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

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (RHC).

Payment for covered services provided by RHCs shall be in accordance with the methods of payment below:

___X___ The payment methodology for RHCs will conform to section 702 of the Benefit Improvement and Protection Act (BIPA) 2000 legislation.

___X___ The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

___X___ The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

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

The State is using the cost reports filed with Medicare for FY 1999 and FY 2000. For the period January 1, 2001 to September 30, 2001, RHCs will be paid their average 1999 and 2000 costs, adjusted for any change in scope of services. The RHCs have a variety of fiscal year ends. The clinics already have Medicare cost reports so, as a practical matter, the State will use those reports. With respect to the fiscal year ends, for the 1999 year, the State will use the clinic year end that has the most months in calendar year 1999 and the 2000 year end with the most months in calendar year 2000. For a clinic with a March 31 fiscal year end, the State will use their FYE March 31, 2000 cost report for 1999 (because most of the months fall in 1999), and the State will use their FYE March 31, 2001 cost report for 2000. These are the two years used to compute the average cost for the first part of BIPA and also for computing the prospective rate for the second part.

The State is using the average cost per visit for 1999 and 2000 to compute the prospective payment system (PPS) rate. Total costs are divided by total visits for each year and then averaged to determine the rate. The PPS rate, effective October 1, 2001 will be indexed for a nine-month period to July 1, 2002 which will place the rates on the state's fiscal year. From that point on, the Medicare Economic Index (MEI) will be applied annually so that the PPS remains on the state's fiscal year.

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The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics first inform the State that they have a change and provide the actual costs, visits, and (if applicable) square footage allocated to the new services. The change in cost will then be factored into an adjusted PPS rate.

The State is requiring the clinics to submit cost reports on a continuing basis even though costs will not factor into the PPS in subsequent years. Having the cost reports will aid the State auditing effort and will alert the State to any reductions in scope of services that may not have been reported. The clinics need only incur a small postage charge to meet this requirement, the State is only asking for a copy of their as filed Medicare report.

For clinics that began operations during the 1999 and 2000 period, the State is using the past year cost report filed with Medicare. The State believes that even though one period is a short year, it will not impact the average cost per visit.

For new clinics that qualify after 2000, the State will use the average PPS rate for neighboring clinics with similar caseloads. If there are no such similar clinics, the State will use the average PPS rate for all clinics on an interim basis until the clinic can provide some projected costs upon which the State can base the clinic's projected PPS rate. After the clinic submits its cost report, the State will compare projected costs and visits with the actual data, and the State will adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA required PPS amount. In the event that a clinic does not provide the necessary visits and MCO payments timely, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter are received.

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Alternative payment methodology:

The RHCs have a variety of fiscal year ends. The State is using the two most recent Medicare cost reports on file as of September 30, 2005, to determine an average cost per visit to determine the prospective payment system (PPS) rate. As examples, for a center with a March 31 fiscal year end, the State will use its FYE March 31, 2005 and FYE March 31, 2004 cost reports; for a center with a September 30 fiscal year end, the State will use its FYE September 30, 2004, and September 30, 2003 cost reports.

Total costs are divided by total visits for each of the two cost report periods and then averaged to determine the PPS rate, adjusted for any change in scope of services, to be paid to the RHCs for the period January 1, through September 30, 2006. The facility-specific PPS rates will be indexed, using the Medicare Economic Index (MEI) for a nine-month period effective for dates of service on and after October 1, 2006. The rates will again be indexed for a nine-month period to be effective for dates of service on and after July 1, 2007. Thereafter, the (MEI) will be applied annually so that the PPS coincides with the State's fiscal year end of June 30.

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

* The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics would first inform the State that they have had a change in their scope of services and then would provide the actual costs, visits, and square footage statistics, as applicable, allocated to the new services. The change in costs will be factored into an adjusted PPS rate.

The State is requiring the clinics to submit copies of the as-filed Medicare cost reports annually, though costs will not factor into the PPS in subsequent years. The cost reports will aid the auditing effort by alerting the State to any reductions in scope of services that may not have been reported. The clinics need only incur a nominal fee to meet this requirement.

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For existing clinics that qualify after March 31, 2005, the State is using the most recent cost report filed with Medicare to determine its average cost per visit and PPS rate. The State believes that although only one period is used, it will not materially impact the average cost per visit.

For new clinics that qualify after March 31, 2005 (thus having no cost report history), the State will use the average PPS rate for neighboring clinics with similar caseloads. If no such clinics exist, the State will use the average PPS rate for all clinics statewide on an interim basis until the clinic can provide pro forma data, which the State will use to establish an interim PPS rate. After the first full year actual cost report is received, the State will compare the pro forma data to the actual cost report data and adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State the actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA-required PPS amount.

Regardless of methodology, payment must be at least equal to the BIPA PPS rate. The State will compare the alternative rate against the PPS rate on a yearly basis. If the PPS rate is more, then the State will reimburse the facility the difference. If the PPS is less, then no recoupment will be made.