STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITIES

I. Nursing Facilities Providing Level II Care

A. Reimbursement Principles - Effective January 1, 1978, reimbursement for nursing facilities providing level II care shall be on a reasonable cost-related basis. Participation in the program will be limited to those providers of service who agree by contract to accept as payment in full the amounts paid in accordance with the cost rates determined by the methods described herein. Cost rates shall be determined retrospectively on a facility by facility basis. Such rates shall consist of the level II portion of allowable costs, as limited by this plan. Effective October 1, 1996 and later the per diem rate shall be considered final rates that are payment in full without retrospective cost settlements other than for certifying facilities.

1. Expenses related to disallowed capital expenditures, such as depreciation, interest on borrowed funds, the return on equity capital in the case of proprietary providers, and repairs are not allowable costs. Disallowed capital expenditures are those that have not been approved by the Tennessee Health Facilities Commission or its successor agency in accordance with State law.

2. On a new lease negotiated after December 31, 1977, and renewal of such lease, the lesser of rent on real property and equipment or the amount of the lessor's depreciation, interest, other allowable costs, and return on lessor's equity capital, in accordance with Part 1 of this section, will be considered, on an item by item basis, as an allowable cost. Renewals of a lease negotiated before January 1, 1978, at the same rental amount or at an amount fixed or determinable according to conditions provided for in the original lease will not be considered as a new lease according to this provision. This provision does not apply to the rental of equipment for periods of less than one year.

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3. A reasonable allowance of compensation for services of owners and their relatives is an allowable cost, provided the services are actually performed in a necessary function. Compensation as reported in the cost report will be reviewed and adjusted where necessary. Medicare compensation guidelines and procedures will be used where available. Otherwise, guidelines used for level I NF care will be employed.

4. Bad debts, charity, and courtesy allowances shall not be included in allowable costs.

5. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organizations or the price of comparable services, facilities, or supplies purchased elsewhere. Providers shall be required to identify related organizations and associated costs in the cost report.

6. An incentive payment will be included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80% or greater. Certain expenses are fixed and not controllable on a day-to-day basis. These expenses include allowable rent, property taxes and insurance, depreciation, and interest. Total costs are determined for each provider and converted to a per patient day basis. Fixed costs are also determined for each provider and converted to a per patient day basis. Variable costs are determined by subtracting the fixed costs from the total costs. All providers of level II care whose variable costs are less than the maximum reimbursement rate shall be eligible to receive a fifty percent (50%) cost containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars ($3) per patient day and by the maximum reimbursement rate.

7. OBRA 1987 pass through cost items allowed will be paid over and above the per diem in the fiscal year July 1, 1990 through June 30, 1991 and in the fiscal year July 1, 1991 through June 30, 1992.

8. The annual nursing home tax, passed through as an allowable cost item for nursing facilities for the periods of July 1, 1992 through June 30, 1993; July 1, 1993 through June 30, 1994; July 1, 1994 through June 30, 1995; July 1, 1995 through June 30, 1996; July 1, 1996 through June 30, 1997; July 1, 1997 through June 30, 1998 and July 1, 1998 through June 30, 1999 is being extended for the period of July 1, 1999 through June 30, 2000 and July 1, 2000 through June 30, 2001 and will be excluded for purposes of computing the inflation allowance and cost containment incentive, and will not be subject to the maximum per diem rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

B. Allowable Costs - Allowable costs shall include all items of expense which providers must incur in order to:

1. Meet the definition of a skilled nursing facility set forth in Section 1861(J) of the Social Security Act and in Section 249.10 (b)(4) of Part 250, Chapter II, Title 45 of the Code of Federal Regulations and Title 42 CFR 440.40 of the Federal Regulations.*

2. Satisfy the requirements of Section 1902(a)(28) of the Social Security Act.

3. Comply with the standards prescribed by the United States Secretary of the Department of Health and Human Services, as set forth in Federal Regulations.

4. Comply with any other requirements for licensing under the State Department of Health and Environment, the State agency responsible for establishing and maintaining health standards.

5. Comply with any other requirements for licensing under State law which are necessary for providing skilled nursing services.

6. In addition, allowable costs shall include the costs of routine services as defined by the State Department of Health and Environment, which as a minimum, shall include those items listed in the Federal Regulations.

*Added by Regional Office per authorization of State Official.

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C. Cost Reporting Requirement - Nursing facilities providing level II care shall be required to follow Medicare cost reporting requirements utilizing Medicare cost reporting forms except where otherwise stated in this plan. These cost reporting forms must be submitted no later than five months after the close of the provider's fiscal year. In the event that the provider does not file the required cost report and other information by the first working day after the due date, the institution shall be subject to a penalty of ten dollars ($10.00) a day in accordance with state law.

D. Records Retention - Each provider of level II nursing facility services 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 five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health or the United States Department of Health and Human Services. All cost reports shall be retained by the state Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

E. Rates of Payment

1. Effective August 16, 1980, on July 1st of each succeeding year, or at such other times as it is deemed desirable, the Commissioner of the Department of Health, shall establish a program-wide maximum per diem payment level for Medicaid/TennCare facilities providing level II care other than certifying facilities. For facilities with per diem rates below this maximum, a retrospective cost settlement will be made for this period. Effective for the period July 1, 1996 through September 30, 1996, the level II program-wide maximum is frozen at the rate in effect June 30, 1996. Effective October 1, 1996 and later, per diem rates will no longer be interim rates but shall be considered final rates that are payment in full without a retrospective cost settlement. Effective July 1, 1997 through October 31, 1997, nursing facility rates are frozen at the rate in effect June 30, 1997. Effective November 1, 1997, new reimbursement rates will be set for the duration of the State's fiscal year for Medicaid/TennCare nursing facilities providing level II care. The expected per diem cost for each provider shall be the most recent per diem calculated adjusted to reflect changes for inflation, as described in Section ll., Part A, Item 12 of this Plan. This level shall be the 50th percentile (effective July 1, 1990, 65th percentile of facilities or beds which ever is less) rounded to the nearest one cent, of the expected per diem cost of the providers who have had at least one cost report settlement under the program when these providers are ranked from highest to lowest expected per diem cost. Effective October 1, 1996 capital-related costs are not subject to indexing. Effective August 16, 1980, the maximum per diem payment level for level II nursing facility services shall be the 50th percentile (effective July 1, 1990 the 65th percentile of facilities or beds, whichever is less) rounded to the nearest one cent of the adjusted, expected per diem costs, or the amount which would have been determined under Medicare Principles of Reimbursement, whichever is less.

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For State Fiscal Year 1996-97, the amount budgeted shall be the projected expenditures for State fiscal year 1995-96 plus 7 percent.

For State Fiscal Year 1997-98, the budgeted amount for level I and level II care is $672,040,000. Expenditures will be monitored throughout the year to determine if rate adjustments are necessary to assure that each level of care is spending within the budgeted amount. After analyzing final expenditures for the year, any savings from one level of care will be used to offset short falls from the other level of care. If any funds remain at the end of the year, those dollars will be used to provide additional funding to either level of care to reimburse them the amount that would have been paid had the July 1, 1997 through October 31, 1997 freeze not been implemented.

Effective July 1, 1998, the Commissioner of the Department of Health shall establish a program-wide maximum per-diem payment rate for Medicaid/TennCare nursing facilities providing Level II 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, which ever 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 made to each facility is per diem cost, charges or the maximum program-wide per diem rate, whichever is less.

3. 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.

4. 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.

5. Supplementary payments from relatives or others are not allowed.

6. The Tennessee Medicaid Program will pay to a provider of level II nursing facility services who furnishes services in accordance with the requirements of this State Plan, the amount determined for services furnished by the provider under the Plan.

7. Effective October 1, 1990, payment rates to providers of level II nursing facility services will take into account the costs to be incurred in meeting the requirements of Section 1919 (b), other than paragraph (3)(f), (c) and (d).

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8. Effective October 1, 2005, certifying facilities will be reimbursed on Medicaid cost, based on certification by the facilities of their allowable Medicaid costs of providing nursing home care.

   An interim per diem rate will be established based on each facility's most recently filed Medicare 2540 cost report trended forward to the payment year. The trend will be each facility's previous two year average trend as determined by the Medicare 2540 cost report. After the filed Medicare 2540 cost report for the payment period for which the interim rate was paid has been received, the interim rate will be reconciled to actual allowable Medicaid costs. Upon final settlement of the Medicare 2540 cost report, the difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the allowable Medicaid cost was incurred and initial claim was made.

9. Effective October 1, 2005, certifying facilities will receive supplemental payments from a pool of funds determined by the state but not to exceed the difference between aggregate costs of the facilities as determined pursuant to paragraph 8. above and the upper payment limit under federal regulations, for the classes of certifying state owned or operated facilities and certifying non-state owned or operated facilities. The funds will be distributed to the facilities so that each facility's share of total payments to all Level II facilities for nursing home care for the state fiscal year will be equal to that facility's proportionate share of the total payments for nursing home services for Level II facilities, inclusive of cost containment add-on, on a patient day basis, for state fiscal year 2005. A settlement of total reimbursement will be performed based on the cost reports filed for that year. Settlements will be performed on an annual basis upon receipt of the cost reports.

F. Cost Report Validation -- Nursing facility cost reports submitted to the state in accordance with this Plan shall be desk reviewed prior to rate setting. In accordance with 42 CFR 447.253g, the state has provisions for field auditing of cost reports. A field audit will be designated when a desk review indicates it is necessary.

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G. Public Review and Comment – Interested members of the public will be granted an opportunity of at least thirty (30) days to review and comment on the proposed methods and standards of payment before they become effective.

II. Nursing Facilities Providing Level I Care

A. Reimbursement Principles – Effective August 16, 1980, reimbursement for Nursing Facility services (Level I care) shall be on a reasonable cost-related basis other than for certifying facilities. Participation in the program shall be limited to those providers of service who agree by contract to accept as payment in full the amounts paid in accordance with the cost rates determined by the methods described herein. Cost rates shall be determined prospectively on a facility by facility basis. Such rates shall consist of prior year allowable cost, a cost increase factor, a return on equity, an incentive factor for cost containment, and any allowable cost as referred to in Section II.B. of this attachment as may be required by the Commissioner of the Department of Finance and Administration. The first cost report shall be the providers' first fiscal period ending after July 1, 1976 and shall run no longer than twelve months. OBRA 1987 pass through cost items allowed will be paid over and above the per diem in the fiscal year July 1, 1990 through June 30, 1991 and in the fiscal year July 1, 1991 through June 30, 1992. The annual nursing home tax, passed through as an allowable cost item for nursing facilities for the periods of July 1, 1992 through June 30, 1993; July 1, 1993 through June 30, 1994; July 1, 1994 through June 30, 1995; July 1, 1995 through June 30, 1996; July 1, 1996 through June 30, 1997; July 1, 1997 through June 30, 1998 and July 1, 1998 through June 30, 1999 is being extended for the period July 1, 1999 through June 30, 2000 and July 1, 2000 through June 30, 2001 and will be excluded for purposes of computing the inflation allowance and cost containment incentive, and will not be subject to the maximum per diem rate. With certain exceptions, Medicare standards and principles of reimbursement shall be used. These exceptions are noted below:

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1. An optional allowance for depreciation based on a percentage of operating costs is not allowed.

2. Accelerated methods of depreciation cannot be used for assets acquired after June 30, 1973, without written approval from the Comptroller's Office. Such approval will be granted only if the provider can demonstrate to the satisfaction of the Comptroller's Office that cash flow from depreciation on the total assets of the institution used to provide patient care services during the reporting period, include straight-line depreciation on the assets in question, is insufficient to supply the funds required to meet the reasonable principle amortization schedules on the capital debts related to the provider's total depreciable assets used to provide patient care services.

3. Expenses related to disallowed capital expenditures, such as depreciation, interest on borrowed funds, the return on equity capital in the case of proprietary providers, and repairs are not allowable costs. Disallowed capital expenditures are those that have not been approved by the Tennessee Health Facilities Commission or its successor agency in accordance with State law.

4. Bad debts, charity, and courtesy allowances are not allowable expenses.

5. The Medicare Routine Nursing Salary Differential does not apply.

6. The reimbursement of excessive costs arising from low occupancy is not consistent with the intent of the Intermediate Care Program. Accordingly, the calculated rate, before application of any ceilings, shall be recalculated according to the following scale:

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% Occupancy of ICF Unit	Percent of Calculated Rate
80% and above	100%
75% to 80%	95%
70% to 75%	90%
65% to 70%	85%
60% to 65%	80%
55% to 60%	75%
50% to 55%	70%
Below 50%	60%

In addition, no incentive provision will apply to providers with occupancies below 80%.

7. Assets not relating to patient care, uncollectible accounts and notes receivable, and advances or loans to owners are to be excluded from equity capital.

8. The payment rate for program services shall not exceed the facility's customary charges to the general public for such services.

9.a. On a new lease effective June 30, 1976, and renewal of such lease, the lesser of rent on real property and equipment or the amount of the lessor's depreciation, interest, other allowable costs, and return on lessor's equity capital, in accordance with principle 3 of this section, will be considered on an item by item basis, as an allowable cost. Renewals of a lease negotiated before July 1, 1976, at the same rental amount or at an amount fixed or determinable according to conditions provided for in the original lease will not be considered as a new lease according to this provision. This provision does not apply to the rental of equipment for periods of less than one year.

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9.b. In regard to revaluation and recovery of depreciation on assets sold or transferred at a gain, the Tennessee Medicaid program will allow the lesser of (a) the asset's purchase price at the time of sale, (b) the fair market value at the time of sale, or (c) for bona fide sales occurring on or after September 1, 1988, the seller's initial cost trended forward based on the lower of 50% of the CPI or 50% of the Dodge Construction Multiplier (measured from the seller's date of acquisition) and then reduced by the seller's accumulated depreciation to the time of sale. The Dodge Multiplier shall be the Dodge Historical Index published by Dodge Cost Systems of the McGraw-Hill Information Systems Company. The actual multiplier to be used shall be the average of the published multipliers for the cities of Nashville, Chattanooga, Knoxville, and Memphis. After 1976 when multipliers are published for March and September, the March multiplier shall be used. Furthermore, for sales on and after September 1, 1988, the combination of owner's equity (for proprietary providers) and the principal amount to be allowed for interest expense cannot exceed the revalued basis and/or actual interest expense as defined in this subsection (return on equity is always applied first); and the useful life of the assets acquired cannot be less than the remaining useful life of the seller prior to the sale. The provider of record (buyer) is responsible for providing the necessary initial information to the Comptroller of the Treasury in order to make the necessary revaluation. If appropriate information is not provided, the Comptroller of the Treasury will use the best information available to compute the revaluation. In subsequent years' cost reports, the provider is responsible for maintaining and submitting records of assets (and associated debt) that are subject to the revaluation limitations. Assets and debt acquired subsequent to and not related to the change of ownership are not subject to revaluation limitations and must be separately disclosed and reported. Commingling of information may result in depreciation and interest reductions on assets not subject to revaluation limits. In no case can interest expense (on assets subject to revaluation limits) exceed actual interest expense incurred by the new owner.

For all subsequent sales, the original basis for computing the revalued basis to the new owner shall be the revalued basis of the seller unless the sales price is lower than such revalued basis.

10. For reimbursement purposes, a reasonable allowance of compensation for services of an owner or persons related to an owner is an allowable cost, provided the services are performed in a necessary function. The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another

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person to perform them. The services must be related to patient care and be pertinent to the operation and sound management of the institution. Medicare definitions relating to ownership or control will apply. Total compensation to such persons must be listed and justified in Section E of the cost report. Where such amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits. All such costs included in Section F must be reported in Section E. The Comptroller's Office will review these amounts, compare them with allowable compensation ranges, and make necessary adjustments. The Comptroller will utilize similar Medicare guidelines, salaries paid for comparable services in proprietary and nonproprietary institutions and any other information he considers relevant to future revisions of these ranges. The Comptroller will consider the duties, responsibility, and managerial authority of the person as well as the services performed for other institutions and his engagement in other occupations. Only one full-time position, or its equivalent, will be allowed to each person. The duties performed, time spent, and compensation received by such persons must be substantiated by appropriate records.

11. A return on net equity of no more than the amount allowed by Medicare for the cost reporting period shall be included as an allowable cost for proprietary providers, limited to $1.50 per patient day.

12. A one year trending factor shall be computed for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor shall be the average cost increase over the three year period, limited to the 75th percentile trending factor of facilities participating for at least three years. Negative averages shall be considered zero. For facilities that have not completed three full years in the program, the one year trending factor shall be the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor shall be zero.

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Using the trending factor determined above, each provider's allowable costs shall be trended from the mid-point of the provider's fiscal year to the mid-point of the state's fiscal year. Rates shall be re-established at the beginning of the state's fiscal year.

13. An incentive payment will be included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80% or greater. Certain expenses are fixed and not controllable on a day-to-day basis. These expenses include allowable rent, property taxes and insurance, depreciation, and interest. Total costs are determined for each provider and converted to a per patient day basis. Fixed costs are also determined for each provider and converted to a per patient day basis. Variable costs are determined by subtracting the fixed costs from the total costs. All intermediate care providers whose variable costs are less than the maximum reimbursement rate shall be eligible to receive a fifty percent (50%) cost containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars ($3) per patient day and by the maximum reimbursement rate.

14. No carryover of allowable costs shall be allowed.

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15. Costs applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall be required to identify related organizations and costs associated in the cost report.

B. Allowable Costs - Allowable costs shall include all items of expenses which providers must incur in order to:

1. Meet the definition of an intermediate care facility set forth in Section 279.10(b)(15) of Part 250, Chapter II, Title 45 of the Code of Federal Regulations and Title 42 CFR 447.150 of the Federal Regulations.*

2. Comply with the standards prescribed by the Secretary of the Department of Health, Education, and Welfare set forth in Federal Regulations.

3. Comply with requirements established by the State Department of Public Health, the State agency responsible for establishing and maintaining health standards, and

4. Comply with any other requirements for licensing under Tennessee State law which are necessary for providing intermediate care services, and

5. Furnish routine services as defined by the Department of Public Health, such definition shall, as a minimum, include all routine services defined as such by Federal Regulations.

C. Cost Reporting Requirements - Intermediate Care providers shall be required at their fiscal year end, or at other times as indicated by the State Comptroller of the Treasury, to submit to the Comptroller a cost report on forms designated by the Comptroller. This report shall be due three months from the end of the provider's designated fiscal period. A new provider entering the program may submit a budgeted cost report for six months or one year in order to obtain a per diem rate assigned by the Comptroller. This information will be compared with costs and other pertinent data of existing or other new providers to determine its reasonableness. This provider will then be required to submit actual cost reports at intervals designated by the Comptroller until the provider can be placed on its fiscal year reporting period. The cost report must be completed in accordance with the Medicare principles of cost reimbursement as stipulated in

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the Medicare Provider Reimbursement Manual, as updated, except as herein specified otherwise. In the event that the provider does not file the required cost report and other information by the first working day after the due date, the institution shall be subject to a penalty of ten dollars ($10.00) a day in accordance with state law.

D. Records Retention - Each provider of Level I care facility services 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 five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health or the United States Department of Health and Human Services. All cost reports submitted by providers shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

E. Rates of Payment

1. Effective August 16, 1980, on July 1st of each succeeding year, or at such other times as it is deemed desirable, the Commissioner of the Department of Health, shall establish a program-wide maximum per diem payment level for Medicaid/TennCare facilities providing level I care other than certifying facilities. Effective for the period July 1, 1996 through September 30, 1996, the level I program-wide maximum is frozen at the rate in effect June 30, 1996. Effective July 1, 1997 through October 31, 1997, nursing facility rates are frozen at the rate in effect June 30, 1997. Effective November 1, 1997 new reimbursement rates will be set for the duration of the State's fiscal year for Medicaid/TennCare nursing facilities providing level I care. The expected per diem cost for each provider shall be the most recent per diem calculated adjusted to reflect changes for inflation, as described in Section II., Part A, Item 12 of this Plan. This level shall be the 50th percentile (effective July 1, 1990, the 65th percentile of facilities or beds, whichever is less) rounded to the nearest one cent, of the expected per diem cost of the providers who have had at least one cost report filed under the program when these providers are ranked from highest to lowest expected per diem cost. Effective October 1, 1996 capital-related costs are not subject to indexing. Effective August 16, 1980, the maximum per diem payment level for level I nursing facility services shall be the 50th percentile (effective July 1, 1990 the 65th percentile of facilities or beds, whichever is less) rounded to the nearest one cent of the adjusted, expected per diem costs, or the amount which would have been determined under Medicare Principles of Reimbursement, whichever is less. For State Fiscal Year 1996-97, the amount budgeted shall be the projected expenditures for State fiscal year 1995-96 plus 7 percent. A payout of approximately $8,500,000 will be issued for Medicaid/TennCare nursing facilities providing level I care in order to reimburse them the amount that would have been paid had the July 1, 1996 through September 30, 1996 freeze not been implemented. For State Fiscal Year 1997-98, the budgeted amount for level I and level II care is $672,040,000. Expenditures will be monitored throughout the year to determine if rate adjustments are necessary to assure that each level of care is spending within the budgeted amount. After analyzing final expenditures for the year, any savings from one level of care will be used to offset short falls from the other level of care. If any funds remain at the end of the year, those dollars will be used to provide additional funding to either level of care to reimburse them the amount that would have been paid had the July 1, 1997 through October 31, 1997 freeze not been implemented.

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Effective July 1, 1998, the Commissioner of the Department of Health shall establish a program-wide maximum per-diem payment rate for Medicaid/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, which ever 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-Mentally Retarded 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 ICF-MR will be the same as a regular Level I nursing facilities, except that the Medicaid portion of mandated salary increases for state employees in state operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR) 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 intermediate care mental retardation facilities 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 July 1, 1995, public intermediate care mental retardation facilities 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 government intermediate care mental retardation facilities. 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.

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6. Supplementary payments from relatives or others are not allowed.

7. The Tennessee Medicaid Program will pay to a provider of intermediate care services who furnishes in accordance with the requirements of this State Plan the amount determined for services furnished by the provider under the Plan.

8. Effective October 1, 1990, payment rates to providers of intermediate care services will take into account the costs to be incurred in meeting the requirements of Section 1919 (b), other than paragraph (3)(F), (c) and (d).

9. Effective October 1, 2005, certifying facilities will be reimbursed on Medicaid cost, based on certification by the facilities of their allowable Medicaid costs of providing nursing home care.

   An interim per diem rate will be established based on each facility's most recently filed Medicaid Nursing Facility Level I cost report trended forward to the payment year. The trend will be each facility's previous two year average trend as determined by the Medicaid Nursing Facility Level I cost report. After the filed Medicaid Nursing Facility Level I cost report for the payment period for which the interim rate was paid has been received, the interim rate will be reconciled to actual allowable Medicaid costs. Upon final settlement of the Medicaid Nursing Facility Level I cost report, the difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the allowable Medicaid cost.

10. Effective October 1, 2005, certifying facilities will receive supplemental payments from a pool of funds determined by the state but not to exceed the difference between aggregate costs of the facilities as determined pursuant to paragraph 9. above and the upper payment limit under federal regulations, for the classes of certifying state owned or operated facilities and certifying non-state owned or operated facilities. The funds will be distributed to the facilities so that each facility's share of total payments to all Level I facilities for nursing home care for the state fiscal year will be equal to that facility's proportionate share of the total payments for nursing home services for Level I facilities, inclusive of cost containment add-ons, on a patient day basis, for state fiscal year 2005. A settlement of total reimbursement will be performed based on the cost reports filed for that year. Settlements will be performed on an annual basis upon receipt of the cost reports.

D1016111

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITIES

F. Cost Report Validation – Nursing facility cost reports submitted to the state in accordance with this Plan shall be desk reviewed prior to rate setting. In accordance with 42 CFR 447.253g, the state has provisions for field auditing of cost reports. A field audit will be designated when a desk review indicates it is necessary.

G. Public Review and Comment – Interested members of the public will be granted an opportunity of at least thirty (30) days to review and comment on the proposed methods and standards of payment before they become effective.

D1020070

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITIES (NF)

Supplement to Attachment 4.19D

1. In compliance with OBRA 87, Tennessee assures that the ICF/SNF distinction in Nursing Facilities is abolished. All NF's participating in the Medicaid program must meet all applicable state and federal requirements in order to receive Medicaid reimbursement. NF's are reimbursed on the basis of one of two levels of patient acuity. Level 1 patients must have a medical condition that requires the availability of licensed nursing services on an inpatient basis twenty-four (24) hours each day of the week and must have a disability or impairment that renders them incapable of self-execution of needed nursing care and incapable of performance of at least one activity of daily living. Level 2 patients must have a medical condition that requires the delivery of a skilled nursing or rehabilitative service on a daily basis in an inpatient setting. (A skilled nursing service is defined as a licensed nursing service which is furnished to a person pursuant to a physician's order and which, because of the inherent complexity of the service, is such that it can only be safely and/or effectively provided directly by a registered nurse or licensed practical nurse.) Because of the complex medical needs of patients meeting Level 2 criteria, Level 2 NF care is reimbursed by Medicaid only in NF's that are certified by Medicare as well as by Medicaid for provision of nursing facility care.

   All references to "Intermediate Care Facilities" in Attachment 4.19D should be replaced with the designation "Level 1 NF Care." All references to "Skilled Nursing Facilities" in Attachment 4.19D should be replaced with the designation "Level 2 NF Care."

2. The additional costs of OBRA 87 are being accounted for in a pass-through payment to be paid initially for a period of nine months from October 1990 through June 1991, and for an additional period July 1, 1991 through June 30, 1992, after which NF rates will account for the costs of OBRA through the normal cost reporting and rate setting process.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITIES (NF)

Supplement to Attachment 4.19D Continued

The pass-through amount consists of $2.33 per day for nursing facilities formerly classified as ICF's and $1.90 per day for nursing facilities formerly classified as SNF's. The difference in these two figures, $.43, is needed by those nursing facilities formerly classified as ICF's in order to meet the RN staffing requirement.

Nurse aide training costs have also been analyzed and are projected to be $.05 per day for nursing facilities, beginning October 1, 1990. These costs will be paid in a separate pass-through amount as part of Medicaid administrative costs.

The methodology for determining the pass-through amount was as follows:

In November, 1989, the state formed a task force to work on identifying and quantifying the items mandated by OBRA 1987 for which nursing facilities would incur additional costs. The task force consisted of state and industry representatives. The task force identified nine such items which are: resident assessments, quality assessment committee, nurse aide training (which is to be accounted for as state administrative costs), RN staffing, social director, providing for "quality of life", drug reviews, inservice education, and rehabilitation. A comprehensive nursing home survey was prepared and sent to nursing facilities in December of 1989. The survey contained descriptions of the standards to be implemented (including a copy of the most recent resident assessment form available), as well as questions designed to assist the state in developing costs for the standards required by OBRA. Basic cost information submitted on the survey was for December 1989. However, where salary data was involved, amounts were increased to estimate the cost of payroll taxes and other benefits.

Tennessee validated the survey in May 1990 by picking a random sample of 14 nursing facilities and sending a team to visit each one. Staff at

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITIES (NF)

Supplement to Attachment 4.19D Continued

these facilities were interviewed to determine the basis for their estimates and their plans for assuring compliance with OBRA.

Survey data was then analyzed by the Comptroller's Office to determine average additional staff time needed by nursing facilities to comply with each of the identified OBRA items. This additional staff time was multiplied by average salary rates for credentialed staff in order to determine average new NF costs for OBRA.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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