DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

Division of Medicaid & Children's Health, Region VI

August 19, 2011

Our Reference: SPA TX 10-61

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 10-61, dated December 23, 2010. This state plan amendment updates the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHCs). Specifically, the state plan amendment (SPA) updates the reimbursement methodology for setting interim rates, adjusts the cost methodology for interim rates and describes the rate setting methodology for out of state FQHCs and FQHCs with a change of ownership. The SPA also describes the methodology for reimbursement selection for a new FQHC and how they may change their selection in the future.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of October 2, 2010. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

/s/

Bill Brooks
Associate Regional Administrator

Enclosures
cc: Emily Zalkovsky, Policy Development Support

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **10-061**	2. STATE: **TEXAS**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: **October 2, 2010**	

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
42 CFR § 405.2462	**a. FFY 2011 $ 0** **b. FFY 2012 $ 0** **c. FFY 2013 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9	**SEE ATTACHMENT TO BLOCKS 8 & 9**

The amendment updates the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHCs). The amendment reflects the reimbursement methodology for setting interim rates, adjusts the cost settlement methodology for interim rates, adds language to describe the rate setting methodology for out-of-state FQHCs and FQHCs that have had a change in ownership, documents the process for how a new FQHC makes a reimbursement methodology selection and how they may change that selection in the future, and eliminates duplicative language.

11. 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: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **Billy R. Millwee**	**Billy R. Millwee** **State Medicaid Director** **Post Office Box 85200** **Austin, Texas 78711-5200**
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: **December 22, 2010**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 23 Dec, 2010	18. DATE APPROVED: 19 August 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 2 Oct, 2010	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

(31) Federally Qualified Health Centers (FQHC)

(a) FQHCs may choose between two prospective payment methodologies for reimbursement purposes. The two methodologies are the Prospective Payment System (PPS) Methodology and the Alternative Prospective Payment System (APPS) Methodology. Both methods are in accordance with section 1902(bb) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000 (42 U.S.C. §1396a(bb)), effective for the FQHC's fiscal year that includes dates of service occurring January 1, 2001 and after. FQHCs will be reimbursed a prospective per visit encounter rate for a visit for Medicaid covered services if the visit meets the requirements of section (31)(b)(10) and (31)(b)(11).

(1) Definitions:

(A) Effective rate - The encounter rate paid to an FQHC during the FQHC's fiscal year. The effective rate is updated by the applicable rate of change described in (31)(b)(4) per the prescribed methodology for each of the FQHC's fiscal years since the setting of its final base rate.

(B) Interim base rate - The encounter rate determined on the first full fiscal year as-filed Medicare cost report for a new FQHC based on 100% of reasonable costs. Interim rates will be adjusted prospectively until the final audited Medicare cost report is processed and used to determine the final base rate.

(C) Initial interim base rate - The encounter rate paid to a new FQHC determined on a short period cost report or projected cost report. After one full fiscal year as-filed Medicare cost report is filed, the rate is updated to the interim base rate.

(D) Final base rate - The encounter rate determined for an FQHC existing in the year 2000 by calculating 100 percent of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The final base rate was calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. For an FQHC formed after the year 2000, the final base rate is calculated on the first full fiscal year audited Medicare cost report based on 100% of the reasonable costs. The final base rate for an FQHC formed after the year 2000 is applied to claims back to the beginning of the FQHC's existence and the payments are reconciled. A change in the effective rate under (31)(b)(6) will result in a new final base rate. The final base rate is the effective rate for each subsequent FQHC fiscal year.

(2) The reimbursement methodologies described in section (31)(b) apply equally to the APPS and PPS methodologies, except for the following:

(A) The effective rate for the APPS methodology described in section (31)(b)(4) does not apply to PPS. For an FQHC reimbursed under PPS, annual increases in the final base rate or effective rate are the rate of change in the Medicare Economic Index (MEI) for primary care.

(B) State-initiated reviews, described in (b)(8)(D), are not applicable for providers who select the PPS methodology.

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(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(1) Prior to HHSC setting a final base rate for each FQHC existing in 2000, each FQHC was reimbursed on the basis of an interim base rate. The interim base rate for each FQHC was calculated from the latest finalized cost report settlement, adjusted as provided for in (b)(4). When HHSC determined a final base rate, interim payments were reconciled back to the beginning of the interim period. For FQHCs that agreed to the APPS methodology prior to August 31, 2010, adjustments were made to the FQHCs' interim payments only if the interim payments were less than what would have occurred under the final base rate. In (b)(8)(A) of this section the interim and final base rate methodology for new FQHCs is described. The final base rate, as adjusted, applies prospectively from the date of the final approval. Payments made under the APPS methodology will be at least equal to the amount that would be paid under PPS.

(2) Reasonable costs, as used in setting the interim or final base rate or any subsequent effective rate, is defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB Circular, with no productivity screens and no per visit payment limit. Administrative costs will be limited to 30 percent of total costs in determining reasonable costs. Reasonable costs do not include unallowable costs.

(3) Unallowable costs are expenses that are incurred by an FQHC and that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules, and standards.

(4) The effective rate for APPS is the rate paid to the FQHC for the FQHC's fiscal year. The effective rate shall be updated by the rate of change in the MEI plus 1.5 percent for each of the FQHC's fiscal years since the setting of its final base rate. If the increase in an FQHC's costs is greater than the MEI plus 1.5 percent for APPS, an FQHC may request an adjustment of its effective rate as described in (6). The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year. The effective rate for PPS is described in (a)(2)(A).

(5) PPS and APPS reimbursement methodology selection is determined as follows:

(A) Each new in-state FQHC will receive a letter from HHSC upon enrollment as a new Medicaid provider along with a FQHC Prospective Payment System Form. The FQHC must indicate on the form the selection as either the PPS or APPS reimbursement methodology and return the form to HHSC.

(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(B) Each out-of-state FQHC will receive the PPS reimbursement methodology. HHSC will compute an effective rate based on reasonable costs provided by the FQHC on its most recent Medicare cost report. The effective rate will reflect the rate that would have been calculated for an in-state FQHC based on the approved scope of services that an in-state FQHC could provide in Texas.

(6) A change of the effective rate is determined as follows:

(A) An adjustment, as described in (b)(8)(C), will be made to the effective rate if the FQHC can show that it is operating in an efficient manner, or show that the adjustment is warranted due to a change in scope of services. Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope. A change in scope provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites.

(i) A change in the scope of services is a change in the type, intensity, duration or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

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(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(ii) Operating in an efficient manner includes:

(I) showing that the FQHC has implemented an outcome-based delivery system that includes prevention and chronic disease management. Prevention includes, but is not limited to, programs such as immunizations and medical screens. Disease Management must include, but not be limited to, programs such as those for diabetes, cardiovascular conditions, and asthma that can demonstrate an overall improvement in patient outcome;

(II) paying employees' salaries that do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

(III) providing fringe benefits to its employees that do not exceed fifteen percent of the FQHC's total costs;

(IV) implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

(V) employing the concept of a "prudent buyer" in purchasing its contracted medical services.

(B) HHSC also may adjust the effective rate of an FQHC on its own initiative, in accordance with section (31)(b)(8)(D), if it is determined that a change in scope has occurred and an adjustment to the effective rate is warranted based on the audit of the cost report.

(7) Each provider is required to submit Medicare cost reports and supplemental worksheets and supporting information as required by HHSC. In addition, the following cost reports may be required:

(A) As-filed Medicare cost report to include Texas Medicaid supplemental worksheets.

(B) Final audited Medicare cost report to include Texas Medicaid supplemental worksheets.

(C) Change of effective rate cost report. The change of effective rate cost report is used by in-state or out-of-state FQHCs that are requesting a change in their effective rate due to a change in scope or operating in an efficient manner. The cost report must contain at least six months of financial information.

(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(D) Projected cost report. The projected cost report is used by in-state or out-of-state FQHCs that are requesting an initial interim rate. The cost report must contain at least twelve months of projected financial information.

(E) Low Medicare Utilization Cost Report. The low Medicare utilization cost report is used by in-state and out-of-state providers to meet the annual filing requirements for providers not required to file a full cost report with Medicare.

(8) FQHC rate determination process.

(A) New FQHC.

(i) A new FQHC must file a projected cost report to establish an initial interim base rate. The cost report must contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The initial interim base rate for a new FQHC shall be set at the lesser of 80 percent of the anticipated reasonable costs or 80 percent of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC or for a change in scope, if applicable.

(ii) Each new FQHC must submit to HHSC or its designee an as-filed Medicare cost report after the end of the FQHC's first full fiscal year. HHSC will determine an updated interim base rate based on 100 percent of the reasonable costs contained in the as-filed Medicare cost report. Interim rates will be adjusted prospectively until the final audited Medicare cost report is processed. An as-filed Medicare cost report must reflect twelve months of continuous service.

(iii) Each new FQHC must submit to HHSC or its designee a final audited Medicare cost report, reflecting twelve months of continuous service. The rate established shall be the final base rate. HHSC will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim base rate, HHSC will compute and pay the FQHC a settlement payment that represents the difference in rates for the services provided during the interim period. If the final base rate is less than the interim base rate, HHSC will compute and recoup from the FQHC any overpayment resulting from the difference in rates for the services provided during the interim period. The final base rate is adjusted in accordance with section (31)(b)(4) to determine the effective rate.

(iv) If a new FQHC cost report described in (ii) or (iii) of this section does not meet the requirement of reflecting twelve months of continuous service, HHSC will prospectively establish the interim rate based on the lesser of the interim rate determined by the cost report or 80 percent of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC or for a change in scope, if applicable, adjusted by applicable increases

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(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(B) Change of ownership. If an existing FQHC facility changes ownership, the new owner must notify HHSC of the ownership change.

(i) If the new owner of an FQHC facility owns no other FQHC facility in Texas, HHSC will treat the FQHC facility as a new FQHC. HHSC will set an initial interim base rate equal to 100 percent of the previous owner's effective rate, and will then follow the procedures under sections (31)(b)(8)(A)(ii) and (31)(b)(8)(A)(iii).

(ii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas, and will include the new facility on the Medicare cost report of another FQHC facility, then HHSC will apply the rate assigned to the other FQHC.

(iii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas, but will not include the new facility on the Medicare cost report of another FQHC facility, then HHSC will determine a rate for the facility in accordance with (i) of this section.

(iv) If the new owner of an FQHC facility is ultimately not allowed by Medicare to include its new FQHC facility on the Medicare cost report of the other FQHC facility that it owns, then HHSC will determine a rate for the facility in accordance with section (31)(b)(8)(A).

(C) Request for change of effective rate.

(i) An FQHC that requests an adjustment of its effective rate (due to a change in scope or operating in an efficient manner) must file a change of effective rate cost report. The FQHC must include the necessary documentation to support a claim that the FQHC has undergone a change in scope or is operating in an efficient manner.

(ii) If HHSC determines through the review of the information provided in (i) of this section that an adjustment to the effective rate is warranted, HHSC will determine an interim base rate based on 100 percent of the reasonable costs contained in the change of effective rate cost report. Interim payments will be adjusted prospectively until the final audited cost report is processed.

(iii) The FQHC must submit to HHSC or its designee an as-filed Medicare cost report. HHSC and the FQHC will then follow the procedures under subsections (31)(b)(8)(A)(ii) and (31)(b)(8)(A)(iii).

(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(D) State-initiated review.

(i) For an in-state FQHC that has chosen the APPS methodology, HHSC may prospectively reduce the FQHC's effective rate to reflect 100 percent of its reasonable costs or the PPS effective rate, whichever is greater. After reviewing the final audited Medicare cost report, HHSC will determine if an in-state FQHC is being reimbursed more than 100 percent of its reasonable cost or the PPS effective rate, whichever is greater, through the following steps:

(I) Determine the reasonable cost per encounter from the final audited Medicare cost report;

(II) Determine the effective PPS rate per encounter as would have been applied to the FQHC if the FQHC had chosen PPS as described in (a) for the same time period corresponding to the FQHC's final audited Medicare cost report;

(III) Select the greater of (I) or (II) of this section;

(IV) If the result in (III) of this section is less than the APPS effective rate for this period, HHSC will set the result in (III) of this section as the new final base rate for this period;

(V) The prospective rate described in section (31)(b)(8)(D)(iii) will be determined by adjusting the new final base rate from (IV) in accordance with section (31)(b)(4) to determine the effective rate.

(VI) The new final base rate from (IV) and subsequent effective rates will not apply to claims for services provided prior to the implementation date described in section (31)(b)(8)(D)(iii).

(ii) State-initiated reviews will be based on a determined 12 month time period and the most recent cost data received.

(iii) HHSC will apply the state-initiated rate reduction prospectively beginning on the first day of the month following 45 days after the date of the final case rate notification letter. The final base rate is adjusted in accordance with section (31)(b)(4) to determine the effective rate.

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(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(iv) HHSC will not increase the effective rate for an FQHC based on the outcome of a state-initiated cost report audit. It is the responsibility of the FQHC to request HHSC to adjust the effective rate.

(v) For PPS, the state-initiated review is not applicable.

(E) Final base rate notification letter. HHSC will provide to an FQHC written notification of any determined final base rate.

(F) Request for review of final base rate. The FQHC may submit a written request for a review of the final base rate if:

(i) The FQHC believes that HHSC made a mathematical error or data entry error in calculating the FQHC's reasonable cost. If HHSC determines the request for review merits a change in the final base rate, HHSC will adjust the final base rate to the effective date of the final base rate notification letter.

(ii) The FQHC believes that the FQHC made an error in reporting its cost or data in the final audited Medicare cost report or the Texas Medicaid Supplemental Worksheets that would result in a different calculation of the FQHC's reasonable cost. If HHSC determines the request for review merits a change in the final base rate, HHSC may adjust the final base rate to the effective date of the final base rate notification letter.

(iii) If the FQHC disagrees with the results of the review, the FQHC may request a formal appeal.

(9) In the event that the total amount paid to an FQHC by a managed care organization is less than the amount the FQHC would receive under PPS or APPS, whichever is applicable, the state will reimburse the difference on a state quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs, or bonuses.

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(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(10) A visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(B) the FQHC patient has a medical visit and an "other" health visit, as defined in section (31)(b)(11).

(11) A medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face encounter between an FQHC patient and a psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist, as well as a Early and Periodic Screening, Diagnosis and Treatment medical checkup.

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