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State/Territory Name: Texas

State Plan Amendment (SPA) : 21-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

August 25, 2026

Stephanie Stephens
State Medicaid/CHIP Director
Health and Human Services Commission
Mail Code: H100
Post Office Box 13247
Austin, Texas 78711

RE: TN 21-0009

Dear Director Stephens,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Texas state plan amendment (SPA) to Attachment 4.19-B 21-0009, which was submitted to CMS on March 12, 2021. This plan amendment has an effective date of February 1, 2021, and is intended to amend the description of the reimbursement methodology for both the Alternative Payment Methodology (APM) and Prospective Payment System (PPS) methodologies for Federally Qualified Health Centers (FQHC).

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 February 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Josh Smith at 214-767-6453 or via email at LaJoshica.Smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN 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: 21-0009

2. STATE: TX

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

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

4. PROPOSED EFFECTIVE DATE
February 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION
Title XIX of the SSA §§1902(a)(10)(A), 1902(bb); 42 U.S.C. §§1396a(a)(10)(A), 1396a(bb)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2021 $ 0
b. FFY 2022 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See Attachment to Blocks 7 & 8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See Attachment to Blocks 7 & 8

9. SUBJECT OF AMENDMENT

The proposed amendment reverts to previous language prior to September 01, 2020 used to describe Federally Qualified Health Center (FQHC) rate determination.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Stephanie Stephens

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
March 12, 2021

15. RETURN TO

Stephanie Stephens
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR CMS USE ONLY

16. DATE RECEIVED
March 12, 2021

17. DATE APPROVED
August 25, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
February 1, 2021

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, FMG Division of Reimbursement Review

22. REMARKS

Attachment to Blocks 7 & 8 of CMS Form 179

Transmittal Number 21-0009

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19B	Attachment 4.19B
Page 24	Page 24 (TN 10-61)
Page 24a	Page 24a (TN 10-90)
Page 24b	Page 24b (TN 10-90)
Page 24c	Page 24c (TN 10-61)
Page 24d	Page 24d (TN 20-0022)
Page 24d.1	Page 24d.1 (TN 20-0022)
Page 24e	Page 24e (TN 10-61)
Page 24f	Page 24f (TN 10-61)
Page 24g	Page 24g (TN 17-0002)
Delete	Page 24g.1 (TN 17-0002)
Delete	Page 24h (TN 20-0022)

(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 an Alternate Payment Methodology (APM) referred to as 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 as described in section (31)(a)(1)(F) through (31)(a)(1)(H).

(1) Definitions:

(A) PPS effective rate - The final encounter rate, with the Medicare Economic Index (MEI) updates paid, to an FQHC during the FQHC's fiscal year.

(B) APPS effective rate – The final encounter rate with the MEI update plus the additional 0.5 percentage of the MEI added to the updates, paid to an FQHC during the FQHC fiscal year.

(C) Interim base rate, Interim PPS base rate, and Interim APPS base rate - The encounter rate paid to a new FQHC after 2000, or the encounter rate determined from a change in scope cost report.

(D) Initial interim base rate, Initial interim PPS base rate, and Initial interim APPS base rate - The encounter rate paid to a new FQHC after 2000. The encounter rate paid to a new FQHC. The encounter rate is calculated using the projected cost report.

(E) Final base rate, Final PPS base rate, and Final APPS base rate - The encounter rate calculated using the final cost report.

(i) For an FQHC existing in the year 2000. The encounter rate was calculated by 2000 cost reports and divided by the total audited visits for these same two periods.

(ii) For an FQHC formed and enrolled after the year 2000 - The encounter rate is calculated based on hundred percent (100%) of the reasonable costs divided by the total audited visits for the first full year first full fiscal year audited Medicare cost report.

(F) A visit is an in-person, telemedicine, or telehealth encounter between and FQHC patient and a 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 if the visit is within the scope of practice for the provider.

(G) A medical visit is an in-person, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, or visiting nurse.

(H) An "other" health visit includes but is not limited to, an in-person, telemedicine, or telehealth 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 an Early and Periodic Screening, Diagnosis and Treatment medical checkup if the visit is within the scope of practice for the provider.

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

(1) General

(A) Wrap Payment – In the event an FQHC is not paid the PPS or APPS rate by a managed care organization or a dental maintenance organization, the state will ensure the FQHC is paid the full amount the FQHC should receive under PPS or APPS for covered services performed by the FQHC. In the event that the amount paid to an FQHC by a managed care organization or dental maintenance organization is less than the amount the FQHC would receive under PPS or APPS, the state will ensure the FQHC is reimbursed the difference on at least a quarterly basis.

(B) Reasonable costs, as used in setting the interim or final base rate or any subsequent effective rate under the PPS or APPS reimbursement methodologies, are defined as those costs that are allowable under Medicaid cost principles, as required in 2 CFR 200, 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.

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

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

(2) Reimbursement Section PPS

(A) Each new in-state FQHC will receive a letter from HHSC or its designee upon enrollment as a new Medicaid provider, with an FQHC prospective payment system form. The FQHC must indicate the selection as either the PPS or the Alternative Payment APPS reimbursement methodology on the form and return the form to HHSC or its designee.

(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.

(C) After a change to the reimbursement methodology, the state may require the reselection of the APPS or PPS methodology.

(3) A Change of the Effective Rate

(A) An adjustment will be made to the PPS or APPS effective rate if the FQHC can 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 had a change in scope. A change in scope provided by an FQHC is defined as 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. A change in the cost of a service is not considered in and of itself a change in the scope of services.

(B) An FQHC that requests an adjustment of its PPS or APPS effective rate must file a change of effective rate cost report. A cost report filed to request an adjustment in the effective rate may be filed at any time during an FQHC's fiscal year, but no later than five (5) calendar months after the end of the FQHC's fiscal year. All requests for adjustment in the FQHC's effective rate must include at least six (6) months of financial data. The FQHC must include the necessary documentation to support a claim that the FQHC has undergone a change in scope.

(C) If HHSC determines through the review of the information provided in (B) of this section that an adjustment to the PPS 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.

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

(3) Change in Effective Rate (continued)

(D) The FQHC must submit to HHSC, or its designee, an as-filed Medicare cost report after the end of the FQHC's full fiscal year. HHSC will determine an interim base rate based on 100 percent of the reasonable costs contained in the as-filed Medicare cost report, using the total allowable FQHC costs divided by the total number of eligible FQHC visits. 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.

(E) The FQHC must submit to HHSC or its designee the final audited Medicare cost report for this period. The rate established shall be the final base rate. HHSC will reconcile payments back to the beginning of the interim period using the final base rate. If the final base rate is greater than the interim base rate, HHSC will calculate 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 calculate and recoup from the FQHC any overpayment resulting from the difference in rates for the services provided during the interim period. HHSC will return the federal portion of recouped payments to CMS consistent with 42 CFR 433 subpart F.

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

(b) Reimbursement Methodologies

(1) Prospective Payment System (PPS) Methodology

(A) Effective January 1, 2001, for an FQHC existing in 2000, the PPS per visit rate for each FQHC was calculated based on one hundred percent (100%) 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 PPS per visit rates were 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 a newly enrolled FQHC after January 1, 2001, see the reimbursement methodology in section (31)(b)(1)(B).

(B) The effective rate for PPS 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 for each of the FQHC's fiscal years since the setting of its final PPS base rate. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year. An FQHC may request an adjustment of its effective rate due to a change in scope as described in section (31)(a)(3).

(C) HHSC requires each provider to submit Medicare cost reports, supplemental worksheets, and supporting information. In addition, the following cost reports may be required:

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

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

(iii) 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 PPS effective rate due to a change in scope. The cost report must contain at least six months of financial information.

(iv) The cost settlement must be completed within six (6) months of receipt of the final audited Medicare cost report.

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

(b) Reimbursement Methodologies (continued)

(1) Prospective Payment System (PPS) Methodology (continued)

(v) Projected cost report. The projected cost report may be 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.

(vi) 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.

(D) FQHC encounter rate determination process for a newly enrolled FQHC after January 1, 2001

(i) A newly-enrolled FQHC resulting from an existing FQHC adding a new service site will be assigned the same effective rate as the existing FQHC. The state verifies the new service site has been approved as a grantee by HRSA for the existing FQHC.

(ii) A newly-enrolled FQHC not associated with an existing FQHC

(I) 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 interim encounter base rate based on 100% (100) percent of the reasonable costs contained in the as-filed Medicare cost report using the total allowable FQHC costs divided by the total number of eligible FQHC visits. 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.

(II) 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 encounter final base rate. HHSC will reconcile payments back to the beginning of the interim period using the final base rate within six months of receipt of the final audited Medicare cost report. If the final base rate is greater than the initial interim base rate and/or 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 within six months of receipt of the final audited Medicare cost report. If the final base rate is less than the initial interim base rate and/or 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 starting within six months of receipt of the final audited Medicare cost report. HHSC will return the federal portion of recouped payments to CMS consistent with 42 CFR 433 subpart F.

(E) HHSC or its designee may delay or withhold vendor payment to a provider upon failure to submit a requested cost report until HHSC or its designee has received a complete and workable cost report.

(i) Once the complete and workable cost report has been received, the vendor hold will be released, and the provider will receive all withheld monies.

(ii) The vendor payment hold will not allow any payments to the provider, this includes encounter rate and any alternative payments for services.

(iii) A provider, not submitting a workable cost report within 5 years of the non-receipt letter to the provider:

(I) If the provider has an APPS rate, the rate will be rolled back to the PPS rate with MEI updates. The provider will be responsible for reimbursing HHSC the difference between the PPS rate and the APPS rate multiplied by the number of encounters paid.

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

(b) Reimbursement Methodologies (continued)

(1) Prospective Payment System (PPS) Methodology (continued)

(II) The provider will have their current rate set as a final rate with no cost settlement. A final base rate change letter will be sent to the provider. This will allow the provider to appeal the assignment of the final rate.

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

(G) State-initiated reviews are not applicable for providers who selected the PPS methodology

(31) Federally Qualified Health Centers (FQHC)

(b) Reimbursement Methodologies (continued)

(2) Other Alternative Payment Methodologies

(A) Initial interim base rate: A newly enrolled FQHC not associated with an existing FQHC may file a projected cost report to establish an initial interim base rate reimbursement methodologies. 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 determined from the projected 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. If an FQHC does not submit a projected cost report, the initial interim rate will be set at 80 percent of the average rate paid to FQHCs on January 1 of the calendar year, during which the FQHC first applies at a new FQHC.

(B) Alternative Prospective Payment System (APPS) final encounter rate will be calculated using the methodology described on (31)(b)(1)(D)(ii)(II).

(i) APPS is an alternative payment methodology under section 1902(bb)(6) of the Social Security Act. The purpose of APPS is to reimburse participating FQHCs using an alternative encounter rate methodology that supports access to Medicaid-covered FQHC services.

(ii) APPS applies only to an FQHC that agrees to receive payment under APPS. An FQHC must indicate its selection of APPS on the FQHC prospective payment system form and return the form to HHSC or its designee.

(iii) Payments made under APPS must be at least equal to the amount that would be paid under the PPS methodology for the same services.

(iv) The effective rate for PPS 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 0.5 percent for each of the FQHC's fiscal years since the setting of its final encounter base rate. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year. An FQHC may request an adjustment of its effective rate due to a change in scope as described in Section (31)(3)(A)(B).

(v) State-initiated review - In the event the state or its designee identifies an FQHC with a reduced scope of services, the APPS effective rate may be adjusted based on the audit of the cost report.

(I) For an in-state FQHC that has chosen the APPS methodology, HHSC may prospectively reduce the FQHC's APPS 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:

(-a-) Determine the reasonable cost per encounter from the final audited Medicare cost report.

(-b-) Determine the PPS effective 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.

(-c-) Select the greater of (-a-) or (-b-) of this section

(-d-) If the result in (-c-) of this section is less than the APPS effective rate for this period, HHSC will set the result in (-c-) of this section as the new final APPS base rate for this period.

(-e-) The prospective rate described in section(31)(b)(2)(B) will be determined by adjusting the new final base rate from (-d-) in accordance with section (31)(b)(2)(B)(i) to determine the APPS effective rate.

(-f-) The new APPS final base rate from (-d-) and subsequent effective rates will not apply to claims for services provided prior to the implementation date described in section (31)(b)(2)(B)(iv)

(31) Federally Qualified Health Centers (FQHC)

(b) Reimbursement Methodologies (continued)

(2) Other Alternative Payment Methodologies (continued)

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

(iv) 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 base rate notification letter. The final APPS base rate is adjusted in accordance with section (31)(b)(2)(C) to determine the APPS effective rate.

(v) 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 APPS effective rate.

(C) Final base rate notification letter. HHSC will notify the FQHC in writing any determined final APPS base rate.