

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850



State Demonstrations Group

April 10, 2026

Stephen Smith
Director of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Director Smith,

On March 12, 2026, the Centers for Medicare & Medicaid Services (CMS) received notice from the state of Tennessee (“the state”) of the intent to make updates to the uncompensated care payments distribution methodology authorized under the Tennessee section 1115(a) Medicaid demonstration entitled “TennCare III” (Project Number 11-W-00369/4), which was approved on January 8, 2021 under the authority of section 1115(a) of the Social Security Act (the Act).

In accordance with the special terms and conditions (STCs) of the TennCare III demonstration, the state must develop and maintain an updated distribution methodology for eligible providers that will continue to participate in the state’s uncompensated care payment program. The state must notify CMS of any changes to the methodology and post a draft methodology for public comment at least 60 days prior to the effective date of the proposed methodology. CMS is issuing this letter acknowledging the receipt of the notice of proposed changes on March 12, 2026. As required by the STCs of the demonstration, the earliest such changes may take effect and federal matching for incurred compensated care costs can be claimed is May 12, 2026.

As part of this acknowledgement letter, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse

(FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority. Please find enclosed the notice the state provided to CMS on March 12, 2026. If you have any questions, please do not hesitate to contact your project officer, Ms. Kamia Rathore. Ms. Rathore can be reached at kamia.rathore@cms.hhs.gov.

Sincerely,



Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

Enclosure

cc: Tandra Hodges, State Lead, Medicaid and CHIP Operations Group



March 12, 2026

Kamia Rathore
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Change to Distribution of Uncompensated Care Payments

Dear Ms. Rathore,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notification to CMS of our intent to make changes to the distribution of uncompensated care payments authorized under the TennCare Demonstration.

Tennessee's revised distribution methodology for eligible providers is attached for your reference. Consistent with STC 67 of the Demonstration, this change will become effective 60 days from the date of this notification.

Tennessee is currently conducting a public notice of this planned change. Tennessee will not claim federal matching funds for payments made under this revised methodology until this public notice process has been completed. Once the public notice process is completed, the revised distribution methodology will be posted to the state's website in accordance with the demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

Stephen Smith
Director, Division of TennCare

Attachment

Attachment:

Updated Distribution Methodology for
Uncompensated Care Payments under the
TennCare Demonstration

Distribution Methodology for Uncompensated Care Payments

The TennCare III demonstration authorizes two funds for uncompensated care payments.

The supplemental pool framework includes two pools with defined caps:

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

Virtual DSH Pool

The State makes payments within the Virtual DSH Pool up to the following amounts in each SFY:

- Critical Access Hospital Sub-pool – \$15 million
- Statutory DSH Method Sub-pool – up to the amount authorized by Congress
- Children’s Safety Net Sub-pool – \$28.6 million
- Other Essential Acute Sub-pool – \$60.7 million
- Safety Net Sub-pool – \$36.3 million
- Psychiatric Facilities Sub-pool – \$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. A hospital cannot receive payments from the Virtual DSH and/or Uncompensated Care Fund for Charity Care in excess of its uncompensated care costs as defined in Appendix A.

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 Health Facilities Commission,
- 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 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. These quarterly interim payments exist on top of the underlying negotiated MCO claims reimbursement and are intended to approximate an estimate of cost on an interim basis. 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. These quarterly interim payments exist on top of the underlying negotiated MCO claims reimbursement and are intended to approximate an estimate of cost on an interim basis.

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. Beginning with the settlement for state fiscal year 2024 and going forward, when a cost settlement is performed, the maximum recoupable amount shall not exceed the total amount paid to the hospital through the quarterly CAH payments described in this section.

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 Health Facilities Commission.

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 – up to the amount authorized by Congress

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 freestanding 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 -\$28.6 million

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

- be licensed by the Tennessee Health Facilities Commission 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, 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).

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 - \$60.7 million

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

- be an acute care hospital licensed by the Tennessee Health Facilities Commission to operate in the State of Tennessee 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 freestanding 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 amount of their total expenses from

the most recent reviewed Joint Annual Report. 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 total expenses

Tier 2: Hospitals between \$30 million and \$100 million total expenses

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

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

Tier 1 - \$3.35 million

Tier 2 - \$13.35 million

Tier 3 - \$44 million

Total - \$60.7 million

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 - \$36.3 million

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

- be licensed to operate in the State of Tennessee
- 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 - \$12 million

Other Safety Net Hospital Tier - \$24.3 million

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 - \$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 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 makes the following payments within the Charity Care Pool in each SFY:

- Public Hospital Sub-pool – \$100 million
- Safety Net Sub-pool - \$35 million
- Research and Rehabilitation Facilities Sub-pool- \$3.0 million
- Meharry Medical College Sub-pool - \$10 million
- Uncompensated Charity and Self-Pay Sub-pool - \$435 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 overpayments do not occur. A hospital cannot

receive payments from the Virtual DSH and/or Uncompensated Care Fund for Charity Care in excess of its uncompensated care costs as defined in Appendix A.

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 recently reviewed Joint Annual Report. In the event total charity care cost for these two hospitals exceeds \$100 million in a given year, the sub-pool will be distributed proportionally using the following methodology. No hospital may receive more than five sevenths of the sub-pool (\$71,428,571) unless the other hospital does not have enough total charity care cost to receive all the remaining two sevenths of the sub-pool (\$28,571,429). In the event one hospital has more than \$71,428,571 in charity cost in the defined period and the other hospital has less in charity cost than \$28,571,429, any remaining funds will be redistributed to the other hospital up to its remaining total charity care cost. If neither hospital has sufficient remaining charity cost to receive \$71,428,571, the sub-pool will be distributed proportionally up to the total amount of charity cost for both hospitals. These sub-pool payments may be made to Regional Medical Center at Memphis Health and Metro Nashville General Hospital. This new methodology for the public hospital sub-pool will take effect in the state fiscal year beginning on July 1, 2026.

Other Safety Net Sub-pool - \$35 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 hospitals exceeds \$35 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 hospitals will be multiplied by the total sub-pool amount of \$35 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 – \$435,000,000

- Up to \$453,886,286 for state fiscal year 2023.
- Up to \$142,950,650 for state fiscal year 2024.
- Up to \$435,000,000 in state fiscal year 2025 and after.

This Sub-Pool is distributed to cover costs associated with uncompensated care provided to the uninsured through charity care programs or self-pay patients.

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
- be licensed as a Rural Emergency Hospital
- 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.

Funds within the sub-pool will be distributed in four quarterly installments 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 cost 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 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 will be multiplied by the total amount 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 10 percent of the total amount of the sub-pool.

Appendix A – Proposed Distribution Formula Update

Data Sources

The State uses 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 2025-26 payments, the 2023 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 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 freestanding 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.

(4) 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.

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 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.