SUMMARY
The Texas Health and Human Services Commission (HHSC) published a final FQHC Affiliations rule in the October 11th edition of the Texas Register, with an effective date of October 17, 2013. Existing FQHC sites will not be required to update their Medicaid enrollment with the new required affiliation agreement attestation forms until the site has to re-enroll in Medicaid as a requirement of the Affordable Care Act. (Please note that TMHP will contact the center when it is your turn to re-enroll.) New sites enrolling in Medicaid must complete the new attestation form as part of the enrollment packet. HHSC has directed TMHP to publish a bulletin advising FQHC providers about the new forms and the requirements. Both the bulletin and the attestation form should be available on the TMHP website within the next 30 days.

The final regulations define an affiliate agreement as an arrangement between the FQHC and a health care provider that can generate a billable encounter in the FQHC setting (physician, PA/APRN, dentist, mental health provider, etc.), under which the affiliate provides services within the FQHC's scope of services on behalf of the FQHC and will be reimbursed by the FQHC. In other words, if you have a contracted (not employed) provider who generates encounters that are billed to Medicaid under the FQHC number, that is considered an affiliation under the final rule. Temporary and substitute providers and locum tenens arrangements are exempt from the definition of affiliate.

Health centers must complete the FQHC affiliations attestation as part of the Medicaid enrollment application, and if the center has affiliate agreements in place, indicate that the affiliation agreement is necessary by answering the following questions:

- Does the affiliation governed by the agreement increase access to care?
- Does the affiliation governed by the agreement:
  - add services to the FQHC's scope of services; or
  - enable the FQHC to maintain access to care or the services currently within the FQHC's scope of services?
- Would a health-care provider employed by the FQHC be less expensive than the affiliation governed by the agreement?

After HHSC receives the affidavit, they have 30 days to make a determination on whether the affiliation is justified. If HHSC determines the affiliation is not justified, the FQHC will not be reimbursed for services billed to Medicaid under the affiliate arrangement.

BACKGROUND
Pursuant to a budget rider passed by the 82nd Legislature in 2011, all FQHCs must attest whether or not they operate under any affiliate agreements with providers. HHSC began implementing this new requirement in late 2011. Many of you may remember filling out Community and Migrant Health Center Affiliation Affidavits, where you were asked whether your affiliate agreements had been approved by the BPHC. If not yet approved by the BPHC, you were asked to send the contracts to your project officer for approval. During the summer of 2012 when this process was occurring, affiliate agreement had been defined by HHSC to include any contracts, including laboratory and radiology groups, etc. This broad definition compounded the confusion, along with the fact that the BPHC does not typically review FQHC affiliate agreements as defined by the state. TACHC worked with HHSC throughout 2012 to arrive at a definition and a process that would meet the legislative requirement without becoming overly burdensome for both health centers and the state.

The results of those conversations are the new rules that were finalized in October and the revised affidavits and process HHSC will use to collect the affidavits. The state will not be using the initial affidavits submitted last summer and will not be requiring BPHC approval of affiliate contracts. Health centers do not need to take action until the Medicaid re-enrollment process begins with TMHP.

Please contact Shelby Massey with any questions.