RULES
OF
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

CHAPTER 1200-13-22
SUPPLEMENTAL PAYMENT FOR RURAL HEALTH CLINICS, FEDERALLY QUALIFIED HEALTH CENTERS, AND FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKES

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1200-13-22-.01 DEFINITIONS.

(1) Administrative Costs. Expenses incurred in operating the clinic as a whole that are reasonable and 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 personnel 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 as described in this Chapter, are proper and necessary for the efficient delivery of RHC and FQHC services, and are incurred by a participating RHC or FQHC.

(3) Alternative Payment Methodology (APM). A Supplemental Payment Rate established under Rule .09 of this Chapter. Alternative Payment Methodology includes APM rates established for an RHC or FQHC under the TennCare State Plan methodology in place prior to the effective date of this Chapter.

(4) Base Year. The first full fiscal year for the facility following a facility's request to the Comptroller to have a Supplemental Payment Rate established under this Chapter. The data collected during the base year will provide the basis to determine the provider's final Supplemental Payment Rate.

(5) Covered Services. See definition in Rule 1200-13-13-.01.

(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. See 20 C.F.R. § 404.1007 and 26 C.F.R. § 31.3121(d)-1(c) for application of these common law rules.

(7) Federally Qualified Health Center (FQHC). An entity that meets the definition of 42 U.S.C.A. § 1396d(l)(2)(B) of the Social Security Act and has registered with TennCare as an FQHC. For purposes of this Chapter, this definition also includes Federally Qualified Health Center Look-Alikes.

(Rule 1200-13-22-.01, continued)

(8) Grand Division. See T.C.A. §§ 4-1-201–204.

(9) Interim Rate. A rate established for new facilities after registration with TennCare as an RHC or FQHC and prior to the establishment of a final Supplemental Payment Rate.

(10) Medicaid Cost Report. A cost report established by TennCare for use in the administration of the supplemental payment program contained in this Chapter. The Medicaid Cost Report template will be published on the TennCare website.

(11) Owner. A person, persons, or entities with an enforceable claim or title to the asset or property, and who or which is recognized as having such claim or title by law.

(12) Reimbursable Visit. A Visit (as defined in this Rule) that meets the requirements of Rule .05.

(13) Related Parties. A 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 or FQHC itself.

(14) Rural Health Clinic (RHC). An entity that meets the definition of 42 U.S.C.A. § 1396d(l)(1)(A) of the Social Security Act and has registered with TennCare as an RHC.

(15) Supplemental Payment Rate. Supplemental Payment Rate shall refer to any of the following:

(a) A payment rate established under Rule .04 of this Chapter;

(b) A cost-based payment rate based on one (1) year of cost data established for an existing RHC or FQHC prior to the effective date of this Chapter; or

(c) A payment rate established for an RHC based on the average rate of existing clinics in the same Grand Division with similar caseloads (“average caseload rate”) prior to the effective date of this Chapter.

A Supplemental Payment Rate may also refer to a separate service rate as outlined in Rule .11 of this Chapter.

(16) TennCare. The state governmental Medicaid agency administratively located within the Tennessee Department of Finance and Administration; TennCare includes references to the Division of TennCare, the Bureau of TennCare, and to all employees and subdivisions of the agency.

(17) Visit. A medically necessary (as defined in Rule 1200-13-16-.01) face-to-face medical, dental, or mental health encounter or a qualified preventive health encounter during which one or more qualified covered services are furnished between the patient and one of the following qualifying licensed providers:

(a) Physician;

(b) Nurse Practitioner (NP);

(c) Physician Assistant (PA);

(d) Certified Nurse Midwife (CNM);

(e) Clinical Psychologist (CP);

(Rule 1200-13-22-.01, continued)

(f) Clinical Social Worker (CSW);

(g) Licensed Professional Counselor (LPC);

(h) Certified Provider for Diabetes Self-Management Training/Medical Nutrition Therapy (DSMT/MNT);

(i) Dentist (DMD, DDS);

(j) Registered Dental Hygienist (RDH);

(k) Optometrist (OD);

(l) Pharmacist (PharmD);

(m) Licensed Marriage and Family Therapist (MFT); or

(n) Licensed Mental Health Counselor (MHC).

An encounter involving only a registered nurse or licensed practical nurse is not included in the definition of Visit and does not qualify for supplemental payment under this Chapter. The face-to-face component of this definition may be satisfied via a telehealth encounter as long as the encounter meets the requirements of Rule .05(9) of this Chapter. Qualifying licensed providers must be registered with TennCare for a Visit to be a Reimbursable Visit.

(18) 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) FTE – Full Time Equivalent

(f) HRSA – Health Resources and Services Administration

(g) MCC – Managed Care Contractor

(h) MEI – Medicare Economic Index

(i) PHS – Public Health Service

(j) RHC – Rural Health Clinic

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.02 SUPPLEMENTAL PAYMENT SYSTEM FOR RHCS AND FQHCS.

(1) TennCare establishes this Chapter for the management of the prospective payment system established under section 1902(bb) of the Social Security Act and the determination of the

(Rule 1200-13-22-.02, continued)

reimbursable per Visit cost for services provided to Medicaid recipients who receive services at an RHC or FQHC.

(2) Only a facility registered with TennCare as an RHC or FQHC may participate in and be reimbursed as a provider under this Chapter. In order to qualify for supplemental payments under this Chapter, facilities must submit to the Comptroller of the Treasury:

(a) Proof of its RHC or FQHC designation;

(b) Proof of its registration as a participating provider with TennCare as an RHC or FQHC;

(c) A request in writing that a Supplemental Payment Rate be established pursuant to Rule .04 of this Chapter.

RHCs and FQHCs participating in this program must at all times continue to meet state and federal requirements for qualification as an RHC or FQHC in order to receive supplemental payments.

(3) The specific items and services covered under the RHC or FQHC program shall be those defined and approved by TennCare. See Rules .01 and .05 of this Chapter. Medicaid services that are not RHC or FQHC services designated by TennCare may be provided and billed outside of the Supplemental Payment Rate or APM payment structure, provided the service is a covered service. TennCare shall reimburse a participating RHC or FQHC one hundred percent (100%) of its reasonable and Allowable Cost of providing services as defined in section 1902(a)(2) of the Social Security Act and included in the Tennessee State Plan as a Medicaid-covered service.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.03 MEDICAID COST REPORTING.

(1) New and existing RHCs and FQHCs shall annually submit a Medicaid Cost Report, a template of which will be available on the TennCare website, to the Comptroller within one hundred and fifty (150) days of the RHC's or FQHC's end of fiscal year. An FHQC with multiple locations shall submit a single consolidated Medicaid Cost Report regardless of the number of locations, provided that an FQHC may choose to submit a separate Medicaid Cost Report for the first fiscal year of a new location.

(2) A change in scope may be initiated by TennCare based on review of a facility's annual Medicaid Cost Report or other information available to the State. A TennCare-initiated change in scope may only be initiated by TennCare and will follow the process and be subject to the criteria outlined in Rule .07. Facilities must comply with requests for information from the Comptroller as part of a TennCare-initiated change in scope. TennCare will have one hundred and twenty (120) days from the date of submission of the Medicaid Cost Report to initiate a change in scope that is based on the information submitted in the cost report. Submission of an amended Medicaid Cost Report shall restart the timeframe for TennCare to initiate a change in scope under this Paragraph. Failure to participate in a change in scope initiated by TennCare will result in a suspension of payments under this Chapter until the change in scope can be processed.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.04 SUPPLEMENTAL PAYMENT ESTABLISHMENT FOR A NEW RHC OR FQHC.

(1) New RHCs or FQHCs are those facilities which meet the definition for the provider type in Rule .01 and meet the requirements of Rule .02(2) after the effective date of this Chapter. New facilities must make a request to the Comptroller to establish a Supplemental Payment Rate.

(2) Once a request to establish a Supplemental Payment Rate is received by the Comptroller, new facilities shall be reimbursed using an Interim Rate based on the rate of a similar entity (other FQHCs for an FQHC, or other RHCs for an RHC) with a similar caseload, if applicable, in the same Grand Division, or in the entire state if there are not enough similar entities in the same Grand Division. The Interim Rate shall be established by the Comptroller and shall be effective the first day of the calendar quarter following the request to establish a rate.

(3) To establish a final Supplemental Payment Rate, an RHC or FQHC must submit to the Comptroller a Medicaid Cost Report that contains twelve (12) full months of cost data for the designated base year.

(4) Upon receipt of a Medicaid Cost Report submitted by an RHC or FQHC to the Comptroller as required by Rule .03:

(a) The Comptroller shall review the Medicaid Cost Report.

(b) The Comptroller shall notify the RHC or FQHC if additional documentation is necessary.

(c) If additional documentation is necessary to establish a final Supplemental Payment Rate, the RHC or FQHC shall:

1. Provide the additional documentation to the Comptroller within sixty (60) days of the notification of need for additional documentation; or

2. Request an extension beyond sixty (60) days to provide the additional documentation. Extensions shall be granted at the discretion of the Comptroller. An extension shall not exceed thirty (30) additional days.

(d) If the Comptroller requests additional documentation from the RHC or FQHC but does not receive additional documentation or an extension request within thirty (30) days, TennCare shall cease supplemental payments under an Interim Rate until:

1. The additional documentation has been received by the Comptroller; and

2. The Comptroller has established a final Supplemental Payment Rate or APM rate.

(e) If an RHC or FQHC fails to provide a Medicaid Cost Report containing a full year of cost data for the base year within one hundred and fifty (150) days of the end of the facility's most recent fiscal year, TennCare shall cease supplemental payments under an Interim Rate until:

1. The RHC or FQHC submits Medicaid Cost Report to the Comptroller;

2. The RHC or FQHC has submitted any additional documentation required by the Comptroller; and

3. The Comptroller has established a final Supplemental Payment Rate or APM rate.

(Rule 1200-13-22-.04, continued)

(f) The Comptroller may review an RHC's or FQHC's paid claims listing for the period of time corresponding to the submitted Medicaid Cost Report.

(g) When an RHC or FQHC has submitted all necessary information to the Comptroller, within one hundred twenty (120) days, the Comptroller shall:

1. Establish a final Supplemental Payment Rate or APM rate for the RHC or FQHC; and

2. Notify the RHC or FQHC in writing of the RHC's or FQHC's final Supplemental Payment Rate and effective date of the final Supplemental Payment Rate or APM rate. The implementation date of the final Supplemental Payment Rate or APM rate shall the first day of the calendar quarter after the final rate is set by the Comptroller. The final Supplemental Payment Rate shall then be retroactive to the effective date of the interim for the purpose of reconciling payments made under the Interim Rate with the final Supplemental Payment Rate.

(h) Upon setting the final Supplemental Payment Rate, TennCare shall reconcile all supplemental payments made under the Interim Rate to the final Supplemental Payment Rate, adjusting payments upward or downward as necessary. In the event that supplemental payments under the Interim Rate ceased due to noncompliance with this Rule, reconciliation will occur only for the months the Interim Rate was in effect. In any instance where payments under the Interim Rate ceased due to noncompliance with this Rule, no supplemental payments will be made for the months in which the Interim Rate was not in effect, and supplemental payments will resume only as of the effective date of the final Supplemental Payment Rate.

(i) A new RHC or FQHC may appeal the final Supplemental Payment Rate within thirty-five (35) days of the date of the notice setting the final Supplemental Payment Rate. Appeals must be in accordance with Chapter 1200-13-18. Interim Rate determinations are not appealable.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.05 DETERMINATION OF A REIMBURSABLE VISIT.

(1) Supplemental Payment Process.

(a) When calculating a facility's supplemental payment, TennCare or its designee will multiply the number of Reimbursable Visits for the applicable time period, as determined in this Rule, times the established Supplemental Payment Rate or APM rate for that facility to calculate the total that should be received for services rendered. From that total, TennCare or its designee will subtract any reimbursement received for those services from TennCare MCCs and third-party payors less any special program payment provisions offered by TennCare as outlined in Paragraph (11) of this Rule, to calculate the supplemental payment amount.

(b) Each supplemental payment will be calculated by the Comptroller using paid claims data received from TennCare. Facilities must use the billing instructions provided by TennCare in the FQHC/RHC Supplemental Payment Manual, including the appropriate encounter code and procedure codes as outlined in Rule .05(2), to ensure the calculated supplemental payment is accurate.

(Rule 1200-13-22-.05, continued)

(c) An RHC or FQHC may self-report claims for Visits the facility believes were not included in the calculated payment to the Comptroller. Supplemental payment determinations for these Visits shall be made by TennCare or its designee. Self-reporting of Visits must adhere to the instructions for Visit reports provided in the FQHC/RHC Supplemental Payment Manual.

(d) Facilities must self-report all Visits associated with pregnancy and maternity services and provide documentation requested by the Comptroller's office in order to receive supplemental payment for these Visits. Facilities must report these Visits, if applicable, no more frequently than monthly and no less frequently than once per quarter. Self-reporting of Visits must adhere to the instructions for Visit reports provided in the FQHC/RHC Supplemental Payment Manual.

(2) All claims associated with Reimbursable Visits must be submitted to a TennCare managed care contractor (MCC) for payment. RHCs or FQHCs shall only be reimbursed under this Chapter for Visits paid by a TennCare managed care contractor (MCC). This applies to both the Supplemental Payment Rate and the APM rate. For claims that are denied by an MCC, facilities may self-report these claims to the Comptroller in writing for consideration as a Reimbursable Visit. Supplemental payment determinations for Visits based on claims denied by an MCC shall be made by TennCare or its designee. Self-reported claims submitted for reconsideration may not include claims denied for the following reasons: denial solely due to the RHC or FQHC's failure to timely file; denial on the basis of medical necessity; or denial on the basis that the service was excluded under TennCare rules. Reconsideration determinations are not appealable; however, facilities may request review of MCC claims denials under the independent review process established by T.C.A. § 56-32-126(b)(2).

(3) TennCare shall adopt or amend a list of procedure codes that will be published on the TennCare website.

(a) The list of procedure codes will be presumed Reimbursable Visits for both the supplemental payment and APM methodologies and may be periodically updated with additions, deletions, or modifications.

(b) Inclusion of a procedure code on the list does not guarantee payment if its inclusion conflicts with federal or state law, including the rules promulgated under this Chapter.

(c) TennCare will post any amendments to the list of procedure codes on its website on a quarterly basis. When amendments to the procedure codes list become effective, any changes in payments to providers will become effective on the first day of the month the amended list of CPT codes is published.

(4) If an encounter between an RHC or FQHC provider and a TennCare enrollee involves a procedure code that is not on the TennCare procedure code list, the RHC or FQHC may request addition of the procedure code to the TennCare procedure code list. Requests for inclusion of a procedure code not on the TennCare codes list shall be made in writing to the Comptroller, and the decision regarding inclusion will be at the discretion of TennCare. Determinations regarding the procedure code list are not appealable.

(5) The following shall not be considered a Reimbursable Visit under this Chapter under either a Supplemental Payment Rate or APM rate:

(a) An encounter for the sole purpose of medication therapy management, whether provided by a pharmacist or other provider.

(Rule 1200-13-22-.05, continued)

(b) Encounters for enrollees dually enrolled in both Medicaid and Medicare Part B (or any Medicare-approved plan which includes Medicare Part B, such as Medicare Advantage); however, dental Visits provided to dual enrollees with no dental coverage through either Medicare Part B or a Medicare Advantage Plan are Reimbursable Visits.

(c) Group services. Group services does not include family therapy Visits.

(d) Screening encounters or services unless:

1. The screening meets all other criteria under this Chapter to be considered a Reimbursable Visit; and

2. The claim includes an allowable procedure code as enumerated in the list of procedure codes published by TennCare pursuant to this Chapter.

(e) Visits for the sole purpose of administering a vaccine. Vaccine administration revenue is excluded under Paragraph (11)(c) of this Rule.

(6) TennCare may exclude Visits and/or revenue from the supplemental payment calculation for certain services where the fixed costs exceed the Supplemental Payment Rate or APM received by facilities. Specific exclusions include but are not limited to:

(a) Revenue received for Long-Acting Reversible Contraception (LARC) devices. Visits associated with the insertion or removal of LARC devices will qualify for supplemental payment provided all other applicable criteria for a Reimbursable Visit are met.

(b) Revenue received for dentures, including partial dentures. Visits associated with the provision of dentures, including partial dentures, will qualify for supplemental payment provided all other applicable criteria for a Reimbursable Visit are met.

(7) Encounters with more than one healthcare provider and/or multiple encounters with the same healthcare provider that take place on the same day will constitute a single Reimbursable Visit. Facilities may bill for more than one Reimbursable Visit on the same day under either a Supplemental Payment Rate or APM rate in the following circumstances:

(a) If an encounter includes a combination of a medical Visit and/or a behavioral health Visit and/or dental Visit, the RHC or FQHC may request supplemental payment for each Visit category.

(b) An RHC or FQHC may request supplemental payment for more than one Reimbursable Visit on the same day when the enrollee, subsequent to the first Visit, suffers an illness or injury subsequent to the initial Visit that requires additional diagnosis or treatment on the same day.

(c) An RHC or FQHC shall not request supplemental payment for multiple procedure codes that comprised one (1) Visit as multiple Visits except when a minor child receives both a well-child Visit and a sick Visit at the same time. In such cases, each Visit may constitute a separate Visit for a maximum of two (2) Reimbursable Visits.

(8) Visit Setting.

(a) Visits must occur in an outpatient setting to be reimbursable under this Chapter. Outpatient settings eligible for supplemental payment are the RHC or FQHC itself, the enrollee’s residence, school, or residential facility.

(b) Consistent with 42 C.F.R. 405.2411(b)(4) and related guidance from the CMS, RHC and FQHC Visits cannot take place at an inpatient or outpatient hospital department, including a critical access hospital. Visits and revenue related for hospital Visits, including labor delivery Visits, are excluded from the supplement payment settlement.

(9) Telehealth Visits. Visits performed via telehealth are considered face-to-face Visits eligible for supplemental payment provided the following criteria are met:

(a) The Visit meets all other necessary criteria to be considered a Reimbursable Visit under this Chapter, including having an associated paid claim by the MCC as outlined in Paragraph (1) of this Rule; and

(b) The Visit meets the definition of "provider-based telemedicine" as defined in T.C.A. § 56-7-1003(a)(6)(A). Encounters in which the RHC or FQHC serves solely as the originating site are not considered Reimbursable Visits under this Chapter.

(10) For any Visits submitted by an RHC or FQHC outside of the supplemental payment methodology in Rule .05, the RHC or FQHC may submit Visit reports—or amend an already submitted Visit report—within twelve (12) months of the date of service. Facilities must submit a request to amend to the Comptroller and receive written approval to submit an amendment to a previously submitted Visit report. Self-reporting for Visits must adhere to the instructions for Visit reports provided in the FQHC/RHC Supplemental Payment Manual.

(11) The following rules apply to the revenue types that are included in the claims-based reimbursement already paid to the facility by the MCCs:

(a) All payments for ancillary services, screening services, and other services included in the federal definitions of FQHC and RHC services at 42 § U.S.C.A. 1396d(l) must be included in the determination of the settlement amount.

(b) All payments made on behalf of the TennCare member unless otherwise excluded under these rules. This includes MCC payments, including any capitated or other payment arrangement the facility may have with the MCC, and any third-party liability or patient liability payments.

(c) Vaccine administration revenue is excluded from the supplemental payment settlement.

(d) The following payments are not intended as part of the supplemental payment program under this Chapter and must not be included as part of received revenue for purposes of the supplemental payment calculation:

1. Patient-centered medical home (PCMH) program payments, including the activity payments, practice transformation payments, and outcome payments.

2. Tennessee Health Link program payments, including activity payments and outcome payments.

3. Other payment types received as a result of payment reform or value-based initiatives that may be implemented by TennCare, structured either as per member per month case rates or as outcome payments based on established performance criteria.

(Rule 1200-13-22-.05, continued)
Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.06 DETERMINATION OF REASONABLE COSTS.

(1) Only reasonable costs will be reimbursed under this Chapter. Reasonable cost determinations shall be made by TennCare or its designee in accordance with this Chapter and applicable Medicare cost principles established in 42 C.F.R. Part 413 and 45 C.F.R. Part 75, Subpart E. Cost principles in Part 413 will control in instances where Part 413 and Part 75 conflict.

(2) The following specific criteria will be considered in determining reasonable costs:

(a) Fees paid by an RHC or FQHC 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. Fees paid to billing vendors compensated on a fixed percentage basis known at the time of cost reporting are considered reasonable costs.

(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. In circumstances where Internal Revenue Service policies do not allow for these forms of documentation, other documentation of earnings will be accepted.

(c) Salaried or contracted costs shall be accompanied by an FTE calculation. Facilities must annualize the FTE calculation based on hours work estimating a 2,080 hours per year as a full-time equivalency.

(d) If applicable, Owner’s compensation and compensation to any Related Parties claiming administrative salary or wages from the RHC or FQHC 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, contractor, or Owner whose job functions include responsibilities other than direct patient care, the RHC or FQHC will be required to report, if applicable, the total number of hours the Employee, contractor, or Owner spent performing functions that were not direct patient care.

(3) For supplemental payment purposes, a reasonable allowance or compensation for services of an Owner shall be subject to the following specific criteria:

(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 or contract with 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 or its designee shall be responsible for determining which services are related to patient care and pertinent to the operation and sound management of the facility.

(b) Total compensation to Owners must be listed on the Medicaid 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.

(Rule 1200-13-22-.06, continued)

(c) TennCare or its designee will review these amounts and compare them with the allowable compensation ranges established by the Bureau of Labor Statistics for Medical and Health Services Managers and make necessary adjustments. TennCare or its designee 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 per facility, 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) Costs submitted by an RHC or FQHC for a final Supplemental Payment Rate determination or change in scope request that are not otherwise specifically addressed in this Rule will be reviewed by TennCare or its designee in accordance with Rule .06(1).

(5) This Rule applies to cost determinations made under Rules .05, .07, and .09 of this Chapter.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.07 CHANGE IN SCOPE AND FINAL SUPPLEMENTAL PAYMENT RATE OR APM RATE ADJUSTMENT.

(1) Change in Scope Overview.

(a) An RHC may only request a rate adjustment based on a change in scope once per the facility's fiscal year. An FQHC may only request a rate adjustment based on a change in scope once per the facility's fiscal year for the FQHC's Tax Identification Number (TIN). In the case of a denial of a request of a change in scope, an RHC or FQHC must wait six (6) months from the date of the written denial to request a new change in scope.

(b) If an RHC or FQHC changes its scope of services after the base year rate is established, the Comptroller shall adjust its final Supplemental Payment Rate if the change in scope qualifies for an adjustment under this Rule, upon review and approval of the change in scope. Only the actual costs specifically attributable to the requested change in scope of services will be considered. Costs upon which the existing facility rate has already been set cannot be reassessed through the change in scope process.

(c) An adjustment to a final Supplemental Payment Rate resulting from a change in scope that occurred after a facility's base year rate is established shall be effective from the beginning of the quarter that the change in scope request was submitted subject to the provisions of this Rule.

(d) A change in scope may be initiated by TennCare based on information available to the State. A TennCare-initiated change in scope may only be initiated by TennCare and will follow the process outlined in this Rule, and facilities must comply with requests for information from the Comptroller as part of the TennCare-initiated change in scope. Failure to participate in a change in scope initiated by TennCare will result in a suspension of payments under this Chapter until the change in scope can be processed.

(e) An RHC whose Supplemental Payment Rate is set as an average caseload rate is not subject to the TennCare-initiated change in scope process; however, an RHC may submit a request for a change in its scope of services. Such requests will be subject to the following requirements in addition to the requirements under this Rule:

(Rule 1200-13-22-.07, continued)

1. Before the Comptroller can establish a change in scope, the RHC must submit annual cost reports for the most recent two full fiscal years prior to the request so that the Comptroller can establish a cost-based payment rate.

2. Once the Comptroller determines the cost-based payment rate and then the associated incremental rate change resulting from the requested change in scope of services, the RHC may choose to either:

   (i) Move to the cost-based supplemental payment rate inclusive of the change in scope of services; or

   (ii) Continue to receive the average rate without a change in the scope of services.

3. If an RHC elects to move to a cost-based payment rate, then the RHC will be subject to the TennCare-initiated change in scope process set forth in Rule 1200-13-22-.03(2) and Rule 1200-13-22-.07(1)(d) going forward.

(2) A change in scope of service means a change in the type, intensity, duration, and/or amount of services:

(a) Type. The RHC or FQHC has added or discontinued any service that:

1. Meets the definition of an FQHC or RHC service as provided in section 1905(a)(2)(B) and (C); and

2. Is included as a covered Medicaid service under the Medicaid state plan or TennCare's 1115 Demonstration Waiver.

(b) Intensity, duration, and/or amount means a material change to the services provided in an average Visit. This includes a material change in the staff providing an existing service.

(c) A statutory or regulatory change that materially impacts the costs or Visits of an RHC or FQHC and otherwise meets the requirements of this Rule.

(3) The following items individually shall not constitute a change in scope without an associated change in costs that otherwise meets the requirements of this Rule:

(a) A general increase or decrease in the costs of existing services;

(b) A reduction or an expansion of hours of operation without a change in the duration or amount of services;

(c) A wage increase;

(d) A renovation or other capital expenditure;

(e) A change in ownership;

(f) An addition of a service provided by a non-licensed/certified professional or specialist; or

(g) An increase or decrease in the total number of facility Visits.

(Rule 1200-13-22-.07, continued)

(4) A requested change in scope shall meet the following requirements:

(a) The change in scope of services must increase or decrease the existing final Supplemental Payment Rate or APM rate by at least five percent (5%). To determine if the 5% threshold is met, the portion of the provider's cost-per-visit specifically attributable to the change in scope will be divided by the Supplemental Payment Rate in effect at the time the change in scope was submitted for approval.

(b) The change in scope of services must remain in effect for at least twelve (12) months in order to receive a final Supplemental Payment Rate and permanent change in scope rate adjustment.

(c) The change in scope of services must have been fully implemented for at least a full calendar quarter prior to submission of a change in scope request. Requests for a change in scope of services cannot be submitted prior to the first day of the calendar quarter after reaching at least ninety (90) days of implementation.

(d) To submit a request for a change in scope, an RHC or FQHC must provide notice to the Comptroller of its intent to submit a request for a change in scope and shall submit the following documents with the notice:

1. A written request describing in detail the change in scope, including the service(s) subject to change, the location(s) offering the service, the date the change in service was made, and a brief narrative of how the service change will benefit the patient population, if applicable;

2. A provisional Medicaid Cost Report or other TennCare designated change in scope report for the affected time period; and

3. Relevant documentation to support the request.

(5) The costs related to a change in the scope of services must be reasonable. Determinations of reasonable costs are determined by TennCare or its designee in accordance with the rules contained in this Chapter and the cost criteria identified in Rule .06 of this Chapter. Consistent with Rule .06, it is within the discretion of TennCare to determine what reasonable costs may be included in requests for changes in scope.

(6) TennCare or its designee shall use the most recent Visit counts for calculation of changes in scope except in cases of the discontinuation of a service. For discontinuation of a service, TennCare or its designee shall use the initial count of Visits on the first cost report which included the service. In addition, for a discontinuation of a service, TennCare or its designee shall use the cost attributable to the service at the time the service was originally added to the reimbursement rate, provided that those costs shall be trended forward with MEI, if applicable.

(7) Upon receipt of a valid request to change the scope of services:

(a) The Comptroller shall review the submitted documentation.

(b) The Comptroller shall notify the RHC or FQHC in writing of the:

1. Approval or denial of the request for change in scope within ninety (90) days from the date the Comptroller received all information necessary to make a determination; or

2. Need for additional documentation from the RHC or FQHC to establish a final Supplemental Payment Rate or APM rate associated with the change in scope.

(c) The Comptroller may request additional information needed to process the request including but not limited to 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, documentation regarding usage of contractors, and adjustments. If the Comptroller requests additional documentation to calculate the final Supplemental Payment Rate or APM rate for a change in scope, the RHC or FQHC shall:

1. Provide the additional documentation to the Comptroller within sixty (60) days of the request for additional documentation; or

2. Request an extension beyond sixty (60) days to provide the additional documentation. An extension shall not exceed an additional thirty (30) days. Extensions shall be at the discretion of the Comptroller.

(8) Failure by an RHC or FQHC to comply with the timelines in this Rule may result in the change in scope being denied.

(9) If the Comptroller approves the request for a change in scope after receiving all of the necessary documentation from an RHC or FQHC within the timelines established in this Rule, the RHC or FQHC shall begin receiving an Interim Rate for any newly approved service associated with the change in scope until a final Supplemental Payment Rate can be set. The effective date of the Interim Rate shall be the first day of the calendar quarter in which the change of scope was submitted.

(10) The Comptroller shall set the final Supplemental Payment Rate for an approved change in scope only after submission of a full fiscal year of actual cost data for the change in scope by the RHC or FQHC. The effective date of the final Supplemental Payment Rate for the approved change in scope shall be the first day of the first calendar quarter following approval of the final Supplemental Payment Rate. The final Supplemental Payment Rate shall then be retroactive to the effective date of the interim for the purpose of reconciling payments made under the Interim Rate with the final Supplemental Payment Rate.

(11) If an RHC or FQHC fails to provide a full year of cost data for the requested change in scope within 90 (ninety) days of twelve (12) months from the date of implementation of the change in scope, TennCare shall cease supplemental payments attributable to the change in scope under the Interim Rate until the final Supplemental Payment Rate is established. In any instance where payment under the Interim Rate ceased due to noncompliance with this Rule, no supplemental payments will be made for the months in which the Interim Rate was not in effect and supplemental payments will resume only as of the effective date of the final Supplemental Payment Rate. Facilities shall not be entitled to any reconciliation settlements for the time period the supplemental payments under the Interim Rate ceased.

(12) An RHC or FQHC may appeal the denial of a request for a change in scope or a final Supplemental Payment Rate adjustment due to a change in the scope of services. Appeals must be filed within thirty-five (35) days of the date of the notice denying the request or the date of the notice setting the final Supplemental Payment Rate resulting from a change in scope. Appeals must be in accordance with Chapter 1200-13-18. Interim rate determinations made while a change in scope is being processed are not appealable.

(Rule 1200-13-22-.07, continued)
Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.08 SUPPLEMENTAL PAYMENT FOR AN EXISTING RHC OR FQHC.

(1) Existing RHCs or FQHCs are those providers which met the definition for the provider type in Rule .01 and received supplemental payments under a Supplemental Payment Rate or APM rate prior to the effective date of this Chapter.

(2) The Comptroller shall adjust a final Supplemental Payment Rate or APM rate of an existing clinic as follows:

(a) For RHCs, by the percentage increase in the MEI applicable to RHC services on July 1 of each year;

(b) For FQHCs, by the market basket measure for FQHC services; or

(c) For RHCs and FQHCs, pursuant to a change in scope as outlined in Rule .07.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.09 ALTERNATIVE PAYMENT METHODOLOGY FOR AN RHC OR FQHC.

(1) TennCare may offer to an RHC or FQHC, for which a final Supplemental Payment Rate exists, an alternative payment methodology. The RHC or FQHC, at its election, may receive the APM rate if it notifies TennCare in writing that it elects to receive the APM as its Supplemental Payment Rate.

(2) Establishment of base years and periodic updating.

(a) If the RHC or FQHC elects to use the alternative payment methodology, it will undergo establishment of a new rate based on the average of the two (2) most recent fiscal years of cost data for the facility. The Comptroller shall collect and review Medicaid Cost Report data from the previous two (2) fiscal years for the facility. If the RHC or FQHC has been in existence for fewer than two (2) years, then the facility will remain on the existing Supplemental Payment Rate until there is sufficient data to set the APM rate. Once the data is collected, the Comptroller will use this data to compute the APM rate.

(b) Following that reconciliation year, the APM rate for an RHC or FQHC shall be adjusted by the market basket measure applicable to RHC or FQHC services on July 1 of each year.

(c) The APM rate is subject to the requirements of Rule .06 of this Chapter.

(d) APM rates may be updated by TennCare and the Comptroller no more frequently than one (1) time every five (5) years by using the two (2) most recent fiscal years of Medicaid Cost Report data.

(e) The Comptroller may not offer, and an RHC or FQHC may not collect, the APM rate unless the total payments under the APM are equal to or higher than the total payments under the facility's existing Supplemental Payment Rate as calculated according to this Chapter.

(Rule 1200-13-22-.09, continued)

(f) The effective date of APM rate will be the first date of the calendar quarter after the date RHC or FQHC elects in writing to the Comptroller to receive the APM rate.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.10 AUDITING OF PROVIDER-REPORTED DATA.

(1) The cost reports and any Visit reports filed under this Chapter by an RHC or FQHC, 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 facility 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. Failure to comply with an audit of the Comptroller may result in the suspension of supplemental payments under this Chapter.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*

1200-13-22-.11 SUPPLEMENTAL PAYMENT RATES FOR SEPARATE SERVICES.

(1) RHCs or FQHCs are permitted to establish a separate Supplemental Payment Rate for dental services. Requests to establish a separate dental rate must be submitted to the Comptroller. The requirements of this Chapter apply to dental service rates in the same manner as to the RHC's or FQHC's Supplemental Payment Rate or APM rate.

(2) As of the effective date of this Chapter, TennCare will no longer offer separate Supplemental Payment Rates for optometry or pharmacy services. Clinics with separate service rates for optometry or pharmacy services established prior to the effective date of this Chapter may elect to continue to receive a separate Supplemental Payment Rate for either service.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-107, 71-5-109, and 71-5-130.* ***Administrative History:*** *New rules filed March 6, 2025; effective June 4, 2025.*