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State/Territory Name: Texas

State Plan Amendment (SPA) #: 20-0022

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved Page

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

November 18, 2020

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

RE: Texas TN 20-0022

Dear Ms. Stephens:

We have reviewed the proposed Texas State Plan Amendment (SPA) to Attachment 4.19-B, TX#20-0022, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2020. This state plan amendment ensures that a Federally Qualified Health Center (FQHC) is reimbursed for covered telemedicine medical services or telehealth services delivered by a health care provider to a Medicaid recipient. This amendment will also clarify how rates are set for multiple FQHCs that are authorized to file a consolidated cost report.

Based upon the information provided by the State, we have approved the amendment with an effective date of September 1, 2020. 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 Tamara Sampson at 214-767-6431 or Tamara.Sampson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: **20-0022**

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:
September 1, 2020

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:
42 CFR §440.20; 42 USC § 1396a(bb)

7. FEDERAL BUDGET IMPACT:
a. **FFY 2020 $0**
b. **FFY 2021 $0**
c. **FFY 2022 $0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19b
Page 24d
Page 24d.1
Page 24h

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19b
Page 24d (~~TN 10-0016~~) TN-10-0061
N/A - New page
Page 24h (~~TN 10-0016~~) TN-10-0061

10. SUBJECT OF AMENDMENT:

The proposed amendment will ensure that a Federally Qualified Health Center (FQHC) is reimbursed for covered telemedicine medical services or telehealth services delivered by a health care provider to a Medicaid recipient. As amended, a visit for an FQHC will include covered telemedicine and telehealth medical services. The proposed amendment will also clarify how rates are set for multiple FQHCs that are authorized to file a consolidated cost report.

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. [redacted]

13. TYPED NAME:
Stephanie Stephens

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 30, 2020

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/30/2020

18. DATE APPROVED:
11/18/2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
9/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Todd McMillion

22. TITLE:
Director, Division of Reimbursement Review

23. REMARKS:

*Pen and ink change requested in block 9.

FORM CMS – 179 (07-92)

(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) If the owner of a new 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 as the interim base rate of the new FQHC. If the owner of a new FQHC facility does not include the new facility on the Medicare cost report of another FQHC facility, the 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 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.

(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.

(8) FQHC rate determination process (continued)

(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.

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

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

(10) 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, 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. 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, 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 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.