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Fax: 615-741-5133

Email: register.information@tn.gov**For Department of State Use Only**Sequence Number: 1201-10Rule ID(s): 4875File Date: 12/02/2010Effective Date: 03/02/2011

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
Address:	Bureau of TennCare 310 Great Circle Road Nashville, Tennessee
Zip:	37243
Phone:	(615) 507-6446
Email:	George.woods@tn.gov

Revision Type (check all that apply):☒ Amendment☐ New☐ Repeal

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

Chapter Number	Chapter Title
1200-13-13	TennCare Medicaid
Rule Number	Rule Title
1200-13-13-.08	Providers

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

Chapter 1200-13-13
TennCare Medicaid

Emergency Rule Subparagraph (c) of Paragraph (2) of Rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 CFR § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

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

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 11/22/2010 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 08/27/2010

Rulemaking Hearing(s) Conducted on: (add more dates). 10/21/2010

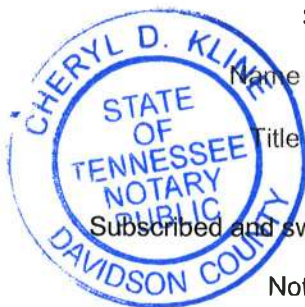
Date: 11/22/2010

Signature: [Signature]

Name of Officer: Darin J. Gordon

Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 11/22/10

Notary Public Signature: Cheryl D Kline

My commission expires on: 9/3/2012

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

Robert E. Cooper, Jr.

Robert E. Cooper, Jr.
Attorney General and Reporter

12-1-10

Date

Department of State Use Only

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2010 DEC -2 AM 11:02
SECRETARY OF STATE
PUBLICATIONS

Filed with the Department of State on: 12/2/10

Effective on: 3/2/11

[Signature]

Tre Hargett
Secretary of State

Public Hearing Comments

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

Copies of responses to comments are included with filing.

Regulatory Flexibility Addendum

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

(If applicable, insert Regulatory Flexibility Addendum here)

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

Impact on Local Governments

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

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

Additional Information Required by Joint Government Operations Committee

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

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

The rule replaces an emergency rule that established a payment methodology for payment of inpatient hospital services admissions required as a result of emergency outpatient services, when provided by non-Participating Providers.

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

The rule is lawfully adopted by the Department of Finance and Administration in accordance with Tennessee Code Annotated §§ 4-5-202, 71-5-105 and 71-5-109.

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

The persons and governmental entity most directly affected by this rule are the TennCare Providers and the Tennessee Department of Finance and Administration.

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

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

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

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

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

Darin J. Gordon
Director, Bureau of TennCare

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

Darin J. Gordon
Director, Bureau of TennCare

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

310 Great Circle Road
Nashville, TN 37243
(615)507-6443
Darin.J.Gordon@tn.gov

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

None

GW10210287



**STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243**

November 18, 2010

Mr. Craig Becker, FACHE
President
Tennessee Hospital Association
500 Interstate Blvd. South
Nashville, TN 37210

RE: Proposed Rule 1200-13-13-.08(2)(c)

Dear Mr. Becker:

We received your letter of October 20, 2010, with your comments on our proposed Rule 1200-13-13-.08(2)(c).

As you may know, the rules we presented at hearing on October 21, 2010, were based on the State's State Plan Amendment #10-003, which was approved by CMS with an effective date of March 17, 2010. The purpose of the SPA and the rules was to clarify the State's policy with respect to how the Managed Care Organizations are to pay out-of-network hospitals for emergency inpatient admissions associated with emergency services delivered by the hospital on an outpatient basis. The methodology stated in the rules was designed to be budget neutral, meaning that the amounts being paid out under the new methodology would be no less, in the aggregate, than the amounts being paid out previously.

Thank you for your comments.

Sincerely,

Darin J. Gordon
Director, Bureau of TennCare



October 20, 2010

Darin J. Gordon, TennCare Director
Deputy Commissioner, Finance & Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

The Tennessee Hospital Association (THA), on behalf of the hospitals in Tennessee, is writing to share with you our thoughts and concerns regarding the proposed rule regarding the setting of a payment rate for covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services when provided to Medicaid managed care enrollees by non-contract hospitals (amends Paragraph (2) of Rule 1200-13-13-.08).

Under the MCOs contract with the State of Tennessee, MCOs must provide (or arrange for the provision of) health care services to its enrollees. To fulfill these obligations, the MCOs must establish a contractual relationship with various health care providers to create a network of participating providers to render health care services to its enrollees.

Hospitals that participate in the Medicare program have a duty under the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide for screening and stabilization of all persons who come to its hospital seeking examination or treatment of emergency medical conditions. This required screening and stabilization must occur regardless of the patient's insurance status and before the hospital makes any inquiry as to whether the presenting patient belongs to a managed care plan.

In TennCare (Tennessee's Medicaid waiver program), the TennCare MCOs establish contractual relationships with health care providers to provide health care services to their enrollees at negotiated rates. The question of appropriate reimbursement for out-of-network providers for emergency and post-emergency medical services was addressed in a recent court decision (*The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System v. AmeriGroup Tennessee, Inc.*). For EMTALA services, there was no dispute among the parties that the Federal Deficit Reduction Act of 2005 (the DRA) "provides that, in states, like Tennessee, where rates paid to hospitals are negotiated by contract pursuant to the State plan, the rate of reimbursement for Emergency Services furnished by non-contract providers shall be the 'average contract rate that would apply under such plan for tertiary hospitals'".

Regarding post-EMTALA services, the Court states that "under the principles of RiverPark Hospital, Inc. v. Blue Cross BlueShield of Tennessee, Inc.,AmeriGroup is required unless otherwise agreed to pay Erlanger a reasonable rate of reimbursement for services that Erlanger provides to AmeriGroup's TennCare enrollees after its legal obligations under EMTALA end."

Additionally, the Court states, "the Court is unaware of any obligation by Erlanger, to accept any agreement or policy between TennCare and its MCOs. Tennessee has opted out of the 'fee-for service' Federal Medicaid program in favor of TennCare, under which the State contracts with MCOs and pays them fixed capitation fees, and the MCOs, in turn, negotiate payment contracts with participating providers on an at-risk basis." (Erlanger is an out-of-network provider.)

As an initial matter, what is the impetus for the 57% rule? If so, how did the Bureau derive the 57% rate and determine that 57% constitutes a "reasonable rate"?

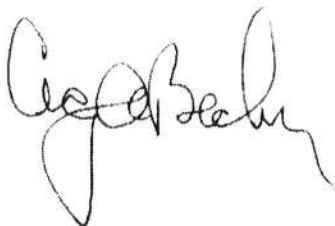
In our view, this proposed rule, if enacted and enforceable hurts Tennessee hospitals. By forcing non-contract hospitals to accept artificially low reimbursement rates for medically necessary services they are required by law to provide, it hurts hospitals financially and takes away the negotiating ability of hospitals with TennCare MCOs. Since TennCare is a market-based program with MCOs entering into contractual agreements with providers, having a mandated out-of-network rate defeats the very essence of the program. In effect, such a provision gives providers no choice but to not only contract with MCOs but to accept the MCO rates or else face a lower state-mandated rate.

Such a rule is also a subsidy for the MCOs. As at-risk providers, TennCare MCOs – not the hospitals – are the parties who have contractually agreed with the State to bear the costs of their enrollees seeking emergency medical services from non-participating hospitals. If MCOs want to avoid those costs, they can negotiate with any or all non-participating hospitals to include them in their network. This rule, however, upsets that market dynamic, setting an artificial ceiling on the amount the MCOs have to pay non-contracted providers and, in effect, shirking the MCOs' contractual risk of non-participation to the hospitals.

If, however, the state is to set any rates for out-of-network reimbursement, we believe that the process for coming to any such rate should be transparent and that the proposed rate of "57 percent the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share (DSH) components)" is too low. Medicare rates barely cover true costs of providing services and 57% of 2008 Medicare rates with no allowance for DSH or Medical Education provides reimbursement far below actual costs.

We appreciate the opportunity to comment on this proposed rule and look forward to continuing to work collaboratively with the TennCare Bureau.

Sincerely,

A handwritten signature in black ink, appearing to read "Craig Becker". The signature is fluid and cursive, with a large, stylized "C" at the beginning and a long, sweeping underline.

Craig Becker, FACHE
President
Tennessee Hospital Association



**STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243**

November 18, 2010

Mr. Franke P. Elliott
HCA
Tri-Star Health System
110 Winners Circle, 1st floor
Brentwood, Tennessee 37027

RE: Payment of Out-of-Network Providers for Emergency Inpatient Services

Dear Mr. Elliott:

Thank you for your letter of October 20, 2010, regarding TennCare's policy with respect to reimbursement of Out-of-Network hospitals for the provision of emergency inpatient services to TennCare enrollees who have received emergency services on an outpatient basis.

As you note in your letter, TennCare's methodology was approved by CMS with an effective date of March 17, 2010. This methodology was intended to standardize payments across MCOs and hospitals. It was also intended to be budget neutral. The total amount expended under the new methodology will be no less than the total amount expended under the methodology that was in place prior to March 17.

We appreciate your letting us know your concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. J. Gordon', is written over a horizontal line.

Darin J. Gordon
Director, Bureau of TennCare

October 20, 2010

Darin J. Gordon, TennCare Director
Deputy Commissioner, Finance & Administration
310 Great Circle Road
Nashville, TN 37243

RE: 57% Rule Implications

Dear Mr. Gordon:

Effective March 17, 2010, the TennCare Bureau effected an amendment that changed the rate that a Managed Care Organization (MCO) is required to pay for out-of-network services provided by non-participating hospitals (see Attachment, "*Notice of Change in TennCare II Demonstration*"). The payment rate set forth by the Notice was allegedly established at 57% of the 2008 Medicare rate (the "57% Rule"); however, the actual rate falls short of 57% of the full 2008 Medicare rate.

The short and long term impact of the implementation of the 57% Rule will significantly impact hospitals' ability to recoup their true costs and to negotiate at arm's-length with MCOs in order to remain as participating providers. In the short term, non-participating hospitals will be unable to effectively negotiate against the 57% Rule with MCOs as they abandon the negotiation process to take advantage of the out-of-network rate, thus reducing beneficiaries' choice and access. In the long term, hospitals, which are obligated by law to treat patients who present emergently, will continue to provide care under an unsustainable formula where the costs of providing that care far outweigh reimbursement.

As written, the 57% Rule is an impediment to the overall success of the TennCare MCO model the state has adopted. We have further described the impact of the Notice below:

Rate Structure

Under Medicare, hospitals are entitled to receive a wage-adjusted base rate multiplied by the relative weight of the MS-DRG assigned to each patient, plus additional payments for certain add-on services including but not limited to medical education add-ons, outliers, and new technology add-ons. Many hospitals in Tennessee also receive supplemental disproportionate share (DSH) funding from the federal government to help compensate hospitals for the high cost of treating a disproportionately large share of low-income patients. Under the 57% Rule; however, the out-of network payment rate does not account for any of these often significant payment amounts. Rather, the rate set forth accounts only for a Medicare base rate that was in effect three fiscal years ago. Due to the exclusion of DSH, the calculated reimbursement under the 57% Rule can be many percentage points less than the payments received from Medicare for that same time period. In other words, 57% of Medicare is not actually 57% of Medicare.

As written, the 57% Rule excludes the biggest add-on to Medicare rates that was designed to pay for the underprivileged. Again, the 57% Rule implemented by TennCare is not actually equivalent to 57% of Medicare; in reality it is closer to 40% or 50% of Medicare because many Middle Tennessee hospitals have DSH add-on percentages of 10 to 20%.

Our internal research indicates most states set their Medicaid reimbursement around 80% to 85% of the full Medicare rate. At 100% of the Medicare rate, hospitals would be reimbursed for their costs. The 57% Rule, at 40% to 50% of costs falls unreasonably short of the Medicare-equivalent reimbursement across the nation and of the cost for providing care. For HCA hospitals, the 57% Rule equates to 50% of 2008 Medicare thereby covering only 50% of our costs. Hospitals cannot sustain providing quality care at these reimbursement rates.

For these reasons, we encourage the addition of DSH funds in any calculation toward developing a more realistic rate that does not put hospitals at a greater risk than other partners in the TennCare Program.

Contracting with Out-of-Network (OON) Hospitals

By virtue of this unreasonably low OON rate, arms-length negotiations have become unachievable as TennCare has inadvertently provided MCOs with incentive to delay, avoid entering into, or even terminating agreements with hospitals. Further, this reduction in rate places an even higher cumulative cost-share burden on other citizens whose premiums and costs to access care are increased in order for hospitals to subsidize the cost of maintaining TennCare services that are not reimbursed at a sufficient rate.

As part of addressing the 57% Rule, TennCare must reevaluate its definition of Network Adequacy for the TennCare program. As currently written, an MCO could feasibly contract with just one tertiary hospital in an entire Grand Region and still meet the requirements of an adequate network. Together, the introduction of the 57% Rule and the current definition of Network Adequacy have further diminished the need for MCOs to make good faith efforts to contract with all willing hospitals in the market. If a hospital attempted to sign a contract at a rate that is competitive with the 57% Rule, they would likely place all their other Managed Medicaid contracts in jeopardy for termination by other MCOs seeking a similarly uneven rate.

Hospitals simply cannot maintain their ability to treat patients effectively at this rate. OON rates should be geared toward incentivizing BOTH parties to reach agreement in order to provide the broadest access and choice to Medicaid beneficiaries.

We respectfully request TennCare give careful consideration to the broader implications of the 57% Rule on hospitals. In addition, we encourage the 57% Rule be reevaluated and the rate increased in order to promote MCOs to work with hospitals to appropriately service the State of Tennessee and its Medicaid beneficiaries.

Thank you for your consideration of these important issues as they relate to providing quality care. We will gladly make our staff available for more detailed discussions and welcome the opportunity to work collaboratively with TennCare and MCOs to best address these concerns.

Sincerely,



Franke P. Elliott

cc: Rep. Joey Hensley, Chair, TennCare Oversight Committee

Attachment

Notice of Change in TennCare II Demonstration

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR 447.205 and 59 Fed. Reg. 49249, concerning intent to file an amendment to the Tennessee Medicaid State plan. The amendment will be filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland.

The amendment will clarify the payment rates for covered medically inpatient hospital admissions that are required as the result of emergency outpatient services, when delivered to TennCare enrollees by non-contract hospitals in accordance with Section 1923(b)(2)(D) of the Social Security Act. The payment rates for these services will be established at 57 percent of the 2008 Medicare rates for those services. For CMS codes adopted after 2008, the payment rate will be 57% of the rate in effect in the year of adoption.

These payment rates will continue to be used for individual inpatient stays until the earlier of the following: (1) the date the inpatient stay is no longer medically necessary or (2) the date the patient can be safely transported by his Managed Care Organization to a contract hospital or to another contract service. This payment methodology does not apply to Medicare crossover claims, which are paid in accordance with the Medicaid State plan, Attachment 4.19B, Section 24.

It is our intention to submit this State plan amendment to CMS with the request that it be approved with an effective date of March 17, 2010. We estimate that implementation of the amendment will have no fiscal impact on overall program expenditures.

Copies of this notice will be available in each county office of the Tennessee Department of Human Services. Written comments should be addressed to Mr. Darin Gordon, Director, Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243.

**Department of State
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Chapter 1200-13-13
TennCare Medicaid

Emergency Rule Subparagraph (c) of Paragraph (2) of Rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 CFR § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. ~~These~~ Such an inpatient stays will continue until ~~they are~~ no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

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