Sec. 17-312-104. Determination of TEFRA reimbursement level

(a) **TEFRA Payment Methodology**

The Department will determine Medicaid allowable inpatient costs pursuant to TEFRA principles of reimbursement. The components of Medicaid allowable inpatient cost will be determined in the following manner:

(1) Computation of Target Rates

(A) Base Costs for Computing Target Rates

Target rates will be based on the provider's fiscal year ending during the calendar year 1982. The Department will use the appropriate cost and statistical data from the provider's TEFRA base year. The Department will calculate the total Medicaid allowable inpatient cost by applying Medicare Principles of Reimbursement in effect at that time. The Medicaid allowable inpatient cost is divided by the number of Medicaid discharges to produce the TEFRA base year operating cost per discharge. Hospital based physicians, capital, direct medical education, malpractice and kidney acquisition costs, as determined by using Medicare principles of reimbursement, will be excluded from this calculation. The methodology for computing the TEFRA Base Year Operating Cost per Discharge (BPOR) is defined as:

$$BPOR = OC/D$$

where: OC= Total Title XIX Inpatient Operating Cost for the TEFRA base year net of excludable cost (Form HCFA-2552, Worksheet D-1, Part II, line 56).

D= Medicaid discharges for the hospital's TEFRA base year.

(B) Annual Adjustment Factor

To compute the TEFRA allowed amount, the Department will continue to use the update factor used by Medicare to revise the yearly rates for nonparticipating PPS hospitals and units. The update factor is published annually in the Federal Register.

(C) Computation of Hospital Target Rates

The hospital specific final target rate will be calculated by multiplying the TEFRA Base Year Operating Cost per Discharge by the accumulated update factor from the TEFRA base year to the cost report.

(2) Determination of Allowable Costs for the Cost Report Year

Once the Department determines the costs which are allowable pursuant to the Medicare principles of reimbursement, the Department determines which costs are applicable to the Medicaid program. Ancillary costs are determined by a ratio of total cost to total charges factor. This ratio is applied to Medicaid charges for the various ancillary cost centers. Routine costs are determined by computing the cost per day. This amount is multiplied by the total number of Medicaid days. The total allowable cost including routine and ancillary costs net of excludable costs is then compared to the final target amount. The total allowable costs are divided by the Medicaid discharges to determine the allowable cost per discharge.

If the hospital's allowable costs per discharge is greater than their hospital specific final target rate then the Department will not consider as Medicaid allowable inpatient costs any costs above the hospital specific final target rate.

If the hospital's allowable costs per discharge is less than their hospital specific final target rate, the Department will consider the Medicaid allowable inpatient costs to be allowable costs per discharge plus (a) 50% of the difference between the allowable costs per discharge and the hospital specific final target rate, or (b) 5% of the hospital specific final target rate, whichever is less.

(3) Determination of Total TEFRA Allowable Payments

Total TEFRA allowable payments for the year will be based on total allowable costs, as defined to be the sum of:

(A) allowable Title XIX costs for malpractice, hospital based physicians, capital, medical education, and kidney acquisition, as set forth in Section 17-312-105 (d) and

(B) allowable inpatient routine and ancillary costs, and

(C) the allowable incentive as defined in Section 17-312-104 (2) of these regulations.

(b) **Allowed Payments under TEFRA for the Medicaid Program—Cost Settlement**

The total allowed payment under TEFRA will be the sum of all allowable costs as determined above for each hospital. The total allowed costs will be compared to the interim payments made by the Department plus other payments made on behalf of Title XIX recipients, and the amount owed to the State or to the hospital pursuant to cost settlement will be paid.

(Effective January 19, 1988)