

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

2.b. & c. Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) and Federally Qualified Health Center Look-Alike (FQHCLA).

Payment for covered services provided by RHCs, FQHCs and FQHCLAs shall be in accordance with methods of payment below:

- The payment methodology for RHCs, FQHCs and FQHCLAs will conform to section 702 of the Benefit Improvement and Protection ACT (BIPA) 2000 legislation.
- The payment methodology for RHCs, FQHCs and FQHCLAs will conform to the BIPA 2000 requirements Prospective Payment System.
- The payment methodology for RHCs, FQHCs and FQHCLAs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

- (1) is agreed to by the State and the center or clinic: and
- (2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

I. Definitions. The following definitions apply to Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and Federally Qualified Health Center Look-Alike (FQHCLA) provider reimbursement.

- (1) Administrative Costs. Expenses incurred in operating the clinic as a whole which are reasonable and that are related to the cost of administration and management of the clinic and are not directly associated with furnishing patient care. Administrative costs include but are not limited to: office salaries; office supplies; legal, accounting, or billing services; consulting services; insurance; telephone; fringe benefits; and, payroll taxes.
- (2) Allowable Costs. Costs that are reasonable in amount and proper and necessary for the efficient delivery of RHC and FQHC services and that are incurred by a participating RHC, FQHC or FQHCLA.
- (3) Base Year. The first full fiscal year following the effective date of a provider's registration with TennCare as an RHC, FQHC, or FQHCLA. The data collected during this fiscal year will provide the basis to determine the provider's PPS or APM #1 rate. If a rate is rebased, the period of time on which the rebase is calculated becomes the new base year.

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- (4) **Core Reimbursement Rate.** The payment under an established PPS or APM rate for medically necessary primary health services and qualified preventive health services furnished by an RHC, FQHC, or FQHCLA to Medicaid enrollees. Note that additional services of dental, optometry, or pharmacy are reimbursed outside of the core reimbursement rate and a separate rate is calculated for each additional service.
- (5) **Core Visit.** A reimbursable visit that counts toward the Core Reimbursement Rate.
- (6) **Employee.** Any individual who, under the common law rules that apply in determining the employer-employee relationship as defined by § 3121(d)(2) of the Internal Revenue Code of 1986 (26 U.S.C. § 3121(d)(2)), is considered to be employed by, or an employee of, an entity. Application of these common law rules is discussed in 20 C.F.R. § 404.1007 and 26 C.F.R. § 31.3121(d)-1(c).
- (7) **Federally Qualified Health Center (FQHC).** An entity that has been federally certified as an FQHC and meets one (1) of the three following criteria:
 - (a) Is registered with TennCare as an FQHC; and is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. § 254b) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; and is determined by the Health Resources and Services Administration (HRSA) to meet the requirements for receiving such a grant; or
 - (b) Was treated by CMS, for purposes of Medicare Part B, as a comprehensive federally funded health center as of January 1, 1990; or
 - (c) Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.
- (8) **Federally Qualified Health Center Look-Alike (FQHCLA).** A community-based health care provider that meets the requirements of the HRSA Health Center Program, but does not receive HRSA Health Center Program funding.
- (9) **Interim Rate.** A rate established for new facilities after registration with TennCare as an RHC, FQHC, or FQHCLA and prior to the establishment of a final PPS or APM rate, as required by 42 U.S.C.A. §1396a(bb)(4).

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- (10) Medicare Cost Report. Form CMS-222 and Form CMS-224, the instructions for which are provided at CMS Publication 15-2, Sections 2908-2908.2, and CMS Publication 15-2, Sections 4404.1-4404.3; or their successor forms or publications.
- (11) Non-Core Visit. A reimbursable visit that counts towards a rate established under Section XI.
- (12) Non-Core Reimbursement Rate. The payment under a rate established pursuant to XI for additional services, including but not limited to, dentistry, optometry, or pharmacy services, that are reimbursed outside the Core Reimbursement Rate and where a separate rate is calculated for each additional service.
- (13) Owner. A person, persons, or entities with an enforceable claim or title to the asset or property, and is recognized as such by law.
- (14) Rebase. A new calculation of a provider's base rate utilizing cost data to determine a new reimbursement rate.
- (15) Reimbursable Visit. A visit as defined in this state plan amendment and which also meets the requirements of Section V.
- (16) Related Parties. Any person, persons, or entities that are related to the owner, if applicable, either by familial relationship or by a business association other than the RHC, FQHC, or FQHCLA itself.
- (17) Rural Health Clinic (RHC). A facility that has:
 - (a) Been determined by the Secretary of Health and Human Services to meet the requirements of § 1861(aa)(2) of the Social Security Act (42 U.S.C. § 1395x(aa)(2)) and 42 C.F.R. Part 491, concerning RHC services and conditions for approval; and
 - (b) Filed an agreement with CMS that meets the requirements in 42 C.F.R. § 405.2402 to provide RHC services under Medicare; and
 - (c) Has registered with TennCare as an RHC.
- (18) TennCare. The state governmental agency administratively located within the Tennessee Department of Finance and Administration; includes references to the Division of TennCare, the Bureau of TennCare and to all employees and subdivisions of the agency.

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- (19) Visit. A medically-necessary face-to-face medical or mental health encounter or a qualified preventive health encounter between the patient and a physician, nurse practitioner (NP), physician's assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), licensed professional counselor (LPC), or PharmD during which time one (1) or more qualified RHC, FQHC, or FQHCLA Medicaid covered services are furnished. In certain limited situations, an RHC, FQHC, or FQHCLA visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient. For a provider that has an established Non-Core Reimbursement Rate, a Non-Core Visit will include a face-to-face encounter with a licensed professional for which the rate was established, during which time one (1) or more qualified Non-Core Visit covered services are furnished.
- (20) Acronyms. Following is a list of acronyms used in this amendment:
- (a) APM: Alternative Payment Method
 - (b) CMS: Centers for Medicare and Medicaid Services
 - (c) CPT: Current Procedural Terminology
 - (d) FQHC: Federally Qualified Health Center
 - (e) FQHCLA: Federally Qualified Health Center Look-Alike
 - (f) FTE: Full Time Equivalent
 - (g) HRSA: Health Resources and Services Administration
 - (h) MEI: Medicare Economic Index
 - (i) PHS: Public Health Service
 - (j) PPS: Prospective Payment System
 - (k) RHC: Rural Health Clinic

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- II. Determination of Reimbursable Costs for RHCs, FQHCs, or FQHCLAs.
- (1) TennCare, in consultation with the Comptroller of the Treasury, establishes this amendment for the determination of the reimbursable per visit cost for services provided to Medicaid recipients who receive services at an RHC, FQHC, or FQHCLA. The Comptroller, pursuant to an agreement with TennCare, will review cost report and countable visit data submitted by providers to recommend a final PPS or APM rate.
 - (2) Only a facility registered with TennCare as an RHC, FQHC, or FQHCLA may participate in and be reimbursed as a provider under this amendment. TennCare shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.
 - (3) The specific items and services covered under the RHC, FQHC, or FQHCLA program shall be those defined and approved by TennCare. See V. Other Medicaid services that are not RHC, FQHC, or FQHCLA services may be provided and billed outside of the PPS or APM payment structure, providing TennCare covers those services.
 - (4) When calculating an RHC's, FQHC's, or FQHCLA's PPS settlement, the Comptroller and TennCare will multiply the number of reimbursable visits, as determined in V, times the established PPS or APM rate for that facility to calculate the total that should be received for services rendered under each established Core or Non-Core Reimbursement Rate. From that total, the Comptroller and TennCare will subtract any claims-based reimbursement received for those services to calculate the settlement amount.
- III. Medicaid Cost Reporting.
- (1) New and existing RHCs, FQHCs, or FQHCLAs shall, under the Medicare Cost Report Instructions, annually submit a Medicare Cost Report, located on the TennCare website, to the Comptroller by the due date imposed by Medicare. This cost report shall be for the RHC's, FQHC's, or FQHCLA's most recent fiscal year that ends at least six months before July 1.
 - (2) New and existing RHCs, FQHCs, or FQHCLAs shall annually submit a supplemental Medicaid Cost Report, which will be located on the TennCare website, to the Comptroller by the same due date for the Medicare Cost Report. This cost report shall be for the RHC's, FQHC's, or FQHCLA's most recent fiscal year that ends at least six months before July 1.

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- (3) Along with a Medicare Cost Report and supplemental Medicaid Cost Report, an RHC, FQHC, or FQHCLA shall submit to the Comptroller annually by the same due date imposed by Medicare for the Medicare Cost Report, a written statement of the RHC's, FQHC's, or FQHCLA's maximum hours per day, days per week, and weeks per year of operation, trial balance, detailed general ledger, depreciation schedule, schedule listing allocations, all management and consulting contracts, all billing NPI numbers, a listing of all related parties with which the provider does business, total visit log, schedule of owner's compensation, a schedule of all employee salaries by title, documentation for reclassification, and adjustments. If an RHC, FQHC, or FQHCLA does not submit this written statement, TennCare shall continue to pay the RHC, FQHC, or FQHCLA as it pays primary care centers that are not an RHC, FQHC, or FQHCLA.
- (4) RHCs, FQHCs, or FQHCLAs that have just undergone an ownership change will continue to receive the same rate as before the ownership change. The new owner may formally request the setting of a new rate from TennCare. TennCare will consult with the Comptroller and evaluate the request and determine whether to issue a new rate.

IV. Standard Reimbursement for a New RHC, FQHC, or FQHCLA.

- (1) New RHCs, FQHCs, or FQHCLAs are those providers which meet the definition for the provider type in Section I but were not enrolled with TennCare prior to October 25, 2017 and have not had a final PPS or APM rate established by the Comptroller. New providers shall be reimbursed using an interim rate based on the average rate of similar entities (other FQHCs for an FQHC, or other RHCs for an RHC) in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division.
- (2) Upon receipt of a Medicare Cost Report and supplemental Medicaid Cost Report submitted by an RHC, FQHC, or FQHCLA to the Comptroller as required by Section III, the Comptroller shall:
 - (a) Review the Medicare Cost Report and supplemental Medicaid Cost Report; and
 - (b) Notify the RHC, FQHC, or FQHCLA if additional documentation is necessary.

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- (c) 1. If additional documentation is necessary to establish a final PPS rate or APM rate, the RHC, FQHC, or FQHCLA shall:
 - (i) Provide the additional documentation to the Comptroller within thirty (30) days of the notification of need for additional documentation; or
 - (ii) Request an extension beyond thirty (30) days to provide the additional documentation.
- 2. The Comptroller has full discretion on whether to grant the extension.
- 3. An extension shall not exceed thirty (30) days.
- (d) 1. If the Comptroller requests additional documentation from the RHC, FQHC, or FQHCLA but does not receive additional documentation or an extension request within thirty (30) days, TennCare shall reimburse the RHC, FQHC, or FQHCLA as it reimburses primary care centers that are not an RHC, FQHC, or FQHCLA until:
 - (i) The additional documentation has been received by the Comptroller; and
 - (ii) The Comptroller has established a final PPS or APM rate.
- 2. If an RHC, FQHC, or FQHCLA does not submit both a Medicare Cost Report and supplemental Medicaid Cost Report to the Comptroller, TennCare shall reimburse the RHC, FQHC, or FQHCLA as it reimburses primary care centers that are not an RHC, FQHC, or FQHCLA until the RHC, FQHC, or FQHCLA submits both a Medicare Cost Report and supplemental Medicaid Cost Report to the Comptroller.
- (e) The Comptroller may review an RHC's, FQHC's, or FQHCLA's paid claims listing for the period of time corresponding to the submitted cost report.
- (f) When an RHC, FQHC, or FQHCLA has submitted all necessary information to the Comptroller, within one hundred twenty (120) days, the Comptroller shall:
 - 1. Establish a final PPS rate for the RHC, FQHC, or FQHCLA; and

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2. Notify the RHC, FQHC, or FQHCLA in writing of the RHC's, FQHC's, or FQHCLA's Final PPS or APM rate.

(g) Upon setting the final rate, TennCare shall reconcile all quarterly settlements made under the interim rate to the final rate, adjusting payments upward or downward as necessary.

V. Determination of a Reimbursable Visit.

- (1) RHCs, FQHCs, or FQHCLAs shall only be reimbursed for visits paid by a TennCare managed care contractor (MCC). This applies to both the PPS and APM methodologies. Claims for visits denied by an MCC that met all filing requirements of all state and federal laws and regulations, as well as the applicable MCC provider agreement, may be submitted to TennCare to be considered a reimbursable visit. Reimbursement determinations will be made at the discretion of TennCare upon consultation with the Comptroller. If TennCare determines a visit shall not be counted as a reimbursable visit based on the denied claim, the provider may appeal the determination pursuant to Section XII.
- (2) TennCare shall adopt or amend a list of CPT codes that will be published on the TennCare website. The list of CPT codes will be presumed reimbursable visits for both the PPS and APM methodologies and may be periodically updated with additions, deletions, or modifications. TennCare will post any amendments to the list on its website at least thirty (30) days prior to making any changes. When amendments to the CPT codes list become effective, any changes in payments to providers will also become effective on the same date.
- (3) If an encounter between an RHC, FQHC, or FQHCLA provider and a TennCare enrollee involves a CPT code that is not on the TennCare CPT codes list, the RHC, FQHC, or FQHCLA may request reimbursement for the CPT code. Requests for inclusion of a CPT code not on the TennCare codes list shall be made via the visit report and the decision regarding inclusion will be at the discretion of TennCare upon consultation with the Comptroller. If TennCare determines a requested CPT code will not be included for reimbursement, the provider may appeal the determination pursuant to Section XII.
- (4) An encounter for the sole purpose of medication therapy management, whether provided by a pharmacist or other provider, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.
- (5) An encounter or service related to patient-centered medical home payments, including the activity payments, practice transformation payments, and outcome payments, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.

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- (6) An encounter or service related to payments for Tennessee's health home program, including activity payments and outcome payments, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.
- (7) An encounter or service related to any other types of payment reform initiatives that may be implemented by TennCare, structured as per member per month case rates or outcome payments based on established performance criteria, shall not be considered a reimbursable visit, as payment for this service is made outside of the PPS or APM methodology.
- (8) If an encounter includes both a medical visit and a mental health visit, the RHC, FQHC, or FQHCLA shall report it as two separate visits. This applies to both the PPS and APM methodologies. In addition, the RHC, FQHC, or FQHCLA shall be allowed to submit both a core visit and a non-core visit for the same patient on the same day.
- (9) An RHC, FQHC, or FQHCLA shall not report multiple CPT codes that comprised one (1) visit as multiple visits in a submission to the Comptroller, except when a minor child receives both a well-child visit and a sick visit at the same time, each visit may be billed separately for a maximum of two (2) allowable paid TennCare visits. This applies to both the PPS and APM methodologies.
- (10) Medicare Crossover claims are ineligible for being counted as visits in either the PPS or APM methodologies.
- (11) Each billed item for patient care must include an invoice date and at least one (1) CPT code for the visit to be considered a reimbursable visit in either the PPS or APM methodologies.
- (12) For both PPS and APM purposes, the RHC, FQHC, or FQHCLA must submit visits to the Comptroller using the template that will be posted at the TennCare website, in order for the visits to be reimbursed. All data elements on the template must be complete and in the requested format for a claim to be considered as a visit. TennCare may change the template after providing at least thirty (30) days prior notice.

VI. Determination of Reasonable Costs.

- (1) Only reasonable costs will be reimbursed under this State Plan. It is within the Comptroller's discretion to determine what is a reasonable cost and if it may be reimbursed in accordance with this State Plan.
- (2) The following factors will be considered in determining reasonable costs:

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- (a) Fees paid by an RHC, FQHC, or FQHCLA pursuant to any contract to pay contingency fees for consulting, accounting, bookkeeping or similar services, or any contract to pay the vendor a percentage of the fees recovered from TennCare, will be presumed unreasonable and will not be reimbursed.
 - (b) Imputed salaries will be presumed unreasonable. All salary amounts must be reported on an IRS Form W-2 or an IRS Form 1099 to be considered for reasonableness.
 - (c) Salaried or contracted costs shall be accompanied by an FTE calculation.
 - (d) Owner's compensation and compensation to any related parties claiming salary or wages from the RHC, FQHC, or FQHCLA will be indexed to the Tennessee Occupational Employment and Wage Rates or other sources as determined by the Comptroller and will be paid only in circumstances as described in this State Plan. Compensation exceeding the indexed amount will be presumed unreasonable.
 - (e) For any employee or owner whose job functions include responsibilities other than direct patient care, the RHC, FQHC, or FQHCLA will be required to report the total number of hours the employee or owner spent performing functions that were not direct patient care.
 - (f) Administrative costs will be capped at thirty percent (30%) of the total costs, with imputed costs excluded. Total administrative costs exceeding 30% will be presumed unreasonable. Actual administrative costs must be established by each facility.
- (3) For reimbursement purposes, a reasonable allowance or compensation for services of an owner shall be subject to the following:
- (a) The services provided by the owner must be a necessary function, meaning that had the owner not rendered the services, the facility would have been required to employ another person to perform them. The services must be related to patient care or pertinent to the operation and sound management of the facility. TennCare shall be responsible for determining which services are related to patient care and pertinent to the operation and sound management of the facility, upon consultation with the Comptroller.

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- (b) Total compensation to owners must be listed on the Medicare Cost Report. Where these amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits.
- (c) The Comptroller's Office will review these amounts and compare them with allowable compensation ranges and make necessary adjustments. The Comptroller will consider the duties, responsibilities, and managerial authority of the owner as well as the services performed for other facilities and his engagements in other occupations. Only one-and-one-half (1.5) full-time positions, or the equivalent, will be allowed for each owner. Individual owner(s) and related party(ies) will be allowed no more than one (1.0) full-time position each, or the equivalent, for hours performing administrative functions. The duties performed, time spent, and compensation received by the owner must be substantiated by appropriate records.
- (4) The Comptroller may review any item in the cost report for reasonableness and to determine whether it should be an allowable cost.
- (5) This State Plan applies to both the standard PPS and APM methodologies.

VII. Change in Scope and Final PPS or APM Rate Adjustment.

- (1) (a) If an RHC, FQHC, or FQHCLA changes its scope of services after the base year rate is established, the Comptroller shall adjust its final PPS or APM rate if the change in scope qualifies for an adjustment under this State Plan, upon review and approval of the change in scope.
- (b) An adjustment to a final PPS or APM rate resulting from a change in scope that occurred after an RHC's, FQHC's, or FQHCLA's base year rate is established shall be effective from the beginning of the quarter that the change in scope request was submitted.
- (2) A change in scope of service shall be restricted to:
 - (a) A change in type: adding or deleting a Medicaid-covered ambulatory service; or
 - (b) A change in intensity: a change in the type or quality of services offered in an average visit such that the average patient receives a different array of services than the service mix patients received when the PPS or APM rate was last set. Examples include changes caused by new statutory or regulatory requirements or the introduction or expansion of specialty care; or

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- (c) A change in duration: a change in the average length of time it takes RHC, FQHC, or FQHCLA providers to complete an average patient visit due to changing circumstances such as the introduction of a health care delivery system transformation program or patient-centered care, or a change in patient demographics including, but not limited to, populations with HIV or AIDS or other chronic diseases, homeless, elderly, migrant, or other special populations; or
 - (d) A change in amount: an increase or decrease in the quantity of services that an average patient receives in an average Medicaid-covered visit such as improvements to technology or facilities that result in increased services to the RHC's, FQHC's, or FQHCLA's patients; or
 - (e) A statutory or regulatory change that materially impacts the costs or visits of an RHC, FQHC, or FQHCLA.
- (3) The following items individually shall not constitute a change in scope:
- (a) A general increase or decrease in the costs of existing services;
 - (b) A reduction or an expansion of hours per day, days per week, or weeks per year;
 - (c) A wage increase;
 - (d) A renovation or other capital expenditure;
 - (e) A change in ownership; or
 - (f) An addition of a service that is not a TennCare covered service.
- (4)
- (a) The addition of a new category of service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the RHC, FQHC, or FQHCLA by a licensed professional employed or contracted by the facility.
 - (b) The deletion of a category of service shall be restricted to the deletion of a licensed professional staff member who performed a Medicaid covered service that was being performed within the RHC, FQHC, or FQHCLA by the licensed professional staff member.
- (5) The Comptroller shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an RHC, FQHC, or FQHCLA if:

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- (a) A government entity imposes a mandatory minimum wage increase and the increase was:
 - 1. Not included in the calculation of the final PPS or APM rate; or
 - 2. Not subsequently included in the MEI applied yearly; or
 - (b) A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification; or
 - (c) The state imposes new requirements on its managed care plans that are then passed down as obligations to the RHCs, FQHCs, or FQHCLAs, if the obligations result in an increase in clinic costs of at least five percent (5%).
- (6) A requested change in scope shall:
- (a) Increase or decrease the existing final PPS or APM rate by at least five percent (5%);
 - (b) Remain in effect at least twelve (12) months; and
 - (c) Be submitted to the Comptroller as a written detailed description including documentation of the service change.
 - 1. For the addition of a service: the description must include the service the RHC or FQHC is adding, the location(s) offering the service, the date the RHC or FQHC began providing the service, and a brief description of how the new service will benefit the patient population.
 - 2. For a change in intensity, duration, or amount: the description must include the service change, the location(s) where the change has occurred, a description of how the average visit has changed from when the RHC's or FQHC's rate was set, along with relevant supporting documentation, and how the change has benefitted the patient population.
- (7) (a) An RHC, FQHC, or FQHCLA that requests a change in scope shall submit the following documents to the Comptroller within twelve (12) months of the requested effective date of a change in scope:

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1. A narrative describing the change in scope;
 2. A Medicare Cost Report for the affected fiscal year; and
 3. Relevant documentation including a trial balance, depreciation schedule, detailed general ledger, schedule listing allocations, total visit log, schedule of owner's compensation, a schedule of all employee's salaries by title, a list of related parties, documentation for reclassification, and adjustments.
- (b) If the Comptroller requests information from the provider and does not receive the required documentation within ninety (90) days, the change in scope shall be denied.
- (c) 1. The Comptroller shall:
- (i) Review the documentation listed in this State Plan; and
 - (ii) Notify the RHC, FQHC, or FQHCLA in writing of the:
 - (I) Approval or denial of the request for change in scope within ninety (90) days from the date the Comptroller received the request; or
 - (II) Need for additional documentation from the RHC, FQHC, or FQHCLA to establish a final PPS or APM rate associated with the change in scope.
2. If the Comptroller requests additional documentation to calculate the final PPS or APM rate for a change in scope, the RHC, FQHC, or FQHCLA shall:
- (i) Provide the additional documentation to the Comptroller within thirty (30) days of the request for additional documentation; or
 - (ii) Request an extension beyond thirty (30) days to provide the additional documentation.
3. (i) An extension shall not exceed thirty (30) days.
- (ii) The Comptroller shall have complete discretion regarding whether to grant or deny an extension.

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4. If the Comptroller approves the request for a change in scope and receives all of the necessary documentation from an RHC, FQHC, or FQHCLA within the timelines established in this State Plan, the facility shall begin receiving the current PPS or APM rate for any newly approved service associated with the change in scope until a final rate can be set.
5. If an RHC, FQHC, or FQHCLA has submitted all necessary information to the Comptroller, within one hundred twenty (120) days, the Comptroller shall:
 - (i) Establish a final PPS or APM rate for the RHC, FQHC, or FQHCLA; and
 - (ii) Notify the RHC, FQHC, or FQHCLA in writing of the RHC's, FQHC's, or FQHCLA's Final PPS or APM rate.
- (8) If an RHC, FQHC, or FQHCLA requests a change in scope and it is granted, all of the rates, including the Core Reimbursement Rate and other rates outside the Core Reimbursement Rate, will be rebased.

VIII. Standard Reimbursement for an Existing RHC, FQHC, or FQHCLA.

- (1) Existing RHCs, FQHCs, or FQHCLAs are those providers which meet the definition for the provider type in Section I and either enrolled with TennCare prior to October 25, 2017 or have a final PPS or APM rate established by the Comptroller.
- (2) For existing providers, for a visit by a recipient who is a TennCare enrollee, TennCare shall reimburse:
 - (a) An RHC, FQHC, or FQHCLA: a quarterly settlement based on the final PPS or APM rate as required by 42 U.S.C. 1396a(bb); or
 - (b) A satellite facility of an RHC, FQHC or FQHCLA: a quarterly settlement based on the final PPS or APM rate.
- (3) The Comptroller shall calculate a final PPS or APM rate for a new RHC, FQHC, or FQHCLA under Section IV.

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- (4) The Comptroller shall adjust a final PPS or APM #1 rate:
 - (a) By the percentage increase in the MEI applicable to RHC services on July 1 of each year; or
 - (b) By the market basket measure for FQHC and FQHCLA services; and
 - (c) As permitted by Section VII:
 - 1. Upon request and documentation by an RHC, FQHC, or FQHCLA that there has been a change in scope of services; or
 - 2. Upon review and determination by the Comptroller that there has been a change in scope of services; or
 - 3. If necessary as a result of a desk review or audit.
- (5) A final PPS or APM rate established under this rule shall not be subject to an end of the year cost settlement.
- (6) Upon this amendment becoming effective, the Comptroller will review all PPS rates using the cost data used to set those rates if available, or if not, using the newest available cost data of at least 12 months, in order to determine if the included costs are allowable costs according to the requirements in this amendment. If it is determined that some of the costs are not allowable costs according to this amendment, the RHC, FQHC, or FQHCLA will be offered the opportunity to change to an APM methodology and either:
 - (a) Accept APM #2 (described below), where the APM rate will equal the previous final rate established for the facility prior to the Comptroller's review.; or
 - (b) Accept the revised PPS rate established pursuant to the Comptroller's review under this paragraph.

IX. Alternative Payment Methodologies for an RHC, FQHC, or FQHCLA.

- (1) TennCare may offer to an RHC, FQHC, or FQHCLA, for which a final PPS rate exists, one of two alternative payment methodologies, APM #1 or APM #2. The RHC, FQHC, or FQHCLA, at the RHC, FQHC, or FQHCLA's election, may receive an alternative payment methodology rate if it notifies TennCare in writing that it elects to receive the alternate reimbursement.

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- (2) APM #1: Establishment of base years and periodic rebasing.
- (a) If the RHC, FQHC, or FQHCLA elects to use the APM #1, it will undergo establishment of a new base year. The Comptroller shall collect and review Medicare Cost Report data from the previous two (2) fiscal years, or if the provider has been in existence for fewer than two (2) years, then for as many months as are available, and use this data to compute a new PPS rate, which will be called the APM rate. A minimum of twelve (12) months data must be available in order to set an APM #1 rate, and the rate must be rebased as soon as there are twenty-four (24) months of available cost report data.
 - (b) Following that rebase year, the APM #1 rate for an RHC, FQHC, or FQHCLA shall be adjusted by the market basket measure applicable to FQHC and FQHCLA services on July 1 of each year.
 - (c) The factors included in Section VI will be calculated into the APM rate.
 - (d) The Comptroller may perform a rebase of all RHCs, FQHCs, or FQHCLAs no more than one (1) time per fiscal year and no less than one (1) time every five (5) fiscal years, without prior notice and using the previous two (2) fiscal years of Medicare Cost Report data.
 - (e) The Comptroller may not offer, and an RHC, FQHC, or FQHCLA may not collect, the APM #1 rate unless the APM rate is equal to or higher than the Standard PPS Rate, as calculated according to this State Plan. When an APM #1 rate is first implemented, or when it is rebased, TennCare will ensure that the APM rate is equal to or greater than the Standard PPS Rate as calculated according to the provisions in this State Plan.
 - (f) The offer of the APM #1 is valid for only the year in which the payment is offered. Entities that do not choose the APM #1 in the year it is offered will be required to wait until APM is offered again. This will be a minimum of five (5) years.

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- (3) APM #2: For any RHC, FQHC, or FQHLA for which the Comptroller has determined that some base year costs are not allowable in accordance with this amendment:

The APM #2 rate will

- (a) equal the previous final rate established for the facility prior to the Comptroller's review.
- (b) APM #2 rate will receive no annual inflationary adjustment until it is determined that the revised PPS rate of the RHC, FQHC or FQHLA, plus annual inflationary adjustments, has surpassed the APM #2 rate. At that point, the rate will equal the PPS rate and receive annual inflationary adjustments equal to the inflationary adjustments provide to the PPS Rate.
- (c) The Comptroller may not offer, and an RHC, FQHC, or FQHCLA may not collect, the APM #2 rate unless the APM rate is equal to or higher than the Standard PPS Rate, as calculated according to this State Plan, including any revisions based on the Comptroller's review of costs described in X(6). When an APM #2 rate is first implemented, TennCare will ensure that the rate is equal to or greater than the Standard PPS Rate as calculated according to the provisions in this State Plan.
- (4) If a facility elects to use an APM, it must use the APM for all rates, including the Core Reimbursement Rate and those rates outside of the Core Reimbursement Rate.

X. Auditing of Provider-Reported Data.

- (1) The cost reports and visit reports filed under this chapter by an RHC, FQHC, or FQHCLA, and all pertinent provider records shall be subject to audit by the Comptroller of the Treasury or his agents based on the criteria in this State Plan or the Medicare regulations, as applicable.
- (2) The cost reports filed under this chapter must provide adequate cost and statistical data. This data must be:
- (a) Based on and traceable to the provider's financial and statistical records; and

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- (b) Adequate, accurate and in sufficient detail to support payment made for services rendered to enrollees; and
 - (c) Available for and capable of verification by the Comptroller of the Treasury or his agents.
- (3) The provider shall permit the Comptroller or his agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due.
 - (4) Data reflected on the cost report which cannot be substantiated may be disallowed with reimbursement being required of the provider.

XI. PPS Rates Outside of Core Reimbursement Rate.

RHCs, FQHCs, or FQHCLAs are permitted to establish Non-Core Reimbursement Rates for services outside of the Core Reimbursement Rate, including but not limited to, dental, pharmacy, and optometry. In order to do this, a request must be submitted to the Comptroller to set these rates. All provisions in this Section apply to Non-Core Reimbursement Rates in the same way that they apply to Core Reimbursement Rates.

XII. Provider Appeals.

Information contained in a provider's cost and visit reports or supplemental filings required to be submitted to the Comptroller by this State Plan is utilized by the Comptroller to determine reimbursement. Reimbursement rate determinations made by the Comptroller and implemented by the state shall be appealable as set out in the state's existing provider appeals processes. A provider may request review of Reimbursable Visit determinations pursuant to Section V paragraphs (1) and (3). A denial following review by TennCare shall be appealable pursuant to the state's provider appeals processes.