary to bring the hospital rates into the Rate Corridors effective July 1, 2015.
- (3) In the case of a hospital with contracts in existence on July 1, 2013, which contracts include rates outside of the Rate Corridors, the affected MCOs shall implement contract amendments to bring total TennCare rates into the Rate Corridors with an effective date of July 1, 2015. The Bureau shall verify that the new contract rates in conjunction with contracts between the hospital and all other MCOs bring the hospital's total TennCare rates within the Rate Corridors.

1200-13-05-.03 Implementation of New Contracts between Hospitals and MCOs Entered into after July 1, 2013.

These contracts have not yet been in effect for a period of time sufficient to negotiate rate amendments for a July 1, 2015, implementation date. In the case of a hospital that entered into a contract with an MCO

after July 1, 2013, including a hospital that entered into a contract with an MCO with rates within Year 1 Corridors effective January 1, 2015, the affected MCOs shall implement contract amendments that bring the hospital rates within the Rate Corridors no later than September 30, 2015.

1200-13-05-.04 Exclusion of Any Hospital from TennCare Networks.

A hospital that does not accept a contract amendment required by this Rule shall be excluded effective October 1, 2015, from participation in the TennCare MCO network to which the contract amendment applies.

1200-13-05-.05 Out-of-Network Reimbursement.

Out-of-Network payments to all hospitals shall be governed by TennCare Medicaid Rule 1200-13-13-.08(2)(a)-(c) and TennCare Standard Rule 1200-13-14-.08(2)(a)-(c).

1200-13-05-.06 Agreements between Hospitals and MCOs for Limited Services.

Rates for a single case agreement negotiated between the MCOs and hospitals that are not in network with the MCO to ensure access to services for TennCare enrollees may not exceed the ceiling or be below the floor of the Rate Corridors appropriate for those services.

1200-13-05.07 Changes to Hospital Rates Negotiated between MCOs and Hospitals after September 30, 2015.

To ensure that each hospital's total TennCare reimbursement remains within the Rate Corridors, proposed rate changes after September 30, 2015, shall be evaluated by the Bureau to determine if the proposed rate change will move the hospital's total TennCare rates outside of the Rate Corridors. If the evaluation indicates the change will put the hospital outside of the Rate Corridors, the Bureau shall provide the adjustments necessary to ensure that the contract is compliant with the limits of the Rate Corridors. TennCare rates between a hospital and an MCO may not be modified after September 30, 2015, without approval from the Bureau.

1200-13-05-.08 Categorization of New Services Added after July 1, 2015.

MS-DRG classifications serve as the basis for identifying services as inpatient or specialized. MS-DRG classifications may change and new MS-DRG classifications may be added from time to time. New or modified MS-DRG classifications shall be evaluated for assignment to appropriate inpatient or specialized categories by the Bureau in consultation with THA and the TennCare Actuary.

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