Bureau of TennCare
Policy Manual

Policy No: ORG 06-003	
Subject: Medicaid State Plan	
Approval: [signature]	Date: 9/12/2006

POLICY:

The Medicaid State Plan serves as the state's "contract" with the Centers for Medicare and Medicaid Services regarding the operation of the Medicaid program in Tennessee. This "contract" deals with the components of the TennCare program that are not covered under the state's 1115(a) demonstration waiver. There are parts of the State Plan which are superseded by the TennCare demonstration waiver, although the State Plan is intended to serve as a "back-up" should the demonstration waiver cease to exist.

DISCUSSION:

Every state that operates a Medicaid program must have a State Plan. This is required by CMS. The State Plan consists of a series of documents, usually preprints supplied by CMS, which address issues such as administration, eligibility, benefits covered, and reimbursement methodologies. The format for the State Plan is as follows:

Section 1. Single State Agency Organization Unit
Section 2. Coverage and Eligibility
Section 3. Services: General Provisions
Section 4. General Program Administration
Section 5. Personnel Administration
Section 6. Financial Administration
Section 7. General Provisions

Each State Plan page has information at the bottom indicating what the effective date of that page is and when the SPA was approved by CMS.

The accuracy and timeliness of the State Plan are key factors in the state's ability to collect Federal Financial Participation (FFP) from the federal government for services delivered. It is critical that the State Plan be updated whenever needed.

Intersection between the State Plan and TennCare

TennCare is a Section 1115(a) demonstration waiver program. It serves Medicaid eligibles as well as others who meet specified criteria.

A "demonstration waiver" means that certain federal statutes have been "waived," or disregarded, so that a state can demonstrate a particular health care hypothesis. The TennCare waiver, like other 1115(a) waiver programs, includes a list of statutes that have been waived by CMS in order for the program to be implemented.

Sometimes the TennCare waiver and the State Plan are inconsistent. When this happens, usually a particular requirement of the State Plan has been waived and is therefore not applicable to the TennCare program during the life of the waiver.

General principles

Federal regulations regarding the development and maintenance of the State Plan are contained at 42 CFR 430, Part B.

State Plan Amendments (SPAs) are filed whenever there are changes or updates to the State Plan. An individual SPA contains only those pages which the state is requesting to change. (Any page which is submitted as part of a SPA becomes subject to new action by CMS, even if that page was previously approved.) A SPA does not become effective until it has been approved by CMS. The effective date of the State Plan is determined in one of several ways.

First of all, no SPA can have an earlier effective date than the quarter in which it is submitted. A SPA submitted on June 15, for example, could have an effective date of April 1, but not an effective date of March 31. (March 31 would have been the last day of the previous quarter.)

Second, those SPAs that describe significant changes in the state's methods and standards of setting payment rates can be effective no earlier than the date that the state can demonstrate that public notice has been provided. A SPA submitted on June 15, for example, for which public notice was accomplished on May 12, could be effective no earlier than May 12.

CMS generally has 90 days to approve a SPA. If no action is taken by CMS during the 90 days following the filing of an SPA, the SPA may be deemed to be approved. CMS has the authority

to send the state a Request for Additional Information, or "RAI," which stops the clock. If an RAI is sent, a new 90-day review period for CMS begins on the day the state's response to the RAI is received by CMS.

PROCEDURES:

1. Each program manager at TennCare should be aware of the portions of the State Plan that affect his or her program area. The program manager is responsible for assuring that the State Plan is appropriate and adequate for supporting the operations of his or her area. The program manager is responsible for identifying areas where new SPAs are required and for notifying the Policy Office accordingly.

2. Sometimes the Policy Office receives State Plan preprints from CMS with instructions for filing SPAs. Program managers will be consulted on how the Bureau will respond to these preprints.

3. The Policy Office is responsible for preparing and processing SPAs. SPAs must be filed using forms required by CMS.

4. SPAs must include anticipated federal budget impacts for the remainder of the current federal fiscal year and the next federal fiscal year. The Policy Office will inform the Fiscal Budget staff as soon as a decision has been made to file a SPA so that Fiscal Budget staff will have adequate time to prepare the fiscal impact statement.

5. Persons in the Bureau requesting SPAs should give the Policy Office **a minimum of 5 working days** to prepare these SPAs. SPAs that are especially complicated or that require extensive legal review will necessitate additional time.

OFFICE OF PRIMARY RESPONSIBILITY:

- Policy Office

Original: 09/12/06: SB
Reviewed / No revisions required: 09/2007: SB
Reviewed / No revisions required: 09/2008: SB
Reviewed / No revisions required: 10/2009: SB
Reviewed / No revisions required: 09/27/10: GW
Reviewed / No revisions required: 10/03/11: GW