TO: Medical Care Advisory Committee

DATE: November 12, 2020

FROM: Rene Cantu,
Director of Hospital Provider Finance

SUBJECT: Federally Qualified Health Center Services Reimbursement

Agenda Item No.: 10

Amendment to: §355.8261, relating to Federally Qualified Health Center Services Reimbursement

BACKGROUND: ☐ Federal Requirement ☒ Legislative Requirement ☐ Other: (e.g., Program Initiative)

The Texas Health and Human Services Commission (HHSC) proposes to amend Texas Administrative Code (TAC) Title 1, Part 15, Chapter 355, Subchapter J, Division 14, §355.8261, related to Federally Qualified Health Center Services Reimbursement to ensure that a Federally Qualified Health Center Services (FQHC) is reimbursed for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient at the facility.

The amendment to this rule is proposed to comply with SB 670, 86th Legislature, Regular Session, 2019, which requires HHSC to ensure that a FQHC may be reimbursed for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient. The proposed amendment will also clarify how rates are set for newly enrolled FQHCs that are authorized to be included on a consolidated cost report of another FQHC.

ISSUES AND ALTERNATIVES:

The purpose of this rule amendment is to specify that reimbursement to FQHCs for providing telemedicine/telehealth services is allowable, with no adverse impact on other types of providers. There are no significant concerns related to this proposed rule as increased transparency is a positive impact for FQHCs.

STAKEHOLDER INVOLVEMENT:

This rulemaking was expedited and proposed to comply with SB 670. External stakeholder involvement during the rule development process was minimal as the amendment provides additional detail on existing reimbursement structure.

FISCAL IMPACT:

☒ None ☐ Yes

RULE DEVELOPMENT SCHEDULE:

November 2020	Publish proposed rules in *Texas Register*
November 12, 2020	Present to Medical Care Advisory Committee
November 19, 2020	Present to HHSC Executive Council
February 2021	Publish adopted rules in *Texas Register*
February 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 14 FEDERALLY QUALIFIED HEALTH CENTER SERVICES
PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.8261, concerning Federally Qualified Health Center Services Reimbursement.

BACKGROUND AND PURPOSE

The purpose of the proposal is to comply with Senate Bill 670, 86th Legislature, Regular Session, 2019, which requires HHSC to ensure that a federally qualified health center (FQHC) be reimbursed for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient. The proposed amendment will also clarify how rates are set for newly enrolled FQHCs that are authorized to be included on a consolidated cost report of another FQHC.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8261(b)(10)(A)(i) specifies that a new FQHC that is included on the cost report of another FQHC (i.e., part of a consolidated cost report) should be assigned the rate of the other FQHC.

The proposed amendment to §355.8261(b)(12) and §355.8261(b)(13) includes telemedicine and telehealth services in the definition of a “visit” and a “medical visit.” This change increases transparency and provides additional detail on the existing reimbursement structure for FQHCs.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule amendment will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years the amendments will be in effect:

(1) the proposed amendment will not create or eliminate a government program;
(2) implementation of the proposed amendment will not affect the number of employee positions;

(3) implementation of the proposed amendment will not require an increase or decrease in future legislative appropriations to the agency;
(4) the proposed amendment will not require an increase or decrease in fees paid to the agency;
(5) the proposed amendment will not create a new rule;
(6) the proposed amendment will expand an existing rule; and
(7) the proposed amendment will not change the number of individuals subject to the rule.
(8) HHSC has insufficient information to determine the proposed amendment's effects on the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there is no adverse economic impact on small businesses, micro-businesses, and rural communities. There are no FQHCs in rural areas and no FQHCs are small businesses or micro-businesses.

LOCAL EMPLOYMENT IMPACT

The proposed rule amendment will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this amendment because the amendment is necessary to receive a source of federal funds. The amendment is also necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule amendment.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the section is in effect, the public will benefit from adoption of the amended section. The public benefit anticipated as a result of enforcing or administering the amendment will be an enhanced ability of FQHCs to provide healthcare to Medicaid recipients by ensuring that telehealth services are included in options for providing services.

Trey Wood has also determined has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons required to comply with the proposed rule because the proposal does not impose any new costs or fees on persons required to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Kevin Niemeyer in HHSC Rate Analysis at (512) 730-7445.

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, Mail Code H-400, 4900 North Lamar Blvd., Austin, TX 78714-9030; by fax to (512)-730-7475; or by email to RateAnalysisDept@hhsc.state.tx.us within 31 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When faxing or emailing comments, please indicate "Comments on Proposed Rule 21R008" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.0216(i), which requires HHSC to adopt rules to implement the subsection; Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32.

The amendment affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (737) 203-7842.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 14 FEDERALLY QUALIFIED HEALTH CENTER SERVICES

§355.8261. Federally Qualified Health Center Services Reimbursement.

(a) Prospective Payment System (PPS) Methodology. Federally Qualified Health Centers (FQHCs) selecting the PPS methodology, 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, will be reimbursed a PPS per visit encounter rate for Medicaid covered services. FQHCs are reimbursed a prospective per visit encounter rate for a visit that meets the requirements of subsections (b)(12) and (13) of this section. The final base rate for each FQHC existing in 2000 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 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. The reimbursement methodologies described in subsection (b) of this section apply to the PPS methodology, except for the following:

(1) The effective rate for APPS described in subsection (b)(4) of this section does not apply to PPS. Increases in the final base rate or the effective rate for a PPS-reimbursed FQHC shall be the rate of change in the Medicare Economic Index (MEI) for primary care. If the increase in an FQHC's costs is greater than the MEI for PPS, an FQHC may request an adjustment of its effective rate as described in subsection (b)(6) of this section.

(2) State initiated reviews, described in subsection (b)(10)(D) of this section, are not applicable for providers who select the PPS methodology.

(b) Alternative Prospective Payment System (APPS) Methodology. FQHCs selecting the APPS methodology, 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, are reimbursed an APPS per visit encounter rate for Medicaid covered services at one hundred percent (100%) of reasonable costs. FQHCs are reimbursed a prospective per visit encounter rate for a visit that meets the requirements of paragraphs (12) and (13) of this subsection. The final base rate for each FQHC existing in 2000 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 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.

(1) Prior to the Health and Human Services Commission (HHSC) setting a final base rate pursuant to this section 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 paragraph (4) of this subsection. 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 FQHC's interim payments only if the interim payments were less than what would have occurred under the final base rate. Paragraph (10) of this subsection contains the interim and final base rate methodology for new FQHCs. 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 Medicare Cost Principles, as outlined in 42 C.F.R. part 413, with no productivity screens and no per visit payment limit. Administrative costs will be limited to thirty percent (30%) 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. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating an interim or final base rate determination. Unallowable costs include, but are not necessarily limited to, the following:

(A) compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(B) personal expenses not directly related to the provision of covered services;

(C) management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(D) advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(E) business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(F) political contributions;

(G) depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(H) trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(I) donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 C.F.R. part 413;

(J) dues to all types of political and social organizations and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs or the rendering of patient care services;

(K) entertainment expenses, except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(L) board of director's fees, including travel costs and meals provided for directors;

(M) fines and penalties for violations of statutes, regulations, and ordinances of all types;

(N) fund raising and promotional expenses, except as noted in subparagraph (D) of this paragraph;

(O) interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid that is reduced or offset by interest income;

(P) insurance premiums pertaining to items of unallowable costs;

(Q) any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(R) mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(S) cost for goods or services that are purchased from a related party and that exceed the original cost to the related party;

(T) out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses that increase the quality of medical care and/or the operating efficiency of the FQHC;

(U) over-funding contributions to self-insurance funds that do not represent payments based on current liabilities;

(V) overhead costs beyond the thirty percent (30%) limitation established by HHSC.

(4) The effective rate for APPS - The effective rate 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 base rate. If the increase in an FQHC's costs is greater than the MEI plus (0.5) percent for APPS, an FQHC may request an adjustment of its effective rate as described in paragraph (6) of this subsection. 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 subsection (a)(1) of this section.

(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 provider along with the Federally Qualified Health Centers (FQHC) Prospective Payment System Form. This form must be signed by an authorized representative and returned to HHSC within thirty (30) days of the enrollment letter date. The form must indicate the selection as either the PPS or APPS reimbursement methodology. If HHSC does not receive the form within the specified time requirement, HHSC will select the PPS reimbursement methodology for this provider. For a provider that fails to return the form selecting the APPS reimbursement methodology, the provider may submit a written request along with the Federally Qualified Health Centers (FQHC) Prospective Payment System Form selecting the APPS reimbursement methodology. Upon approval by HHSC, the new selection will be effective the first day of the provider's next fiscal year.

(B) Each out-of-state FQHCs will receive the PPS reimbursement methodology. Out-of-state FQHCs may not select the APPS reimbursement methodology. HHSC will compute an effective rate based on reasonable costs provided by the FQHC on its most recent Medicare cost report, pursuant to paragraph (8)(A) and (B) of this subsection. 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) When HHSC makes a change to the PPS or APPS reimbursement methodology, HHSC may require FQHCs to reselect the PPS or APPS reimbursement methodology, in accordance with the requirements of subparagraph (A) of this paragraph.

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

(A) An adjustment, as described in paragraph (10)(C) of this subsection, will be made to the effective rate if the FQHC can show that it is operating in an efficient manner as defined in paragraph (7)(B) of this subsection, or show that the adjustment is warranted due to a change in scope as defined in paragraph (7)(A) of this subsection.

(B) HHSC also may adjust the effective rate of an FQHC on its own initiative, in accordance with paragraph (10)(D) of this subsection, if it is determined that a change of scope has occurred and an adjustment to the effective rate as defined in paragraph (7) of this subsection is warranted based on the audit of the cost report described in paragraph (8)(C) of this subsection.

(7) 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.

(A) A change in scope includes:

(i) an increase in service intensity attributable to changes in the types of patients served, including but not limited to, patients with HIV/AIDS, the homeless, the elderly, migrants, those with other chronic diseases or special populations;

(ii) any changes in services or provider mix provided by an FQHC or one of its sites;

(iii) changes in operating costs that have occurred during the fiscal year and which are attributable to capital expenditures, including new service facilities or regulatory compliance;

(iv) changes in operating costs attributable to changes in technology or medical practices at the FQHC;

(v) indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(vi) any changes in scope approved by the Health Resources and Service Administration (HRSA).

(B) 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 (15%) 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 Medicare concept of a "prudent buyer" in purchasing its contracted medical services.

(8) Cost report forms and worksheets are required as follows:

(A) As-Filed Medicare Cost Report. The As-Filed Medicare Cost Report includes:

(i) CMS form 222-92 Independent Rural Health Clinic/Freestanding and Federally Qualified Health Center Worksheet, including the HCFA 339 Form.

(I) Worksheet S part 1 - Statistical Data;

(II) Worksheet S part 2 - Certification By Officer or Administrator

(III) Worksheet S part 3 - Statistical Data for Clinics Filing Under Consolidated Cost Reporting;

(IV) Worksheet A page 1 - Reclassification and Adjustment of Trial Balance of Expenses;

(V) Worksheet A page 2 - Reclassification and Adjustment of Trial Balance of Expenses;

(VI) Worksheet A-1 - Reclassifications;

(VII) Worksheet A-2 - Adjustments to Expenses;

(VIII) Worksheet A-2-1, Parts I to III - Statement of Cost of Services from Related Organizations;

(IX) Worksheet B part I and II - Visits and Overhead Cost for RHC/FQHC Services; and

(X) Worksheet C part I and II - Determination of Medicare Reimbursement.

(ii) Texas Medicaid Supplemental Worksheets.

(I) Determination of FQHC Cost Based Rate;

(II) Exhibit 1 - Determination of FQHC Medicaid Reimbursable Cost - Rate Worksheet;

(III) Exhibit 2 - Visit Reconciliation - Employed Providers; and

(IV) Exhibit 3 - Visit Reconciliation - Contract Service Providers.

(iii) Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance.

(iv) A mapping of the Trial Balance that shows the tracing of each Trial Balance account to a line and column on Worksheet A pages 1 and 2.

(v) Documentation supporting the provider's reclassification and adjustment entries.

(vi) A Schedule of Depreciation of depreciable assets.

(vii) A listing of all satellites, if applicable.

(viii) Federal Grant Award notices or changes in scope approved by HRSA.

(ix) All items must be complete and accurate.

(B) Final Audited Medicare Cost Report. In-state providers must file the final audited cost report received from Medicare, as required in paragraph (9) of this subsection. The final audited Medicare cost report includes:

(i) A copy of the final audited CMS form 222-92 Independent Rural Health Clinic/Freestanding and Federally Qualified Health Center Worksheets, including the HCFA 339 Form filed with Medicare.

(ii) Texas Medicaid Supplemental Worksheets.

(I) Determination of FQHC Cost Based Rate;

(II) Exhibit 1 - Determination of FQHC Medicaid Reimbursable Cost - Rate Worksheet;

(III) Exhibit 2 - Visit Reconciliation - Employed Providers; and

(IV) Exhibit 3 - Visit Reconciliation - Contract Service Providers.

(iii) All items must be complete and accurate.

(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 (6) months of financial information. The documents needed for in-state and out-of-state providers filing a change of effective rate cost report are the same as required for the as-filed cost report in paragraph (8)(A) of this subsection.

(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 (12) months of projected financial information. The required documents are the same as required for the as-filed cost report in paragraph (8)(A) of this subsection, except that the information contained in clauses (iii), (iv) and (v) are not required.

(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. A provider filing the Low Medicare Utilization cost report must complete and submit all required forms and supporting documentation described in paragraph (8)(A) of this subsection for all rate determination processes described in paragraph (10) of this subsection.

(F) If a provider fails to submit a required cost report, HHSC or its designee may delay or withhold vendor payment to the provider until a complete cost report has been received and accepted by HHSC or its designee.

(9) Cost Report Filing Requirement. Each FQHC must submit a copy of its Final Audited Medicare Cost Report, as described in paragraph (8)(B) of this subsection, to HHSC or its designee within thirty (30) days of receipt of the report from Medicare. An FQHC filing a Low Utilization Cost Report with Medicare may comply with this subsection by filing a copy of such cost report with HHSC annually, within thirty (30) days of filing the report with Medicare.

(10) FQHC rate determination process.

(A) New FQHC.

(i) If the owner of a new FQHC owns one or more FQHCs in Texas and will include the new facility on the Medicare cost report of another FQHC, then HHSC will apply the rate assigned to the other FQHC as the interim base rate of the new FQHC. If the owner of a new FQHC does not include the new facility on the Medicare cost report of another FQHC, the [~~A~~] new FQHC must file a projected cost report, pursuant to paragraph (8)(D) of this subsection, within 90 days of their designation as an FQHC 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 this [~~a~~] new FQHC shall be set at the lesser of eighty percent (80%) of the anticipated reasonable costs determined from the projected cost report or eighty percent (80%) 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, pursuant to paragraph (8)(A) of this subsection, within five (5) calendar months after the end of the FQHC's first full fiscal year. HHSC will determine an updated interim base rate based on one hundred percent (100%) of the reasonable costs contained in the As-Filed Medicare Cost Report. An As-Filed Medicare Cost Report must reflect twelve (12) months of continuous service that meets the requirements of paragraph (7)(B) of this subsection. Interim rates will be adjusted prospectively until the Final Audited Medicare Cost Report reflecting twelve (12) months of continuous service is processed. HHSC will, within eleven (11) months of receipt of the As-Filed Medicare Cost Report reflecting twelve (12) months of continuous service determine the updated interim base rate.

(iii) Each new FQHC must submit to HHSC or its designee a Final Audited Medicare Cost Report, pursuant to paragraph (9) of this subsection. The Final Audited Medicare Cost Report settlement, reflecting twelve (12) months of continuous service, must be completed within eleven (11) months of receipt of a cost report. 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 paragraph (4) of this subsection to determine the effective rate.

(iv) If a new FQHC cost report described in clause (ii) or (iii) of this subparagraph does not meet the requirement of reflecting twelve (12) months of continuous service that meets the requirements of paragraph (7)(B) of this subsection, HHSC will prospectively establish the interim rate based on the lesser of

the interim rate determined by the cost report or eighty percent (80%) 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.

(B) Change of Ownership. If an existing FQHC facility changes ownership, the new owner must notify HHSC of the ownership change within ten (10) calendar days of the 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 one hundred percent (100%) of the previous owner's effective rate, and will then follow the procedures under subparagraph (A)(ii) and (iii) of this paragraph.

(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 clause (i) of this subparagraph.

(iv) If the new owner 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 subparagraph (A) of this paragraph.

(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 described in paragraph (8)(C) of this subsection. 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 pursuant to paragraph (7) of this subsection. 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. Within sixty (60) days of receiving the Change of Effective Rate Cost Report described in paragraph (8)(C) of this subsection, HHSC or its designee will make a determination regarding a new interim base rate.

(ii) If HHSC determines through the review of the information provided in clause (i) of this subparagraph that an adjustment to the effective rate is warranted, HHSC will determine an interim base rate based on one hundred percent (100%) 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, described in paragraph (8)(A) of this subsection, within five (5) calendar months after the end of the FQHC's fiscal year. HHSC and the FQHC will then follow the procedures under subparagraph (A)(ii) and (iii) of this paragraph.

(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 one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater. After reviewing the Final Audited Medicare Cost Report described in paragraph (8)(B) of this subsection, HHSC will determine if an in-state FQHC is being reimbursed more than one hundred percent (100%) 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 subsection (a) of this section for the same time period corresponding to the FQHC's Final Audited Medicare Cost Report described in subclause (I) of this clause;

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

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

(V) The prospective rate described in clause (iii) of this subparagraph will be determined by adjusting the new final base rate from subclause (IV) of this clause in accordance with paragraph (4) of this subsection to determine the effective rate.

(VI) The new final base rate from subclause (IV) of this clause and subsequent effective rates will not apply to claims for services provided prior to the implementation date described in clause (iii) of this subparagraph.

(ii) State initiated reviews will be based on a determined twelve (12) month time period and the most recent cost data received in accordance with paragraph (9) of this subsection. For any provider filing a Low Utilization Cost Report with Medicare in accordance with paragraph (9) of this subsection, upon request by HHSC, the provider must complete and submit the forms and worksheets described in paragraph (8)(A) of this subsection for the fiscal years

ending within the determined twelve (12) month time period, even if the cost report was not required to be filed by Medicare.

(iii) HHSC will apply the state initiated rate reduction prospectively beginning on the first day of the month following forty-five (45) days after the date of the Final Base Rate Notification letter. The final base rate is adjusted in accordance with paragraph (4) of this subsection to determine the effective rate.

(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 if the FQHC can show that it is operating in an efficient manner as defined in paragraph (7)(B) of this subsection, or can show a change in scope as defined in paragraph (7)(A) of this subsection.

(v) For PPS the state initiated reviews is not applicable, as described in subsection (a)(2) of this section.

(E) Final Base Rate Notification Letter. HHSC will provide to an FQHC written notification of any determined final base rate forty-five (45) days prior to implementation of the final base rate. The effective date of the final base rate is determined by the applicable FQHC Rate Determination Process described in subparagraph (A) - (D) of this paragraph.

(F) Request for Review of Final Base Rate. The FQHC may submit a written request for review of the final base rate within 30 days of the date of the Final Base Rate Notification Letter in the circumstances described in clauses (i) - (iii) of this subparagraph.

(i) The FQHC believes that HHSC made a mathematical error or data entry error in calculating the FQHC's reasonable cost. The request for review must include the supporting documentation of the perceived mathematical error or data entry error in calculating the final base rate. HHSC will evaluate the request for review and the merit of the supporting documentation. 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 Texas Medicaid Supplemental Worksheets described in paragraph (8)(A) of this subsection that would result in a different calculation of the FQHC's reasonable cost. The request for review must include the corrected Texas Medicaid Supplemental Worksheets and supporting documentation of the correction of error in reporting of cost or data. 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) The FQHC believes that the FQHC made an error in reporting its cost or data in the Final Audited Medicare Cost Report described in paragraph (8)(B) of this subsection that would result in a different calculation of the FQHC's reasonable

cost. The request for review must include the correspondence submitted to the Medicare fiscal intermediary to amend the Medicare cost report. HHSC will consider the request for review upon receipt of the provider amended Final Audited Medicare Cost Report and supporting documentation of the correction of error in reporting of cost or data. 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.

(iv) HHSC will send the FQHC written notification of the results of its request for review.

(v) If the FQHC disagrees with the results of the review in clause (iv) of this subparagraph, the FQHC may formally appeal in accordance with §§357.481 - 357.490 of this title (relating to Hearings Under the Administrative Procedure Act).

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

(12) A visit is a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, a qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an 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 paragraph (13) of this subsection.

(13) A medical visit is a face-to-face, telemedicine, or telehealth 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, telemedicine, or telehealth encounter between an FQHC patient and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a Texas Health Steps Medical Screen.

(c) Payment dispute.

(1) An FQHC that believes an MCO or DMO has improperly denied a claim for payment or has provided insufficient reimbursement may appeal to the MCO or DMO. The MCO or DMO must address provider appeals as required by Texas Government Code §533.005(a)(15) and (19) and its contractual obligations with HHSC.

(2) If the MCO or DMO is not able to resolve the appeal, the FQHC may submit a complaint to HHSC for review. If HHSC finds the MCO or DMO has not correctly reimbursed the FQHC in accordance with contractual obligations, HHSC may require the MCO or DMO to reimburse the FQHC and assess remedies against the MCO or DMO in accordance with HHSC's contract with the MCO or DMO.

(3) The state will ensure the FQHC is paid the full PPS or APPS encounter rate for all valid claims.

(4) This subsection applies to claims for services provided by an FQHC on an in-network or out-of-network basis.