Change in Scope of Services for New Dental, Pharmacy, and Optometry Services

Scope of Services Changes

1. The process outlined in this document should be completed when an FQHC/RHC wishes to add or delete a service that has a PPS rate separate from that of the medical/core rate. These services include dental, pharmacy, and optometry. This change qualifies as a change in the type of services offered. A change in type is defined as:

    a. **Type:** the addition or deletion of a Medicaid-covered ambulatory service.

2. If an FQHC/RHC wishes to change the scope of services offered in terms of intensity, duration, or amount in dental, pharmacy, or optometry, the FQHC/RHC should complete the Change in Scope Process.

3. FQHCs/RHCs may request to add dental, pharmacy, or optometry for changes incurred in the previous two State fiscal years.

4. To request a change in scope for the addition or deletion of dental, pharmacy, or optometry:

    a. Addition of a Service: FQHCs/RHCs will notify the state in writing, including a detailed description and documentation of the service change. The description should include the service the FQHC/RHC is adding, the location(s), the date the FQHC/RHC began providing the service, and a brief description of how the new service will benefit the patient population. FQHCs/RHCs will also submit a cost report showing a budgeted costs for provision of the service and number of visits provided. The State will utilize the cost report to set an interim PPS rate for the new service.

    b. The State will review the submitted documentation and notify the FQHC/RHC within 90 days whether the proposed change meets criteria for a change in scope.

    c. Upon approval by the State, the FQHC/RHC will begin receiving an interim PPS rate for the service until the cost of the change in scope can be determined as described in Sections (4) and (5). FQHCs/RHCs will receive PPS payments for the service retroactively back to the first day of the quarter in which a change in scope was requested.

    d. Deletion of a Service: FQHCs/RHCs will notify the State that they have discontinued a given service and will cease including the visits on invoices on the date the service was discontinued.

Reconciliation of Interim PPS rate and Actual PPS Rate

5. FQHCs/RHCs will submit Medicare cost reports, corresponding trial balances and depreciation schedules, cost report submission checklist, schedule listing allocations,

documentation for reclassification, adjustments, and protested items and provider questionnaires for the most recent two full years to determine an average cost per visit cost. Total costs are divided by total visits for the two cost report periods. The State will evaluate the Medicare cost reports and cost centers and visits excluded by Medicare, but covered by Medicaid, will be restored along with applicable overhead costs. The State shall calculate the cost per visit based on the reasonable cost of providing Medicaid covered, ambulatory services. This will determine their prospective payment system (PPS) rate.

a. The State will implement the new rate at the beginning of the next quarter and the interim PPS rate and the new PPS rate will be reconciled back to the first day of the quarter in which the change in scope was requested.

b. An FQHC/RHC may appeal a denial of a request for a change in scope or a rate adjustment due to a change in the scope of services or may appeal the failure of the State to act on a rate adjustment request within 90 days using the process described in Tennessee Rules and Regulations § 120013-18.01, et seq.

6. Opportunity for a Change in Scope to Account for Changes Made in Past Years

Each FQHC/RHC shall have the option during State fiscal year 2017 (July 1, 2016 – June 30, 2017) to submit a change in scope request for changes made in previous years. This will allow FQHCs/RHCs to establish accurate scopes and PPS rates as a baseline for use in determining subsequent change in scope requests as described above. An FQHC/RHC will not be required to apply for a change in scope under this provision.

This option is for changes for which the health center has two full years of cost reports. If a health center does not yet have two full years of cost reports they should utilize the process outlined in Sections 1 – 5 above.

FQHCs/RHCs will notify the state in writing, including a detailed description and documentation of the service change. For the addition of a service: the description should include the service the FQHC/RHC is adding, the location(s), the date the FQHC/RHC began providing the service, and a brief description of how the new service benefits the patient population. For a change in intensity, duration, or amount: the description should include the service change, the location(s), a description of how the average visit has changed from when the FQHC/RHC's rate was set, along with relevant supporting documentation, and how the change has benefitted the patient population. FQHCs/RHCs will submit Medicare cost reports, trial balances, depreciation schedules, cost report submission checklist, schedule listing allocations, documentation for reclassification, adjustments, and protested items, and provider questionnaires for the most recent two full years to determine an average cost per visit cost. The supporting documentation listed above will be utilized to verify the information reported on the cost report. Total costs are divided by total visits for the two cost report periods. The State will evaluate the Medicare cost reports and cost centers and visits excluded by Medicare, but covered by Medicaid, will be

restored along with applicable overhead costs. The State shall calculate the cost per visit based on the reasonable cost of providing Medicaid covered, ambulatory services. This will determine their prospective payment system (PPS) rate.

Due to the large number of potential requests for this one time rate adjustment, the State will notify the FQHC/RHC within 120 days of receiving all of the necessary documentation whether a dental, pharmacy, or optometry rate will be implemented. The State will begin paying the FQHC/RHC the dental, pharmacy, or optometry rate at the beginning of the next quarter and will reconciled payments back first day of the quarter in which the change in scope was requested.