RULES
OF
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

CHAPTER 1200-13-02
NURSING FACILITY PROVIDER REIMBURSEMENT

TABLE OF CONTENTS

1200-13-02-.01 DEFINITIONS. The following definitions apply to nursing facility (NF) provider reimbursement. Additional definitions are contained in Chapter 1200-13-01.

(1) Acceptable Cost Report – The skilled nursing facility (SNF) cost report (Medicare form 2540-10), or hospital health care complex cost report (Medicare form 2552-10), Medicaid supplemental cost report form, and required additional information. To be acceptable, the appropriate forms and required additional information must be filed with the Comptroller by the required due date, and meet the acceptance criteria on the acceptance check list. The Medicaid supplemental cost report form and acceptance check list are available on TennCare's main website under the LTSS subsection.

(2) Active MDS Assessment – A resident's MDS assessment is considered active when it has been accepted by CMS. The assessment will remain active until a subsequent MDS assessment for the same resident is received by CMS, or the assessment becomes a Delinquent MDS Resident Assessment.

(3) Administrative and Operating Cost Component – The portion of the Medicaid daily NF rate that is attributable to the general administration and operation of the NF. These costs include the allowable and reimbursable SNF/NF costs that are not included in the Direct Care Case Mix Adjusted, Direct Care Non-Case Mix Adjusted, Capital, Cost-Based, or Excluded cost components.

(4) Annualized Medicaid Resident Day-Weighted Median Cost – A numerical value determined by arraying the per diem costs and total annualized Medicaid resident days of each NF provider from low to high and identifying the point in the array at which the cumulative total of all annualized Medicaid resident days first equals or exceeds half the number of the total annual Medicaid resident days for all Medicaid participating NF providers. The per diem cost at this point is the annualized Medicaid resident day-weighted median cost.

(5) Appraisal Value – The most current depreciated NF appraised value as determined by the certified appraisal firm designated by TennCare. TennCare's certified appraisal contractor must be selected through a formal procurement process for a single statewide contract.

(6) Capital Cost Component – The portion of the NF rate that is designed to compensate providers for their capital costs. These cost centers include the SNF/NF portion of: 1) Capital

(Rule 1200-13-02-.01, continued)

Related Costs – Building and Fixtures cost center (and applicable subscripted cost centers); 2) The Capital Related Costs – Moveable Equipment (and applicable subscripted cost centers); and 3) Other Capital Related Costs (and applicable subscripted cost centers). If real estate tax cost related to the SNF/NF is reported in one of these cost centers, then real estate tax cost will be excluded from the capital cost component, and included in the cost-based component.

(7) Case Mix – A measure of the intensity of care a resident required, as documented on the MDS and measured using the RUG-IV 48 Grouper resident classification system. CMS nursing-only RUG weights will be utilized.

(8) Comptroller – The Tennessee Office of the Comptroller of the Treasury, or its successor, and the associated work product of its contractors and agents.

(9) CMS – The Centers for Medicare and Medicaid Services.

(10) Cost-Based Component – The portion of the per diem rate attributable to real estate taxes related to NF services, and NF provider assessment costs.

(11) Delinquent MDS Resident Assessment – An MDS assessment that is more than 113 days old as of the end date of the MDS assessment collection period for each semi-annual rate period, as measured from the Assessment Reference Date (ARD) field on the MDS.

(12) Direct Care Case Mix Adjusted Cost Component – The portion of the Medicaid daily NF rate that is attributable to salaries, contract labor, and direct/apportioned payroll tax and employee benefit expense for registered nurses (RN), licensed practical/vocational nurses (LPN/LVN), and certified nurse aides (CNA) or orderlies that are providing direct SNF/NF patient care services. Costs associated with SNF/NF administrative nursing functions (Director of Nursing (DON), Assistant Director of Nursing (ADON), Minimum Data Set (MDS) coordinator, Quality Assurance (QA) coordinator, In-service/training coordinator) are not included in this cost component. Direct care case mix adjusted cost also includes a proportionate allocation of pooled payroll taxes and employee benefits expenses. Pooled payroll taxes and employee benefits will be apportioned to this cost component using Medicare cost report cost apportionment mechanics. All cost component costs are subject to the methods of apportionment in the Medicare cost report. Any portion of cost component expenses that are allocated to non-reimbursable cost centers or non-nursing facility (SNF/NF) cost centers, as designated by TennCare, will be excluded from cost component totals.

(13) Direct Care Non-Case Mix Adjusted Cost Component – The portion of the Medicaid daily NF rate that is attributable to salaries, contract labor, and direct/apportioned payroll tax and employee benefit expense associated with NF DON and ADON duties, the cost of raw food and special dietary supplements reported on the Medicaid supplemental cost report (includes those dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even when prescribed by a physician as defined by CMS Publication 15-1, The Provider Reimbursement Manual – Part I, section 2203.1), and staff associated with the provision of social services and recreational activities to NF residents. Direct care non-case mix adjusted cost also includes a proportionate allocation of pooled payroll taxes and employee benefits expenses. Pooled payroll taxes and employee benefits will be apportioned to this cost component using Medicare cost report cost apportionment mechanics. All cost component costs are subject to the methods of apportionment in the Medicare cost report. Any portion of cost component costs that are allocated to non-reimbursable cost centers or non-nursing facility (SNF/NF) cost centers, as designated by TennCare, will be excluded from cost component totals.

(14) Excluded Cost Component – The portion of NF provider expense that will be excluded from allowable cost and not included in rate determination:

(Rule 1200-13-02-.01, continued)

(a) The Nursing and Allied Health cost center (and applicable subscripted cost centers).

(b) The Interns and Residents cost centers (and applicable subscripted cost centers).

(c) The ParaMed Program cost center (and applicable subscripted cost centers).

(d) The direct costs of all non-overhead (general services) and non-routine SNF/NF cost centers.

(e) Overhead (general service) cost center expense allocations to non-SNF/NF routine cost centers, outpatient cost centers, and non-reimbursable cost centers, as determined by TennCare.

(f) For hospital-based NF overhead (general services), cost allocations to cost centers other than the SNF/NF routine cost centers, are excluded from rate setting allowable costs.

(15) Fair Rental Value (FRV) – The methodology used to calculate the capital reimbursement per diem rate for Medicaid participating NF.

(16) Final Case Mix Index Report (FCIR) – A semi-annual report reflecting the Medicaid and facility-wide case mix index for each NF using the time-weighted acuity measurement system, and end of therapy dates.

(17) Fixed Assets – Buildings and building equipment, as described by CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, sections 104.2 and 104.3.

(18) Index Factor – The most recently published Skilled Nursing Facility without Capital Market Basket Index, as produced for subscribers by IHS Global Insight (IHS Economics), or a comparable index, if this index ceases to be produced.

(19) Major Movable Equipment – Capitalized assets as defined by CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, section 104.4.

(20) Medicare Cost Report – CMS Forms 2540-10 and 2552-10, or subsequent versions of these forms.

(21) Medicaid Supplemental Cost Report – The supplemental cost reporting schedules designated by TennCare. The Medicaid supplemental cost report form is available on TennCare's main website under the LTSS subsection.

(22) Medicaid Nursing Facility-Wide Semi-Annual Average Case Mix Index – The calendar day weighted average, carried to four (4) decimal places, of all indices for each resident MDS assessment transmitted and accepted by CMS that is considered active within a given semi-annual rate period and where Medicaid is determined to be the primary per diem payer source. The resident case mix indices are calculated utilizing the time-weighted acuity measurement system. Any MDS assessments or MDS assessment periods which coincide with a federally or state declared public health emergency period may be excluded from or have BC1-Delinquent records removed from the calculation of the Medicaid Nursing Facility-Wide Semi-Annual Average Case Mix Index. In the event that less than three (3) months of MDS assessment information is available for the semi-annual case mix index calculation after exclusion, the most recently preceding Medicaid Nursing Facility-Wide Semi-Annual Average Case Mix Index which contains three (3) or more months of MDS assessment information will be utilized for rate setting.

(Rule 1200-13-02-.01, continued)

(23) Minimum Data Set (MDS) – A core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care NF providers certified to participate in the Medicaid program. The Tennessee reimbursement system will employ the current MDS assessment as approved by CMS.

(24) Neutralized – The process of removing cost variations associated with case mix. Neutralized cost is determined by dividing a provider's inflated per diem direct care case mix adjusted costs by its cost report period average case mix index (CMI).

(25) New Nursing Facility Provider – A provider whose licensed beds have not previously been certified for participation by the Medicaid program for NF level of care.

(26) Nursing Facility Cost Report Period Case Mix Index – The calendar day weighted average of all applicable NF-wide semi-annual average case mix indices, carried to four (4) decimal places. The case mix index periods used in this weighted average will be the periods that most closely coincide with the NF provider's cost reporting period that is used for rate setting. The average will be determined by weighting the applicable semi-annual case mix index periods by the number of days the MDS assessments were active during the cost reporting period. The semi-annual rate period case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of MDS assessments available as of the date of the applicable FCIRs. Any MDS assessments, BC1-Delinquent records, or MDS assessment periods excluded from the semi-annual rate setting process will also be excluded from the calculation of the Nursing Facility Cost Report Period Case Mix Index.

For example, a NF provider with a 1/1/2018 to 12/31/2018 cost reporting period would have a nursing facility cost report period case mix index calculated by the following: ((7/1/2018 – 12/31/2018 Rate Period CMI * 59 days)+ (1/1/2019 – 6/30/2019 Rate Period CMI * 184 days)+ (7/1/2019 – 12/31/2019 Rate Period CMI * 122 days))/ 365 days, rounded to 4 decimals.

Portion of Cost Report Year	CMI Period	Rate Period Utilizing CMI	Days for Weighted Calculation
1/1/2018 through 2/28/2018	9/1/2017 through 2/28/2018	7/1/2018 through 12/31/2018	59
3/1/2018 through 8/31/2018	3/1/2018 through 8/31/2018	1/1/2019 through 6/30/2019	184
9/1/2018 through 12/31/2018	9/1/2018 through 2/28/2019	7/1/2019 through 12/31/2019	122

(27) Nursing Facility-Wide Semi-Annual Average Case Mix Index – The calendar day weighted average, carried to four (4) decimal places, of all indices for all resident MDS assessments transmitted and accepted by CMS that are considered active within a given semi-annual rate period. The resident case mix indices are calculated utilizing the time-weighted acuity measurement system. Any MDS assessments or MDS assessment periods which coincide with a federally or state declared public health emergency period may be excluded from or have BC1-Delinquent records removed from the calculation of the Nursing Facility-Wide Semi-Annual Average Case Mix Index. In the event that less than three (3) months of MDS assessment information is available for the semi-annual case mix index calculation after exclusion, the most recently preceding Nursing Facility-Wide Semi-Annual Average Case Mix Index which contains three (3) or more months of MDS assessment information will be utilized for rate setting.

(Rule 1200-13-02-.01, continued)

(28) Preliminary Case Mix Index Report (PCIR) – The preliminary report that reflects the acuity of the residents in the NF. Resident acuity will be measured for each semi-annual rate period, utilizing the time-weighted acuity measurement system.

(29) Quality Informed – A descriptor of any component of the NF reimbursement methodology that is adjusted based on the NF provider's Quality Tier (e.g., Direct Care Case Mix Adjusted Cost Component and Direct Care Non-Case Mix Adjusted Cost Component) or other specified performance measures (e.g., Fair Rental Value).

(30) Quality Tier – The NF provider's classification within a specified range of scores on quality outcome measures.

(31) Rate Year – A one-year period from July 1 through June 30 during which a particular set of rates are in effect, corresponding to a state fiscal year.

(32) Rebase – The process of reestablishing cost component medians and reimbursement rates by incorporating the most recently audited or reviewed qualifying cost reports.

(33) Resource Utilization Group-IV (RUG-IV) Resident Classification System – The resource utilization group used to classify residents. When a resident classifies into more than one RUG-IV group, or RUG-IV successor group, the RUG with the greatest CMI will be utilized to calculate the NF provider's all residents average CMI and Medicaid residents average CMI. The nursing-only weights RUG-IV Version 1.03 Grouper, or its successor, will be utilized for rate determination purposes.

(34) Sales Comparison Approach – Based upon the principle of substitution, when a property is replaceable in the market its value tends to be set at the cost of acquiring an equally desirable substitute property, assuming no costly delay in making the substitution. Since two (2) properties are rarely identical, the necessary adjustments for differences in quality, location, size, services, and market appeal are a function of appraisal experience and judgment. Land is valued via the sales comparison approach.

(35) Semi-Annual Rate Period – A six (6) month period beginning July 1 or January 1 for which new reimbursement rates will be calculated. The semi-annual rate period will use all active MDS assessments for the time period beginning ten (10) months prior and ending four (4) months prior to the begin date of the semi-annual rate period. Any active MDS assessments or active MDS assessment periods which coincide with a federally or state declared public health emergency period may be excluded from or have BC1-Delinquent records removed from the calculation of the applicable case mix index averages. In the event that less than three (3) months of active MDS assessment information is available for use in the semi-annual rate period calculation after exclusion, the most recently preceding applicable case mix index averages which contain three (3) or more months of MDS assessment information will be utilized for rate setting.

For example, the July 1, 2018, semi-annual rate period will use active MDS assessment records from September 1, 2017, through February 28, 2018.

(36) TennCare – The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee; the name of the Division within the Tennessee Department of Finance and Administration encompassing all the health care related agencies located within F&A; and, the name of the Bureau which directly administers the program.

(37) Time-Weighted Acuity Measurement System (TW) – The case mix index calculation methodology that is compiled from the collection of all resident MDS assessments

(Rule 1200-13-02-.01, continued)

transmitted and accepted by CMS that are considered active within a given semi-annual rate period. The resident MDS assessments will be weighted based on the number of calendar days that the assessment is considered an active assessment within a given semi-annual rate period.

(38) Weighted Construction Year Age – The construction age is determined by subtracting the year the building or building addition was constructed as denoted in the appraisal report from the year the appraisal was performed by TennCare's certified appraisal firm. The average of the construction year is weighted by the finished square footage associated with each separate building or addition as denoted in the appraisal report produced by TennCare's certified appraisal firm.

Authority: *T.C.A. §§ 4-5-202, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rule filed January 18, 1979; effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed March 8, 1984; effective June 12, 1984. Amendment filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018. Amendments filed January 28, 2021; effective April 28, 2021.*

1200-13-02-.02 DETERMINATION OF PAYMENT.

TennCare, in consultation with the Comptroller and the Tennessee Health Care Association (THCA), shall establish the rules for the determination of payment for services provided to Medicaid recipients as part of the NF program. Payment determination components shall include acuity adjusted direct care, non-acuity adjusted direct care, quality, administration, fair market value capital, and a cost-based component. Other NF stakeholders shall have input into the quality component of the rate.

Authority: *T.C.A. §§ 4-5-202, 14-1905, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History****: Original rule filed January 18, 1979; effective March 5, 1979. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.03 CONDITIONS FOR REIMBURSEMENT OF NURSING FACILITY CARE.

(1) A NF must enter into a provider agreement with one (1) or more TennCare MCOs, for reimbursement of NF services.

(2) A NF must be certified by the Tennessee Department of Health, showing that it has met the standards set out in 42 C.F.R. Part 442.

(3) A NF participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State. A NF whose certification was terminated may be recertified to provide Medicaid services and may be contracted to provide Medicaid services at the discretion of the MCOs.

(4) If a resident has resources to apply toward payment, including Patient Liability as determined by TennCare, or TPL, which may include LTC insurance benefits, the payment for NF services shall be the NF's per diem rate for the applicable level of NF reimbursement authorized minus the resident's available resources.

(5) Regardless of the Medicaid reimbursement rate established, a NF may not charge TennCare Enrollees an amount greater than the amount per day charged to Non-Medicaid payer patients for equivalent accommodations and services.

(6) The specific items and services covered by the NF program shall be those defined and approved by TennCare. A NF shall not charge a TennCare enrollee for a covered service.

(Rule 1200-13-02-.03, continued)

Non-covered services may be charged directly to the resident, upon prior notification by the NF to the resident that the service is not covered. Rule 1200-13-13-.08(5).

Authority: *T.C.A. §§ 4-5-202, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rule filed January 18, 1979; effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.04 CONDITIONS FOR REIMBURSEMENT OF ENHANCED RESPIRATORY CARE.

(1) The NF must enter into a provider agreement with one (1) or more TennCare MCOs for the provision and reimbursement of Enhanced Respiratory Care (ERC) in a dual certified and licensed SNF/NF.

(a) A TennCare MCO shall, pursuant to T.C.A. § 71-5-1412, contract with any NF for the provision of Medicaid NF services, but shall not be obligated to reimburse any NF for ERC.

(b) Unless an exception is granted, a TennCare MCO shall not reimburse any NF for ERC unless such NF was contracted by the MCO for ERC Reimbursement as of July 1, 2016. An MCO may request an exception from TennCare to the moratorium on reimbursement for ERC upon the MCO's demonstration of the need for additional capacity or improved quality in the geographic area in which the NF is located, and the NF's compliance with all applicable conditions of ERC Reimbursement specified in this rule.

(2) The SNF/NF providing ERC services must be dual certified for the provision of Medicare SNF and Medicaid NF services, showing it has met the federal certification standards. Any NF providing ERC services in the TennCare Program shall be terminated by all TennCare MCOs as a TennCare provider if certification or licensure is canceled by CMS or the State.

(3) NFs providing Ventilator Weaning or chronic ventilator services and NFs receiving short-term reimbursement at the Sub-Acute Tracheal Suctioning Rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention, shall also meet or exceed the following minimum standards:

(a) The NF shall ensure that medical direction of all Ventilator Weaning, Chronic Ventilator Care, and Sub-Acute Tracheal Suctioning services is provided by a physician licensed to practice in the State of Tennessee and board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.

(b) A licensed respiratory care practitioner, as defined by T.C.A. § 63-27-102, shall be on site in the ventilator care unit twenty-four (24) hours per day, seven (7) days per week to provide:

1. Ventilator care;

2. Administration of medical gases;

3. Administration of aerosol medications; and

4. Diagnostic testing and monitoring of life support systems.

(c) The NF shall ensure that an appropriate individualized Plan of Care (POC) is prepared for each resident receiving Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute

(Rule 1200-13-02-.04, continued)

Tracheal Suctioning. The POC shall be developed with input and participation from the medical director of the NF's ERC program as described in Subparagraph (a).

(d) The NF shall establish admissions criteria to ensure the medical stability of ventilator-dependent residents prior to transfer from an acute care setting. The NF shall maintain documentation regarding the clinical evaluation of each resident who will receive ERC for appropriateness of placement in the facility prior to admission.

(e) End tidal carbon dioxide (etCO2) or transcutaneous monitoring of carbon dioxide and oxygen (tcCO2) and continuous pulse oximetry measurements shall be available for all residents receiving Chronic Ventilator Care and provided based on the needs of each resident. For residents receiving Ventilator Weaning or Sub-Acute Tracheal Suctioning, continuous pulse oximetry shall be provided, and end tidal Carbon Dioxide (etCO2) measurements shall be provided no less than every four (4) hours, and within one (1) hour following all vent parameter changes, or for residents receiving Sub-Acute Tracheal Suctioning, after all tracheostomy tube changes, tracheostomy capping trials, or the use of speaking devices.

(f) An audible, redundant external alarm system shall be connected to emergency power and/or battery back-up and located outside the room of each resident who is ventilator-dependent for the purpose of alerting staff of resident ventilator disconnection or ventilator failure.

(g) Ventilator equipment (and ideally physiologic monitoring equipment) shall be connected to back-up generator power via clearly marked wall outlets.

(h) Ventilators shall be equipped with adequate back-up provisions, including:

1. Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;

2. Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery operated concentrators);

3. At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy; and

4. A minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times.

(i) The NF shall be equipped with current ventilator technology to encourage and enable maximum mobility and comfort, ideally weighing less than fifteen (15) pounds with various mounting options for portability (e.g., wheelchair, bedside table, or backpack).

(j) The facility shall have an emergency preparedness plan specific to residents receiving ERC (i.e., Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning) which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

(k) The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving ERC (i.e., Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning), which shall include alarm response, positioning and transfers, care within licensure scope, and rescue breathing.

(Rule 1200-13-02-.04, continued)

(4) A NF must be operating in compliance with all of the conditions specified in Paragraph (3) in order to be eligible for Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning Reimbursement.

(5) The standards set forth in Paragraph (3) are not applicable for Secretion Management Tracheal Suctioning Reimbursement; however, the NF must meet standards specified in Paragraph (6) below for Secretion Management Tracheal Suctioning Reimbursement.

(6) A NF contracted with one or more TennCare MCOs to receive only Secretion Management Tracheal Suctioning Reimbursement shall meet or exceed the following minimum standards:

(a) A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102, shall be on site a minimum of weekly to provide:

1. Clinical Assessment of each resident receiving Secretion Management Tracheal Suctioning (including Pulse Oximetry measurements);

2. Evaluation of appropriate humidification;

3. Tracheostomy site and neck skin assessment;

4. Care plan updates; and

5. Ongoing education and training on patient assessment, equipment and treatment.

(b) The NF shall ensure that an appropriate individualized POC is prepared for each resident receiving Secretion Management Tracheal Suctioning. The POC shall be developed with input and participation from a licensed respiratory care practitioner as defined by T.C.A. § 63-27-102. Medical direction, including POC development and oversight for persons receiving Sub-Acute Tracheal Suctioning shall be conducted according to Paragraph (3).

(c) The NF shall establish admissions criteria which meet the standard of care to ensure the medical stability of residents who will receive Secretion Management Tracheal Suctioning prior to transfer from an acute care setting. The NF shall maintain pre-admission documentation regarding the clinical evaluation of each resident who will receive Secretion Management Tracheal Suctioning for appropriateness of placement in the facility.

(d) Pulse oximetry measurements shall be provided at least daily with continuous monitoring available, based on the needs of each resident. For any resident being weaned from the tracheostomy, the following shall be provided:

1. Continuous pulse oximetry monitoring; and

2. End tidal Carbon Dioxide (etCO2) measurements at least every four (4) hours and within one (1) hour following tracheostomy tube changes, tracheostomy capping trials, or the use of speaking devices. Transcutaneous (tcCO2) shall not be appropriate for intermittent monitoring.

(e) Mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy shall also be available for secretion management, as appropriate for the needs of each resident.

(Rule 1200-13-02-.04, continued)

(f) Oxygen equipment shall be connected to back-up generator power via clearly marked wall outlets.

(g) Adequate back-up provisions shall be in place including:

1. Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery operated concentrators); and

2. At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilation or with a tracheostomy.

(h) The facility shall have an emergency preparedness plan specific to residents receiving Secretion Management Tracheal Suctioning which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

(i) The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving Secretion Management Tracheal Suctioning which shall include alarm response, positioning and transfers, care within licensure scope, and rescue breathing.

(7) When a NF establishes a "Tracheostomy Unit" by accepting Tracheal Suctioning Reimbursement, including Sub-Acute and Secretion Management, for more than three (3) residents on the same day, the licensed respiratory care practitioner described in Subparagraph (6)(a) shall be on site a minimum of daily for assessment, care management, and care planning of residents receiving Tracheal Suctioning.

(8) A NF must be operating in compliance with all of the conditions specified in Paragraph (6) in order to be eligible for Secretion Management Tracheal Suctioning Reimbursement.

(9) Eligibility for and access to ERC services by individuals from out-of-state is governed by 42 C.F.R. § 435.403. A NF shall not recruit individuals from other states to receive ERC in Tennessee. A NF shall not be eligible to receive TennCare reimbursement for ERC services for a resident placed by another state or any agency acting on behalf of another state in making the placement because such services are not available in the individual's current state of residence, including residents admitted to the NF/SNF under the Medicare Skilled Nursing Facility care benefit when such benefit has been exhausted. The NF shall be responsible for arranging, prior to the resident's admission to the facility, Medicaid reimbursement for ERC services from the Medicaid Agency of the state which placed the resident and which will commence when other payment sources (e.g., Medicare, private pay, but not TennCare) have been exhausted.

(10) If the resident has available resources to apply toward payment, including Patient Liability or TPL, which may include LTC insurance benefits, the payment made by TennCare is the per diem rate established by TennCare minus the resident's available resources.

Authority: *T.C.A. §§ 4-5-202, 14-1905, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rule filed January 18, 1979; effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed March 8, 1984; effective June 12, 1984. Amendment filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.05 COST REPORTS.

(1) TennCare, in consultation with the Comptroller and THCA, shall develop the cost report format and submission process to be followed by participating Medicaid NFs. Medicaid participating NFs are required to file annual cost reports in accordance with the following:

(a) Medicaid participating NFs are required to report their allowable costs on the following cost reports:

1. Medicare Cost Report

2. Medicaid Supplemental Cost Report

(b) The version of the Medicaid supplemental cost report required to be filed by the NF providers is the most recently available cost report version on TennCare's website as of the end date of the provider's fiscal year, unless notified by TennCare to use an alternate version. Older versions of the cost report will not be accepted.

(c) All proposed updates and changes to the Medicaid supplemental cost report will be shared with NF industry stakeholders prior to their implementation to ensure the provider community has ample notice and understanding of the changes.

(d) Separate cost reports must be submitted by the home office, central office, or related party management companies when costs of the entity are reported in the NF provider's Medicare cost report or Medicaid supplemental cost report. The Medicare home office cost statement (CMS Form 287-05, or its successor), or an equivalent document must be filed with the provider's cost report submission package.

(e) Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth (5th) month following the NF provider's fiscal year-end. The year-end utilized for the Medicare cost report and the Medicaid supplemental cost report must be the same.

(f) Changes of Ownership. In the event of a change in ownership (CHOW) of the NF, the previous owner shall be required to submit a final cost report, both Medicare and Medicaid supplemental cost reporting forms, from the date of its last fiscal year-end to the date of sale or lease.

1. The previous owner must file a final cost report pursuant to Subparagraph (i).

2. If the new legal entity continues the operations of the NF as a provider of Medicaid services, the new legal entity shall be required to furnish TennCare with an initial cost report from the date of purchase or lease to the new fiscal year-end selected by the new legal entity.

(g) Initial Cost Report. The initial cost report submitted by all providers of NF services under the Medicaid program shall be based on the most recent fiscal year-end, and must be filed by the last day of the fifth (5th) month following the NF provider's fiscal year-end. The year-end utilized for the Medicare cost report and the Medicaid supplemental cost report must be the same.

1. TennCare at its discretion may allow for exceptions to the initial filing period.

2. Subsequent cost reports shall be submitted annually by each NF provider by the last day of the fifth (5th) month following the NF provider's fiscal year-end.

(Rule 1200-13-02-.05, continued)

(h) New Nursing Facility Provider. A new NF provider may select an initial cost reporting period of at least one (1) month but not to exceed thirteen (13) months. The NF provider's cost report must be filed by the last day of the fifth (5th) month following the NF provider's fiscal year-end. Thereafter, the cost reports shall be submitted according to the guidelines for subsequent cost reports as defined in Subparagraph (e).

(i) Final (Terminating) Cost Reports. When a NF provider ceases to participate in the Medicaid program, it must file a cost report covering a period up to the effective date the NF provider ceases to participate in the program. Depending upon the circumstances involved in the preparation of the NF provider's final cost report, the NF provider may file for a period not less than one (1) month and not more than thirteen (13) months. The previous entity has until the end of the fifth (5th) month following the effective date the NF provider ceases to participate in the Medicaid program or the effective date of the CHOW (whichever applies) to submit the final cost report.

(j) There shall be no automatic extension of the due date for the filing of cost reports. If a NF provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, a written request for an extension may be submitted to TennCare prior to the due date.

1. TennCare will have sole authority in approving both the extension and extension time frame.

2. Prior to approving a request for an extension, TennCare maintains the right to request additional information and supporting documentation from the NF in order to support the extension request.

(k) Amended Cost Reports. The Comptroller may accept amended cost reports in electronic format for a period of up to twelve (12) months following the end of the cost reporting period, with the caveat that cost reports may not be amended after an audit or desk review has been initiated. TennCare maintains the right, at its discretion, to supersede the amended cost report filing caveat. Amended cost reports should include a letter explaining the reason for the amendment, an amended certification statement with original signature, and the electronic format completed amended cost reports. Each amended cost report submitted should be clearly marked with "Amended" in the file name.

(2) The Medicare and Medicaid supplemental cost reports must meet all of the following minimum criteria to be deemed acceptable cost reports:

(a) The NF Medicare and Medicaid supplemental provider and home/central office cost reports must be filed in the electronic format prescribed by TennCare.

(b) The Medicaid supplemental cost report version utilized by the NF provider must be the most current version as of the end of its cost reporting period unless notified by TennCare to use an alternate version.

(c) The cost reports must include all supporting documentation as required by the Medicaid supplemental cost report instructions and checklist.

(d) Cost reports must be prepared according to Medicaid supplemental cost reporting instructions, CMS Publication 15-2, cost reporting instructions, and definitions of allowable and non-allowable costs contained in CMS Publication 15-1. The CMS publications will dictate allowable and non-allowable costs, except where Medicaid reimbursement rules and Medicaid supplemental cost reporting instructions are more specific as to the allowability of certain costs.

(Rule 1200-13-02-.05, continued)

(e) Medicaid specific accounting principles and allowable cost rules are as follows:

1. Only the straight-line method of computing depreciation is permitted.

2. Bad debt is not an allowable expense.

3. Costs may be included only for covered services as defined by federal regulations at 42 C.F.R. 483 Subpart B and TennCare.

4. Allowable cost must be adjusted for NF compensation limitations as detailed in Rules 1200-13-06-.11 and .12.

5. All cost report information shall be submitted consistent with generally accepted accounting principles unless state and federal rules and regulations require a separate treatment of an item. The accrual method of accounting is the only acceptable method for NF providers.

6. The Medicare cost report may allow more than one option for classifying costs according to CMS Publication 15, Provider Reimbursement Manual; however, Medicaid will only recognize costs in the cost component totals and direct care floor limit calculations based on the definitions of those cost components contained in this Chapter. If a NF provider classifies cost on the Medicare cost report in a manner other than in compliance with this Chapter, then the cost will be excluded from the applicable cost components and the direct care floor calculation, unless adjusted at audit or desk review.

7. The Medicaid NF assessment is an allowable cost to the Medicaid program; however, the NF assessment will be included in the excluded cost component for rate setting purposes.

(f) The Medicare and Medicaid supplemental cost reports must include consideration of all prior year adjustments and observations from Medicare and Medicaid audits, desk reviews, and settlements. Unresolved or protested prior year adjustments and observations should be noted in the cost reports or in a separate letter filed with the cost reports but cannot be disregarded.

(g) Patient Accounts and Patient Funds. Gross charges to the patients' accounts must match the charges to the patient log. Adjustments to the patients' accounts must then be made to bring the actual charges in line with the contractual and legal collection limits of the various medical programs. All charges in the patients' accounts must be supported by charge slips and the proper notes in the patients' files and must correspond to the charges reported on TennCare billing forms. Personal funds held by the provider for Medicaid patients used in purchasing clothing and personal incidentals must be properly accounted for with detailed records of amounts received and disbursed and shall not be commingled with NF funds. Patient funds in excess of $100 per patient must be kept in an insured interest bearing account. Interest earned must be credited to the patients. Bank fees or charges associated with resident trust fund accounts shall not be charged to or debited against individual resident trust fund accounts.

(h) Patient Logs and Census. Each facility must maintain daily census records and an adequate patient log. The format of the log is to be determined by each individual provider and may be combined with the revenue journal or other records at the convenience of the provider. This log must be sufficient to provide the following

(Rule 1200-13-02-.05, continued)

information on an individual basis and to accumulate monthly and yearly totals for Medicaid patients and for all other patients:

1. Days of service;

2. Charges for items and services covered by the Medicaid NF Program;

3. Charges for items and services not covered by the Medicaid NF Program;

4. Patient income applicable to the cost of covered items and services received by Medicaid NF patients;

5. Amounts collected and receivable from the Medicaid Program; and

6. Amounts collected and receivable from all other sources.

(i) Patient Log.

1. Suggested Patient Log. The headings below should be listed across the top of the page above the respective columns.

Column No.	Heading
(i)	Patient Name
(ii)	Patient Days
(iii)	Room and Board Charge
(iv)	Total Other NF Covered Charges (Non-Room and Board)
(v)	Total NF Covered Charges (Col. 3 + Col. 4)
(vi)	Total NF Non-covered Charges
(vii)	Total Actual Charges (Col. 5 + Col. 6)
(viii)	Date Medicaid NF Claim Paid
(ix)	Amounts Collected and Receivable from NF Program
(x)	Patient Income Applicable to NF Covered Services
(xi)	Amounts Collected and Receivable from Patients from NF Non-covered Services
(xii)	Amounts Collected and Receivable from Other Sources
(xiii)	Total Amounts Collected and Receivable
(xiv)	Comments

2. Directions for Completion of the Patient Log. The log should be maintained on a monthly basis with separate pages used for each month. Medicaid NF patients should be listed in a separate section of the log so that Medicaid NF program statistics can be generated. The columns should be completed and totaled as

(Rule 1200-13-02-.05, continued)

soon after the end of the month as the figures are available. Adjustments should be made to the monthly totals to reflect adjustments in the log due to changes in patient status, additional information, or other reasons. Complete explanations should accompany each adjustment. For non-TennCare patients, columns 8 through 14 can be omitted or adapted for other uses.

(3) Auditing of Cost Reports. The cost reports filed in compliance with this Chapter and all applicable provider records shall be subject to audit or desk review by the Comptroller. The cost reports filed in compliance with this Chapter must provide adequate cost and statistical data. This 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. This data must also be available for and capable of verification by the Comptroller. The provider must permit the Comptroller to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data reflected on the cost report which cannot be substantiated may be disallowed.

(4) Records Retention. Each Medicaid participating provider of NF services 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 ten (10) 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 Department of Finance and Administration, the Comptroller of the Treasury, or the United States Department of Health and Human Services.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rule filed January 18, 1979; effective March 5, 1979. Rule renumbered as 1200-13-02-.06. New rule filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.06 REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES.

(1) Effective July 1, 2018, Medicaid participating NFs will be reimbursed using a case mix reimbursement system with quality informed rate components, and a stand-alone quality-based component. The initial base-year cost report data used to establish the case mix rates will be the most recently audited or desk reviewed NF cost reports covering a period greater than six (6) months, with an end date on or before December 31, 2015.

(2) The base-year annualized Medicaid resident day-weighted median costs and prices shall be rebased at an interval no longer than three (3) years after a new base year period has been established. The new base year median costs and prices will be established using the most recently audited or desk reviewed cost reports that have a cost reporting period greater than six (6) months, with a cost report end date eighteen (18) months or more before the start of the rebase period.

(a) Cost reports issued a disclaimer of opinion during the audit process or cost reports containing substantial issues (including incomplete filing) during the desk review process, as solely determined by the Comptroller, will be excluded from the median and price calculations.

(b) Only audited or reviewed cost reports available prior to the July 1 rate setting will be considered in the median and price calculations.

(3) For rate periods between rebasing, an index factor shall be applied to the following:

(a) Direct care base year annualized Medicaid resident-day-weighted medians;

(b) Administrative and Operating base year annualized Medicaid resident-day-weighted medians; and

(c) The provider's cost-based component.

(4) Each NF provider's reimbursement rate will be determined through the sum of the following cost components:

(a) The sum of the NF provider's direct care case mix adjusted cost component, direct care non-case mix adjusted cost component, and the direct care spending floor adjustment;

(b) The statewide administrative and operating cost component;

(c) The NF provider's capital cost component (FRV);

(d) The NF provider's cost-based component; and

(e) Adjustments to the rate.

(5) Determination of Rate Components.

(a) The NF provider's direct care portion of the reimbursement rate is calculated as the sum of the direct care case mix adjusted cost component, the direct care non-case mix adjusted cost component, and the direct care spending floor adjustment.

1. The direct care case mix adjusted cost component reimbursement rate shall be determined as follows:

(i) The per diem direct care case mix adjusted cost for each NF is determined by dividing the facility's direct care case mix adjusted cost from the base year cost reporting period by the NF's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the rate year using the index factor.

(ii) The per diem neutralized direct care case mix adjusted cost is calculated by dividing each NF provider's inflated direct care case mix adjusted cost per diem by the NF provider's NF cost report period case mix index.

(iii) The per diem neutralized inflated direct care case mix adjusted cost, for each Medicaid participating NF that meets the criteria to be included in the cost component median, is arrayed from low to high and the annualized Medicaid resident-day-weighted median cost is determined.

(iv) The statewide direct care case mix adjusted price is established at one hundred six percent (106.00%) of the direct care case mix adjusted annualized Medicaid resident-day-weighted median cost.

(v) The statewide direct care case mix adjusted price is then multiplied by each NF's own Medicaid NF-wide semi-annual average case mix index for the rate period to establish the direct care case mix adjusted cost component.

(Rule 1200-13-02-.06, continued)

2. The direct care non-case mix adjusted cost component reimbursement rate shall be determined as follows:

   (i) The per diem inflated direct care non-case mix adjusted cost for each NF provider is determined by dividing the facility's direct care non-case mix adjusted cost during the base year cost reporting period by the NF provider's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the NF's base year cost reporting period to the midpoint of the rate year using the index factor.

   (ii) The per diem inflated direct care non-case mix adjusted cost, for each NF that meets the criteria to be included in the cost component median, is arrayed from low to high and the annualized Medicaid resident-day-weighted median cost is determined.

   (iii) The statewide direct care non-case mix adjusted price is established at one hundred six percent (106.00%) of the direct care non-case mix adjusted annualized Medicaid resident-day-weighted median cost.

   (iv) The statewide direct care non-case mix adjusted price is then multiplied by each NF provider's direct care non-case mix adjusted quality incentive multiplier to establish the NF provider's direct care non-case mix adjusted cost component.

   (v) The direct care non-case mix adjusted quality incentive multiplier is determined by the NF provider's Quality Tier. The quality incentive multiplier is determined as follows:

      (I) Quality Tier 1 – One hundred five percent (105.00%) multiplier

      (II) Quality Tier 2 – One hundred two and one-half percent (102.50%) multiplier

      (III) Quality Tier 3 – One hundred percent (100.00%) multiplier

3. The direct care spending floor adjustment is calculated as follows:

   (i) The sum of the NF provider's direct care case mix adjusted and direct care non-case mix adjusted cost components calculated above are multiplied by the NF provider specific spending floor percentage to determine the direct care spending floor threshold.

   (ii) The direct care spending floor percentage for each NF provider is determined by the NF provider's Quality Tier. The spending floor percentage is determined as follows:

Effective Date of Quality Tier Floor Percentage	Quality Tier 1	Quality Tier 2	Quality Tier 3
July 1, 2018	82.50%	85.00%	87.50%
July 1, 2019	85.00%	87.50%	90.00%
July 1, 2020	87.50%	90.00%	92.50%
July 1, 2021	90.00%	92.00%	94.00%

(iii) The direct care spending floor adjustment is calculated as the lesser of the Medicaid direct care cost per diem minus the direct care spending floor threshold, or zero.

(iv) The Medicaid direct care cost per diem used in the direct care spending floor calculation is established as follows:

(I) Utilize the most recently audited or desk reviewed cost reports covering a period of six (6) months or more, with an end date eighteen (18) months or more prior to each July 1 rate setting period.

(II) The per diem inflated direct care non-case mix adjusted cost for each NF provider is determined by dividing the facility's direct care non-case mix adjusted cost during the applicable cost reporting period by the NF provider's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the applicable cost reporting period to the midpoint of the rate year using the index factor.

(III) The per diem direct care case mix adjusted cost for each NF is determined by dividing the facility's direct care case mix adjusted cost from the applicable cost reporting period by the NF provider's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the cost reporting period to the midpoint of the rate year using the index factor.

(IV) The per diem neutralized inflated direct care case mix adjusted cost is calculated by dividing each NF provider's inflated direct care case mix adjusted cost per diem by the NF provider's NF cost report period case mix index.

(V) The per diem neutralized inflated direct care case mix adjusted cost is then multiplied by each NF provider's own Medicaid NF-wide semi-annual average case mix index for the rate period to create the Medicaid direct care case mix adjusted cost per diem.

(VI) The Medicaid direct care case mix adjusted cost per diem is then added to the inflated direct care non-case mix adjusted cost per diem to create the Medicaid direct care cost per diem.

(b) The statewide administrative and operating cost component will be determined as follows:

1. The per diem administrative and operating cost for each NF provider is determined by dividing the provider's administrative and operating cost during the base year cost reporting period by the NF provider's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the rate year using the index factor.

2. The per diem administrative and operating cost, for each NF that meets the criteria to be included in the cost component median, is arrayed from low to high and the annualized Medicaid resident-day-weighted median cost is determined.

(Rule 1200-13-02-.06, continued)

3. The statewide administrative and operating cost component is established at one hundred one percent (101.00%) of the administrative and operating annualized Medicaid resident-day-weighted median cost.

4. Every NF provider will receive the statewide administrative and operating cost component as reimbursement in full for its administrative and operating expenditures.

(c) The capital cost component of the reimbursement rate shall be based on a fair rental value (FRV) appraisal based reimbursement system, in lieu of reimbursement for capital specific costs such as depreciation, amortization, interest, rent/lease expense, etc. The capital cost component will be determined as follows:

1. Each NF provider will receive an appraisal from TennCare's certified appraisal contractor. TennCare's certified appraisal contractor must be selected through a formal procurement process for a single statewide contract.

2. NF appraisal values will be subject to a statewide mandatory reappraisal process in conjunction with the second (2nd) rebase following the implementation of new statewide appraisal values.

3. A NF provider may apply for a voluntary reappraisal. The voluntary NF reappraisal will be effective for rate setting purposes beginning with the semi-annual rate period directly following the completion of the reappraisal process. The reappraisal process will not be determined complete until the reappraisal is final. To obtain a voluntary reappraisal, the NF must meet all of the following criteria:

(i) The NF satisfies one of the following conditions:

(I) NF provider has moved its certificate of need/operations to a new permanent location. The new location is not required to be new construction. However, if the new location is one that has a current active appraisal or reappraisal valuation, the provider will be given the active appraisal value for rate setting purposes.

(II) NF provider has moved more than ten percent (10%) of its total licensed bed capacity to a new location on the current NF campus, and the new location was not previously included in any appraisal or reappraisal process.

(III) NF provider has performed and placed into service within the last 12 months a renovation/improvement greater than or equal to fifteen percent (15%) of its current net depreciated facility appraisal value (excluding land, but including site improvements). The total cost of the renovation shall only consider the cost of fixed assets as defined in this Chapter.

(IV) Any renovation/improvement included in a previous appraisal/reappraisal process must not be considered when determining if the reappraisal participation criteria has been met.

(ii) The NF has provided sufficient documentation to TennCare to support it has satisfied one of the conditions in subpart (i) above.

(Rule 1200-13-02-.06, continued)

(iii) The NF agrees to utilize the certified appraisal firm and appraisal methodology designated by TennCare.

(iv) The NF agrees to be responsible for the cost of the appraisal.

(v) The NF agrees that all semi-annual capital improvement updates submitted prior to the reappraisal request will be considered as part of the new reappraisal, and removed from being separately considered in the rate setting process.

4. TennCare's appraisal contractor will utilize the Marshall and Swift (Boeckh) Building Valuation System for Nursing Facilities, or its successor, to calculate the fee simple replacement cost (undepreciated and depreciated) of the building(s), site improvements and the market value of land for each NF provider.

(i) The fee simple replacement cost of buildings and site improvements is calculated using the cost approach appraisal method.

(ii) Only physical deterioration is considered. The appraisals are performed under the assumption that the NF is financially and functionally viable and economic obsolescence is not considered.

(iii) Land values are determined using the sales comparison approach.

5. Determination of the Building(s) fee simple replacement cost.

(i) The comparative unit method (calculator method) from Marshall and Swift section 15, or its successor, is utilized for this calculation.

(I) All costs, multipliers, and economic lives are directly pulled from the Marshall and Swift Commercial Estimator 7, or its successor.

(II) Only physical depreciation is considered, and assumptions are made that no obsolescence is present.

(III) Physical depreciation is determined based on the certified appraiser's opinion of effective age based on the actual age of the facility and renovations and updates over time.

(IV) Only fixed assets are determined through the appraisal process. Moveable equipment values are determined separately.

(ii) First, an actual weighted age of the facility is determined based on the age of building improvements, and the square footage of each section. Separate buildings or additions to original buildings may be separately valued by the appraiser, if determined necessary. The weighted age will then be grouped into the following ranges:

Actual Age	Implied Age for Depreciation
0 – 10 years	Actual Age
11 – 15 years	13 years
16 – 20 years	18 years
21 – 25 years	23 years
26 – 30 years	28 years
31 – 35 years	33 years
35 years +	10 years remaining life

(iii) After the determination of implied age, recent NF provider capital improvements will be considered to determine whether the implied age needs to be adjusted for depreciation purposes. Capital improvements submitted by the NF provider during the appraisal process are considered for effective age purposes. The allowed range of placed in service dates of capital improvements allowed for submission will be determined by TennCare.

(iv) The final calculated effective age (implied age less improvement considerations) will be divided into an economic life based on Marshall and Swift guidelines as detailed in the table below. At no time will remaining economic life (economic life less effective age) be less than 10 years.

Class	Low Cost and Average	Good and Excellent
A	45	50
B	45	50
C	40	45
D	35	40

(v) The following is a listing of the description of the class of construction:

Class	Description
A	Fireproofed structural steel
B	Reinforced concrete columns/beams
C	Masonry bearing walls
D	Wood or steel studs

(vi) The following is a listing of the rank, or estimate of construction quality based on the Marshall and Swift definition of quality:

Rank	Description
1	Low Cost
2	Average
3	Good
4+	Excellent

6. Determination of Site Improvement fee simple replacement cost. Site improvement cost estimates are based on Marshall and Swift section 66, or its successor. The site improvements will be depreciated based on a 15 year economic life.

7. Determination of Land Market Value. Land values are determined through the sales comparison approach.

(i) Sales and listings of vacant land comparable to the subject property are collected and analyzed.

(ii) The appraiser adjusts the prices to some common unit of comparison, and then adjusts the prices for market conditions, location, physical characteristics, available utilities, zoning, highest and best use, and other relevant variations.

(Rule 1200-13-02-.06, continued)

(iii) From this information the appraiser derives a unit value applicable to the NF. This unit value is then utilized to establish the market value of land as if it was vacant.

(iv) The maximum value of land used in determining FRV per diem rates will be $7,500.00 per licensed bed. Licensed beds used in this calculation will be total current NF licensed beds as of the April 1 prior to each July 1 rate setting.

(v) The lesser of the maximum land value or the appraised land value will be the allowable land value utilized for FRV calculation purposes.

8. Fair Rental Value Per Diem Calculation.

(i) The undepreciated and depreciated values of the NF provider's building(s), site improvements, and land (which is not depreciated) are determined through the appraisal process.

(ii) The depreciated values are subtracted from the undepreciated values to determine the total value of depreciation.

(iii) The calculated depreciation is then modified in the following manner to determine the total modified depreciation to be applied to the fair rental value system:

(I) NF providers with a weighted construction year age less than thirty (30) years will have calculated depreciation multiplied by fifty percent (50%) to determine their total modified depreciation to be applied to the fair rental value system.

(II) NF providers with a weighted construction year age of thirty (30) years or more will have their calculated depreciation multiplied by seventy percent (70%) to determine their total modified depreciation to be applied to the fair rental value system.

(iv) Total modified depreciation is subtracted from the undepreciated facility values (buildings, site improvements, and allowable land) and the value of NF provider fixed asset additions is added to the totals to determine total base facility value.

(v) The total base facility value is then compared to a maximum allowable base value threshold.

(vi) The maximum allowable base facility value threshold is established by multiplying the NF provider total licensed beds by $75,000. NF providers may increase the per licensed bed threshold of $75,000 based on their specific Medicaid private room resident day percentage. The Medicaid private room resident day percentage is calculated from base year cost report Medicaid private room resident days divided by total base year bed days available. Each NF provider is then compared to the thresholds established in the table below to determine any additions to the total per licensed bed value.

Quality Incentive Tier	Total Addition to Per Bed Value	Medicaid Private Room Resident Day Percentage Threshold

(Rule 1200-13-02-.06, continued)

1	$3,000	10%
2	$1,500	5%
3	$0	Less than 5%

(vii) A moveable equipment value will be determined for each provider by multiplying total licensed beds by $7,500.

(viii) The lesser of the maximum allowable base facility value threshold or the actual total base facility value calculated above will be added to the total moveable equipment value to determine the total facility value.

(ix) The total facility value will be multiplied by a rental factor to establish an annual fair rental value. The rental factor will vary depending on the NF provider's quality tier. The rental factor will be established as follows:

(I) Quality Tier 1 – Eight and seven-tenths percent (8.70%)

(II) Quality Tier 2 – Eight and thirty-five hundredths percent (8.35%)

(III) Quality Tier 3 – Eight percent (8.00%)

(x) The annual fair rental value will be divided by the greater of total annualized actual resident days, or the minimum occupancy percentage threshold of eighty-five percent (85%) of annualized licensed beds capacity of the provider to establish the provider's fair rental value per diem.

(xi) The licensed beds utilized for fair rental value purposes will be recognized once annually. Total NF licensed beds will be determined using the current facility licensed beds as of the April 1 prior to each July 1 rate setting.

(xi) No depreciation or inflation factors will be applied to the appraisal totals in non-appraisal years.

9. Modification of Total Facility Value between Appraisal Periods.

(i) In order to continue to incentivize providers to perform capital improvement in non-appraisal years, TennCare will allow each NF provider to modify its total facility value on a semi-annual basis for capitalized fixed assets by meeting the requirements set out below in items (I) through (V). A facility may request a waiver of one or more of the requirements by submitting a written request to TennCare detailing the requirement(s) requested to be waived and the reasons supporting the request.

(I) The request for modification of total facility value is submitted at a minimum three (3) months prior to the July 1 or January 1 rate setting periods, and the modification is reported on the applicable form designated by TennCare.

(II) The total capitalized fixed assets are greater than $1,000 per licensed bed. Licensed bed totals will be determined as of the April 1 following the submission for modification.

(III) The cost must be capitalized according to CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, and have been placed into service within the previous 12 months prior to the submission date of the modification request.

(IV) Capitalized assets must contain only fixed assets as defined by CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, sections 104.2 and 104.3. Major movable equipment that has been capitalized must not be included for modification purposes.

(V) The capitalized assets must be reported to TennCare net of any grant monies or insurance proceeds associated with the purchasing of the asset.

(ii) Qualifying capitalized fixed asset expenditures will be added to the total facility base value portion of the FRV per diem calculation.

(iii) No inflation or depreciation will be applied to the qualifying items.

(iv) A NF statewide mandatory appraisal or voluntary reappraisal will eliminate all previously submitted and accepted fixed asset addition amounts from the FRV per diem calculation.

(v) Request for modification will not be accepted during a statewide mandatory appraisal year, as it is assumed the provider will have received credit for these items within the appraisal process, regardless of whether or not the provider actually submitted the information to TennCare's certified appraisal firm.

(d) Cost-Based Component. The NF provider's cost-based component is the sum of the provider's NF related real estate tax per diem calculation and the provider assessment cost-based reimbursement rate determined by TennCare. The cost-based component is determined as follows:

1. The NF provider's NF real estate tax cost reported on the Medicaid supplemental cost report is divided by the greater of actual base year cost report resident days or eighty-five percent (85%) of base year cost report licensed beds capacity of the provider. These costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the rate year using the index factor.

2. The provider assessment cost-based reimbursement rate is determined by TennCare for only the Medicaid share of the provider assessment cost incurred by NF providers. NF providers will receive their cost-based reimbursement rate based on their specific provider class. The provider class will be determined for each NF provider from the cost report year information utilized in the calculation of the provider assessment. The provider class criteria and associated provider assessment cost-based reimbursement rate are determined as follows:

(i) NF providers with 50,000 or more annual Medicaid patient days. The reimbursement rate is calculated as the total assessment fee collected from this class of NF providers divided by total class resident days (all payer types).

(ii) NF providers that are designated as Continuing Care Retirement Center (CCRC), or NF providers with 50 or fewer licensed beds. The reimbursement rate is calculated as the total assessment fee collected from this class of NF providers divided by total class resident days (all payer types).

(Rule 1200-13-02-.06, continued)

(iii) New NF providers. The reimbursement rate is calculated as $2,225 divided by the number of calendar days in the rate year.

(iv) All other Medicaid participating NF providers that do not meet the criteria for subparts (i), (ii) or (iii) above. The reimbursement rate is calculated as the total assessment fee collected from this class of NF providers divided by total class resident days (all payer types).

(e) Adjustments to the Reimbursement Rate.

1. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data, for example an increase in the federal minimum wage rate. These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change. Adjustments to the rate will be made solely at the discretion of TennCare.

2. Budget Adjustment Factor (BAF). For the beginning of each state rate year effective July 1st TennCare will establish a NF program budget target and compare that to the annual expected Medicaid expenditures on nursing facility days for the upcoming rate year using established rate setting mechanics. TennCare will establish the BAF to adjust the annual expected Medicaid expenditures to meet the program's NF budget target. The BAF may be positive or negative and will be applied as an across the board percentage adjustment to all providers reimbursement rate components calculated according to this rule. The following is the detailed calculation of the BAF:

(i) Rate System Expected Cost

(I) Projected July 1 Provider Reimbursement Rates Calculated Using All Applicable Reimbursement Provisions Specified within this Chapter (prior to application of the BAF)

(II) X New Cost Report Medicaid Days (From Most Recent Comptroller Reviewed Cost Report data, or paid claims data if TennCare determines this data source to be more appropriate)

(III) = Expected Cost of NF Reimbursement System.

(ii) NF Budget Target

(I) Projected July 1 Provider Reimbursement Rates Calculated Using All Applicable Reimbursement Provisions Specified within this Chapter (prior to application of the BAF)

(II) X New Cost Report Medicaid Days (From Most Recent Comptroller Reviewed Cost Report data, or paid claims data if TennCare determines this data source to be more appropriate)

(III) = Target Cost of NF reimbursement System Prior to Adjustments

(IV) +/- State Budgetary Adjustments

(V) = Final Budget Target of NF Reimbursement System.

(iii) BAF Calculation

(I) NF Budget Target / Rate System Expected Cost = BAF % to apply to all provider rates.

(II) For each non-July 1 rate setting period, TennCare will recalculate the BAF to accommodate changes to the reimbursement system from new CMI, new facilities, legislative mandates, and other factors. The BAF is applied to all provider reimbursement rate components, and will be adjusted to ensure the state will continue to meet the NF budget target. The BAF adjustment may be positive or negative depending on circumstance.

3. For rate setting periods from July 1, 2018, to June 30, 2020, a phase-in of provider reimbursement rates will occur in an effort to ease the transition for providers to the case mix reimbursement system. The phase-in process will be calculated as follows:

(i) A NF provider's base reimbursement rate will be established as the Medicaid day weighted average of the Level 1 and Level 2 NF reimbursement rate in effect for each NF provider on July 1, 2017, as determined on January 1, 2018. The Medicaid day weighted average will also consider the NF provider's quarterly bridge payments for acuity and quality. The base reimbursement rate will be the starting point for all phase-in calculations.

(ii) For each July 1 rate setting, the current base reimbursement rates shall be trended forward from the midpoint of the previous rate year to the midpoint of the new rate year using the index factor.

(iii) The providers case mix system reimbursement rate will be determined according to the rate calculation procedures identified in this rule.

(iv) The reimbursement rate differential will be determined by subtracting the NF provider's base reimbursement rate from the applicable case mix system reimbursement rate.

(v) If the calculated reimbursement rate differential exceeds a positive or negative TennCare determined corridor amount, then a rate adjustment will be applied to the NF provider's case mix system reimbursement rate in an amount equal to the difference between the rate differential total and the corridor amount, in order to ensure the NF provider's reimbursement rate is not increased or decreased more than the corridor amount from the calculated base reimbursement rate.

(vi) Effective for rate periods beginning July 1, 2018, the corridor amount will be a floor of minus six dollars (-$6) from the base reimbursement rate, with the ceiling being determined at an amount above the base reimbursement rate necessary to achieve statewide budget neutrality.

(vii) Effective for rate periods beginning July 1, 2019, the corridor amount will be a floor of minus twelve dollars (-$12) from the base reimbursement rate, with the ceiling being determined at an amount above the base reimbursement rate necessary to achieve statewide budget neutrality.

(viii) Effective for rate periods beginning July 1, 2020, the case mix system reimbursement rate will no longer be subjected to a phase-in.

(Rule 1200-13-02-.06, continued)

Authority: *T.C.A. §§ 4-5-202, 14-1905, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *(Formerly numbered as 1200-13-02-.05.) Original rule filed January 18, 1979; effective March 5, 1979. Amendment filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018. Amendments filed January 28, 2021; effective April 28, 2021. Amendments filed July 6, 2022; effective October 4, 2022.*

1200-13-02-.07 CASE MIX INDEX CALCULATION.

(1) The Resource Utilization Groups-IV (RUG-IV) Version 1.03, 48-Grouper, or its successor, index maximizer model shall be used as the resident classification system to determine all case mix indices, using data from the minimum data set (MDS) submitted by each NF provider. Standard Version 1.03, or its successor, case mix indices developed by CMS, using nursing-only RUG weights, shall be the basis for calculating average case mix indices to be used to adjust the direct care case mix adjusted cost component.

(2) Each resident in the facility with a completed and submitted assessment shall be assigned a RUG-IV 48-Grouper, or its successor. The RUG-IV 48 Grouper, or its successor, will be calculated using each resident MDS assessment transmitted and accepted by CMS. These assessments are then translated to the appropriate case mix index using the time-weighted acuity measurement system. Using the individual resident case mix indices, two NF provider case mix indices are calculated, the NF-wide semi-annual average case mix index and the Medicaid NF-wide semi-annual average case mix index. The two case mix indices for each Medicaid participating NF shall be determined two times per year.

(3) Any MDS assessments or MDS assessment periods which coincide with a federally or state declared public health emergency period may be excluded from or have BC1-Delinquent records removed from the calculation of the semi-annual case mix index averages. In the event that less than three (3) months of MDS assessment information is available for the semi-annual case mix index average calculations after exclusion, the most recently preceding semi-annual case mix index average calculations which contain three (3) or more months of MDS assessment information will be utilized for rate setting.

Authority: *T.C.A. §§ 4-5-202, 14-23-105, 14-23-109, 14-23-130, 14-23-201, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *(Formerly numbered as 1200-13-02-.06). Original rule filed June 25, 1985; effective July 25, 1985. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018. Amendments filed January 28, 2021; effective April 28, 2021.*

1200-13-02-.08 CASE MIX INDEX REPORTS PROCESS.

(1) TennCare or its contractor shall provide each NF provider with the Preliminary Case Mix Index Report (PCIR) by approximately the fifteenth (15th) day of the second (2nd) month following the end of the MDS assessment collection period for each semi-annual rate period. The PCIR will serve as notice of the MDS assessments transmitted and provide an opportunity for the NF provider to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction policy where applicable.

(2) As part of the PCIR process, providers are required by TennCare to verify the end of therapy dates associated with their submitted MDS assessments. TennCare will designate the format and process providers must follow in order to satisfy the end of therapy dates reconciliation process. Should a provider choose not to perform the reconciliation of therapy dates, records with no discernable end of therapy date will be given a default date of two days after the start of therapy date associated with the record.

(Rule 1200-13-02-.08, continued)

(3) TennCare or its contractor shall provide each NF provider with a Final Case Mix Index Report (FCIR) utilizing MDS assessments after allowing the NF provider two (2) weeks, or ten (10) business days, to process its corrections. TennCare may extend this time period if a request is received from the provider.

(a) A cut-off date will be published for each case mix index report period. New or revised MDS assessment records or end of therapy date updates submitted by the NF provider after the cut-off date will not be included in the case mix index FCIR. TennCare, at its sole discretion, may override the cut-off date if there are extraordinary circumstances affecting a provider's ability to submit information.

(b) If TennCare determines that a NF provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case mix index associated with the RUG-IV group "BC1-Delinquent" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-IV, or its successor, classification system.

(4) The case mix index values from the FCIR will be utilized in establishing NF provider reimbursement as described in Rule .06.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413 and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed June 2, 1988; effective July 17, 1988. Repeal filed June 22, 1989; effective August 4, 1989. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009. New rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.09 NEW NURSING FACILITY PROVIDERS.

(1) The reimbursement rate for new NF providers will be determined following the methodology detailed in Rules .06–.08 with the following exceptions:

(a) The provider's Medicaid NF semi-annual case mix index will be calculated as the statewide annualized Medicaid resident day-weighted average Medicaid NF semi-annual case mix index until the provider has completed one full semi-annual rate period of operation following the acceptance of Medicaid recipients.

(b) The provider will be exempt from the direct care spending floor until the July 1 rate setting following the date the initial cost report filing is submitted to TennCare, and the Comptroller has completed its review of the cost report filing.

(c) The provider will be included in quality tier three (3) for the rate determination process, as defined in Rule .06, until the July 1 rate setting following the date the provider has submitted at least six (6) consecutive months of quality performance data in order to determine the provider's Quality Tier.

(d) The provider will be included in the new provider class for provider assessment cost-based reimbursement rate purposes. The provider will remain in the new provider class until such time that the provider has its information included in a provider assessment calculation base period. The provider will then receive its provider assessment cost-based reimbursement rate according to its specific provider class attributes as defined in Rule .06.

(e) The provider, if required to pay real estate tax, will receive the statewide annualized Medicaid resident day-weighted average inflated real estate tax cost value. The established real estate cost value will then be divided by the minimum occupancy percentage threshold of eighty-five percent (85%) of annualized bed days available to create the per diem real estate tax portion of the cost-based component of the rate.

(Rule 1200-13-02-.09, continued)

The per diem real estate tax cost-based rate will remain in effect until at least one of the two timelines and criteria below are met:

1. The July 1 rate setting after the provider has submitted an acceptable initial cost reporting package to the Comptroller and the Comptroller has completed the review of the real estate tax portion of the report. The approved NF provider's real estate tax amount from the Medicaid supplemental cost report is divided by the greater of actual base year cost report resident days, or eighty-five percent (85%) of base year cost report licensed beds capacity of the provider. These costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the rate year using the index factor.

2. The semi-annual rate period immediately following compliance with the criteria listed in subparts (i) and (ii). The approved NF provider's real estate tax amount will be divided by the minimum occupancy percentage threshold of eighty-five percent (85%) of the NF provider's annualized licensed bed days available of the provider. No trending factor will be applied as the tax amounts accepted will be assumed to be from the current period.

   (i) The provider submits to the Comptroller documentation to support its real estate tax expense for the current cost reporting period. TennCare will be solely responsible for determining the format in which the information must be submitted, and what supporting documentation will be considered acceptable.

   (ii) The Comptroller has reviewed the provider submission and has determined it to be acceptable.

(f) The capital component of the reimbursement rate will be determined as follows:

1. An appraisal will be conducted by TennCare's certified appraisal contractor. The appraisal will be utilized in capital component reimbursement consistent with Rule .06.

2. Should an assessment process not be completed prior to the facility accepting Medicaid recipients, the facility will have a maximum of ninety (90) days from the Medicaid certification date to complete the appraisal process.

3. A new facility without an appraisal will receive the maximum total facility value possible under the FRV system until the semi-annual rate period in immediate succession to the completion of the appraisal process. When the appraisal process is complete, the appraisal will be utilized in capital component reimbursement consistent with Rule .06. The annual FRV will be divided by the minimum occupancy percentage threshold to establish the FRV per diem for the NF provider. The minimum occupancy percentage threshold applied to the FRV calculation will be modified for a new facility as follows:

   (i) If the NF provider has not previously provided the NF level of care for any payer type, then the minimum occupancy percentage threshold will be calculated as follows:

      (I) The minimum occupancy percentage threshold will be calculated at sixty-five percent (65%) of annualized NF provider bed days available until the July 1 rate setting immediately following the NF providers Medicaid certification date.

(Rule 1200-13-02-.09, continued)

(II) If the initial July 1 rate setting period occurs prior to the NF provider receiving the sixty-five percent (65%) minimum occupancy percentage threshold for a full semi-annual rate period, then the NF provider will receive a minimum occupancy percentage threshold of seventy-five percent (75%) of annualized NF provider bed days available until the next July 1 rate setting occurs.

(III) All subsequent rate periods will have the minimum occupancy percentage threshold calculated according to capital component reimbursement Rule .06.

(ii) A NF provider that is new to Medicaid certification, but has previously provided NF level of care services, will not be subject to the modified minimum occupancy percentage threshold provisions.

4. If the new facility does not meet the ninety (90) day appraisal completion timeline, the facility will receive the lowest total FRV facility value in the state beginning with the semi-annual rate period in immediate succession to the ninety (90) day timeline expiring. The lowest total FRV facility value will be utilized to set the capital component per diem reimbursement rate according to reimbursement Rule .06. The lowest total FRV facility value mandate will remain in effect for a minimum of one (1) semi-annual rate period, and will remain in effect until the semi-annual period in immediate succession to the facility's completion of the appraisal process. Once the appraisal process is complete and the lowest total FRV facility value mandate period has elapsed, the appraisal will be utilized in capital component reimbursement in line with Rule .06.

5. No modification of the minimum occupancy percentage threshold will be applied for providers who have failed to complete the appraisal process within the required ninety (90) day timeline.

6. An appraisal process will not be determined complete until the appraisal is final.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.10 CHANGES OF OWNERSHIP OF EXISTING NURSING FACILITIES.

(1) A CHOW exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to NF providers that have undergone a CHOW will be calculated in the following manner:

(a) The initial NF provider reimbursement rate will be based upon the acuity, costs, days, appraisal data and quality information of the prior owner.

(b) If the CHOW is as a result of a non-related party transaction, the new NF provider may request from TennCare a provisional waiver of the application of any direct care spending floor rate reduction that would otherwise occur. If a direct care spending floor provisional waiver is granted by TennCare, the new NF provider reimbursement rate will be determined without a direct care spending floor reduction. However, for the entire period when a provisional waiver of the direct care spending floor is in effect, the new NF provider will be subject to a retroactive direct care spending floor settlement process, as follows:

(Rule 1200-13-02-.10, continued)

1. If the new NF provider's cost reporting period(s) Medicaid direct care cost per diem(s) are less than the spending floor(s) calculated at each rate period, the new NF provider will be responsible for a retroactive recoupment of the difference between its cost per diem and the spending floor for each Medicaid paid day. At no time will the retroactive recoupment per diem exceed the per diem amount granted under the provisional waiver.

2. In the event there is more than one direct care spending floor active during the new provider's cost reporting period(s), the direct care spending floor settlement process will be independently applied to each spending floor. If the new NF provider's cost reporting period(s) Medicaid direct care cost per diem(s) are less than any of the active spending floor(s), the calculated differences will be multiplied by the number of provider paid Medicaid days associated with the time period each direct care spending floor was active during the applicable cost reporting period. At no time will the retroactive recoupment per diem exceed the per diem amount granted under the provisional waiver.

3. Provisional waivers of the direct care spending floor will not be granted following the first rebase period in which the new NF provider has a six (6) month or more cost reporting period that could have been used in a rebase period.

(c) If the CHOW is as a result of a non-related party transaction, the new NF provider's real estate tax cost-based reimbursement rate will be recalculated, according to Rule .06, on the first July 1st after the new NF provider has submitted a cost report of six (6) months or longer, and that cost report has been reviewed by the Comptroller.

(2) The previous owner and current owner must comply with the cost report filing requirements in Rule .05.

(3) TennCare maintains the right to withhold up to ten percent (10%) of the previous owner's final Medicaid program payments until an acceptable final (terminating) cost report is received by the Comptroller. After receipt of the acceptable cost report, be it timely or non-timely, the withholding amount will be released to the facility (less any incurred penalties for non-timely filing).

(4) When there is a proposed CHOW of any Nursing Facility, the new provider shall provide to TennCare documents sufficient to obtain a Medicaid ID as specified in TennCare policy. TennCare shall issue a new Medicaid ID based on appropriate documentation submitted by the new provider. Any Managed Care Contractor (MCC) previously contracted with the former owner or operator shall, subject to T.C.A. § 71-5-1412, enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID shall be reimbursed at one hundred percent (100%) from the effective date of the CHOW. A new provider with a CHOW that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.11 QUALITY-BASED COMPONENT OF THE REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES.

(1) In addition to Quality Informed aspects of the NF reimbursement methodology, a specified amount of the funding for NF services shall be set aside during each fiscal year for purposes of calculating a quality-based component of each NF provider's per diem payment (i.e., a quality incentive component). At implementation of this Chapter, the amount of funding set aside for the quality-based component of the reimbursement methodology for NFs shall be

(Rule 1200-13-02-.11, continued)

no less than forty million dollars ($40 million) or four percent (4.00%) of the total projected fiscal year expenditures for NF services, whichever is greater. In each subsequent year, the amount of funding set aside for the quality-based component of the reimbursement methodology for NFs shall increase at two (2) times the rate of inflation of the index factor. Index factor inflation shall be calculated from the midpoint of the prior state fiscal year to the midpoint of the new state fiscal year. This annual quality-based component index factor adjustment shall continue until such time that the quality-based component of the reimbursement methodology for NFs constitutes ten percent (10%) of the total projected fiscal year expenditures for NF services. Once the quality-based component of the reimbursement methodology constitutes ten percent (10%) of the total projected fiscal year expenditures for NF services, it shall then increase or decrease at a rate necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%). All noted minimum quality-based component thresholds and index factor inflationary adjustments are made prior to consideration of the BAF.

(2) The quality-based component of each NF provider's per diem payment shall be calculated based on the facility's volume of Medicaid resident days and the percentage of total quality points earned for the measurement period.

(3) The initial quality outcome measures and point values established for the NF reimbursement system implemented on July 1, 2018, shall be based upon the structure of the QuILTSS Nursing Facility Value-Based Purchasing Quality Framework as described in the memorandum of August 5, 2014, to Medicaid NF Providers and described in this rule. Quality outcome measures and point values for each measure shall not be modified for the first three (3) fiscal years of reimbursement following implementation of the reimbursement system. Performance benchmarks shall be established as described in this rule. After the initial three (3)-year period, quality outcome measures, performance benchmarks for each measure, and point values shall be reviewed and may be modified as appropriate in consultation with THCA and other NF stakeholders. Any modifications to such criteria shall be established through rulemaking and shall not be changed for another three-year period.

(4) Quality outcome measures shall reflect those aspects of the delivery of NF services determined based on input from individuals receiving services, their family members and representatives, and other NF stakeholders, and in consultation with THCA and the QuILTSS Stakeholder Advisory Group, to most impact the day-to-day experience of care for NF residents, as follows:

(a) Satisfaction shall be valued at thirty-five (35) of the one hundred (100) possible quality performance points.

1. Satisfaction shall include three separate measures:

(i) Resident satisfaction shall be valued at fifteen (15) of the one hundred (100) possible quality performance points.

(ii) Family satisfaction shall be valued at ten (10) of the one hundred (100) possible quality performance points.

(iii) Staff satisfaction shall be valued at ten (10) of the one hundred (100) possible quality performance points.

2. In order to measure Satisfaction on the basis of outcomes and to establish performance benchmarks for each of the three (3) Satisfaction measures, NFs shall be required to use a standardized survey instrument and methodology that provides for anonymous submission to a neutral third party, which shall be responsible for submission of required data to TennCare.

3. The survey instrument(s) and methodology for conducting each survey shall be selected or designed with input from NF stakeholders, and subject to mutual agreement between TennCare and THCA. Providers shall be notified of the acceptable survey instrument(s) and methodology no later than two (2) months prior to their implementation.

4. For purposes of the NF reimbursement rates effective on July 1, 2018, the methodology used for calculating a facility's Satisfaction score shall be based upon the criteria established by TennCare in the QuILTSS #10 memorandum of March 20, 2017.

5. For purposes of the NF reimbursement rates effective on July 1, 2019, the methodology used for calculating a facility's Satisfaction score shall be based on the facility's adoption and implementation of the survey instrument(s) according to with the methodology described in this subparagraph. Data collected during the baseline year of the Satisfaction survey instrument(s) described in this subparagraph shall be used to establish a performance benchmark for each of the three (3) Satisfaction measures, in consultation with THCA and other NF Stakeholders.

6. For purposes of the NF reimbursement rates effective on July 1, 2020, the methodology used for calculating a facility's Satisfaction score shall be based in part on whether the facility achieves the performance benchmark for each of the three (3) Satisfaction measures described in this subparagraph, and for facilities who do not achieve the performance benchmarks, a lesser score based on the percentage of improvement over the baseline year. Providers shall be notified of the performance benchmark for each of the three (3) Satisfaction measures and the specific methodology for calculating a facility's Satisfaction score no later than July 1, 2019.

7. TennCare shall provide (or arrange for the provision of) training regarding each survey instrument, the survey methodology, and the methodology that will be used to calculate a facility's score for each of the three (3) Satisfaction measures.

8. Upon the collection and analysis of two (2) years of data pertaining to each of the survey instruments, this Chapter shall be modified to include performance benchmarks for each of the three (3) Satisfaction measures that will be applied for the next three-year period.

9. Results of each NF's surveys (excluding any information that could be used to identify respondents) shall be made available to the NF for purposes of quality improvement activities.

(b) Culture Change and Quality of Life shall be valued at thirty (30) of the one hundred (100) possible quality performance points.

1. Culture Change and Quality of Life shall encompass four (4) different aspects of the degree to which a NF's environment, programs, policies, and practices are individualized and person-directed; reflect the core values of self-determination, choice, dignity, and respect; and support meaningful roles and relationships for residents and staff. Culture Change and Quality of Life shall include four (4) separate measures:

(Rule 1200-13-02-.11, continued)

(i) Respectful Treatment shall be valued at ten (10) out of the one hundred (100) possible quality performance points.

(ii) Resident Choice shall be valued at ten (10) out of the one hundred (100) possible quality performance points.

(iii) Resident and Family Input shall be valued at five (5) out of the one hundred (100) possible quality performance points.

(iv) Meaningful Activities shall be valued at five (5) out of the one hundred (100) possible quality performance points.

2. In order to measure Culture Change and Quality of Life on the basis of outcomes and to establish performance benchmarks for each of the four (4) Culture Change and Quality of Life measures, NFs shall be required to use a standardized survey instrument and methodology that provides for anonymous submission to a neutral third party, which shall be responsible for submission of required data to TennCare. The survey questions for measuring Culture Change and Quality of Life may be incorporated into the Resident satisfaction survey described in Subparagraph (a) above to ease survey fatigue.

3. The survey questions and/or instrument and methodology for conducting the survey shall be selected or designed with input from NF stakeholders, and subject to mutual agreement between TennCare and THCA. Providers shall be notified of the acceptable survey instrument(s) and methodology no later than two (2) months prior to their implementation.

4. For purposes of the NF reimbursement rates effective on July 1, 2018, the methodology used for calculating a facility's score encompassing each of the four (4) aspects of Culture Change and Quality of Life shall be developed in consultation with THCA and with input from the NF stakeholders, including individuals receiving services and their family members and representatives. These criteria shall be provided to NFs and posted on the TennCare website no later than two (2) months prior to the implementation of the reimbursement system.

5. For purposes of the NF reimbursement rates effective on July 1, 2019, the methodology used for calculating a facility's Culture Change and Quality of Life score shall be based on the facility's adoption and implementation of the survey questions and/or instrument(s) in accordance with the methodology described in this subparagraph. Data collected during the baseline year of the Culture Change and Quality of Life survey instrument(s) described in this section shall be used to establish a performance benchmark for each of the four (4) Culture Change and Quality of Life measures, in consultation with THCA and other NF Stakeholders.

6. For purposes of the NF reimbursement rates effective on July 1, 2020, the methodology used for calculating a facility's Culture Change and Quality of Life score shall be based in part on whether the facility achieves the performance benchmark for each of the four (4) Culture Change and Quality of Life measures described in this subparagraph, and for facilities who do not achieve the performance benchmarks, a lesser score based on the percentage of improvement over the baseline year. Providers shall be notified of the performance benchmark for each of the four (4) Culture Change and Quality of Life measures and the specific methodology for calculating a facility's Satisfaction score no later than July 1, 2019.

(Rule 1200-13-02-.11, continued)

7. TennCare shall provide (or arrange for the provision of) training regarding the methodology that will be used to calculate a facility's score encompassing each of the four (4) aspects of Culture Change and Quality of Life.

8. Upon the collection and analysis of two (2) years of data pertaining to the survey questions and/or survey instrument, this Chapter shall be modified to include performance benchmarks for each of the four (4) Culture Change and Quality of Life measures that will be applied for the next three-year period.

9. Results of each NF's performance on each of the four (4) aspects of Culture Change and Quality of Life (excluding any information that could be used to identify respondents) shall be made available to the NF for purposes of quality improvement activities.

(c) Staffing and Staff Competency shall be valued at twenty-five (25) of the one hundred (100) possible quality performance points.

1. Staffing and Staff Competency shall include five (5) separate measures, with each measure valued at five (5) of the one hundred (100) possible quality performance points, as follows:

(i) Registered Nurse (RN) hours per resident day.

(ii) Nurse Aide (NA) hours per resident day.

(iii) RN, LPN, and CNA Staff Retention.

(iv) Consistent Staff Assignment.

(v) Staff Training (Onboarding and Continuing).

2. NA resident hours per resident day shall be calculated consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.

(i) The source document for the reported NA hours is the CMS form CMS-671 (Long Term Care Facility Application for Medicare and Medicaid) obtained from CASPER, Certification And Survey Provider Enhanced Reports, the CMS system which NFs must use to report data pertaining to survey and certification processes.

(ii) The resident census is based on the count of total residents from the CMS form CMS-672 (Resident Census and Conditions of Residents).

(iii) NA hours include certified nurse aides, aides in training, and medication aides/technicians.

(iv) Staffing data include both NF employees (full-time and part-time) and individuals under an organization (agency) or individual contract.

(v) Staffing data do not include staff reimbursed by a resident or his/her family, hospice staff, or feeding assistants.

(vi) Staffing hours reported are for the residents in Medicare- and/or Medicaid-certified beds only.

(Rule 1200-13-02-.11, continued)

(vii) Performance benchmarks for RN and NA hours per resident day measures shall be established in consultation with THCA, and with input from other NF stakeholders, including individuals receiving services and their family members and representatives. These criteria shall be provided to NFs and posted on the TennCare website no later than two (2) months prior to the implementation of the reimbursement system.

3. Consistent Staff Assignment shall be defined and calculated consistent with the methodology described in the National Nursing Home Quality Improvement Campaign.

(i) Consistent Staff Assignment shall include two measurements:

(I) The percentage of long-stay residents who have no more than twelve (12) caregivers within a one (1) month measurement period; and

(II) The percentage of short-stay residents who have no more than twelve (12) caregivers within a two-week measurement period.

(ii) Long-stay residents shall be defined as residents who have been in the facility for greater than one hundred (100) days.

(iii) Short-stay-residents shall be defined as residents who have been in the facility for no more than one hundred (100) days.

(iv) A caregiver shall be defined as any staff assigned to provide and delivering direct NA-type care to the resident during the measurement period.

(I) For purposes of measuring Consistent Staff, licensed staff shall not be counted as caregivers unless they are working in the capacity of a CNA. For example, if a nurse is in a resident's room administering medications or performing other skilled tasks, and stops to take the resident to the bathroom, that nurse shall not be counted as a caregiver. However, if a nurse (or other staff) is working as a CNA because the home is short staffed or because nurses (or other staff) routinely provide direct care to residents, that person shall be included in the caregiver count.

(II) Staff assigned to assist one or more residents only with mealtime and/or bathing shall be counted as a caregiver for all residents for whom such assistance is provided, even if the staff functions as a float or as part of a care team dedicated to such functions on behalf of multiple residents.

(v) NAs shall include certified nurse aides, aides in training, and medication aides/technicians.

(vi) Caregivers shall include both NF employees (full-time and part-time) and individuals under an organization (agency) or individual contract that provide care to the resident during the measurement period.

(vii) To be eligible for Consistent Staff Assignment points, a NF must track its performance using the tools created by the National Nursing Home Quality Improvement Campaign (NNHQIC), and report data to it in a manner

consistent with the NNHQIC. A NF must also provide permission to the NNHQIC for it to share the facility's performance data with TennCare.

(viii) The performance benchmark for the Consistent Staff Assignment measure shall be established in consultation with THCA, and with input from other NF stakeholders, including individuals receiving services and their family members and representatives. The performance benchmark for rates effective on July 1, 2018, shall be provided to NFs and posted on the TennCare website no later than two (2) months prior to the implementation of the reimbursement system. The performance benchmark for rates effective on July 1, 2019, and July 1, 2020, shall be provided to NFs and posted on the TennCare website by May 1 of each year.

4. Staff Retention shall be defined as the percentage of specified staff that have been employed (or contracted) by the NF for at least one (1) year.

(i) Specified staff shall include only RNs, LPNs, and NAs.

(ii) RNs shall include registered nurses, RN directors of nursing, and nurses with administrative duties.

(iii) LPNs shall include licensed practical/licensed vocational nurses.

(iv) NAs shall include certified nurse aides, aides in training, and medication aides/technicians.

(v) Specified staff shall include both NF employees (full-time and part-time) and individuals under an organization (agency) or individual contract. Retention of contracted staff shall be reported and measured based on the length of service of each staff person, and not the length of the contract. For example, if a staffing agency is used, a person shall be considered "continuously" contracted only if that staff person has been assigned to and working at the facility throughout the course of the twelve (12) month measurement period, even if the contract with that organization (agency) has been in place for a longer period.

(vi) Specified staff shall not include staff reimbursed by a resident or his/her family, hospice staff, or feeding assistants.

(vii) Specified staff information at the beginning and end of the measurement period shall be provided to TennCare in the required form and format.

(viii) A NF's performance on the Staff Retention measure shall be calculated by dividing the number of specified staff continuously employed (or contracted) by the facility for the twelve (12) month measurement period divided by the total number of specified facility staff employed at the outset of the twelve (12) month measurement period.

(ix) The performance benchmark for the Staff Retention measure shall be established in consultation with THCA, and with input from other NF stakeholders, including individuals receiving services and their family members and representatives. The performance benchmark for rates effective on July 1, 2018, shall be provided to NFs and posted on the TennCare website no later than two (2) months prior to the implementation of the reimbursement system. The performance benchmark for rates

(Rule 1200-13-02-.11, continued)

effective on July 1, 2019, and July 1, 2020, shall be provided to NFs and posted on the TennCare website by May 1 of each year.

5. Staff Training shall be defined as the percentage of specified staff who complete specified training activities.

(i) For purposes of the NF reimbursement rates effective on July 1, 2018, July 1, 2019, and July 1, 2020, the methodology used for calculating a facility's score for the Staff Training measure and the performance benchmark for the Staff Training measure shall be developed in consultation with THCA, and with input from other NF stakeholders including individuals receiving services and their family members and representatives. These criteria shall be provided to NFs and posted on the TennCare website no later than May 1 of each year.

(ii) Upon implementation of the QuILTSS comprehensive competency-based workforce development training program, specified training activities shall be completion of badges based on the CMS-funded core competencies for direct support workforce.

(d) Clinical Performance shall be valued at ten (10) of the one hundred (100) possible quality performance points.

1. Clinical Performance shall include two (2) separate measures, with each measure valued at five (5) of the one hundred (100) possible quality performance points, as follows:

(i) Antipsychotic Medications shall include two measurements:

(I) The percentage of long-stay residents who receive an antipsychotic medication during the measurement period.

(II) The percentage of short-stay residents who receive an antipsychotic medication during the measurement period but not on their initial assessment.

(III) Long-stay and short-stay residents shall be as defined in Subparagraph (c).

(IV) Antipsychotic Medications measures shall be calculated consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.

(ii) Infection Prevention measures shall be calculated based on the rate of urinary tract infections among patients consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.

2. Performance benchmarks for each of the Clinical Performance measures shall be established in consultation with THCA, and with input from other NF stakeholders, including individuals receiving services and their family members and representatives. These criteria shall be provided to NFs and posted on the TennCare website no later than two (2) months prior to implementation of the reimbursement system.

(e) In addition to the one hundred (100) possible quality performance points that a NF may score in the areas described in Subparagraphs (a), (b), (c) and (d) above, a NF may

(Rule 1200-13-02-.11, continued)

also earn ten (10) bonus points for qualifying awards and/or accreditations that evidence the facility's commitment to quality improvement processes. Qualifying awards or accreditations must be current in the review period and are restricted to the following:

1. Full participation in the National Nursing Home Quality Improvement Campaign, which must be active during the period in which bonus points are sought.

2. Membership in Eden Registry, which must be active during the period in which bonus points are sought.

3. Achievement of the Malcolm Baldrige Quality Award. This includes AHCA Award (Bronze, Silver, or Gold) and the TN Center for Performance Excellence Award (Level 2, 3, or 4, which correspond with the Commitment Award, Achievement Award, and Excellence Award; the Level 1 Interest Award is specifically excluded from points). Any such award must have been achieved within the three (3) years prior to the end of the period in which bonus points are sought.

4. Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARE).

5. Accreditation by the Joint Commission.

(5) A NF shall be eligible to receive the quality-based component of the per diem payment for NF services only if it has fully satisfied the following threshold measures:

(a) The facility must be current on its payment of the NF Assessment Fee. Anytime a facility is more than thirty (30) days delinquent on its NF Assessment Fee, the quality-based component of the per-diem payment for NF services shall be suspended, and the facility shall forfeit any quality-based component of its per diem reimbursement rate until such time that the NF is current on its Assessment Fee payments. This shall be operationalized as an MCO rate withhold, pursuant to T.C.A. § 71-5-1006.

(b) The facility has submitted complete, accurate and timely quality measurement data as required by TennCare in order to determine the NF's quality performance.

1. Except as otherwise specified by TennCare, quality measurement data shall be submitted by the NF on an annual basis. Where possible and appropriate, TennCare will utilize existing data sources to minimize administrative burden.

2. The data measurement period shall be January 1 through December 31 of each year, which shall be used to inform the quality-based component of the per diem payment for the fiscal year beginning July 1 immediately after.

3. A NF shall not be entitled to a quality-based component of the per diem payment for any NF services provided if the facility has not complied with quality performance reporting requirements, or if the facility knowingly submits, or causes or allows to be submitted any such data used for purposes of setting quality-based rate components that is determined (including upon post-payment audit or review) to be inaccurate or incomplete.

4. Any facility knowingly submitting false (including inaccurate or incomplete) quality performance data for purposes of calculating its Medicaid payment shall be subject to all applicable federal and state laws pertaining to the submission of false claims.

(Rule 1200-13-02-.11, continued)

5. For purposes of this subparagraph, the term “knowingly” shall mean that a NF, or any person acting on its behalf: (a) has or should have, upon exercise of due diligence, actual knowledge of the information; (b) acts in deliberate ignorance of the truth or falsity of the information; or (c) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent is required.

(6) Based on quality incentive program scoring a NF will be placed into one of three quality tiers. The quality tier cut points may only be updated for the July 1 rate setting of a rebase period. For the July 1, 2018, rate effective date, the quality tier cut points will be as follows:

Quality Tier	Cut Point Range
Quality Tier 1	75 – 100
Quality Tier 2	50 – 74.99
Quality Tier 3	0 – 49.99

(7) A NF’s quality tier and quality incentive program score will be established for each July 1 rate setting. The quality tier and quality incentive program score will be based on the quality incentive program measurement period for the calendar year period immediately preceding the applicable July 1 rate setting.

(8) A NFs quality incentive program score is based on the point structure previously described in this rule. As quality data is collected throughout the quality incentive program measurement period, the following score weighting will be applied to the varying metric collection intervals:

(a) Quality incentive program scoring metrics that are annual in nature will not be weighted.

(b) Quality incentive program scoring metrics that are semi-annual in nature will be weighted as follows:

1. 2/3rds weight for the most recent six month period.

2. 1/3rd weight for the first six month period.

(c) Quality incentive program scoring metrics that are quarterly in nature will be weighted as follows:

1. 50% weight for the fourth quarter of the calendar year.

2. 25% weight for the third quarter of the calendar year.

3. 15% weight for the second quarter of the calendar year.

4. 10% weight for the first quarter of the calendar year.

(d) For any metric collection period, regardless of collection interval, in which the final period is not the highest scoring period, the NF provider’s quality incentive program scoring metrics will use the metric weighting method below that results in the greatest overall quality incentive program score:

1. The quality incentive program scoring metric weighting methods previously described in this paragraph.

2. A quality incentive program scoring metric weighting method that equally weights all metric collection periods, regardless of collection interval.

(Rule 1200-13-02-.11, continued)

(9) Confidentiality of Submitted Quality Information. Any submissions by any facility relating to documentation of and participation in the quality-based component of the Reimbursement Methodology for Nursing Facilities pursuant to Rule .11 shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena or admission into evidence in any judicial or administrative proceeding. However, nothing in this rule shall not be construed to make immune from discovery or use in any judicial or administrative proceeding information, record, or documents that are otherwise available from original sources kept in the facility, and would otherwise be available to a litigant through discovered requested from the Facility. The confidentiality provisions of this paragraph shall also not apply to any judicial or administrative proceeding contesting the determination of TennCare regarding the Facility's quality component reimbursement.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018. Amendments filed January 28, 2021; effective April 28, 2021.*

1200-13-02-.12 ENHANCED RESPIRATORY CARE SERVICES ADD-ON PAYMENT.

(1) ERC Reimbursement in a dual certified and licensed SNF/NF shall be made only by TennCare MCOs in compliance with this Chapter and rates established by TennCare.

(2) Each level of ERC Reimbursement shall be an add-on payment to the NF's established per diem rate. The amount of the NF's add-on payment for each of the specified levels of reimbursement shall be based on the facility's performance on quality outcome and technology measures pursuant to a methodology established by TennCare and set forth in an ERC Operations Manual which shall be provided to NFs and posted on the TennCare website. Quality outcome and technology measures, performance benchmarks, and the methodology to apply such measures and performance benchmarks to each of the specified levels of ERC Reimbursement shall be adjusted no more frequently than annually in order to continuously improve the quality of care and quality of life outcomes experienced by individuals receiving ERC in a NF.

(3) ERC Reimbursement shall be provided only for services authorized and delivered in a facility operating in compliance with conditions of reimbursement for ERC specified in this Chapter, and in a bed specifically licensed for such purpose, as applicable. A NF shall not be eligible for ERC Reimbursement if it does not meet the conditions for reimbursement, or for any ERC services provided in excess of the facility's licensed capacity to provide such services, regardless of payer source. Because Sub-Acute Tracheal Suctioning Reimbursement provides for intensive respiratory intervention during the period immediately following a person's liberation from the ventilator, Sub-Acute Tracheal Suctioning Reimbursement shall be provided only in a bed specifically licensed for ventilator care.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.13 APPEALS PROCESS. Appeals of recoupment or withhold actions shall be filed and conducted according to Chapter 1200-13-18.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.14 AUDIT AND REVIEW AUTHORITY. TennCare maintains the right to audit or review all aspects of the case mix reimbursement system. Findings or adjustments generated from the audit or review may be used to adjust current or future NF provider reimbursement rates. The following are common aspects of the case mix reimbursement system that are subject to an audit or review process:

(Rule 1200-13-02-.14, continued)

(1) NF provider MDS assessments, end-of-therapy date reconciliation submissions, and associated supporting documentation.

(2) NF provider quality incentive program add-on payment and supporting documentation.

(3) ERC services add-on payment and supporting documentation.

(4) NF provider submitted Medicare and Medicaid cost reports and supporting documentation.

(5) New NF provider submitted documentation.

(6) CHOW NF provider submitted documentation.

(7) NF provider submitted FRV updates, licensed bed totals, and requests for reappraisal.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.15 PENALTIES, ADJUSTMENTS, AND WITHHOLDING.

(1) NF providers may be subject to penalties, cost report adjustments, and payment withholdings for:

(a) Disclaimed Cost Reports.

(b) Cost Report Delinquent Filing.

(c) Cost Report Non-Filer.

(d) Final (Terminating) Cost Report.

(2) Disclaimed Cost Reports. A provider who has a disclaimed cost report will have its Medicare and Medicaid supplemental cost reports adjusted for use in the provider's specific reimbursement rate. These cost report adjustments may include, but are not limited to the following:

(a) Adjusting costs without sufficient documentation to zero.

(b) Adjusting total resident days to one hundred percent (100%) occupancy, and reconciling Medicaid's portion of those days to paid claims records.

(c) The direct care spending floor adjustment, as defined in Rule .06, will be calculated utilizing the adjusted cost report.

(3) Cost Report Delinquent Filing.

(a) A cost report will be considered delinquent if an acceptable cost reporting package has not been filed within the timelines specified in Rule .05. The NF provider will be subject to a penalty of ten dollars ($10) per day for each day the NF is not in compliance.

(b) Should the NF provider file a cost report that is received timely and initially accepted by the Comptroller, but upon further review by the Comptroller is determined to not be an acceptable cost report, the following will occur:

1. The Comptroller will provide written notice to the NF provider that an acceptable cost report has not been filed.

(Rule 1200-13-02-.15, continued)

2. The NF provider will have thirty (30) days from receipt of the written notice to correct any issues noted and file an acceptable cost report.

3. If the NF provider does not file a corrected acceptable cost report within thirty (30) days of notice, it will be subjected to the penalty outlined in this paragraph from the date of the received written notice.

(4) Cost Report Non-Filer.

(a) A NF provider will be considered a cost report non-filer if its cost report is delinquent as of February 1 prior to the July 1 rate rebase in which it would have been used regardless if rebase actually occurs. A NF provider that is considered a cost report non-filer will have its reimbursement rates adjusted to be set equal to the lowest rate of any other active NF provider. The rate adjustments will commence with the July 1 rate setting following the NF provider obtaining a cost report non-filer status, and remain in effect for a minimum of one (1) year. The non-filer reimbursement rate will be determined using NF provider reimbursement rates prior to phase-in considerations. Reimbursement rate phase-in provisions established in Rule .06 are not applicable to the non-filer reimbursement rates.

(b) TennCare maintains the right to grant a waiver from the application of a portion or all of the rate and direct care spending floor adjustments should certain extenuating circumstances exist with the NF provider. TennCare must be contacted by the NF provider prior to the initial cost report filing deadline, for a waiver to be considered by TennCare.

(5) Final (Terminating) Cost Report. A NF provider is required to submit a final cost report as defined in Rule .05, and will be subject to a withholding of up to ten percent (10%) of the previous owner's final Medicaid recipient payments until an acceptable terminating cost report is received by the Comptroller. After receipt of the acceptable cost report, whether timely or non-timely, the withholding amount will be released to the facility (less any incurred penalties for non-timely filing).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-130, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.16 BED HOLDS. Effective July 1, 2018, Medicaid bed hold days will no longer be reimbursed.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*

1200-13-02-.17 OTHER REIMBURSEMENT ISSUES.

(1) No change of ownership or controlling interest of an existing Medicaid provider, including NFs, can occur until monies as may be owed to TennCare or its contractors are provided for. The purchaser shall notify TennCare of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to TennCare or its contractors for one (1) year from the date of purchase or for one (1) year following TennCare's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of NFs are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.

(Rule 1200-13-02-.17, continued)

(2) If TennCare or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, TennCare or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-1413.* ***Administrative History:*** *Original rules filed May 1, 2018; effective July 30, 2018.*