

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Finance and Administration

DIVISION: TennCare

SUBJECT: Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes

STATUTORY AUTHORITY: Tennessee Code Annotated, Sections 4-5-202, 71 -5- 105, 71-5-107, 71 -5-109, 71-5-118, and 71 -5-130

EFFECTIVE DATES: April 29, 2019 through June 30, 2020

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: This rulemaking hearing rule is being promulgated to provide the reimbursement methodology necessary to determine appropriate reimbursable costs and payments for TennCare services provided by RHCs, FQHCs and FQHCLAs to TennCare enrollees.

Public Hearing Comments

TennCare received comments from 26 individuals and organizations in response to this rulemaking. The comments and TennCare's responses are summarized below.

One commenter suggested an alternative to the reimbursement methodology in the rule whereby TennCare would establish a flat rate for RHCs. In response, TennCare expressed its view that a flat rate cannot adequately account for the significant variation in locations, patient mixes, and services represented by clinics around the state. No modifications were made to the rule based on this comment.

Several commenters expressed concern about the length of time needed to set rates under the current payment system. In response, TennCare noted that the rule adds a new requirement that in all circumstances rates must be finalized within 120 days of the facility providing all information necessary to set the rate. TennCare interpreted these comments as supportive of the rule's provision establishing a timeframe for setting final rates. No modifications were made to the rule based on these comments.

Two commenters suggested that the rule be clarified to specify that the 120-day timeframe for the Comptroller to set final rates begins upon the Comptroller's receipt of all necessary information from the provider. TennCare agreed with these suggestions and modified the rule accordingly.

One commenter suggested that the provision of the rule specifying that the Comptroller may grant no more than one extension to a provider that has been asked to submit additional documentation is unnecessary, since the also rule specifies that extensions are granted at the discretion of the Comptroller. TennCare agreed with this recommendation and removed the provision in question from the rule.

Multiple commenters expressed concern that the provisions of the rule would be applied retroactively to established PPS rates. In response, TennCare clarified that it is not the intent of the rule to recoup from rates applicable to prior years by applying new requirements that appear only in this rule.

A number of commenters expressed concern about the rule's limitation on reimbursement for administrative expenses. In response, TennCare noted that a reasonable limitation on administrative expenses is appropriate, helps minimize the risk of fraud, waste, and abuse, and helps protect the integrity of the payment system. The cap in the rule was based on a comprehensive statewide rate analysis performed by the Comptroller. One commenter expressed support for the rule's proposed cap on administrative expenses. TennCare thanked this commenter for his support. No modifications were made to the rule based on these comments.

One commenter questioned why the rule limits compensation for clinic owners. In response, TennCare clarified that nothing in the rule limits compensation for the owners of FQHCs or RHCs. Clinics continue to have discretion to establish their own salaries. The rule caps the amount of compensation for owners that can be considered an allowable expense for enhanced reimbursement through the prospective payment system. This cap is intended to help minimize the risk of fraud, waste, and abuse. No modifications were made to the rule based on this comment.

A few commenters objected to the exclusion of imputed owners' salaries in the rule. In response, TennCare noted that imputed salaries represent costs that were not actually paid by the clinic, and disallowing these costs helps protect the payment system from fraud, waste, and abuse. No modifications were made to the rule based on these comments.

One commenter expressed concern that the rule appeared not to account for reimbursement for clinic owners who perform both direct care and administrative duties. In response, TennCare clarified that it is not TennCare's intent to implement a rule that prevents owners from being reimbursed for both direct care and administrative work. TennCare modified the pertinent rule language to clarify that this is allowed.

Several commenters expressed concern about the rule's limitation on allowable reimbursement for compensation of clinic owners to 1 FTE. These commenters believed this limitation would have an adverse impact on providers who consistently work more than 40 hours per week. In response, TennCare elected to raise the applicable limit in the rule to 1.5 FTE. TennCare further clarified that for clinic owners and related parties, no more than 1 FTE per individual can be claimed for administrative hours.

Several commenters expressed concern that the rule's indexing of salaries and wages to the Tennessee Occupational Employment and Wage Rates would negatively impact clinics' ability to recruit and hire providers. In response, TennCare noted that the limit applies only to clinic owners and related parties, and thus, should not affect a clinic's ability to recruit new providers. Some commenters also objected to applying this limit on reimbursement for compensation of clinic owners. TennCare noted that reasonable limits on reimbursement for compensation of owners are necessary in order to help prevent the possibility of fraud, waste, and abuse in the payment system. No modifications were made to the rule based on these comments.

A few commenters expressed concern that the rule appeared to prohibit the use of productivity-based salaries. In response, TennCare clarified that the rule does not limit or prohibit the use of productivity-based salaries. No modifications were made to the rule based on these comments.

Multiple commenters expressed concern about the requirement in the rule for the annual submission of Medicaid cost reports. These commenters suggested that this required submission would represent an additional administrative burden for providers. One commenter suggested alternative documentation requirements to those outlined in the rule. In response, TennCare noted that cost reports are needed to ensure the appropriateness of payments and to minimize the risk of fraud, waste, and abuse. TennCare noted that its intent is to limit the cost report to as few data elements as possible in order to minimize administrative burden on clinics to the extent possible. No modifications were made to the rule based on these comments.

One commenter objected to a provision in the rule allowing the Comptroller to request additional information from providers. This commenter recommended that the rule should contain an exhaustive list of all documentation that could be requested. This commenter also recommended that the rule specify that the Comptroller may not deny any reasonable request from a provider for an extension in providing additional documentation. In response, TennCare noted that the Comptroller must maintain the ability to collect all necessary information in order to set the most accurate rates and guard against fraud, waste, and abuse in the payment system. No modifications were made to the rule based on these comments.

Several commenters objected to the rule's prohibition on contingency fee-based contracts. In response, TennCare noted that it is deeming these contracts impermissible in order to minimize the risk of fraud, waste, and abuse. One commenter expressed support for the rule's exclusion of contingency fee-based contracts. TennCare thanked this commenter for his support. No modifications were made to the rule based on these comments.

Multiple commenters expressed concern that the rule has no provision for providers to appeal decisions made by TennCare or the Comptroller's office. TennCare agreed with these commenters, and added a rule providing for such an appeals process.

One commenter suggested that the rule contains inconsistent standards as to what constitutes reasonable costs. TennCare respectfully disagreed with the commenter's assessment. No modifications were made to the rule based on this comment.

One commenter suggested that interim rates be set using statewide figures rather than regional figures for independent and provider-based RHCs. In response, TennCare noted that it is electing to calculate interim rates on the basis of Grand Division in order to account for regional variation in the cost of providing care and clinic operations. No modifications were made to the rule based on this comment.

One commenter suggested that the rule should include language addressing the reconciliation of primary care payments made under an interim rate to the payments that would have been made under the final rate and making any necessary additional payments. TennCare agreed with this recommendation and added corresponding language to the rule. The language added to the rule reflects the practice within the current payment system of adjusting payments upward or downward depending on the relationship between the interim rate and the final rate.

One commenter requested clarification as to whether certain information requirements in the rule would apply to all health centers or be limited to new health centers. In response, TennCare clarified that these requirements will apply to all FQHCs and RHCs. Based on consultation with the Comptroller, TennCare believes this list of information is necessary to protect the integrity of the payment system. No modifications were made to the rule based on this comment.

One commenter expressed concern about TennCare's use of paid visits as the basis for PPS/APM payments, and noted that similar paid visit policies have been challenged in other states. In response, TennCare noted that it believes the language in the rule related to paid claims is consistent with applicable state and federal laws and regulations. However, in response to this concern, TennCare added language to the rule to allow for reconsideration of visits denied by the MCO in limited circumstances.

One commenter requested that the rule be clarified to explicitly allow health centers to submit core visits and non-core visits performed on the same day as two visits. TennCare agreed with the commenter's recommendation and modified the rule accordingly.

One commenter suggested that the rule allows the Comptroller too much discretion to determine reasonable costs and suggested that more objective standards be included in the rule. In response, TennCare noted that the rule provides a significant level of detail concerning what constitutes allowable costs. No modifications were made to the rule based on this comment.

One commenter recommended the deletion of language from the rule concerning the Comptroller's ability to review cost reports for reasonableness. TennCare regards altering this language to be unnecessary as the rule already contains references to federal reasonableness language and adds new reasonableness requirements. These are the basis for determinations of reasonableness. No modifications were made to the rule based on this comment.

One commenter requested that language be added to the rule concerning changes that impart a change in type, intensity, duration, or amount. In response, TennCare noted that it regards the addition of this language as unnecessary, because such changes in type, intensity, duration, or amount are already addressed in the rule. No modifications were made to the rule based on this comment.

One commenter requested that language be added to the rule concerning changes in scope that occur when the state imposes new requirements on managed care organizations, which in turn result in new requirements for health clinics. TennCare agreed with the commenter's recommendation and added the requested language to the rule. The language added by TennCare applies when a change in requirements results in an increase in clinic costs of at least five percent.

One commenter suggested that TennCare replace the language related to change in scope in the rule in favor of TennCare's existing change of scope policy. In response, TennCare noted that much of the language cited by the commenter is necessary for the new payment system. TennCare agreed with a portion of the comment that it is unnecessary to first set an interim rate and then a final rate for a change of scope, and amended the rule accordingly to align with the current practice of using the facility's current rate until the final rate can be set.

One commenter expressed concern that the provision of the rule concerning reimbursement via quarterly settlements based on the final PPS rate is inconsistent with current procedures. In response, TennCare clarified that the rule does not change current procedures for submission of visits with regard to a main facility and its satellites, and that in fact, this provision of the rule is intended to make explicit that visits at satellites can be eligible for settlement. No modifications were made to the rule based on this comment.

One commenter requested clarification as to the use of the term "market basket measure" in the rule. In response, TennCare clarified that this term refers to the market basket established under Section 1834 of the Social Security Act. No modifications were made to the rule based on this comment.

One commenter requested confirmation that the review of all PPS rates by the Comptroller described in the rule will apply only to standard BIPA PPS rates. In response, TennCare confirmed that the commenter's understanding of the rule was accurate. No modifications were made to the rule based on this comment.

One commenter objected to a provision of the rule concerning circumstances in which a PPS rate may be frozen, and suggested that this provision is inconsistent with federal requirements. Upon review, TennCare elected to modify the rule to clarify that PPS rates will not be frozen.

One commenter requested that TennCare or the Comptroller provide information to health centers concerning which type of rate they have (PPS or APM). Although outside the scope of this rulemaking, TennCare agreed to work with the Comptroller to provide this information. No modifications were made to the rule based on this comment.

One commenter requested clarification concerning how a health center that has elected the APM can opt out of the APM and return to PPS. In response, TennCare noted that once an RHC, FQHC, or FQHCLA is on an APM rate, it permanently stays on an APM rate. There is no mechanism for returning to a standard BIPA PPS rate. No modifications were made to the rule based on this comment.

One commenter noted that the state is required to demonstrate that an APM is equal to or greater than the BIPA PPS rate and inquired how TennCare intends to demonstrate this. In response, TennCare noted that it is aware of its obligations concerning APMs, and will annually demonstrate that the APM is higher than the BIPA PPS rate, as calculated using methodology in the rule. No modifications were made to the rule based on this comment.

One commenter suggested that the rule should clearly state which service categories will be subject to a secondary PPS rate or a PPS rate outside of core reimbursement. In response and in an effort to clarify the rule's intent by reflecting all rates that are set outside of the core, TennCare added "optometry" to the relevant section of the rule.

One commenter requested clarification about the meaning of "Grand Division" in the rule. TennCare clarified that for purposes of TennCare rules, Grand Division has the same meaning as that located at T.C.A. 4-1-2. No modifications were made to the rule based on this comment.

One commenter questioned a provision in the rule allowing facilities to submit partial-year cost reports in instances when a complete fiscal year of data may not be available due to a change in ownership or a facility being new. TennCare elected to remove this provision of the rule in order to prevent confusion and unnecessary administrative burden for providers.

Two commenters questioned a provision in the rule allowing new RHCs and FQHCs to submit budgeted cost reports. TennCare elected to remove this provision of the rule in order to prevent confusion and unnecessary administrative burden for providers.

One commenter asked about the availability of the supplemental Medicaid cost report format. In response, TennCare indicated that the cost report will be available in the near future (prior to the rule's implementation), and that TennCare will communicate about the Medicaid cost report with the provider community. Another commenter requested that providers be allowed to review and provide feedback on the visit reporting template prior to its implementation. In response, TennCare noted that it intends to provide opportunities for review and feedback on the visit submission template. No modifications were made to the rule based on these comments.

One commenter requested clarification about the requirement in the rule for facilities to submit a written statement of the entity's maximum hours per day. To clarify, TennCare responded that facilities are required to report the hours of operation that the facility is available to provide FQHC/RHC services. No modifications were made to the rule based on this comment.

One commenter requested clarification about the documentation that will be required for the compensation of sole proprietors, partners, and single member LLCs to be considered reasonable and allowed on the cost report. To clarify, TennCare responded by noting that these requirements are addressed in the rule at 1200-13-10-.06(2)(b). No modifications were made to the rule based on this comment.

One commenter expressed concern and two commenters requested clarification about a provision in the rule concerning the periodic rebasing of clinics that have elected the Alternative Payment Methodology (APM). In response, TennCare confirmed that this rebasing applied only to clinics that have elected the APM. By rule, the APM must be at least as high as the standard BIPA PPS rate (as calculated using the new rule methodology), and a facility must elect to be reimbursed using the APM. No modifications were made to the rule based on these comments.

One commenter requested clarification about the support that will be required to document reasonable costs for the allocation of hospital costs to rural health clinics. To clarify, TennCare responded by noting that hospital-based RHCs will be required to submit hospital cost reports and supporting documentation as detailed at Rule 1200-13-10-.04(2). No modifications were made to the rule based on this comment.

Several commenters expressed concern about the proposed list of CPT codes for allowable visits. In response, TennCare noted that it has decided to implement a list of CPT codes in response to concerns that the current

system is unclear as to what constitutes a visit. TennCare also clarified that while the rule implements the use of a list, the rule does not speak to specific items that are included on the list. TennCare has developed a preliminary list of codes, and intends to work with the provider community to arrive at the most appropriate list of codes. In addition, in cases where the CPT codes list is missing a code that a provider believes to qualify as a visit, the rule provides a mechanism for the provider to submit that code separately and request that it be added to the CPT codes list. No modifications were made to the rule based on these comments.

One commenter observed that the reasonableness standards in the rule for codes not on the CPT codes list pertain to the reasonableness of costs, and not the reasonableness of visits. This commenter suggested that this point be clarified in the rule. TennCare agreed with the commenter's observation and modified the rule accordingly.

One commenter suggested that TennCare use HCPCS codes rather than CPT codes as the basis for how qualifying visits are identified. In response, TennCare noted that it has determined that CPT codes are a more accurate representation of the data TennCare needs to collect in order to operate the prospective payment system. No modifications were made to the rule based on this comment.

One commenter expressed concern regarding the rule's applicability to specific types of encounters that are excluded from the definition of allowable or reimbursable visits, particularly as they pertain to TennCare's payment reform initiatives. In response, TennCare clarified that those specific services will not be eligible to be reported as a visit and settled at the PPS rate. No modifications were made to the rule based on this comment.

One commenter expressed concern that "medication therapy management" is not counted as a visit in the rule. In response, TennCare clarified that the rule does not prohibit providers from performing medication management, but clarifies that a limited set of services defined as "medication therapy management" do not constitute a visit for purposes of enhanced reimbursement. No modifications were made to the rule based on this comment.

One commenter expressed concern as to the rule's application to patient-centered medical home (PCMH) services. In response, TennCare pointed out that the commenter appeared to have misunderstood the rule, and that payments for PCMH services are specifically carved out of the reimbursement methodology in the rule. No modifications were made to the rule based on this comment.

One commenter suggested that the definition of administrative costs in the rule should contain additional detail. TennCare respectfully disagreed with this suggestion and noted that the definition of administrative costs in the rule is adequate for implementation of the rule. No modifications were made to the rule based on this comment.

One commenter suggested modifications to the rule's definition of covered services. Upon review, TennCare determined that the definition in question is not necessary for implementation of the rule and elected to remove the definition from the rule.

One commenter suggested a clarification to the definition of FQHC in the rule. TennCare agreed with the commenter's suggestion and updated the rule to reflect this recommendation. Another commenter suggested removing a Medicare-related citation to the CFR from the rule's definition of FQHC. Upon review, TennCare elected to remove the citation in question from the definition of FQHC in the rule.

One commenter expressed concern about the definition of visit in the rule. In response, TennCare noted that the rule's definition is consistent with current practice, which TennCare does not intend to change. However, this does not mean that eligible CPT codes performed by some other provider types would not be eligible for settlement. No modifications were made to the rule based on this comment.

One commenter suggested that the provisions of the rule pertaining to determination of reimbursable visits are not in alignment with federal law. TennCare agreed with the commenter that any services that are required to be compensated according to federal laws and regulations would also be required to be compensated under Tennessee's payment system. TennCare elected to add clarifying information as to which services are reimbursed under non-core PPS rates to Rule 1200-13-10-.11.

One commenter suggested that TennCare tether reasonable cost determinations to applicable Medicare cost reimbursement principles. In response, TennCare noted that it believes that specific criteria for reasonableness are necessary in the rule to provide greater transparency and clarity to the payment system, while also protecting taxpayer dollars. No modifications were made to the rule based on this comment.

One commenter suggested that TennCare should limit the number of RHCs to one per county and/or one per specialty per county. In response, TennCare noted that this recommendation is outside the scope of this rulemaking. No modifications were made to the rule based on this comment.

One commenter expressed support for the rule because it would only allow reasonable costs to be included in the cost report. TennCare thanked the commenter for his support. No modifications were made to the rule based on this comment.

Multiple commenters expressed general concern about the rule's potential impact on rural health clinics in Tennessee. In response, TennCare noted that the purpose of these rules is to add transparency and clarity to the prospective payment system in Tennessee, to ensure the appropriateness of payments, and to minimize the risk of fraud, waste, and abuse in the payment system. No modifications were made to the rules based on these comments.

One commenter criticized the lack of clear cost reporting guidelines in the current reimbursement system. In response, TennCare noted that one of the purposes of these rules is to add transparency and clarity to the prospective payment system in Tennessee. No modifications were made to the rules based on this comment.

Multiple commenters expressed concern about TennCare's moratorium on new Rural Health Clinics entering the TennCare program. Although the RHC moratorium is not the subject of Rule Chapter 1200-13-10, TennCare noted that the moratorium was enacted in response to a significant increase in the potential for fraud, waste, and abuse, and that it is TennCare's intention to lift the moratorium once Rule Chapter 1200-13-10 is in effect. No modifications were made to the rule based on these comments.

One commenter requested clarification about payment processes that will be used for clinics that were certified as Rural Health Clinics during the moratorium. Although the RHC moratorium is not the subject of Rule Chapter 1200-13-10, TennCare noted that it has issued separate guidance on this subject. No modifications were made to the rule based on this comment.

One commenter suggested that TennCare establish an advisory body comprised of rural health providers and their representatives to advise TennCare on reimbursement and other issues related to rural health services. Although outside the scope of this rule, TennCare noted in response that it has communicated with various members of the provider community throughout the development of the new reimbursement methodology, including provider associations, individual clinics and owners, and consultants that support FQHCs and RHCs. TennCare values the input that providers have offered and intends to remain engaged with the provider community as the rule is implemented. No modifications were made to the rule based on this comment.

One commenter suggested that MCOs participating in the TennCare program should be required to allow patients to select FQHCs as their primary care provider. In response, TennCare clarified that TennCare enrollees are currently able to select any qualified provider in their MCO's network, including FQHCs, as their designated primary care provider, and that this choice is not affected by this rule. No modifications were made to the rules based on this comment.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule;

The rule will impact health centers that are Rural Health Clinics. TennCare estimates that there are currently approximately 100 Rural Health Clinics in the state that are also small businesses.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record;

The rule requires affected health centers to submit a Medicaid cost report, which will be used by TennCare to establish payment rates. The reporting, recordkeeping, and other administrative processes associated with these cost reports are not substantially different than what is otherwise already required for health centers.

3. A statement of the probable effect on impacted small businesses and consumers;

The rule will have no impact on consumers. Small businesses impacted by the rule will benefit from greater transparency, clarity, consistency, and uniformity in the payment system. Because the rule establishes clear standards for acceptable costs, health centers will experience less ambiguity around payment and lower levels of audit risk.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business;

There are no less burdensome, less intrusive, or less costly methods of achieving the purpose and objectives of the rule.

5. A comparison of the proposed rule with any federal or state counterparts; and

There are no federal or state counterparts to the rule.

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

The purpose of the rule is to provide greater transparency, clarity, consistency, and uniformity to the payment system for Rural Health Clinics and Federally Qualified Health Centers. Because a significant number of Rural Health Clinics are also small businesses, exempting small business from the rule would prevent the rule from achieving this objective. The rule does not provide for exemptions for small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The rule chapter is not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

This rule chapter is being promulgated to provide the reimbursement methodology necessary to determine appropriate reimbursable costs and payments for TennCare services provided by RHCs, FQHCs and FQHCLAs to TennCare enrollees.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rule chapter is lawfully adopted by the Division of TennCare in accordance with T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, 71-5-118 and 71-5-130.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by this rule chapter are TennCare enrollees, providers, and managed care contractors. The governmental entities most directly affected by this rule chapter is the Tennessee Comptroller of the Treasury, and the Division of TennCare, Tennessee Department of Finance & Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

The rule chapter was approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of this rule chapter is anticipated to have a minimal impact on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Donna K. Tidwell
Deputy General Counsel

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Donna K. Tidwell
Deputy General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10119024dt

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Sequence Number: 01-28-19
 Rule ID(s): 8530
 File Date: 1/29/19
 Effective Date: 4/29/19

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Finance and Administration
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Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-13-10	Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes
Rule Number	Rule Title
1200-13-10-.01	Definitions
1200-13-10-.02	Determination of Reimbursable Costs for RHCs, FQHCs, or FQHCLAs
1200-13-10-.03	Medicaid Cost Reporting
1200-13-10-.04	Standard Reimbursement for a New RHC, FQHC, or FQHCLA
1200-13-10-.05	Determination of a Reimbursable Visit
1200-13-10-.06	Determination of Reasonable Costs
1200-13-10-.07	Change in Scope and Final PPS or APM Rate Adjustment
1200-13-10-.08	Standard Reimbursement for an Existing RHC, FQHC, or FQHCLA
1200-13-10-.09	Alternative Payment Methodology for an RHC, FQHC, or FQHCLA
1200-13-10-.10	Auditing of Provider-Reported Data
1200-13-10-.11	PPS Rates Outside of Core Reimbursement Rate
1200-13-10-.12	Provider Appeals
1200-13-10-.13	Implementation of this Chapter

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to <https://sos.tn.gov/products/division-publications/rulemaking-guidelines>.

Rules of the Tennessee Department of Finance and Administration, Division of TennCare, are amended by replacing repealed Chapter 1200-13-10 with a new Chapter 1200-13-10 Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and Federally Qualified Health Center Look-Alikes which shall read as follows:

Rules
of
Tennessee Department of Finance and Administration
Division of TennCare

Chapter 1200-13-10
Reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and
Federally Qualified Health Center Look-Alikes

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1200-13-10-.05 Determination of a Reimbursable Visit
1200-13-10-.06 Determination of Reasonable Costs
1200-13-10-.07 Change in Scope and Final PPS or APM Rate Adjustment
1200-13-10-.08 Standard Reimbursement for an Existing RHC, FQHC, or FQHCLA
1200-13-10-.09 Alternative Payment Methodology for an RHC, FQHC, or FQHCLA
1200-13-10-.10 Auditing of Provider-Reported Data
1200-13-10-.11 PPS Rates Outside of Core Reimbursement Rate
1200-13-10-.12 Provider Appeals
1200-13-10-.13 Implementation of this Chapter

1200-13-10-.01 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 rate. If a rate is rebased, the period of time on which the rebase is calculated becomes the new base year.
- (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).
- (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 rule .11.
- (12) Non-Core Reimbursement Rate. The payment under a rate established pursuant to rule .11 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 rule and which also meets the requirements of rule .05.
- (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.
- (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 chapter:
 - (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

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.02 Determination of Reimbursable Costs for RHCs, FQHCs, or FQHCLAs.

- (1) TennCare, in consultation with the Comptroller of the Treasury, establishes this chapter 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 chapter. 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 rule .05. 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 rule .05, 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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.03 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.
- (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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.04 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 rule .01 but did not register with TennCare prior to the implementation of the moratorium on the registration of new facilities approved by CMS on 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 rule .03, 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.
 - (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
 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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.05 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 rule .12.
- (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 rule .12.
- (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.
- (6) An encounter or service related to Tennessee Health Link payments, 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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.06 Determination of Reasonable Costs.

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

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.07 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 rule, 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
 - (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:
- (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:
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 rule; 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.
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 rule, 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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.08 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 rule .01 and either registered with TennCare prior to implementation of the moratorium on the registration of new facilities approved by CMS on 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 rule .04.
- (4) The Comptroller shall adjust a final PPS or APM 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 rule .07:
 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 both this chapter becoming effective and TennCare's corresponding State Plan Amendment being approved by CMS, 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 chapter. If it is determined that some of the costs are not allowable costs according to this chapter, the RHC, FQHC, or FQHCLA will be offered the opportunity to change to an APM methodology and either:
 - (a) Accept an APM methodology where the APM rate will equal the previous final rate established for the facility prior to the Comptroller's review. This APM rate will receive no annual inflationary adjustment until it is determined that the revised PPS rate plus annual inflationary adjustments has surpassed this APM rate. At that point, the APM rate will equal the PPS rate and receive annual inflationary adjustments as described in this rule; or
 - (b) Accept the revised PPS rate established pursuant to the Comptroller's review under this paragraph.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.09 Alternative Payment Methodology for an RHC, FQHC, or FQHCLA.

- (1) TennCare may offer to an RHC, FQHC, or FQHCLA, for which a final PPS rate exists, an alternative payment methodology. The RHC, FQHC, or FQHCLA, at the RHC, FQHC, or FQHCLA's election, may receive the alternative payment methodology rate if it notifies TennCare in writing that it elects to receive the alternate reimbursement.
- (2) Establishment of base years and periodic rebasing.
 - (a) If the RHC, FQHC, or FQHCLA elects to use the alternative payment methodology, 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 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 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 rule .06 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 rate unless the APM rate is equal to or higher than the Standard PPS Rate, as calculated according to this chapter. When an APM 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 chapter.
 - (f) The offer of the APM is valid for only the year in which the payment is offered. Entities that do not choose the APM 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.
- (3) If a facility elects to use the APM, it must use the APM for all rates, including the Core Reimbursement Rate and those rates outside of the Core Reimbursement Rate.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.10 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 chapter 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
 - (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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.11 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 rule apply to Non-Core Reimbursement Rates in the same way that they apply to Core Reimbursement Rates.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109 and 71-5-130.

1200-13-10-.12 Provider Appeals.

Information contained in a provider's cost and visit reports or supplemental filings required to be submitted to the Comptroller by this chapter is utilized by the Comptroller to determine reimbursement. Reimbursement rate determinations made by the Comptroller and implemented by the Bureau shall be appealable as set out in Chapter 1200-13-18. A provider may request review of Reimbursable Visit determinations pursuant to rule .05 paragraphs (1) and (3). A denial following review by TennCare shall be appealable pursuant to Chapter 1200-13-18.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, 71-5-118 and 71-5-130.

1200-13-10-.13 Implementation of this Chapter.

It is the intention of TennCare that this Chapter 1200-13-10 shall become effective the later of the date of effectiveness assigned by the Secretary of State or the date the corresponding State Plan Amendment is approved by CMS.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, 71-5-118 and 71-5-130.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Division of TennCare on 01/24/2019 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 09/26/18

Rulemaking Hearing(s) Conducted on: (add more dates). 11/27/18

Date: 1/24/19

Signature: [Handwritten Signature]

Name of Officer: John G. Roberts

Director, Division of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 1/24/19

Notary Public Signature: Vicki L. Johnson

My commission expires on: May 17, 2021

MY COMMISSION EXPIRES: MAY 17, 2021

Agency/Board/Commission: Division of TennCare

Rule Chapter Number(s): 1200-13-10

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]

Herbert H. Slatyer III
Attorney General and Reporter

1/25/2019

Date

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Filed with the Department of State on: 1/29/19

Effective on: 4/29/19

[Handwritten Signature]

Tre Hargett
Secretary of State