

Table of Contents

State/Territory Name: Tennessee

State Plan Amendment (SPA) #:14-0001

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page



Centers for Medicaid, CHIP, and Survey & Certification

Financial Management Group

May 4, 2015

Mr. Darin J. Gordon
Director, Bureau of TennCare
State of Tennessee
Department of Finance and Administration
Division of Health Care Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

RE: State Plan Amendment TN 14-001

Dear Mr. Gordon:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-001. Effective July 1, 2014 this amendment proposes to revise the payment methodology for intermediate care facilities/individuals with intellectual disabilities services. Specifically, the amendment proposes to reduce payments by one percent (1.0%) to for profit and not-for-profit facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of July 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

//s//

Tim Hill
Director

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|--|--|--|-----------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 14-001 | 2. STATE TENNESSEE |
| FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE July 1, 2014 | |
| 5. TYPE OF PLAN MATERIAL (<i>Check One</i>): | | | |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Subpart C. | | 7. FEDERAL BUDGET IMPACT: a. FFY 2014 (\$461,500) b. FFY 2015 (\$1,837,700) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19D, page 12 of 13. | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19D, page 12 of 13. | |
| 10. SUBJECT OF AMENDMENT: Methods and Standards for Establishing Payment Rates – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): | | | |
| <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT | | <input type="checkbox"/> OTHER, AS SPECIFIED: | |
| <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | | | |
| <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: //s// | | 16. RETURN TO: Tennessee Department of Finance and Administration Division of Health Care Finance and Administration Bureau of TennCare 310 Great Circle Road Nashville, Tennessee 37243 Attention: George Woods | |
| 13. TYPED NAME: Darin J. Gordon | | | |
| 14. TITLE: Director, Bureau of TennCare | | | |
| 15. DATE SUBMITTED: | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 06-30-14 | | 18. DATE APPROVED: 05-04-15 | |
| PLAN APPROVED – ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-14 | | 20. SIGNATURE OF REGIONAL OFFICIAL: //s// | |
| 21. TYPED NAME: Timothy Hill | | 22. TITLE: Director | |
| 23. REMARKS: Approved with the following changes to Block # 7a and 7b as authorized by state agency: Block # 7a changed to read: (\$187,985); Block # 7b changed to read: (\$748,479) | | | |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES-NURSING FACILITIES

Effective July 1, 1998, the Commissioner of the Department of Health shall establish a program-wide maximum per-diem payment rate for Medicare/TennCare nursing facilities providing Level I nursing care. The maximum rate shall be established at such time(s) as deemed desirable by the Commissioner. The maximum per-diem rate shall be set at the 65th percentile cost of participating facilities or beds, whichever is lower, rounded to the nearest one cent. The rate of reimbursement, however, will be adjusted as necessary to assure that spending does not exceed the amount budgeted for each state fiscal year. Savings from one level of care will be used to offset any shortfalls from the other level of care.

2. The maximum per diem payment level for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) shall be reasonable allowable costs or charges, whichever is less. This level shall be the amount that the state reasonably expects to be adequate to reimburse in full such reasonable allowable costs of a facility that is economically and efficiently operated. The principles of cost determination for ICFs/IID will be the same as regular Level I nursing facilities, except that the Medicaid portion of mandated salary increases for state employees in state operated ICFs/IID shall be considered a pass-through payment for per diem rate and inflation factor computations. Such computations may be made effective with the annual per diem rate change based on the previous year cost report. Private for-profit and private not-for-profit ICFs/IID shall be reimbursed using the same prospective payment methodology as level I nursing facilities except that reimbursement shall be at 100% of allowable Medicaid costs with no cost-containment incentive. Effective January 1, 2012, the reimbursement rate calculated for private for-profit and private not-for-profit ICFs/IID will be reduced by a factor of 2.5%. Effective July 1, 2014, the reimbursement rate calculated for private for-profit and private not-for-profit ICFs/IID will be reduced by a factor of 1.0%. Effective July 1, 1995, public ICFs/IID that are owned by government, shall be reimbursed 100% of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the public ICFs/IID. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year end cost settlement within 30 days of submission of the cost reports and a final settlement within 12 months of submission of the cost reports.
3. The maximum per diem payment made to each facility is per diem cost, charges or the maximum program-wide per diem rate, whichever is less.
4. If the resident has no resources to apply toward payment, the payment made by the state will be per diem cost, charges or the maximum program-wide per diem payment rate, whichever is less.
5. If the resident has resources to apply toward payment, the payment made by the state will be per diem costs less the available patient resources, charges less the available patient resources, or the maximum program-wide per diem payment rate less the available patient resources, whichever is less

TN No. 14-001
Supersedes
TN No. 11-015

Approval Date: ~~MAY 04 2015~~

Effective: 07/01/14