STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

REIMBURSEMENT METHODOLOGY FOR PROVIDERS OF ACUTE CARE HOSPITAL SERVICES

All hospitals enrolled in the Tennessee Medicaid Program, except those specified as exempt, with fiscal years beginning on or after October 1, 1983, shall be reimbursed on a prospective payment methodology. Exempt providers, shall be reimbursed in accordance with Medicare, Title XVIII principles and standards in effect on October 1, 1982, and described in 42 CFR 405. Exempt providers are subject to the revaluation of assets provision, Section 2314 of the Deficit Reduction Act (DEFRA). Enrolled hospitals shall meet state licensure requirements for an acute care hospital and shall be certified by the Medicare program as an acute care hospital as of the date of the hospital's enrollment in the Tennessee Medicaid Program.

Cost Reporting Requirement - 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, 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. All covered services are to be in accordance with the Medicaid Program definition of covered services.

Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR 405 shall be subject to penalties imposed by such regulations. Except as stated in Providers Exempted from Prospective Payment Methodology, hospitals not filing cost reports for a specific period shall be required to refund all payment made under this program for that period.

Any contracting provider that does not adopt the uniform classification of accounts, or other acceptable accounting methods as shall be established by the Department of Health in consultation with the Comptroller and the Tennessee Hospital Association, or does not submit cost data as required by the Department of Health, shall be assessed a penalty of ten dollars ($10.00) for each day such provider is not in compliance.

Records Retention - Each hospital provider is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health or the United States Department of Health and Human Services. All cost reports shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

Audit Requirements - All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Medicaid Agency 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. 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 in a rate change.

Providers Exempted From Prospective Payment Methodology - (A) Long-term care facilities (hospitals that have an average length of stay of more than 25 days). (B) Hospitals that elect not to submit a cost report and 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 do not include charges associated with transplants covered by Tennessee Medicaid and are reimbursed as specified in Section 1-Prospective Payment Methodology.

Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items 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 Section 1-Prospective Payment Methodology.

(b) All other hospitals will be exempt from the prospective payment methodology and are reimbursed as specified in Section 2-Method for Paying Providers which are Exempt from Prospective Payment Methodology.

1. Prospective Payment Methodology

A. Effective October 1, 1983, 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 form 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. Where appropriate, Tennessee Medicaid costs will be determined either by a computed utilization ratio from form HCFA- 2552 81(11-81) or, at the option of the provider, from form HCFA- 1007 which must be submitted by the provider.

B. Beginning July 1, 1987 the prospective payment will be made as a rate per inpatient day for the operating component and a quarterly lump-sum payment for the pass-through, disproportionate share, and indirect education adjustment.

Beginning January 1, 1988 the prospective payment will be made as a rate per inpatient day for the operating component and a monthly lump-sum payment for the pass-through, disproportionate share, and indirect education adjustment.

Beginning July 1, 1989, 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, 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, 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, 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.

C. 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.

D. Pass Through Component

(1) Each facility's initial prospective rate will be based on a 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. Effective July 1, 1992, The Services Tax will be an allowable cost included in the pass through component.

2(a) Effective October 1, 1991 capital costs will be reduced by 15% for dates of service October 1, 1991 through June 30, 1992. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reductions in capital costs. Effective July 1, 1992, hospitals will be reimbursed 100% of capital costs for dates of service July, 1, 1992 and later.

(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 on record on or after July 18, 1984. 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. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

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(3) 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	5/1/83
Initial Prospective Rate Determined	6/1/83
Beginning of Prospective Payment	1/1/84
12/31/83 Cost Report Received	5/1/84
12/31/83 Cost Report Rate Adjustment Completed	6/1/84

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. Adjustments in reimbursement for return on equity applicable to proprietary providers is in accordance with Medicare's (Title XVIII) schedule which is set out at page 5 of 11 of Attachment 4.19-A of this state plan.

(4) Beginning July 1, 1987 the pass-through component will be paid as a quarterly lump-sum payment established in June of each year. The quarterly payment will be prospective based upon the most recent cost report with adjustment for all audited cost.

Example

First year
Pass through cost based on an unaudited cost report for year-end June 30, 1986. $200,000

Second year
Pass through cost based on an unaudited cost report for year-end June 30, 1987. $240,000

Third year
Pass through cost based on an unaudited cost report for year-end June 30, 1988. $260,000

Final audit cost for July 1, 1987 through June 30, 1988. $180,000

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*7/1/87 through 6/3/88 payment	-200,000
less audit cost 7/1/87 thru 6/30/88	+180,000
Adjustment to current year	-20,000
Current year payment	
Based on last unaudited report	+260,000

(5) Beginning January 1, 1988 the pass-through component will be paid as a monthly lump-sum payment established in June of each year. The monthly payment will be prospective based upon the most recent cost report with adjustment for all audited costs.

E. Operating Component - Each facility's initial prospective rate shall also include an operating component which is based on the base year cost report. The operating component will be trended forward each year. The trending index which shall be used to arrive at the operating component in the initial prospective year shall be the estimated actual rate of increase in Medicare inpatient operating costs which is in effect during the trending period and which is furnished by the Health Care Financing Administration's Office of the Actuary. The trending period shall be from the midpoint of the hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Except for trending to the new rebased year (1988 cost reports or if not available the prior cost report) which will be the indexing rate recommended by the Prospective Payment Assessment Commission, the trending index which shall be applied to operating component shall be as follows:

Period Covered	Rate
10/1/85-9/30/86	0%
10/1/86-9/30/87	1.15%
10/1/87-6/30/88	2.7%
7/1/88-6/30/89	0%

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 the midpoint of each provider's fiscal year, to the midpoint of the subsequent fiscal year. 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 each fiscal year.

Example: Provider X has a 9/30/86 fiscal year end. Indexing midpoint to midpoint would be from 4/1/86 to 3/31/87. The appropriate index is .575 computed as follows:

$$(0\% \times 6/12) + (1.15\% \times 6/12) = .575$$

F. 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 adjustment will be computed as follows and will be made at the same time as the pass through adjustment.

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

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. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. Effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty.

G. 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 Medicaid Disproportinate Share minimum occupancy adjustment for October 1, 1983 thru June 30, 1987.

		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	320.68
7.	Prospective Rate (line 2 + line 4 + line 6)	$324.50	$354.30	$382.46

(3) Beginning July 1, 1987, the resident and intern cost adjustment will be paid on a quarterly basis established in June of each year. The quarterly payment will be prospective based on the RI rate established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established from paid claims from June - May fiscal year plus expected improvement based uopn a historical basis for the upcoming fiscal year July - June.

Beginning January 1, 1988, the resident and intern cost adjustment will be paid on a monthly basis established in June of each year. The monthly payment will be prospective based on the RI rate established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established from paid claims from June - May fiscal year plus expected improvement based upon a historical basis for the upcoming fiscal year July - June.

Based on example (2) above:

Days for June 86 - May 87.	4,000 days
Expected improvement. (for example increase in day limit)	100 days

Resident and intern payment 7/1/87 thru 6/30/88
4100 X $22 = $90,200

H. Medicaid Disproportionate Share Adjustment (MDSA) effective July 1, 1988

(1) Acute care hospitals having over 3,000 inpatient 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) + (b) 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 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) 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.

(2) Acute care hospitals that do not qualify under the criteria in (1) 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:

o 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,

o 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 Sate plan) that is, reductions in charges given to other third party payers, such as HMO's, Medicare or Blue Cross.

(d) 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.

(3) 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.

(4) Beginning July 1, 1988 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 improvement.

(5) Beginning January 1, 1991, any hospital designated as a perinatal center by statute or regulation and with a service plan approved by the Tennessee Department of Health and Environment, Maternal and Child Health Section or any hospital providing without charge services to high-risk, multi-handicapped persons under age 21 who are in need of specialized children's services, 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 (1) and (2) 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 the above formula.

(6) Beginning July 1, 1991, any acute care hospital qualifying for a disproportionate share adjustment under the qualifying criteria listed in (1) and (2) 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~~ to 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 (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 (1), (2), and the enhanced payment computed in (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.

d. For the period December 15, 1991 through December 31, 1991 an additional payment will be made to qualifying hospitals in accordance with the following formula:

1. The prospective rate will be adjusted upward by an amount equal to the difference of the hospital's annual Medicaid utilization ratio and the annual industry average utilization ratio multiplied by a factor of 800.

2. This additional enhanced MDSA payment will be based on the enhanced disproportionate share adjustment calculated in 1. above multiplied by the anticipated number of Medicaid days for the fiscal year July through June.

3. The sum of the MDSA payment calculated in (1), (2), and the enhanced payment computed in (6) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments based on the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The amount paid during this period, December 15, 1991 through December 31, 1991, will not be included when applying the limit described in 6c.

4. This methodology will be effective from December 15, 1991, through December 31, 1991. After that time, all payments will be made in accordance with the methodology approved in the State Plan and in effect for July 1, 1991.

(7) Effective October 1, 1992, the Medicaid disproportionate share adjustment will not be determined per above, but will be determined as described as herein. 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 ratio 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 calculation, Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this calculation 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. For the purposes of computing the MDSA, the MDSA prospective rate will be considered to be the operating per diem for the current year, prior to the application of the current year trend, plus a capital per diem and a direct medical education per diem.

(a) The prospective rate will be adjusted upward by factor of 27.169 times the difference between the actual utilization rate if it exceeds 7.94% 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 if it exceeds 25% 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 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.

(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 non-emergency obstetric services as of December 21, 1987.

(f) Any hospital whose inpatient and outpatient 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 Medicaid 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 exceeds 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. 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.

(i) 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 item (g) above, 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.

(8) 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 items (a), (b), or (c), whichever is higher, and added to item (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 calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this calculation 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 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 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 a 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% of 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 item (g) above, 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.

The calculation would be made in this manner: Tennessee Medicaid will total the amount of MDSA to be provided to all hospitals, both acute and psychiatric, prior to the test for the federal cap. If this total exceeds the federal cap, we will subtract from the cap amount the amount calculated as a result of item (g) (referenced above). We will take the remaining amount and divide it by the total potential MDSA for the industry less item (g) to obtain a percentage by which each hospital's MDSA payments outside of item (g) will be reduced.

I. Other Adjustments to the Prospective Rate or Prospective Payment

(1) Adjustments to the prospective rate shall be made for the following reasons:

(a) An error 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 $50,000 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 $50,000 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.

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J. New Providers - 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 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.

K. 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. Carryforwards of unreimbursed costs will not be recognized once a provider's initial fiscal year under the prospective payment methods has begun.

L. Rate Notification and Effective Dates - Beginning 30 days after October 1, 1983 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. 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 fiscal year subject to prospective payment and submitted for payment after such date shall be paid at the rate in effect during the peirod the service was rendered. Providers must split bill for services spanning the first prospective year and the prior year.

M. For payment beginning July 1, 1987, all providers will be notified of adjustment to prospective per day rate which will be the operating component only. The quarterly payment will be established in June 1987 and re-established each June of subsequent years. Providers will be notified in June of each year for the quarterly payment. Beginning January 1, 1988, providers will be paid on a monthly basis for the pass through component, resident and intern cost adjustment and Medicaid Disproportionate Share Adjustment.

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.

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.

Providers will be notified of special rate adjustment no later than 45 days after the receipt of the appropriate data. Such rate change shall apply only to services provided on or after the forty-fifth day subsequent to the receipt of the adjustment data. Providers must split bill for services spanning the effective date of the rate change.

Subsequent years' adjustments for Medicaid disproportionate share, minimum occupancy (effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty), and resident and intern costs shall be completed at the same time and become effective at the same time as the pass-through adjustment.

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.

N. Automatic Adjustment for Medicare Adjustment - The following components of the prospective rate will be changed to reflect Medicare changes when announced by Medicare thru the Federal Registers or Federal law.

(1) Operating component - will be indexed according to Prospective Payment Assessment Commission (PROPAC) recommendations.

(2) Pass-thru component - will be adjusted for changes in Medicare reimbursement principles.

(3) Indirect education - will be adjusted for Medicare index.

(4) Operating component - will be rebased by Medicare announced PPS rebasing.

2. Method for Paying Providers Which Are Exempt From Prospective Payment Methodology - The per diem reimbursable costs for the Medicaid providers of inpatient hospital services exempted from the prospective methodology will be determined in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described in 42 CFR 405, except those hospitals described in Providers Exempted from Prospective Payment Methodology, 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, (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 as defined by Tennessee Medicaid. 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.

In-state providers which are public hospitals rendering services free or at a nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accordance with the provisions of 42 CFR 405. Each provider's per diem reimbursable cost will be based on the provider's cost report.

A. Interim Rate - An interim per diem reimbursable rate for these providers will be established. 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 revisions upon further review, audit and/or subsequent finding. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.

B. Approval of Initial Settlement - When a provider's cost report is received, it is reviewed and compared with:

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

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

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

On the basis of the comparison and review, an initial determination will be made 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. On the basis of the initial settlement, the Department of Health will 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 of Health for the amount of overpayment made to the provider during the fiscal year.

C. 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 Health of the final cost settlement approved. On the basis of the approved final settlement, the Department of Health will 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 of Health for the amount of overpayment made to the provider during the fiscal year.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

This methodology will be used only during a designated emergency period that has been mutually agreed upon by the State and HCFA. It will be discontinued at the time that the designated emergency period is determined to have ended.

Acute care inpatient hospital providers will be reimbursed the per diem rate in effect as of December 31, 1993. The rate will be adjusted to include the capital component and eliminate the education and disproportionate share components. There will no longer be a tax component. Payment will be considered to be "reimbursement in full" with no cost settlement. In the event there are new providers since December 31, 1993, for which Medicaid provider numbers have been issued, a rate will be established for them using their most recent cost report submitted to the Office of the Comptroller. The rate will be trended back to December 31, 1993 to be consistent with other hospital providers.

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REIMBURSEMENT METHODOLOGY FOR PROVIDERS OF PSYCHIATRIC HOSPITAL SERVICES

Effective July 1, 1988, the single state agency shall reimburse inpatient psychiatric providers on a prospective basis for services provided under the State Plan.

All inpatient psychiatric hospitals, except those specified as exempt, with fiscal years beginning on or after July 1, 1988, shall be reimbursed on a prospective payment methodology. Exempt providers shall be reimbursed in accordance with Medicare, Title XVIII Principles and Standards in effect October 1, 1982, and described in 42 CFR 405. Exempt providers are subject to the revaluation of assets provision, Section 2314 of the Deficit Reduction Act (DEFRA).

Cost Reporting Requirement - 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, 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.

Providers that fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR Part 405 shall be subject to penalties imposed by such regulations. Except as stated in item "C" of Providers Exempted from Prospective Payment Methodology, hospitals not filing cost reports for a specified period shall be required to refund all payments made under this program for that period.

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Any contracting provider that does not adopt the uniform classification of accounts, or other acceptable accounting methods as shall be established by the Department of Health and Environment in consultation with the Comptroller and the Tennessee Hospital Association, or does not submit cost data as required by the Department of Health and Environment, shall be assessed a penalty of ten dollars ($10.00) for each day such provider is not in compliance.

Records Retention - Each hospital provider is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health and Environment or the United States Department of Health and Human Services. All cost reports shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

Audit Requirements - All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Medicaid Agency 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. 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.

Providers Exempted from Prospective Payment Methodology - The prospective payment system shall not apply to the following hospitals and services:

A. Any health care facility that is not a hospital, skilled nursing facilities and intermediate care facilities located within hospitals when certified or licensed as "nursing" homes and swing beds, while being used to provide nursing services at less than the acute level of hospital care.

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B. Inpatient services provided before July 1, 1988, by providers of either inpatient psychiatric services to persons under the age of twenty-one (21), or inpatient hospital services in institutions for mental disease to individuals age sixty-five (65) or older.

C. Psychiatric hospitals which elect not to submit a cost report and which have less than $10,000 annually, based on the provider's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee. Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed $10,000 in total Tennessee Medicaid charges annually, they will be treated as new providers.

D. Outpatient hospital services, as defined by the October 1, 1986, edition of 42 CFR 440.20.

1. Prospective Payment Methodology

A. Except as provided by other provisions of this State Plan amendment, each hospital's reimbursable inpatient costs will be determined in accordance with Medicare 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 component only. The prospective rate will consist of the trended operating component. Tennessee Medicaid costs will be determined by a computed utilization ratio from HCFA Form 2552 which must be submitted by the provider. The prospective payment (operating costs) will be made as a rate per inpatient day. On and after July 1, 1988, in psychiatric hospitals and institutions for mental disease, which dates apply without regard to the date upon which the provider's fiscal year may end, the pass-through component will not be a part of the per diem rate, but will, instead, be paid in lump sum amounts on a monthly basis.

B. Pass Through Component

(1) For inpatient services in psychiatric facilities on or after July 1, 1988, irrespective of provider fiscal year end, the

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reimbursable per diem rate will consist of only the operating component. The remaining components: capital and direct medical education will be paid in a lump sum amount. Capital and direct medical education costs will be estimated from each provider's most recent cost report on file as of 4:30 p.m. C.D.T., Monday, June 30, 1988. The estimate will be used to compute a lump sum amount for capital and direct medical education. Payment will be made monthly starting July 1, 1988. Each provider's subsequent cost report will be used to adjust the capital and direct medical education for the subsequent fiscal year. This adjustment shall be effective on the first day of the next month, one month subsequent to the date of receipt of the provider's cost report. Capital and direct medical education costs will be subject to year end cost settlement for inpatient psychiatric services on and after July 1, 1988. Effective July 1, 1992, the services tax will be an allowable cost included in the pass through component.

2(a) Effective October 1, 1991, capital costs will be reduced by 15% for dates of service October 1, 1991 through June 30, 1992. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reductions in capital costs. Effective July 1, 1992, hospitals will be reimbursed 100% of capital costs for dates of service July 1, 1992 and later.

2(b) Additional 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, 1984. 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. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

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(3) 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.

(a) The return on equity for acute care and psychiatric proprietary providers will be reduced as follows: for cost reporting periods beginning after September 1986, payment will be 75% of the current amount; 50% of the current amount for reporting periods beginning after September 1987; 25% of the current amount for reporting periods beginning after September 1988; and zero thereafter.

C. Operating Component - Each facility's initial prospective rate shall also include an operating component which is based on the base year cost report. In base years all providers including providers that are within the first three years of operation will be subject to the routine per diem cost limitation for prospective rate purposes. The routine per diem limitations for these purposes will be set in the same manner as those used for acute care hospitals. All new providers may have their prospective rate adjusted at the end of the first five year period. The operating component will be trended forward each year. The trending period shall be from the midpoint of each hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Except for trending to the new rebased year (1988 cost reports or if not available the prior cost report) which will be the indexing rate recommended by the Prospective Payment Assessment Commission, the trending index which shall be applied to the operating component shall be as follows:

Period Covered	Rate
10/1/85-9/30/86	0%
10/1/86-9/30/87	1.15%
10/1/87-6/30/88	2.7%
7/1/88-6/30/89	0%

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Thereafter, the trending index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and is published in the Tennessee Administrative Register. The trending indexes above shall be applied from the midpoint of each provider's fiscal year, to the midpoint of the subsequent fiscal year. When necessary, indexes will be prorated to correspond to the provider's year end. Each provider will be notified of their new operating rate due to indexing within 30 days of the beginning of each fiscal year.

Medical malpractice insurance reimbursement will be limited to 7.5% of allowable malpractice insurance premiums for prospective rate purposes.

D. 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 adjustment will be computed as follows and will be made at the same time as the pass through adjustment.

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

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 mean 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,

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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 is subject to audit. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. For psychiatric providers, the minimum occupancy adjustment will apply to services on and after July 1, 1988. The minimum occupancy adjustment will be applied before the adjustment specified in B(4). Effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty.

E. Rate or Payment Adjustment

(1) Prospective per diem rates or lump sum payment amounts are subject to adjustment in the event of a mistake.

(2) Operating per diem rates may be adjusted if there is a significant change in case mix resulting in a $50,000 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. Requests for adjustments must be accompanied by detailed supporting information. Such rate adjustments if approved become effective on the first day of the month following the approval.

(3) Providers may request an increase in monthly interim payments for capital and direct medical education if a provider's actual amounts are expected to exceed the estimated amount by at least 25%. Supporting financial data must be submitted with the request. No more than one request per year for an increase will be accepted per provider. The Commissioner reserves the right, after notifying the provider, to decrease estimated payments when information is made available indicating the estimated payments are materially higher than what is actually being incurred.

F. Medicaid Disproportionate Share Adjustment (MDSA) effective July 1, 1988. Inpatient psychiatric hospitals having a utilization

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ratio at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments or a low income utilization rate exceeding 25 percent will receive a 1% adjustment to the prospective rate for each percentage above the 14% up to a cap of 3%; or a 2% adjustment to the prospective rate for each percentage above the 25% low income utilization rate up to a cap of 3%.

(1) Low income utilization rate will be calculated as follows and will use information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

(a) 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,

(b) 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.

(2) 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 Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(3) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This

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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.

(4) Beginning July 1, 1988, 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.

(5) Effective July 1, 1989, psychiatric 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%.

(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 are less than 4,000.

(c) No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

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(6) Psychiatric hospitals that do not qualify under the criteria in (5) 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% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest 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 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.

(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

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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) 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, the Medicaid disproportionate share adjustment will not be determined as defined at F. and subsequent paragraphs (1)-(8), but will be determined as described herein. Psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 9.31% Medicaid utilization ratio 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) but cannot exceed 10% of the inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this calculation 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. For the purposes of computing the MDSA, the MDSA prospective rate will be considered to be the operating per diem for the current year, prior to the application of the current year trend, plus a capital per diem and a direct medical education per diem.

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(a) The prospective rate will be adjusted upward by factor of 5.8 times the difference between the actual utilization rate if it exceeds 9.31% and a 9.31% utilization rate.

(b) The prospective rate will be adjusted upward by 5.8% 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 if it exceeds 25% 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 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 Medicaid 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.

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(e) Each year a redetermination of the MDSA will be made. 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.

(f) 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. For the period beginning July 1, 1993, the disproportionate share adjustment will be established in June and will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming state fiscal year, July-June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on item (7)(g) of the state plan for reimbursement for inpatient hospital services, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

(10) Effective July 1, 1993, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a 10.45% Medicaid utilization ratio 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) but cannot exceed 10% of inpatient and outpatient charity

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charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this calculation 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 5.8 times the difference between the actual utilization rate and a 10.45% utilization rate.

(b) The prospective rate will be adjusted upward by 5.8% 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 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 are reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) 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.

(f) 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 unavailable, the latest report on file will be used.

(g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made the amount of payments based on item 8(g) of the State plan for reimbursement for inpatient hospital services will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

The calculation would be made in this manner: Tennessee Medicaid will total the amount of MDSA to be provided to all hospitals, both acute and psychiatric, prior to the test for the federal cap. If this total exceeds the federal cap, we will subtract from the federal cap amount, the amount calculated as a result of item (7)(g) of the state plan for reimbursement for inpatient acute care hospitals (referenced above). We will take the remaining

amount and divide it by the total potential MDSA for the industry less item (7)(g) to obtain a percentage by which each hospital's MDSA payments outside of item (7)(g) will be reduced.

G. New Providers - New providers who have not submitted a cost report and who are entering the program for the first time will be required to submit a budgeted cost report from which an interim prospective operating rate will be set. Each new provider must submit an actual cost report covering the first full year of actual operations, at which point a final prospective operating rate, with a retroactive adjustment, will be set. A change of ownership does not constitute a new provider. The budgeted cost report will also be used to estimate interim payments for capital and direct medical education.

H. 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.

2. Method for Paying Providers Which Are Exempt from Prospective Payment Methodology - The per diem reimbursable costs for the Medicaid providers of inpatient hospital services exempted from the prospective methodology will be determined in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described in 42 CFR

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405, except those hospitals described in Item C. of Providers Exempted from Prospective Payment Methodology, 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 a 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 the provisions of 42 CFR 405. Each provider's per diem reimbursable cost will be based on the provider's cost report.

A. Interim Rate - An interim per diem reimbursable rate for these providers will be established by the Comptroller of the Treasury. 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 revisions upon further review, audit and/or subsequent finding. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.

B. Approval of Initial Settlement - When a provider's cost report is received, it is reviewed and compared with:

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

(2) The amount of interim payments paid by the Department of Health and Environment to the provider for the provider's fiscal period.

(3) The number of inpatient days approved for the provider by the Department of Health and Environment during the provider's fiscal period.

On the basis of the comparison and review, an initial determination will be made 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

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of the Comptroller of the Treasury. On the basis of the initial settlement, the Department of Health and Environment will 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 of Health and Environment for the amount of overpayment made to the provider during the fiscal year.

C. 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 Health and Environment of the final cost settlement approved. On the basis of the approved final settlement, the Department of Health and Environment will 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 of Health and Environment for the amount of overpayment made to the provider during the fiscal year.

D. 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 that rate of increase on prospective payments allowed by Medicare as published annually in the Federal Register and in the Tennessee Administrative Register.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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Supplemental Pool Payments to Select Tennessee Hospitals

The purpose of this amendment is to describe the state's methodology for making Disproportionate Share Hospital (DSH) payments to Tennessee hospitals and for claiming federal participation for the payments.

Qualifications

Hospitals eligible to participate in the Disproportionate Share Hospital (DSH) payments are defined by Section 1923 (b) of the Social Security Act. To determine which pool a 1923 (b) hospital qualifies for will depend on various criteria set forth below.

Allocation of the DSH payments to segments of Hospitals

The DSH payments should be segmented into 5 distinct groups in the following:

- Group 1 - Essential Service Safety Net – 50 percent of the remaining allotment after it is reduced for the Group 5 pool amount – These hospitals are defined as Section 1923 (b) hospitals that are both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved. These hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization in the TennCare program during the quarter in which the payment covers. If a hospital does not meet this requirement at the start of the quarter but subsequently does contract with Select and one other MCO during the quarter, the payments would be prorated accordingly. These hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost.

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- Group 2 - Children's Safety Net – 5 percent of the remaining allotment after it is reduced for the Group 5 pool amount – These hospitals are defined as Section 1923 (b) hospitals that are licensed by the Tennessee Department of Health whose primary function is to provide general acute care services to children under the age of 21 years in Tennessee. Each hospital must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization in the TennCare program during the quarter in which the payment covers. If a hospital does not meet this requirement at the start of the quarter but subsequently does contract with Select and one other MCO during the quarter, the payments would be prorated accordingly. These hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost.

- Group 3 - Free Standing Psychiatric hospitals – 2 percent of the remaining allotment after it is reduced for the Group 5 pool amount – These hospitals are defined as Section 1923 (b) hospitals that are licensed by the Tennessee Department of Mental Health and Developmental Disabilities for the provision of psychiatric hospital services in Tennessee excluding the State Mental Health Institutes. Each free standing psychiatric hospital must be a contracted provider with at lest one of the Behavioral Health Organizations in the TennCare program and at least 30% of its total adjusted days must be covered by TennCare. These hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost. The hospitals in this group excludes the five (5) state mental health institutes

- Group 4 - Other Essential Acute Care – 43 percent of the remaining allotment after it is reduced for the Group 5 pool amount – These hospitals include all other Section 1923 (b) hospitals that are licensed by the Tennessee Department of Health to provide services in Tennessee excluding the critical access hospitals. These hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization in the TennCare program during the quarter in which the payment covers. If a hospital does not meet this requirement at the start of the quarter but subsequently does contract with Select and one other MCO during the quarter, the payments would be prorated accordingly. Each acute care hospital must have either of the following: (i) at least 13.5% or more of its total adjusted days covered by TennCare; or (ii) if 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days for all hospitals in the other essential acute care group. These hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost. This group excludes the Critical Access Hospitals (CAHs). The CAHs receive cost-based reimbursement from the TennCare program and therefore do not have any unreimbursed TennCare costs.

- Group 5 - All Other DSH Hospitals - $10,000 – These hospitals are defined by Section 1923 (b) of the Social Security Act and do not qualify for Group 1-4.

Data – Calculation of the payment amount will be based on the Joint Annual Report of Hospitals used for the current year's Essential Access payment.

Allocation will be based on an assignment of points for groups 1 through 4:

- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

Calculation of Points

(1) TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all hospitals in the "other essential acute care" hospitals group , which excludes the psychiatric, critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater than 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

(2) Bad debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points – less than 4.5%
- 1 point – greater than or equal to 4.5% and less than 9.5%
- 2 points – greater than or equal to 9.5% and less than 14.5%
- 3 points – greater than or equal to 14.5%

For group 5 the allocation will be divided equally among all of the facilities that qualify as group 5 so that the allocation for each hospital equals:

$10,000/(number of hospitals in group 5)

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Medicaid Disproportionate Share Hospital (DSH) Redistribution

Auditing and Reporting

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Bureau of TennCare will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with an effective date of January 19, 2009, to ensure that the hospital-specific DSH limits have not been exceeded.

Redistribution Method for Recoupment of DSH Funding

Effective in State Fiscal Year 2011, in the event that a hospital received DSH payments in State Fiscal Year 2010-11 or a subsequent State Fiscal Year that exceeded the hospital-specific DSH limit in that year, the amount of the DSH excess payments received in that Fiscal Year will be recovered from the hospital and redistributed among the other hospitals in that hospital's DSH group. The data and method used to redistribute excess DSH payments will be consistent with the original determination of DSH payments for that Fiscal Year. The redistribution of funds related to a prior year's allotment shall not count against the State's current year DSH funding allotment.

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Calculation of Amounts of DSH Payments

These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 5 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. So if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million/$9 million.

The State will adhere to the OBRA 93 hospital specific DSH limits.

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EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS FOR MEDICAID MANAGED CARE ENROLLEES.

Covered medically necessary admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act, shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates determined in accordance with 42 CFR 412 for those services. For DRG codes that are adopted after 2008, 57% of the rate from the year of adoption will apply. These inpatient stays will continue until they are no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first. This methodology does not apply to Medicare crossover claims, which are paid in accordance with Attachment 4.19B, Section 24.

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PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to inpatient hospitals and inpatient psychiatric hospitals.

2. No reduction in payment for a provider-preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3. Reductions in provider payment may be limited to the extent that the following apply:

   a. The identified provider-preventable conditions would otherwise result in an increase in payment.

   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner:

      Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Provider-Preventable Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In adjusting their claims for payment, hospitals are required to identify these non-covered days.

   c. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

4. Hospital records will be retroactively reviewed by the State or its agent. If any days are identified that are associated with a lengthened stay due to a PPC, then the State or its agent will initiate recoupment for the identified overpayment.

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PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19A.

_X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19A and 4.19B.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan: