Tennessee FQHC/RHC Change in Scope Policy

Scope of Services Changes

1. A change in the scope of services is defined as a change in the type, intensity, duration, or amount of services. Examples of such changes, which can take place at a given point in time or cumulatively, are the following:

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

    b. **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 rate was last set. Examples include changes caused by new statutory or regulatory requirements or the introduction or expansion of specialty care;

    c. **Duration:** a change in the average length of time it takes FQHC providers to complete an average patient visit due to changing circumstances such as the introduction of 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. **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 FQHC's patients.

2. FQHCs/RHCs may request a change in scope once per State fiscal year for each PPS rate for changes incurred in the previous two State fiscal years.

3. To request a change in scope of a service as described in Section 1.

    a. 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 will benefit 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.

    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 the current 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 date of change in scope application.

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. The cost of the change in scope will be determined as described in Sections (4) and (5).

PPS Rate Adjustments

4. The FQHC/RHC's per-encounter PPS rate will be adjusted to account for increases or decreases in the scope of services subject to the following:

    a. The rate adjustment is attributable to an increase or decrease in the scope of the services as defined in Section 1.

    b. To be considered, any costs supporting the rate adjustment must be allowable under the Medicare reasonable cost principles set forth in 42 C.F.R. § 413.

    c. A change in costs alone without a qualifying change in the scope of services as defined in Section 1 does not qualify for a rate adjustment.

5. To qualify for a PPS rate change, changes in the scope of services must result in at least a 5% increase or decrease in the allowable per-encounter over a two year period as outlined in Section (5) (a). The percentage will be calculated by comparing the FQHC/RHC's PPS rate at the time the change in scope was approved by the State with the cost per visit as calculated as outlined below.

    a. 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.

    b. The State will review the submitted documentation, along with MCO claims data to understand the quantity and breadth of services, and will notify the FQHC/RHC

within 90 days of receiving all of the necessary documentation whether a PPS rate change will be implemented.

c. If implemented, the PPS rate change will reflect the cost difference of the scope of service. 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.

c. 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 the 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 PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service. 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 first day of the quarter in which the change in scope was requested.