

**RULES
OF
TENNESSEE DEPARTMENT OF HEALTH**

**DIVISION OF MEDICAID
CHAPTER 1200-13-9
PSYCHIATRIC HOSPITAL REIMBURSEMENT PROGRAM**

TABLE OF CONTENTS

1200-13-9-.01	Definitions	1200-13-9-09	Minimum Occupancy Adjustment
1200-13-9-.02	Determination of Reimbursable Cost	1200-13-9-.10	Medicaid Disproportionate Share Adjustment (MDSA)
1200-13-9-.03	Approval of the Department Required For Participation	1200-13-9-.11	Rate or Payment Adjustment
1200-13-9-.04	Cost Report Required	1200-13-9-.12	New Providers
1200-13-9-.05	Billing Procedure	1200-13-9-.13	Lower of Cost or Charges Limit
1200-13-9-.06	Application of Prospective Payment Method	1200-13-9-.14	Method for Paying Providers which are Exempt from Prospective System
1200-13-9-.07	Providers Exempted from Prospective Payment System	1200-13-9-.15	Audit
1200-13-9-.08	Prospective Payment Methodology	1200-13-9-.16	Termination of Medicaid Psychiatric Hospital Reimbursement Program

1200-13-9-.01 DEFINITIONS. The following definitions shall apply to Rules 1200-13-9-.02 through 1200-13-9-.14 inclusive, unless otherwise indicated.

- (1) Capital Costs means those costs which are required or allowed by Title XVIII principles to be included in all depreciation columns on worksheet B of HCFA form 2552-85 (12/85). Capital costs shall not include costs associated with non-reimbursable cost centers.
- (2) Direct Medical Education Costs means those costs associated with a nursing school or intern-resident services in an approved residency program which are required or allowed by Title XVIII principles to be included on worksheet B of HCFA form 2552-85 (12/85). Medical education costs shall not include costs associated with non-reimbursable cost centers, nor shall they include costs for routine, in-service training.
- (3) Utilization Ratio means the ratio of Medicaid covered inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee to total inpatient days. Education costs are considered as a part of the operating component when educational services are an integral part of a recipient's acute inpatient psychiatric care involving active treatment pursuant to an individual plan of care developed by an interdisciplinary treatment team, and ordered by the recipient's attending physician.
- (4) Medicaid Day means any part of a day, including the day of admission in which a person determined eligible for Medicaid by the State of Tennessee is admitted as an inpatient with the intention of remaining overnight. The day of discharge is not counted as a day. If admission and discharge occur on the same day, the day is considered one inpatient day.
- (5) Operating Component means those costs, applicable to inpatient services only, which are required or allowed by Title XVIII principles to be included on worksheet E of HCFA form 2552-85 (12/85), including costs relating to hospital-based physicians if applicable, and COSTS for educational services when they are an integral part of a recipient's acute inpatient psychiatric care involving active treatment, pursuant to an individual plan of care developed by an interdisciplinary treatment team, and ordered by the recipient's attending physician, less the portion of capital-related and direct medical education costs attributable to patients determined eligible for Medicaid by the State of Tennessee.

(Rule 1200-13-9-.01, continued)

- (6) Pass Through Component means the share which is attributable to patients determined eligible for Medicaid by the State of Tennessee of actual capital costs and actual direct medical education costs. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass-through component.
- (7) Title XVIII principles means, except where indicated otherwise, those Medicare principles which are applicable to hospitals, which were in effect on October 1, 1982, and which are described at 42 CFR Part 405.
- (8) Base Year Cost Report for inpatient psychiatric services is the 12 month cost report (for each provider) ending in calendar year 1986. If a provider does not have a 12 month cost report ending within that time period, then the base year shall be the next preceding 12 month cost report. If there is no such cost report, then the base year shall be the most recently filed 12 month cost report. Inpatient psychiatric providers not meeting any of the above conditions shall be handled in accordance with Rule 1200-13-9-.11 NEW PROVIDERS.
- (9) Hospital means both those health care facilities defined by *T.C.A. §68-11-201(10)*, which are licensed by this Department and the Tennessee Board for Licensing Health Care Facilities pursuant to regulatory Chapter 1200-8-1, and those inpatient facilities licensed by the Tennessee Department of Mental Health and Mental Retardation, pursuant to *T.C.A. §33-2-501 et. seq.* as defined by regulatory chapter 0940-5-1-.06(1) and (3). "Hospital" also means the whole, or the distinct part, of a health care facility that has been certified by this Department and the Federal Health Care Financing Administration to participate as a provider of Medicaid inpatient hospital services (as defined by the October 1, 1986, edition of 42 CFR 440. 10 and 440.140) or inpatient psychiatric services for individuals under twenty-one (21) (as defined by the October 1, 1986, edition of 42 CFR 440.160).

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71-5-109, Public Chapter 913 of the Acts of 1992.*
Administrative History: *Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed September 25, 1992; effective November 9, 1992.*

1200-13-9-.02 DETERMINATION OF REIMBURSABLE COST. The Comptroller of the Treasury in accordance with this chapter of the Department's rules and regulations shall make the determination of reimbursable per them cost for hospitals.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* **Administrative History.** *Original rule filed June 2, 1992; effective July 17, 1988.*

1200-13-9-.03 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those in situations or distinct parts thereof accredited by the Joint Commission on Accreditation of Hospitals as psychiatric facilities and contracting with Medicaid may participate and be reimbursed as providers under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

Authority. *T. C.A. §§71-5-105, 71-5-109 and 4-5-202.* **Administrative History:** *Original rule filed June 2, 1992; effective July 17, 1988.*

1200-13-9-.04 COST REPORTS REQUIRED.

- (1) In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, as per Rule 1200-13-9-.11, to submit to the

(Rule 1200-13-9-.04, continued)

Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise by these rules.

- (2) Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR Part 405 shall be subject to penalties imposed by such regulations. Except as stated in Rule 1200-13-9-.07(3), hospitals not filing cost reports for a specified period shall be required to refund all payments made under this program for that period.
- (3) To be eligible to receive payment, contracting hospitals shall use uniform hospital statistics and classification of accounts as published by the American Hospital Association for all accounting records, or any other acceptable accounting methods approved by the Department of Health and Environment in consultation with the Comptroller and the Tennessee Hospital Association. However, accounts, statistics and records pertaining to "medical indigents", "bad debts" and "charity" shall be classified as defined by T.C.A. §68-1-109, as amended by Chapter 319 of the Public Acts of 1987.
- (4) After a period of five years following the implementation of the TennCare Program on January 1, 1994, amended or corrected hospital cost reports with claims for reimbursement for services prior to January 1, 1994 shall not be accepted.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History.** Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed October 14, 1998; effective December 28, 1998.

1200-13-9-.05 BILLING PROCEDURE. Institutions or distinct parts thereof rendering hospital care shall bill the Department or other agency or organization designated by the Department on the forms and in the manner designated. No provider shall charge for Medicaid patients more than is charged for private paying patients for equivalent accommodations and services.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed June 2, 1988, effective July 17, 1988.

1200-13-9-.06 APPLICATION OF PROSPECTIVE PAYMENT METHOD. Except for those providers exempted by the provisions of Rule 1200-13-9-.07, all Medicaid providers of inpatient psychiatric services shall be paid by the prospective methods set forth in this chapter. For hospitals, or distinct parts thereof, certified to participate in Medicaid as providers of inpatient psychiatric services to persons under the age of twenty-one (21) these provisions apply to dates of service beginning on, or after, July 1, 1988. For institutions for mental diseases or distinct parts thereof, that are certified to participate in Medicaid as providers of inpatient hospital services for individuals age sixty-five (65) or older, these provisions apply to dates of service beginning on, or after, July 1, 1988. These effective dates apply without regard to the provider's fiscal year end.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History.** Original rule filed June 2, 1988; effective July 17, 1988.

1200-13-9-.07 PROVIDERS EXEMPTED FROM PROSPECTIVE PAYMENT SYSTEM. The prospective payment system shall not apply to the following hospitals and services:

- (1) Any health care facility that is not a "hospital", as defined by Rule 1200-13-9-.01(9), skilled nursing facilities and intermediate care facilities located within hospitals when certified or licensed as "nursing" homes and swing beds, while being used to provide nursing services at less than the acute level of hospital care.

(Rule 1200-13-9-.07, continued)

- (2) Inpatient services provided before July 1, 1988, by providers of either inpatient psychiatric services to persons under the age of twenty-one (21), or inpatient hospital services in institutions for mental disease to individuals age sixty-five (65) or older.
- (3) Psychiatric hospitals which elect not to submit a cost report and which have less than \$10,000 annually, based on the provider's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee. Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed \$10,000 in total Tennessee Medicaid charges annually, they will be treated as new providers as specified in Rule 1200-13-9-.11.
- (4) Outpatient hospital services, as defined by the October 1, 1986, edition of 42 CFR 440.20.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988.

1200-13-9-.08 PROSPECTIVE PAYMENT METHODOLOGY.

- (1) Except as provided by other provisions of this chapter, each hospital's reimbursable inpatient costs will be determined in accordance with Medicare Title XVIII principles from a base year cost reporting period, as defined by Rule 1200-13-9-.01(8). Costs will be separated into an operating component (defined by Rule 1200-13-9-.01(5)) and a pass-through component (defined by Rule 1200-13-9-.01(6)). A trending factor (defined by Rule 1200-13-9-.08(3)) will be applied to the operating component only. The prospective rate will consist of the trended operating component. Tennessee Medicaid costs will be determined by a computed utilization ratio (defined by Rule 1200-13-9-.01(3)) from HCFA Form 2552 which must be submitted by the provider. The prospective payment (operating costs) will be made as a rate per inpatient day. On and after July 1, 1988, in psychiatric hospitals and institutions for mental disease, which dates apply without regard to the date upon which the provider's fiscal year may end, the pass-through component will not be a part of the per diem rate, but will, instead, be paid in lump sum amounts on a monthly basis.
- (2) Pass Through Component
 - (a) For inpatient services in psychiatric facilities on or after July 1, 1988, irrespective of provider fiscal year end, the reimbursable per diem rate will consist of only the operating component. The remaining components: capital, direct medical education, and return on equity will be paid in a lump sum amount. Capital, direct medical education, and return on equity costs will be estimated from each provider's most recent cost report on file as of 4:30 p.m. C.D.T., Monday, June 30, 1988. The estimates will be used to compute a lump sum amount for capital, direct medical education, and return on equity. Payments will be made monthly starting July 1, 1988. Each provider's subsequent cost report will be used to adjust the capital, direct medical education, and return on equity for the subsequent fiscal year. This adjustment shall be effective on the first day of the next month, one month subsequent to the date of receipt of the provider's cost report. Capital, direct medical education, and return on equity costs will be subject to year end cost settlement for inpatient psychiatric services on and after July 1, 1988. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass-through component.
 - (b) Additional costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of

(Rule 1200-13-9-.08, continued)

ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1984. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs.

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

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

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

- (3) Operating Component - Each facility's initial prospective rate shall also include an operating component which is computed from the base year cost report. In base years all providers including providers that are within the first three years of operation will be subject to the routine per diem cost limitations for prospective rate purposes. The routine per diem limitations for these purposes will be set in the same manner as those used for acute care hospitals. All new providers may have their prospective rate adjusted at the end of the first five year period. The operating component will be trended forward each year. The trending period shall be from the midpoint of each hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Trending to the new rebased year (1988 cost reports or if not available the prior cost report) will be computed by utilizing the indexing rate recommended by the Prospective Payment Assessment Commission, applied from the end of the hospital's fiscal year to October 1, 1989.

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

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

Education costs are considered as a part of the operating component, when educational services are an integral part of a recipients acute inpatient psychiatric care involving active treatment, pursuant to an individual plan of care developed by an inter-disciplinary treatment, and ordered by the recipient's attending physician.

(Rule 1200-13-9-.08, continued)

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71-5-109; *Public Chapter 913 of the Acts of 1992.*
Administrative History: Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed August 8, 1990, effective September 22, 1990. Amendment filed September 25, 1992, effective November 9, 1992. Amendment filed November 17, 1983; effective January 31, 1994.

1200-13-9-.09 MINIMUM OCCUPANCY ADJUSTMENT. Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

Hospitals over 100 beds - 70%

Hospitals with 100 beds or fewer - 60%

The adjustment will be computed as follows and will be made at the same time as the pass through adjustment as set out in rule 1200-13-9-.08.

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

ACC = allowable capital costs

TCC = total capital costs

TBD = total beds used during the period

ABD = total bed days available during the period

Y = .6 for hospitals with 100 beds or fewer

= .7 for hospitals over 100 beds

All references to beds mean staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use, such as being closed for reasons including but not limited to, painting, maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine, at least monthly, its number of staffed beds. A schedule showing the number of staffed and unstaffed beds, along with the reasons for being unstaffed, must be submitted with the cost report. This schedule is subject to audit in accordance with rule 1200-13-9-.14. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. For psychiatric providers, the minimum occupancy, adjustment will apply to services on and after July 1, 1988. The minimum occupancy adjustment will be applied before the adjustment specified in rule 1200-13-9.08(2)(d). Effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty.

Authority: T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71--5-109. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed August 8, 1990; effective September 22, 1990.

1200-13-9-.10 MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT (MDSA).

- (1) Effective July 1, 1988, inpatient psychiatric hospitals having a utilization ratio at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments or a low income utilization rate exceeding 25 percent will receive a 1% adjustment to the prospective rate for each percentage above the 14% up to a cap of 3%; or a 2% adjustment to the prospective rate for each percentage above the 25% low income utilization rate up to a cap of 3%.
 - (a) Low income utilization rate will be calculated as follows and will use information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of.
 1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost

(Rule 1200-13-9-.10, continued)

reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost report period; and,

2. The total amount of the hospitals charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.
- (b) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.
 - (c) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
 - (d) Beginning July 1, 1988, the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July-June. This will be estimated based on projections from historical experience and the addition of any expected improvements.
- (2) Effective July 1, 1989, psychiatric hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34%.
- (a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.
 - (b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but are less than 4,000.
 - (c) No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.
 - (d) Psychiatric hospitals that do not qualify under the criteria in (2) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:
 1. The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.

(Rule 1200-13-9-.10, continued)

2. No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.
3. Low income utilization rate will be calculated as follows from information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:
 - (I) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,
 - (ii) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.
- (e) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
- (f) The disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July - June. This will be estimated based on projections from historical experience and the addition of any expected improvements.
- (3) Effective October 1, 1992, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 9.31 % Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25 % will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this rule, Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this rule charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services.
 - (a) The prospective rate will be adjusted upward by a factor of 5.8 times the difference between the actual utilization rate and a 9.31% utilization rate.

(Rule 1200-13-9-.10, continued)

- (b) The prospective rate will be adjusted upward by 5.8% times the number of days above 1,000 days divided by 1,000 days.
 - (c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.
 - (d) Low-income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:
 - 1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and
 - 2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.
 - (e) Each year a predetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.
 - (f) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements.
 - (g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on subparagraph (g) of paragraph (9) of the amendment to rule 1200-13-5-.11, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.
- (4) Effective July 1, 1993, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 10.45% Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of inpatient and outpatient "charity" charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this rule Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this rule "charity", unless otherwise specified, will be defined as inpatient and outpatient "charity" charges (including medical), indigent, low income, and medically indigent other), bad debt, and Medicare and

(Rule 1200-13-9-.10, continued)

Medicaid contractual adjustments adjusted to cost. "Charity" will include charges for both in-state and out-of-state services.

- (a) The prospective rate will be adjusted upward by a factor of 5.8 times the difference between the actual utilization rate and a 10.45% utilization rate.
- (b) The prospective rate will be adjusted upward by 5.8% times the number of days above 1,000 days divided by 1,000 days.
- (c) The prospective rate will be adjusted upwards by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.
- (d) Low-income utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:
 - 1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from the state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and
 - 2. The total amount of the hospital's charges for inpatient hospital services attributable to "charity care" (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to "charity care" shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.
- (e) Each year a redetermination of the MDSA will be made at the same time the new pass-through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass-through adjustment.
- (f) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is unavailable, the latest report on file will be used.
- (g) The total amount of MDSA for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on subparagraph (g) of paragraph (10) of the amendment to rule 1200-13-5-.11, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

Authority: T.C.A. §§12-4-301, 71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed August 2, 1989; effective September 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed January 20, 1993; effective March 6, 1993.

1200-13-9.11 RATE OR PAYMENT ADJUSTMENTS

- (1) Prospective per diem rate or lump sum payment amounts are subject to adjustment in the event of a mistake.
- (2) Operating per diem rates may be adjusted if there is a significant change in case mix resulting in a \$25,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio. Requests for adjustments must be accompanied by detailed supporting information. Such rate adjustments if approved become effective on the first day of the month following the approval.
- (3) Providers may request an increase in monthly interim payments for return on equity, capital, and direct medical education if a provider's actual amounts are expected to exceed the estimated amount by at least 25%. Supporting financial data must be submitted with the request. No more than one request per year for an increase will be accepted per provider. The Commissioner reserves the right, after notifying the provider, to decrease estimated payments when information is made available indicating the estimated payments are materially higher than what is actually being incurred.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed June 2, 1992; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.

1200-13-9.12 NEW PROVIDERS. New providers who have not submitted a cost report and who are entering the program for the first time will be required to submit a budgeted cost report from which an interim prospective operating rate will be set. Each new provider must submit, in accordance with rule 1200-13-9-.04 an actual cost report covering the first full year of actual operations, at which point a final prospective operating rate, with a retroactive adjustment, will be used. A change of ownership does not constitute a new provider. The budgeted cost report will also be used to estimate interim payments for capital, direct medical education, and return on equity.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History :**Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.

1200-13-9.13 LOWER OF COST OR CHARGES LIMIT. In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first Fiscal year under prospective payment. Carry forwards of unreimbursed costs will not be recognized once a provider's initial Fiscal year under the prospective payment method has begun.

Authority: T.C.A. §§ 71-5-105, 71-5-109 and 4-5-202. **Administrative History.** Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.

1200-13-9.14 METHOD FOR PAYING PROVIDERS WHICH ARE EXEMPT FROM PROSPECTIVE SYSTEM.

- (1) The Comptroller of the Treasury, will determine, in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described at 42 CFR Part 405, per diem reimbursable costs for those Medicaid providers of psychiatric hospital services exempted from the prospective system set out in Rules 1200-13-9-.06 through 1200-13-9-.12 inclusive, except

(Rule 1200-13-9-.14, continued)

those hospitals described in item (3) of Rule 1200-13-9-.07 which shall be reimbursable as described in that item. The maximum limit of such reimbursable costs shall be the lessor of: (a) the reasonable cost of covered services, or (b) the customary charges to the general public for such services. Provided, however, that such providers which are public hospitals rendering services free or at a nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accordance with provisions of 42 CFR Part 405 in effect on October 1, 1982. Covered services means covered services as defined by the Department. Each provider's per diem reimbursable cost will be based on the provider's cost report which is to be filled out and submitted in accordance with Rule 1200-13-9-.04.

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

- (3) *Approval of Initial Settlement.*

When a provider's cost report is received, it is reviewed and compared with:

- (a) The amount of charges for covered services provided to Medicaid beneficiaries by the provider during the provider's fiscal period.
- (b) The amount of interim payments paid by the Department to the provider for the provider's fiscal period.
- (c) The number of inpatient days approved for the provider by the Department during the provider's fiscal period.

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

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

- (5) *Inpatient Routine Operating Per Diem Cost Limitation.* In the event that data is not available to compute the inpatient routine operating per diem cost limitation for all or any part of a provider's fiscal year, the Comptroller of the Treasury will use each provider's per diem cost limitation in effect prior to the provider's first fiscal year subject to prospective payment which will be appropriately trended, by that rate of increase on prospective payments allowed by Medicare as published annually in the *Federal Register* and in the *Tennessee Administrative Register*.

(Rule 1200-13-9-.14, continued)

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.

1200-13-9-.15 AUDIT

- (1) All hospital cost reports are subject to audit at anytime by the Comptroller of the Treasury and the Department or their designated representative. Cost report data must be based on and traceable to the provider's financial statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions.
- (2) Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay". Medical audit exceptions may result in a direct recoupment rather than a rate change.
- (3) The Department will provide for all costs of auditing which may be required.

Authority: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.

1200-13-9-.16 TERMINATION OF MEDICAID PSYCHIATRIC HOSPITAL REIMBURSEMENT PROGRAM. For psychiatric hospital services provided prior to January 1, 1994, the rules as set out at rule chapter 1200-13-9 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except that Tennessee Medicaid will continue to pay Medicare premiums, deductibles and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.

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