



Division of TennCare

TennCare II Demonstration

Project No. 11-W-00151/4

Amendment 41

DRAFT

Table of Contents

Section I: Description of the Amendment.....	1
Section II: Expected Impact on Budget Neutrality	3
Section III: Expected Impact on CHIP Allotment Neutrality	3
Section IV: Modifications to the Evaluation Design	3
Section V: Demonstration of Public Notice and Input	3
Appendices:	
Appendix A: Proposed Edits to the TennCare Demonstration	
Appendix B: Expected Impact on Budget Neutrality	

Amendment to the TennCare II Demonstration

The TennCare demonstration has existed since 1994 as one of the oldest and most comprehensive Medicaid managed care demonstrations in the nation. The most recent extension of the TennCare demonstration in 2016 established two new funds through which the State reimburses qualifying hospitals for unreimbursed costs realized as a result of Medicaid shortfall and charity care.

- The Virtual DSH Fund totals up to \$463,996,853 annually and can be used to pay for Medicaid shortfall and charity care costs.
- The Uncompensated Care Fund for Charity Care (“Charity Care Fund”) totals up to \$252,845,886 annually and can be used to pay for charity care costs.

The state began implementing the Virtual DSH and Charity Care Funds on July 1, 2018.

The TennCare demonstration also governs the State’s financial support for graduate medical education (GME) in Tennessee. GME is supported by a separate fund totaling \$50 million annually. This amount has been unchanged since the inception of the TennCare II demonstration.

In Amendment 41, Tennessee proposes to amend the Special Terms and Conditions (STCs) governing payments from its two uncompensated care funds. These proposed changes reflect the actual experience of Tennessee healthcare providers furnishing uncompensated care and will help to ensure that TennCare has adequate flexibility to provide support to these providers. This includes updates to the methodology used to distribute monies from these two funds to hospitals. The State also proposes to increase the level of support provided for GME through the TennCare demonstration.

I. Description of the Amendment

Amendment 41 consists of these three components:

1. Adjust the funding amount in TennCare’s GME Fund.
2. Adjust the maximum funding amounts in TennCare’s Charity Care and Virtual DSH Funds.
3. Update the distribution methodology for the Charity Care and Virtual DSH Funds.

Each of these proposed changes is discussed below.

Adjust the Funding Amount in the GME Fund

TennCare’s current GME fund of \$50 million annually has been in place since the inception of the TennCare II demonstration. Under the terms of the TennCare demonstration, TennCare makes GME payments to the four medical universities in Tennessee that operate graduate physician medical

education programs.¹ These payments are for use by those universities to fund the graduate medical education activities of associated teaching hospitals or clinics, and are allocated each year based on each university's relative number of primary care residencies.

The State proposes to increase the funding amount in the TennCare GME fund in order to increase support for graduate medical education in Tennessee and the development of primary care physicians in Tennessee generally. The proposed increase in the GME fund will consist of an amount to be determined each year by applying the applicable year's FMAP to an annual increase of \$3,750,000 in state funding. This additional GME funding will be allocated based on the extent to which the four universities increase the number of primary care residents above their historical baseline levels. The State's proposed edits to the STCs governing the TennCare GME fund are illustrated in Appendix A.

Adjust the Maximum Funding Amounts in the Charity Care Fund and Virtual DSH

The Charity Care Fund and the Virtual DSH Fund are the two funds through which TennCare reimburses Tennessee hospitals for the cost of providing uncompensated care. The initial amount of the Charity Care Fund was established when the current TennCare STCs were approved on December 16, 2016.² However, these STCs also contemplate that the State may seek a demonstration amendment to adjust this amount, if the State provides a data analysis produced by an independent entity of the actual uncompensated care incurred by Medicaid providers in the state. The State has procured the services of an independent accounting firm (Myers and Stauffer, LC) to conduct a study of net unreimbursed charity care costs incurred by Tennessee providers, using a methodology patterned on the approach used by CMS to set the initial charity care amount in 2016. Using data from the CMS Medicare Cost Report Form 2552-10 and the Tennessee Department of Health's Joint Annual Report of Hospitals, the study concluded that net unreimbursed charity care costs for reporting periods ending in calendar year 2016 were \$589,886,294. (See attached report.) This amount exceeds the \$252,845,886 annual limit for payments from the Charity Care Fund. Accordingly, the State requests that the annual limit on payments from the Charity Care Fund be adjusted by \$337,040,408. This adjustment would appropriately recognize the charity care costs incurred by Medicaid providers in Tennessee and help ensure the state has flexibility to provide support for Tennessee hospitals.

In addition to unreimbursed charity care costs, the same independent study estimates that Medicaid providers in Tennessee experienced \$508,936,029 in net unreimbursed Medicaid shortfall costs for reporting periods ending in calendar year 2016. (See attached report.) This amount is \$44,939,176 more than the current cap on the Virtual DSH Fund specified in the STCs of the TennCare demonstration. Because these costs cannot be paid from the Charity Care Fund, the state requests that the Virtual DSH Fund be increased by \$44,939,176. The State notes that when the Virtual DSH fund was established in 2016, the amount of the fund was based on the TennCare demonstration's existing DSH adjustment amount, and that this amount has not been changed since Demonstration Year 10 (2011-2012). A small

¹ Universities that receive TennCare GME payments are East Tennessee State University, Meharry Medical College, the University of Tennessee at Memphis, and Vanderbilt University.

² CMS subsequently made a technical correction to this amount on October 23, 2018.

adjustment in the size of the Virtual DSH Fund would allow the state to ensure that Medicaid providers in Tennessee do not experience excessive Medicaid shortfall costs.

Update the Distribution Methodology for the Charity Care Fund and Virtual DSH

Adjusting the amounts of the Charity Care Fund and Virtual DSH Fund will also entail revisions to the State's approved distribution methodology for these funds in order to account for the distribution of the additional dollars. In addition, the State proposes the creation of a new sub-pool within the Charity Care Fund, to be known as the Uncompensated Charity and Self-Pay Sub-Pool, to address unreimbursed charity and self-pay costs that are otherwise unaddressed within the current system. The State's proposed edits to the uncompensated care distribution methodology are illustrated in Appendix A.

II. Expected Impact on Budget Neutrality

Implementation of Amendment 41 will increase the state's capacity to reimburse qualifying hospitals for costs incurred in providing uncompensated care by \$381,979,584 per year. It is projected that actual demonstration expenditures will increase by approximately \$11 million per year in additional GME expenditures, and approximately \$144 million per year in additional uncompensated care payments.

Attached is an updated overview of the demonstration's finances that reflects this adjustment.

III. Expected Impact on CHIP Allotment Neutrality

This amendment will not result in any changes to Tennessee's CHIP allotment neutrality.

IV. Modifications to the Evaluation Design

The state does not anticipate modifying the demonstration evaluation design based on these changes.

V. Demonstration of Public Notice and Input

The state has used multiple mechanisms for notifying the public about this amendment and for soliciting public input on the amendment. These public notice and input procedures are informed by—and comply with—the requirements specified at 42 CFR § 431.408.

Public Notice

The State's public notice and comment period began on September 9, 2019, and lasted through October 11, 2019. During this time, a comprehensive description of the amendment to be submitted to CMS was made available for public review and comment on an amendment-specific webpage on the TennCare website. An abbreviated public notice—which included a summary description of Amendment 41; the

locations, dates, and times of two public hearings; and a link to the full public notice on the State’s amendment-specific webpage—was published in the newspapers of widest circulation in Tennessee cities with a population of 50,000 or more. TennCare disseminated information about the proposed amendment, including a link to the relevant webpage, via its social media (i.e., Twitter, Facebook). TennCare also notified the members of the Tennessee General Assembly of Amendment 41 via an electronically transmitted letter.

The state held two public hearings to seek public comment on Amendment 41. The first hearing took place on September 25, 2019, at 11:30 a.m. at the Bellevue branch of the Nashville Public Library, 720 Baugh Road in Nashville. The second public hearing took place on September 26, 2019, at 2:00 p.m. Central Time at the TennCare Building, 310 Great Circle Road in Nashville. Telephonic access to the September 26 hearing (in the TennCare Building) was offered to individuals who were unable to attend in person and who notified the state of their desire to participate by telephone. Members of the public also had the option to submit comments throughout the notice period by mail and/or email. Documentation of the state’s public notice process is included as Appendix D.

Public Comments

[RESERVED]

Appendix A

Proposed Edits to the TennCare Demonstration

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: **No. 11-W-00151/4 Title XIX**

TITLE: **TennCare II Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II):

5. Indirect Payment of Graduate Medical Education.

Expenditures, up to \$50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics. An additional amount determined by applying the applicable year's FMAP to the annual state share of \$3,750,000 will be distributed to the same group of universities for the purpose of increasing the number of primary care residents in training.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

X. GENERAL FINANCIAL REQUIREMENTS

58. Extent of Federal Financial Participation for the Demonstration.

Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 59, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs. When referenced, actual cash disbursements is intended to signify that certified public expenditures may not be used to establish expenditures for these pools.

- d. Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to \$50 million in total computable expenditures, plus an additional amount determined by applying the applicable year's FMAP to the annual state share of \$3,750,000, for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

GME Pool Methodology: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual base GME Pool funds of \$50M total (state share plus federal match) will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency. The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual

ratio is applied to the total GME Pool funding to be allocated. The additional GME funding that is determined by applying the applicable year's FMAP to the annual state share of \$3,750,000 will be allocated based on the annual ratio derived by dividing each university's total primary care residents over the historical baseline set by TennCare into the total of every university's total primary care residents over the total historical baseline. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

- 61. Permissible Uncompensated Care Payments.** Funds for uncompensated care payments under the demonstration may be used for health care costs that would be within the definition of medical assistance in section 1905(a) of the Act. For purposes of Tennessee uncompensated care, beginning July 1, 2018 there are two funds for which different types of uncompensated care may be paid under the demonstration.

- a. Virtual DSH Fund.** The virtual DSH fund includes the state's DSH adjustment amount in budget neutrality described in Table 8 below, and subsumes the statutory DSH allotment provided in section 1923 of the Act. Funds in virtual DSH (which includes statutory DSH) will be used to reimburse hospitals for uncompensated care (consistent with the definition of uncompensated care in 42 CFR 447.299) and can serve the same purposes of a DSH allotment provided under the statute. The state is authorized for the DSH Adjustment (federal share) set forth in Table 8; the total computable amount will depend on the State's FMAP in each DY. The DSH Adjustment (federal share) will be adjusted using a methodology consistent with the changes to the federal DSH allotments in other states under section 1923(f)(7) of the Act for federal fiscal year 2019 and thereafter, to the extent those changes to the federal DSH allotment are in effect for other states.
- b. Uncompensated Care Fund for Charity Care.** Funds in the Uncompensated Care Fund for Charity Care will be used for health care costs that are incurred by the state, hospitals, or health care clinics to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association. The state is authorized for \$252,845,886 total computable for the Uncompensated Care Fund for Charity Care in DY 17 ~~and each DY thereafter.~~ The state is authorized for \$589,886,294 total computable for the Uncompensated Care Fund for Charity Care in DY 18 and each DY thereafter.

69. Budget Neutrality Ceiling. The following describes the method for calculating the budget neutrality expenditure limit:

- d. The DSH adjustment is based upon Tennessee’s DSH allotment for 1992 and was calculated in accordance with current law. Table 8 gives the DSH adjustments for DY 1 through DY 19, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Beginning in DY 10, the DSH adjustment was held constant while awaiting to determine the impact of Medicaid expansion under the Affordable Care Act on uncompensated care and DSH. Beginning with DY 15, the DSH adjustment is considered “Virtual DSH” for purposes of paying for uncompensated care due to Medicaid shortfall under the demonstration. The federal share of the DSH adjustment is based on the state’s federal medical assistance percentages (FMAP) for the applicable demonstration year.

Table 8		
DSH Adjustments and Virtual DSH		
	DSH Adjustment (total computable)	DSH Adjustment (Federal share)
DY 1	\$413,700,907	\$268,409,148
DY 2	\$479,893,052	\$310,106,890
DY 3	\$479,893,052	\$310,538,794
DY 4	\$479,893,052	\$308,091,339
DY 5	\$479,356,649	\$305,451,928
DY 6	\$479,657,638	\$305,451,928
DY 7	\$485,299,094	\$311,270,839
DY 8	\$488,969,517	\$319,052,610
DY 9	\$470,369,327	\$309,408,043
DY 10	\$463,996,853	\$305,451,928
DY 11	\$463,996,853	\$305,451,928
DY 12	\$463,996,853	\$305,451,928
DY 13	\$463,996,853	\$305,451,928
DY 14	\$463,996,853	\$305,451,928
DY 15-DY 19 DY 17 Virtual DSH	\$463,996,853	Based on Applicable FMAP
<u>DY 18 - DY 19</u> <u>Virtual DSH</u>	<u>\$508,936,029</u>	<u>Based on Applicable</u> <u>FMAP</u>

ATTACHMENT H

DISTRIBUTION METHODOLOGY FOR UNCOMPENSATED CARE PAYMENTS

The supplemental pool framework effective in SFY ~~2018-2019~~ 2019-2020 (Demonstration Year ~~17~~ 18) includes two pools with defined caps:

- A “Virtual DSH” pool not to exceed ~~\$463,996,853~~ \$508,936,029 total computable annually.
- An Uncompensated Care Fund for Charity Care (the Charity Care pool) not to exceed ~~\$252,845,886~~ \$589,886,294 total computable annually.

Virtual DSH Pool

The State proposes to make the following payments within the Virtual DSH Pool in each SFY:

- Critical Access Hospital Sub-pool – \$15 million
- Statutory DSH Method Sub-pool – approximately \$81 million (fixed annual federal allocation of \$53.1 million, total varies with FMAP)
- Children’s Safety Net Sub-pool - ~~\$25-million~~ \$28.6 million
- Other Essential Acute Sub-pool - ~~\$43.5-million~~ \$60.7 million
- Safety Net Sub-pool - ~~\$30.5-million~~ \$36.3 million
- Psychiatric Facilities Sub-pool - ~~\$1.5-million~~ \$2,173,144
- Public Hospital Costs Sub-Pool – up to \$240 million

Some hospitals may be eligible to receive supplemental payments to be distributed from more than one sub-pool. In such cases, as payment from one sub-pool is calculated, the amount of that payment will be taken into account as additional sequential sub-pool payments are calculated to ensure that duplication and overpayment do not occur.

Critical Access Hospital Sub-pool –\$15 million

Qualifications -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee,
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health,
- The hospital contracts with a managed care organization participating in TennCare,
- The hospital contracts with TennCare Select,
- The hospital provides accurate and timely admission, discharge, and transfer data to TennCare, and
- The hospital participates in the State’s payment reform initiatives, including episodes of care, as appropriate.

Reimbursement -- TennCare will pay ~~to~~ Critical Access Hospitals under the following terms.

Inpatient Services -- Payment for uncompensated TennCare inpatient services costs that are furnished by Critical Access Hospitals will be made quarterly with interim per diem rates

with year-end cost settlements. Using the as-filed Medicare Cost Reports for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration of payments for TennCare services to hospitals by managed care organizations and any special payments to hospitals.

The inpatient interim per diem rate is calculated as follows:

- Values for Inpatient Routine and Ancillary Service Medicaid costs and total Medicaid inpatient days are obtained from Worksheet D-1 of the most recent as-filed Medicare Cost Report (lines 39, 48 and 9 respectively). From this information, a Medicaid cost per diem can be calculated.
- The “Interim MCO Payment” for the CAH is determined by the payments for inpatient services (excluding any TennCare Quarterly Interim Settlement Reimbursements) as reported on Worksheet E-3 (line 41).
- These payments are divided by the number of reported Medicaid days for the quarter to determine the per diem amount the CAH received as payment from the TennCare managed care organization.
- The inpatient interim per diem rate for the CAH is the difference between the total allowed Medicaid cost per diem and the per diem amount paid to the hospital by the MCO.

Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

Outpatient Services -- Payment for uncompensated TennCare outpatient services costs that are furnished by Critical Access Hospitals will be made quarterly based on a percentage of charges with year-end cost settlements.

Using the as filed Medicare Cost Reports for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals.

The interim outpatient rate will be calculated as follows:

- First, total Medicaid Outpatient costs and total Medicaid Outpatient charges are referenced from the MCR from Worksheet E-3; (line 2 and line 12, respectively).
- The MCO outpatient payments to the CAH (excluding any TennCare Interim Quarterly Payments) are divided by the CAH’s total Outpatient Medicaid Charges to derive an MCO Payment to Charge ratio.
- This MCO Payment to Charge Ratio is then compared to the CAH’s calculated overall Outpatient Cost to Charge Ratio. The difference between the Outpatient CCR and the MCO Payment to Charge ratio equals the Interim Supplemental Reimbursement Rate for the CAH for Outpatient Services.

Total Payment – Each hospital’s total payment will be calculated as follows:

1. Each hospital’s interim inpatient per diem is multiplied by their Medicaid inpatient days.
2. Each hospital’s interim outpatient rate (percentage) is multiplied by their Medicaid outpatient charges.
3. The products of steps 1 and 2 are added together to derive an amount for each hospital.

Cost Settlements -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

New Designations of Critical Access Hospitals -- For new hospitals that qualify after July 1, 2018, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

Audit Trail and Audit Requirements -- Each CAH 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 5 years from the date of the submission of the Joint Annual Report and the related Medicare Cost Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

Statutory DSH Method Sub-pool – \$53,100,000 divided by FMAP (approximately \$81 million)

In addition to federal requirements for DSH participation, hospitals in Tennessee must meet the following eligibility criteria:

- The hospital must have at least one of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days; or (iii) be a children’s hospital defined as a free standing hospital that serves primarily children under 18 years of age and is identified to the public as a children’s hospital with a separate emergency department staffed and equipped to provide emergency services to pediatric patients.
- The hospital must have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost.
- The hospital contracts with a managed care organization participating in TennCare.
- The hospital contracts with TennCare Select.
- The hospital provides accurate and timely admission, discharge, and transfer data to TennCare.
- The hospital participates in the State’s payment reform initiatives, including episodes of

care, as appropriate.

This sub-pool is the only sub-pool within the Virtual DSH pool for which all participating hospitals are required to meet the DSH requirements in Section 1923 of the Social Security Act including the requirement to provide OB services. Participation in all other Virtual DSH sub-pools is not contingent on meeting the requirement to provide OB services.

In Tennessee, multiple facilities may be included on a single license and the facilities that share a license are all included on a single Medicare cost report. Hospitals that share a Medicare cost report are identified separately in the State's Joint Annual Report data and the JAR data for those facilities would be grouped together so that the DSH audit values would align correctly. The State proposes to distribute the funds within the Sub-pool using the methodology outlined in the Distribution Formula Update included in Appendix A.

Children's Safety Net Sub-pool - ~~\$25-million~~ \$28.6 million

Hospitals eligible to participate in the Children's Safety Net Sub-pool must:

- be licensed by the Tennessee Department of Health as an independent or satellite facility with a primary function to serve children under the age of 21 in Tennessee and file a separate Joint Annual Report,
- be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program,
- have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days,
- have unreimbursed Medicaid cost and/or charity care cost~~;~~,
- provide accurate and timely admission, discharge, and transfer data to TennCare, and
- participate in the State's payment reform initiatives, including episodes of care, ~~and~~ as appropriate.

Data for use in distribution of the sub-pool will come from the most recent reviewed Joint Annual Report (JAR).

Funds within the Sub-pool will be distributed using the methodology outlined in the Distribution Formula Update included in Appendix A.

Other Essential Acute Sub-pool - ~~\$43.5-million~~ \$60.7 million

Hospitals eligible to participate in the Other Essential Acute Sub-pool must:

- be an acute care hospital licensed by the Tennessee Department of Health to operate in the State of Tennessee ~~(excluding state mental health institutes and CAH)~~, that is not eligible for the Critical Access Hospital Sub-pool, the Children's Safety Net sub-pool or the Safety Net sub- pool,
- be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program,
- have at least one of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average

number of TennCare Adjusted Days; or (iii) be a children's hospital defined as a free standing hospital that serves primarily children under 18 years of age and is identified to the public as a children's hospital with a separate emergency department staffed and equipped to provide emergency services to pediatric patients,

- have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost,
- provide accurate and timely admission, discharge, and transfer data to TennCare, and
- participate in the State's payment reform initiatives, including episodes of care, as appropriate.

This group of hospitals will be divided into three Tiers based on the size of their operating total expenses from the most recent reviewed Joint Annual Report. Operating Total expenses are obtained from the Joint Annual Report, Schedule E (Financial Data), Section B, Lines 1 (f) and 2 (i) summed on Line 3. Line 1 expenses are the various payroll expenses for MDs, residents, trainees, RN and LPNs, and all other personnel. Line 2 expenses are the nonpayroll expenses for benefits, professional fees, contracted staff, depreciation, interest, energy, and all other expenses (supplies, nonoperating expenses, purchased services, etc.). The hospitals will be grouped into the appropriate tiers based on their reported total expenses.

The Tiers are:

Tier 1: Hospitals under \$30 million operating total expenses

Tier 2: Hospitals at \$30 million operating total expenses up to \$100 million operating

expenses Tier 3: Hospitals at or above \$100 million operating total expenses

Based on the percentage of the total operating expenses for all eligible hospitals in each Tier, the maximum amount of the total ~~\$43.5 million~~ \$60.7 million pool available to be distributed in each Tier will be:

Tier 1 - ~~\$2.5 million~~ \$3.35 million

Tier 2 - ~~\$10 million~~ \$13.35 million

Tier 3 - ~~\$31 million~~ \$44 million

Total - ~~\$43.5 million~~ \$60.7 million

~~Funds within each Tier will be distributed using the methodology outlined in the Distribution Formula Update included in Appendix A.~~

Funds within each Tier will be distributed based on points for Medicaid utilization, charity care costs, and/or children's hospital status using the methodology outlined in the Distribution Formula Update included in Appendix A.

Safety Net Sub-pool - ~~\$30.5 million~~ \$36.3 million

Hospitals eligible to participate in the Safety Net Sub-pool must:

- be licensed to operate in the State of Tennessee (~~excluding state mental health institutes-~~

~~and CAH),~~

- be both a Level 1 Trauma Center and a Regional Perinatal Center, or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved,
- be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program,
- have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days,
- have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost,
- provide accurate and timely admission, discharge, and transfer data to TennCare, and
- participate in the State's payment reform initiatives, including episodes of care, as appropriate.

Data for use in distribution of the sub-pool will come from the most recent reviewed Joint Annual Report (JAR).

Safety Net Sub-pool is divided into two Tiers:

Local Government Owned Safety Net Hospital Tier - \$24 million

Other Safety Net Hospital Tier - ~~\$6.5 million~~ \$12.3 million

~~Funds within each Tier will be distributed using the methodology outlined in the Distribution Formula Update included in Appendix A.~~

Funds within each Tier will be distributed based on points for Medicaid utilization, charity care costs, and/or children's hospital status using the methodology outlined in the Distribution Formula Update included in Appendix A.

Psychiatric Facilities Sub-pool - ~~\$1.5 million~~ \$2,173,144

Hospitals eligible to participate in the Psychiatric Facilities Sub-Pool must:

- be licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes,
- be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program,
- have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost,
- provide accurate and timely admission, discharge, and transfer data to TennCare, and
- participate in the State's payment reform initiatives, including episodes of care, as appropriate.

~~Funds within the Sub-pool will be distributed using the methodology outlined in the Distribution Formula Update included in Appendix A.~~

Funds within the sub-pool will be distributed based on points for Medicaid utilization, and/or charity care costs, using the methodology outlined in the Distribution Formula Update included in Appendix A.

Public Hospital Costs Sub-Pool – up to \$240 million

Hospitals eligible to participate in the Public Hospital Costs Sub-Pool must:

- be licensed to operate in the State of Tennessee,
- be a government operated hospital.
- have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost.

This sub-pool will be calculated per the CPE Protocol by independent auditors. This calculation will be completed at the level of individual eligible hospitals.

Charity Care Pool

The State proposes to make the following payments within the Charity Care Pool in each SFY:

- Public Hospital Sub-pool – \$100 million
- Safety Net Sub-pool - \$23 million
- Research and Rehabilitation Facilities Sub-Pool- \$3.0 million
- Meharry Medical College Sub-pool - \$10 million
- Uncompensated Charity and Self-Pay Sub Pool - \$116.8 million

Some hospitals may be eligible to receive supplemental payments to be distributed from more than one sub-pool, including sub-pools from the Virtual DSH pool. In such cases, as payment from one sub-pool is calculated, the amount of that payment will be taken into account as additional sequential sub-pool payments are calculated to ensure that duplication and overpayment do not occur.

Public Hospital Sub-pool – \$100 million

The amount paid each year to each hospital in this sub-pool must equal the hospital's charity care cost as identified on the most recent reviewed Joint Annual Report. In the event total charity care cost for these three hospitals exceeds \$100 million in a given year the Sub-pool will be distributed proportionally. Each individual hospital's percent of the total charity care cost for the three hospitals will be multiplied by the total sub-pool amount of \$100 million to determine each hospital's share of the sub-pool. The maximum amount any hospital may receive from this sub-pool per year will be \$50 million. These sub-pool payments may be made to the following hospitals: Regional Medical Center at Memphis, Metro Nashville General Hospital, and Erlanger Medical Center at Chattanooga.

Other Safety Net Sub-pool - \$23 million

The criteria used to establish the "Other Safety Net Hospital Tier" as part of the Virtual DSH Safety Net Sub-pool will be used to identify the hospitals to be included in this Sub-pool. Funds in this Sub-pool will be distributed as laid out in the Distribution Formula Update included in Appendix A. Data for use in distribution of the sub-pool will come from the most recent reviewed Joint Annual Report (JAR).

The amount paid each year to each hospital in this sub-pool must equal the hospital's unreimbursed self-pay cost as identified on the most recent reviewed Joint Annual Report. In the event total unreimbursed self-pay cost for these three hospitals exceeds \$23 million in a given year the sub-pool will be distributed proportionally. Each individual hospital's percent of the total unreimbursed self-pay cost for the three hospitals will be multiplied by the total sub-pool amount of \$23 million to determine each hospital's share of the sub-pool.

Research and Rehabilitation Facilities Sub-pool - \$3 million

Hospitals eligible to participate in the Research and Rehabilitation Facilities Sub-Pool must:

- be licensed to operate in the State of Tennessee
- be a rehabilitation facility, long term acute care facility reimbursed by Medicare under the IRF or LTAC methodology, or a pediatric research hospital
- provide accurate and timely admission, discharge, and transfer data to TennCare if the facility is a rehabilitation facility or long term acute care facility.
- be a contracted provider with at least one Managed Care Organization in the TennCare program, and
- have unreimbursed Medicaid cost, unreimbursed self-pay, and/or charity care cost.

Meharry Medical College Sub-pool - \$10 million

Payments may be made based on the uncompensated uninsured charity care costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to uninsured charity care patients. The Meharry Medical College Sub-pool payments are limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report.

Uncompensated Charity and Self-Pay Sub Pool - \$116.8 million

Hospitals eligible to participate in the Uncompensated Charity and Self-Pay Sub Pool must:

- be a hospital licensed to operate in the State of Tennessee that is eligible to receive a payment from any sub-pool in the Virtual DSH or Charity Care pool
- not have received an allotment from the public hospital sub-pool of the charity care pool
- not be a children's research facility
- be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program
- have remaining uncompensated charity and/or self-pay costs after all other supplemental pool payments have been distributed, including the Public Hospital Costs Sub Pool
- provide accurate and timely admission, discharge, and transfer data to TennCare, and
- participate in the State's payment reform initiatives, including episodes of care, as appropriate.

The Uncompensated Charity and Self-Pay Sub Pool will be divided into two tiers:

Public Hospitals: \$14,430,000

Non-Public Hospitals: \$102,415,886

The State proposes to distribute the funds for the Sub-pool based on each eligible facility's proportional remaining unreimbursed charity and self-pay costs. The amount paid each year to each hospital in this sub-pool must equal the hospital's remaining unreimbursed charity care c o s t plus unreimbursed self-pay cost as identified on the most recent reviewed Joint Annual Report after those costs and unreimbursed TennCare costs have been reduced by the amount of all Virtual DSH and all other charity care pool payments for the same year. In the event the remaining total charity care and unreimbursed self-pay costs for all eligible hospitals exceeds the amount allocated to the appropriate tier of the sub-pool, the payments will be distributed proportionally. Each individual hospital's percent of the total charity care and unreimbursed self-pay cost for the eligible hospitals in each tier will be multiplied by the total tier amount to determine each hospital's share of the sub-pool. The maximum amount any hospital may receive from each tier of this sub-pool per year will be 10 percent of the total amount of the tier.

ATTACHMENT H DISTRIBUTION METHODOLOGY FOR UNCOMPENSATED CARE PAYMENTS

Appendix A

Proposed Distribution Formula Update

Data Sources

The State proposes to continue to use charity care cost data, unreimbursed self-pay cost data, and Medicaid utilization data taken from the Joint Annual Report (JAR), an annual report the State has required from hospitals for many years and a longstanding data source for our supplemental pool distribution calculations. The JAR is required by Tennessee law (T.C.A. 68-11-310) to be filed by each hospital 150 days following the close of their fiscal year. For those with a calendar year end the due date would be May 31. The state is then required by the same law to create a compilation of the data that is to be available to the public no later than November 30 of the year following the year of the data collection. The data that would be used in the calculation would be the most current final data that had been compiled by the state at the beginning of the fiscal year for which payments are to be made. For example, for the SFY 2018-19 payments, the 2016 JAR data is the most current final data file.

To determine Medicaid volume, the Joint Annual Report patient days and inpatient and outpatient charges will be used to determine adjusted days for TennCare and the total facility. Patient days are adjusted to account for inpatient and outpatient volume in a single measure. The formula is: reported inpatient days multiplied by the ratio of inpatient charges plus outpatient charges to inpatient charges. For the total facility adjusted days, the charges and inpatient days are as reported for the total facility; for TennCare adjusted days, the days and charges in the formula are specific to TennCare.

Charity care costs will be determined by multiplying the unreimbursed charity care charges reported on the JAR by the facility cost to charge ratio, which is calculated as total expenses divided by total charges for each facility. Unlike the prior methodology that defined charity care to include both charity care and bad debt, only unreimbursed charity care cost is included in the new proposed methodology.

Unreimbursed self-pay costs will be determined by multiplying the self-pay charges reported on the JAR by the facility cost to charge ratio, which is calculated as total expenses divided by total charges for each facility, to determine self-pay costs. The reported revenue received from self-pay patients is then subtracted from the self-pay cost to determine unreimbursed self-pay costs. The instructions on the JAR for this data element are: Include charges for all patients who clearly paid the hospital for services only because they were uninsured or insurance did not cover the services provided. Do not include co-pay or deductibles for insured patients.

For payments made from the Virtual DSH Fund, payments will be based on points assigned for TennCare volume, charity care costs and/or children's hospital status based on the most recent reviewed Joint Annual Report as described below. For payments made

from the Charity Care Fund, payments will be based on either a hospital's proportionate share of charity care costs ~~in a particular Sub-pool, or charity care cost and children's-hospital points only, and unreimbursed self-pay costs.~~

Where points are used in the determination of the pool, the allocation will be based on an assignment of points for:

- TennCare adjusted days expressed as a percent of total adjusted patient days;
- Charity care costs expressed as a percent of total expenses; and/or
- Children's hospital status.

Calculation of Points

TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare.

Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the state mental health institutes, critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 30.5%;
- 3 points – greater than 30.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

(2) Charity Care – Charity Care costs as a percent of total expenses

- 0 points - less than 0.5%
- 1 point - greater than or equal to 0.5% and less than 4.5%
- 2 points - greater than or equal to 4.5% and less than 10.0%
- 3 points - greater than or equal to 10.0%

(3) Children's hospitals

- 1 point for being a free standing hospital that serves primarily children under 18 years of age and is identified to the public as a children's hospital with a separate emergency department staffed and equipped to provide emergency services to pediatric patients.

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

- 7 or more points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR

- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each Sub-pool or Tier, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. The TennCare adjusted days are calculated as the number of TennCare inpatient days multiplied by the ratio of total TennCare charges to TennCare inpatient charges - this adjusts the number of days up to reflect outpatient utilization. These amounts are summed for all of the hospitals that qualify for the Sub-pool or Tier. Each hospital's initially calculated amount will then be adjusted to the total in the Sub-pool or Tier. This is done by first calculating each individual hospital's proportion of the total for all hospitals of the initial calculated amounts and then multiplying that proportion times the total amount available in the pool.

~~For the "Other Safety Net Sub-Pool" in the amount of \$23 million that is included in the Charity Care Pool, the State will replace Adjusted TennCare Days in the distribution calculation with another source of unreimbursed cost attributed to uninsured patients on the Joint Annual Report, unreimbursed self-pay costs. This item includes the amount of the cost not covered by uninsured patients. The instructions on the JAR for this data element are: Include charges for all patients who clearly paid the hospital for services only because they were uninsured or insurance did not cover the services provided. Do not include co-pay or deductibles for insured patients. The calculation would be to first determine each of the facility's portions of the total unreimbursed self-pay cost for the facilities qualifying for this sub-pool and then apply that percentage to the total \$23 million in the sub-pool.~~

Distribution of Charity Care Pools

The Sub-Pools in the Charity care pool will be distributed based on each facility's unreimbursed charity care cost and/or unreimbursed self-pay cost. Each sub-pool provides every qualifying hospital a proportionate share of the sub-pool based on the hospital's proportionate share of the aggregate charity care costs and/or unreimbursed self-pay cost for the qualifying hospitals in the sub-pool. The Uncompensated Charity and Self-Pay Sub Pool will be the final pool amount determined and the unreimbursed costs will be reduced by the amount of all of the other sub-pools before determining a hospital's share of that sub-pool.

The calculation for that sub-pool is as follows:

- Calculate each facility's Virtual DSH and Charity Fund payments from other pools (rolled up to the cost report level)
- Using latest JAR data, calculate each facility's unreimbursed TennCare costs, charity costs and unreimbursed self-pay costs.
- Offset the total unreimbursed costs by the projected Virtual DSH and other Charity Pool payments, including CPE, by first exhausting the remaining TennCare costs,

then charity costs, and finally self-pay costs, to calculate the remaining unreimbursed charity and self-pay costs.

- Apply each facility's proportional amount of the remaining unreimbursed costs to the total pool amount for the appropriate tier to calculate each facility's payment.
- If any hospital's calculated amount from this pool represents more than 10% of the total pool, cap the hospital's amount at 10% and recalculate the proportions for the remaining hospitals.

Appendix B

Anticipated Impact on Budget Neutrality

Baseline Budget Neutrality - Budget Impact Analysis

Amendment 41 - Supplemental Payments and GME

II. Actual Expenditures

Group 1 and 2

	Projected 2020	Projected 2021
1-Disabled (can be any ages)	\$ 2,163,450,476	\$ 2,249,988,495
2-Child <=18	\$ 2,030,046,662	\$ 2,119,368,715
3-Adult >= 65	\$ 2,050,556	\$ 2,120,275
4-Adult <= 64	\$ 1,683,574,455	\$ 1,771,120,327
Duals (17)	\$ 1,295,028,885	\$ 1,342,944,954
Total	7,174,151,033	7,485,542,765

Group 3

	2020	2021
1-Disabled (can be any ages)	\$ 20,206,534	\$ 21,014,796
2-Child <=18	\$ 1,441,401	\$ 1,504,823
3-Adult >= 65	\$ 107,786,964	\$ 111,451,721
4-Adult <= 64	\$ 596,207	\$ 627,210
Duals (17)	\$ 326,829,889	\$ 338,922,595
Total	456,860,996	473,521,144

Projected Pool Payments and Admin

	2020	2021
Total Pool & Admin	1,233,177,275	1,265,524,683

Total Net Quarterly Expenditures

\$ 8,864,189,304 \$ 9,224,588,592

III. Surplus/(Deficit) - Per change in CMS policy

Annual With Am 41 Changes Cumulative With Am 41 Changes

	2020	2021
Annual With Am 41 Changes	\$ (38,732,581)	\$ (38,732,581)
Cumulative With Am 41 Changes	\$ 27,991,393,579	\$ 30,653,740,253

Annual Before Am 41 Changes Difference

	2020	2021
Annual Before Am 41 Changes	\$2,513,257,547	\$2,662,346,674
Difference	\$ (38,732,581)	\$ (38,732,581)

Cumulative Before Am 41 Changes

	2020	2021
Cumulative Before Am 41 Changes	\$28,030,126,160	\$30,692,472,835

Difference

(38,732,581)	(77,465,162)
--------------	--------------

IV. Amendment 37 On-Off Switch

Amendment 41 (1 = yes,
0 = no)

1

Net FFP Impact of Amendment 41
FFP with Amendment 41

\$102,034,013
\$5,837,777,792

\$102,034,013
\$6,075,129,555