DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

February 25, 2026

Mr. Stephen M. Smith
Director, Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

RE: TN 25-0001

Dear Mr. Smith:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Tennessee State Plan Amendment (SPA) to Attachment 4.19B, TN 25-0001, which was submitted to CMS on March 14, 2025. This plan amendment is establishing payment rates for Rural Health Clinics and Federally Qualified Health Centers.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the State, we have approved the amendment with an effective date of June 4, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Lindsay Michael at 410-786-7197 or lindsay.michael@cms.hhs.gov.

Sincerely,

[redacted]

Enclosures

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0001

2. STATE: TN

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 4, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B, Pages 3, 4, 5, 6, 6a, 8, 9, 10, 11, and 11a.

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19B, Pages ~~3, 4, 5, 6, 8, 9, 10, and 11.~~
3, 4, 5, 6, 6a, 8, 9, 10, 11, 11a

9. SUBJECT OF AMENDMENT
Methods and Standards for Establishing Payment Rates - Rural Health Clinics and Federally Qualified Health Centers

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Stephen Smith

13. TITLE
Director, Division of TennCare

14. DATE SUBMITTED
March 14, 2025

15. RETURN TO
Tennessee Department of Finance & Administration
Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Attention: Aaron Butler

FOR CMS USE ONLY

16. DATE RECEIVED
3/14/25

17. DATE APPROVED
February 25, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
6/4/25

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, DRR

22. REMARKS
3/2/26: state authorized pen n ink on page numbers.

Instructions on Back

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.

Prospective Payment System (PPS) Reimbursement

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 BlPA 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.

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

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.

Prospective Payment System (PPS) Reimbursement for New Facilities Beginning June 4, 2025

For newly qualifying RHCs after June 4, 2025, clinics will have initial payments reimbursed using an interim rate. The interim rate will be based on the rate of a similar RHC with a similar caseload, if applicable, in the same Grand Division (which are defined geographical regions in Tennessee), or in the entire state if there are not enough similar entities in the same Grand Division. Once the clinic's average per visit reasonable costs of providing Medicaid-covered services based on its first full year of operation is determined and the PPS rate set based on the actual cost to provide those services for their first full year, the interim payments of the RHC will be reconciled to the newly established PPS rate.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made. Once the PPS rate has been set, the PPS rate for an RHC shall be adjusted by the MEI applicable to RHC services on July 1 of each year. Any other changes to the PPS rate(s) will be considered an APM and will be outlined in this State Plan.

Supplemental Payments for RHCs enrolled with a Managed Care Organization (MCO)

After the end of each quarter, the State will make payments at least quarterly to RHCs for the actual difference between the amount of MCO reimbursements received by an RHC and the PPS amount based on the State's claims data for RHC services. RHCs may also manually report any visits and revenue for visit(s) not captured by the State's claims data (for example, OB visits), on which the State will also make payment at least quarterly to the clinics for the actual difference between the amount of MCO reimbursement received by the RHC and the PPS amount based on the State's claims data for RHC services. The State will review the claims data at least annually to ensure the applicable PPS or APM rate has been paid through this process.

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

Alternative Payment Methodologies

Alternative Payment Methodology (APM) Options Beginning June 4, 2025

Effective June 4, 2025, an RHC, at its election, may receive the following APM rate options if it notifies the State in writing that it elects to receive the APM rate as its reimbursement rate and the APM rate will be at least equal to the PPS encounter rate. The APM must be agreed to by the State and by each individual RHC to which the State wishes to apply the methodology. Regardless of methodology, payment under the APM must be at least equal to the BIPA PPS rate and agreed to by the RHC. If the PPS rate is greater than the payment resulting from the APM, then the State will reimburse the facility the difference. If the PPS rate is less than the payment resulting from the APM, then no recoupment will be made.

1. APM Option 1: Rebased Prospective Payment System

   If an RHC elects to use this alternative payment methodology, it will undergo establishment of a new rate based on the average of the two most recent fiscal years of cost data for the facility. The State will collect and review Medicaid Cost Report data from the previous two fiscal years for the facility. If the RHC has been in existence for fewer than two years, then the facility will remain on its existing payment rate until there is sufficient data to set the APM rate. Once the data is collected, the State will use this data to compute a new reimbursement rate, which will be called the APM rate.

   Once the APM rate has been set, the APM rate for an RHC shall be adjusted by the market basket measure applicable to RHC services on July 1 of each year.

   APM rates established under this option may be updated no more frequently than one time every five years by using the two most recent fiscal years of Medicaid Cost Report data.

   The State may not offer, and an RHC 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 PPS rate.

   RHCs under an APM may submit changes in scope of services to the State.

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

2. APM Option 2: Supplemental Payment Rates for Separate Services

RHCs are permitted to establish a separate reimbursement rate for dental services. Requests to establish a separate dental rate must be submitted to the State. A separate rate for dental service rates will be established based on the average of the two most recent fiscal years of cost data for dental services. If a facility has less than two fiscal years of cost report data for dental services, the facility will be reimbursed using an interim rate based on the statewide average of existing dental service rates until a final rate can be established. Once the cost report data is collected, the State will use this data to compute a rate for dental services, which will be called the APM dental rate.

Once the APM dental rate has been set, it will be adjusted for inflation on July 1 of each year.

RHCs under an APM dental rate may submit change in scope of services to the State.

Change in Scope of Services

A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services (a "qualifying event") provided by the clinic. A change in scope of service applies only to Medicaid covered services.

Change in scope of service qualifying events are (1) adding or discontinuing a qualifying service, (2) material changes in intensity, duration, and/or amount of the services provided in an average visit, and (3) a statutory or regulatory change that materially impacts the scope of services. A general increase or decrease in the costs of existing services does not, by itself, constitute a change in scope of services. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined in this State plan.

The State will have 120 days from the date of submission of the Medicaid cost report to initiate a change in scope of services that is based on the information submitted in the cost report. Submission of an amended Medicaid Cost Report shall restart the timeframe for the State to initiate a change in scope of services.

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

If the State approves the request for a change in scope of services after receiving all of the necessary documentation from an RHC, the RHC will begin receiving an interim rate for any newly approved service associated with the change in scope until a final 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. The interim rate will be calculated based on the available data for the implemented change in scope of services. Clinics must provide at least one calendar quarter of actual cost data to be approved for a change in scope of services and that data must demonstrate at least a five percent increase or decrease in the clinic's existing reimbursement rate. If approved, the interim rate will be the rate calculated based on the submitted actual cost data. The final rate will be determined by the first full fiscal year of actual cost data for the change in scope of services.

Record Keeping and Audit

As of the effective date of this state plan amendment, clinics will submit a state-specific Medicaid Cost Report for annual reporting and for reporting changes in the scope of services. The cost reports will aid the auditing effort by alerting the State to any changes in scope of services that may not have been reported.

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

2.c Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 423 1 of the State Medicaid Manual (HCFA-Pub. 45-4).

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

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

_X_ The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

_X_ The payment methodology for FQHCs 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.

Prospective Payment System (PPS) Reimbursement

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, FQHCs will be paid their average 1999 and 2000 costs, adjusted for any change in scope of services. The FQHCs 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 BlPA 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.

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

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.

Prospective Payment System (PPS) Reimbursement for New Facilities Beginning June 4, 2025

For newly qualifying FQHCs June 4, 2025, centers will have initial payments reimbursed using an interim rate. The interim rate will be based on the rate of a similar FQHC with a similar caseload, if applicable, in the same Grand Division (which are defined geographical regions in Tennessee), or in the entire state if there are not enough similar entities in the same Grand Division. Once the center's average per visit reasonable costs of providing Medicaid-covered services based on its first full year of operation is determined and the PPS rate set based on the actual cost to provide those services for their first full year, the interim payments of the FQHC will be reconciled to the newly established PPS rate.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made. Once the PPS rate has been set, the PPS rate for an FQHC shall be adjusted by the MEI applicable to FQHC services on July 1 of each year. Any other changes to the PPS rate(s) will be considered an APM and will be outlined in this State Plan.

Supplemental Payments for FQHCs enrolled with a Managed Care Organization (MCO)

After the end of each quarter, the State will make payments at least quarterly to FQHCs for the actual difference between the amount of MCO reimbursements received by an FQHC and the PPS amount based on the State's claims data for FQHC services. FQHCs may also manually report any visits and revenue for visit(s) not captured by the State's claims data (for example, OB visits), on which the State will also make payment at least quarterly to the clinics for the actual difference between the amount of MCO reimbursement received by the FQHC and the PPS amount based on the State's claims data for FQHC services. The State will review claims data at least annually to ensure the applicable PPS or APM rates has been paid through this process.

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

Alternative Payment Methodologies

Alternative Payment Methodology (APM) Options Beginning June 4, 2025

Effective June 4, 2025, an FQHC, at its election, may receive the following APM rate options if it notifies the State in writing that it elects to receive the APM rate as its reimbursement rate and the APM rate will be at least equal to the PPS encounter rate. The APM must be agreed to by the State and by each individual FQHC to which the State wishes to apply the methodology. Regardless of methodology, payment under the APM must be at least equal to the BIPA PPS rate and agreed to by the FQHC. If the PPS rate is greater than the payment resulting from the APM, then the State will reimburse the facility the difference. If the PPS rate is less than the payment resulting from the APM, then no recoupment will be made.

1. APM Option 1: Rebased Prospective Payment System

   If an FQHC elects to use this alternative payment methodology, it will undergo establishment of a new rate based on the average of the two most recent fiscal years of cost data for the facility. The State will collect and review Medicaid Cost Report data from the previous two fiscal years for the facility. If the FQHC has been in existence for fewer than two years, then the facility will remain on its existing payment rate until there is sufficient data to set the APM rate. Once the data is collected, the State will use this data to compute a new reimbursement rate, which will be called the APM rate.

   Once the APM rate has been set, the APM rate for an FQHC shall be adjusted by the market basket measure applicable to FQHC services on July 1 of each year.

   APM rates established under this option may be updated no more frequently than one time every five years by using the two most recent fiscal years of Medicaid Cost Report data.

   The State may not offer, and an 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 PPS rate.

   FQHCs under an APM may submit changes in scope of services to the State.

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

2. APM Option 2: Supplemental Payment Rates for Separate Services

FQHCs are permitted to establish a separate reimbursement rate for dental services. Requests to establish a separate dental rate must be submitted to the State. A separate rate for dental service rates will be established based on the average of the two most recent fiscal years of cost data for dental services. If a facility has less than two fiscal years of cost report data for dental services, the facility will be reimbursed using an interim rate based on the statewide average of existing dental service rates until a final rate can be established. Once the cost report data is collected, the State will use this data to compute a rate for dental services, which will be called the APM dental rate.

Once the APM dental rate has been set, it will be adjusted for inflation on July 1 of each year.

FQHCs under an APM dental rate may submit change in scope of services to the State.

Change in Scope of Services

A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services (a "qualifying event") provided by the clinic. A change in scope of service applies only to Medicaid covered services.

Change in scope of service qualifying events are (1) adding or discontinuing a qualifying service, (2) material changes in intensity, duration, and/or amount of the services provided in an average visit, and (3) a statutory or regulatory change that materially impacts the scope of services. A general increase or decrease in the costs of existing services does not, by itself, constitute a change in scope of services. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined in this State plan.

The State will have 120 days from the date of submission of the Medicaid cost report to initiate a change in scope of services that is based on the information submitted in the cost report. Submission of an amended Medicaid Cost Report shall restart the timeframe for the State to initiate a change in scope of services.

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

If the State approves the request for a change in scope of services after receiving all of the necessary documentation from an FQHC, the FQHC will begin receiving an interim rate for any newly approved service associated with the change in scope until a final 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. The interim rate will be calculated based on the available data for the implemented change in scope of services. Centers must provide at least one calendar quarter of actual cost data to be approved for a change in scope of services and that data must demonstrate at least a five percent increase or decrease in the clinic's existing reimbursement rate. If approved, the interim rate will be the rate calculated based on the submitted actual cost data. The final rate will be determined by the first full fiscal year of actual cost data for the change in scope of services.

Record Keeping and Audit

As of the effective date of this state plan amendment, clinics will submit a state-specific Medicaid Cost Report for annual reporting and for reporting changes in the scope of services. The cost reports will aid the auditing effort by alerting the State to any changes in scope of services that may not have been reported.