State Policy Report #40

# Update on the Status of the FQHC Medicaid Prospective Payment System in the States

November 2011

*Based on an assessment of State Primary Care Associations*

**COPYRIGHT November 2011**
**National Association of Community Health Centers**

# State Policy Report #40:

## 2011 Update on the Status of the Medicaid Prospective Payment System in the States

*Prepared by:*

**Dawn McKinney, Director, State Affairs**
**Robert Kidney, Assistant Director, State Affairs**
**Kersten Burns, Public Policy Intern, State Affairs**

**National Association of Community Health Centers**
Department of Federal and State Affairs
1400 Eye Street, NW Suite 910
Washington, DC 20005
(202) 296-3800
www.nachc.org

For more information, please contact:
Dawn McKinney
dmckinney@nachc.org

**About NACHC**
Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's Health Centers and as an advocate for health care access for the medically underserved and uninsured.

**NACHC's Mission**
To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

## Contents

Introduction…………………………………………………………………………………3

Summary of Findings……………………………………………………………………...……4

Table 1: Methodology………………………………………………………………………7

Table 2a: Service-specific Rates…………………………………………………...…11

Table 2b: OB Services…………………………………………………………………..…....16

Table 3: Types of Providers that can Generate a PPS Encounter…..………….......….20

Table 4a: Billable Encounters……………………………………………………………...26

Table 4b: Billable Encounters (con't)……………………………………………………..31

Table 5a: Scope of Service Definition....................................................................…...35

Table 5b: Scope of Service Rate Adjustment Process……………………………………43

Table 6: Cost Reports…………………………………………………………………….52

Table 7a: Timing of Rate Changes………………………………………………………..56

Table 7b: Health Centers Seeking Rate Changes…………………………………………61

Table 8a: Wrap-around Payments to FQHCs……………………………………………64

Table 8b: Wrap-around Payments to HMOs…………………………………………..…74

Table 9: Impact of PPS/APM on FQHCs…………………………………………………..76

Table 10: Changes to PPS/APM…………………………………………………………..80

## About this Report

- PCAs representing 44 states, the District of Columbia and Puerto Rico responded at least in part to the survey.
- Tables 1-10 include the PCA responses.
- If a PCA did not respond to a specific part of a question that portion of the table is blank.
- If a PCA did not respond to a question in its entirety, that state is not included in the table.
- 6 states are not included in the survey: Alaska, Florida, Georgia, Iowa, Kentucky, and Maryland.

## Introduction

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) replaced the traditional cost-based reimbursement system for federally-qualified health centers (FQHCs) with a new prospective payment system (PPS).[1] The PPS reestablishes the Federal requirement that FQHCs be reimbursed at a minimum rate for services provided to Medicaid patients. This payment baseline is not nationwide but rather is based on the average of each FQHC's FY1999 and FY2000 reasonable costs per visit rates - therefore, it is a unique payment rate for each FQHC. For existing FQHCs, a baseline per visit rate was established for services provided between January 1, 2001 and September 30, 2001, and then adjusted to take into account any change in the scope of services during that year. For FY2002 and the years thereafter, the per visit rate equals the previous year's per visit rate, adjusted by the Medicare Economic Index (MEI) for primary care and any change in the FQHC's scope of services.[2]
While the PPS establishes a Medicaid per visit payment rate floor, it does not require states to reimburse FQHCs using the PPS methodology. States may choose to implement an alternative payment methodology (APM), including continuation of reasonable cost reimbursement, as long as it does not pay less than what FQHCs would have received under PPS and the affected FQHCs agree to the APM.

Since 2003, the National Association of Community Health Centers (NACHC) has annually reviewed PPS implementation and policy in the states with the help of the Primary Care Associations (PCAs). The findings in this report represent information provided solely by the PCAs, although in some cases PCAs may have consulted with their state Medicaid agencies.

---

[1] 1 Public Law No. 106-554.
[2] 2 NACHC Medicare/Medicaid Technical Assistance Issue Brief #69 “Understanding the Medicaid Prospective Payment System for Federally Qualified Health Centers (FQHCs)”. January 2001.

# Summary of Findings

**PPS Snapshot**

- 21 states report using PPS, 12 APM and 12 both. NH has yet to implement PPS.
- 5 states (MN, NJ, NY, RI, and TN) use an APM other than reasonable cost.
- The vast majority of states use the MEI for an inflation factor, but Texas reported receiving MEI + .5%, which is actually a reduction from a higher rate health centers previously received.

**Payment—Rates, Services, Visits**

- 20 states reported that the same PPS/APM rate is paid for all services, while 24 states have more than one rate. 14 states have a medical rate, 22 dental, and 8 mental health. Other rates include: off-site, lab, radiology, pharmacy, group therapy, obstetrics, and optometry.
- With regard to obstetric (OB) services, most states include these services in the rate with reimbursement for deliveries as the major variable. Most states pay for deliveries either fee for service or part of a global rate.
- 82% of states allow for more than one visit per day, although many have conditions on additional visits such as one medical, one dental and one mental health. 5 states don't place limits on the numbers of visits, while 7 states have a one visit limit.
- 12 states have placed some sort of limits on the number of Medicaid visits per year, not just on FQHCs but other providers as well. For example, some limit the number of a certain type of service like behavioral health or family planning, while 3 states (AR, LA, MS) have a total annual visit limit of 12.
- 16 states reported that co-pays are deducted from FQHC payments.
- While federal law requires state Medicaid programs to cover services provided by certain providers approved under Medicare (Physicians, Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, Licensed Clinical Social Workers and Clinical psychologists) some states have added to the list. The other most

commonly covered are dentists (35) and dental hygienists (18). See table 3 for a complete list of other providers.

**Scope of Service**

- 16 states reported that there is no definition of scope of service. Of those states with a definition, the majority said they would like to see it changed.
- 12 states do not have a rate adjustment process. Similarly to the definition, of those that do, the majority said they would like to see it changed.
- In 8 states rate changes are effective the day the new service is added, 6 states also use the date the request is approved and 3 use the date Medicaid receives the request.
- In terms of the time from request to payment, a few states reported as little as 30 or 60 days, but many others reported significant delays from 2 to 5 years.

**Wrap-Around Payments**

- 22 states provide wrap-around payments to FQHCs treating Medicaid managed care enrollees. 14 states indicated that there are no managed care enrollees.
- 9 states provide wrap-around payments on a quarterly basis, 4 provide monthly payments and 4 pay as claims are submitted while 5 more pay every 4-12 months. 15 states reconcile at the end of the year, while 12 do not.
- The PCAs in the majority of states feel that the wrap-around process is problematic, reporting significant delays, even years in a few cases.
- 5 states (CO, CT, MA, MS, DE) actually pay the managed care organizations the wrap-around who in turn pay the health centers. Texas just made this change, which is effective September 1st. NJ, NC, and TN are considering this change.

**Other**

- Health centers in 32 states file cost reports. 15 reported they don't want to eliminate costs reports, while 7 do.

### Recent Changes

- 11 states reported policy changes to PPS in the last year. For example, Texas health centers saw their inflation factor reduced, Hawaii required managed care organizations to pay health centers the full amount, and Washington reverted to MEI and significantly reduced the APM for health centers.
- 18 states reported that changes to PPS are currently being considered. Changes being explored include: adding medical education costs (MA), developing APM to implement primary care homes (OR), claims based reimbursement with managed care organizations paying the wrap-around (TN).

### Best and Worst Practices

- The most common problems PCAs cited with their state's PPS included:
  - Delays in wrap-around
  - Lack of change in scope definition and process
  - Caps and screens
- Here is a sampling of some of the more beneficial aspects of PPS that PCAs reported in their states:
  - Electronic health records as a triggering event for change in scope (CA)
  - Fee for service reimbursement for deliveries (CT)
  - Multiple visits per day (HI)
  - Addition of LCPCs as billable providers (ME)
  - Add-on payments for after-hours urgent care (MA)

## TABLE 1: Methodology

| State N=46 | FQHC Reimbursement Methodology | | | APM Methodology | | MEI Used? | Comments |
|---|---|---|---|---|---|---|---|
| | PPS | APM | Both | Reasonable Cost | Other | | |
| **Alabama** | X | | | | | YES | |
| **Arizona** | | | X | X | | | |
| **Arkansas** | | | X | X | | YES | |
| **California** | | | X | X | | YES | |
| **Colorado** | | X | | X | | YES | |
| **Connecticut** | X | | | | | YES | |
| **Delaware** | X | | | | | YES | |
| **District of Columbia** | | | X | X | | YES. Increases in January. | |
| **Hawaii** | X | | | | | YES | |
| **Idaho** | X | | | | | YES | |
| **Illinois** | X | | | | | YES | |
| **Indiana** | X | | | | | YES | |
| **Kansas** | | | X | X | | NO | |
| **Louisiana** | X | | | | | YES | |
| **Maine** | X | | | | | YES | |
| **Massachusetts** | | X | | X | | YES | |
| **Michigan** | | X | | X | | YES | |
| **Minnesota** | | | X | | X | YES | Three rates: 1. PPS - 1999 & 2000 costs trended forward inflated by the MEI annually 2. APM1 - 100% of costs |

| State<br><br>N=46 | FQHC Reimbursement Methodology | | | APM Methodology | | MEI Used? | Comments |
|---|---|---|---|---|---|---|---|
| | PPS | APM | Both | Reasonable Cost | Other | | |
| | | | | | | | (Medicare limit applies) + add-on's for enrolled teaching FQHC's and Pay for Performance bonus incentive add-on's 3. APMII - PPS + 2% currently(for MCRE tax) + add-on's for enrolled teaching FQHC's + Pay for Performance + tentatively PCC |
| **Mississippi** | X | | | | | YES | |
| **Missouri** | | X | | X | | NO | |
| **Montana** | X | | | | | YES | |
| **Nebraska** | X | | | | | YES | |
| **Nevada** | X | | | | | NO | |
| **New Hampshire** | | N/A | | | | YES. While NH has yet to implement PPS/APM, we are still working with the state on the project. The MEI is the index that they have recommended using. | |
| **New Jersey** | | X | | | X | YES | We were given the option of using the highest year (1999 or 2000) versus using a blended rate. For that reason, it is an alternate payment methodology. |
| **New Mexico** | X | | | | | YES | |
| **New York** | | | X | | X | YES | Ambulatory Patient Groups - The State replaced Medicaid outpatient "threshold visit" methodology with the Ambulatory Patient Groups (APG) payment methodology. The goal was for the APG Medicaid payment methodology to provide greater reimbursement for high intensity services and relatively less reimbursement |

| State<br><br>N=46 | FQHC Reimbursement Methodology | | | APM Methodology | | MEI Used? | Comments |
|---|---|---|---|---|---|---|---|
| | PPS | APM | Both | Reasonable Cost | Other | | |
| | | | | | | | for low intensity services. The payment methodology also allows for greater payment homogeneity for comparable services across all ambulatory care settings. |
| **North Carolina** | | | X | X | | YES | |
| **North Dakota** | | | X | X | | YES | |
| **Ohio** | X | | | | | YES | |
| **Oklahoma** | X | | | | | YES | |
| **Oregon** | X | | | | | YES | |
| **Pennsylvania** | X | | | | | YES | |
| **Puerto Rico** | X | | | | | YES | |
| **Rhode Island** | | X | | | X | NO. Cost-based system. | Reasonable cost, with explanation: complicated cost-based system utilizing 5 cost centers with averages, corridors and caps |
| **South Carolina** | | X | | X | | NO | |
| **South Dakota** | X | | | | | YES | |
| **Tennessee** | | X | | | X | YES | PPS using 2004-2005 or 2005-2006 costs. |
| **Texas** | | X | | X | | NO. MEI+0.5% | |
| **Utah** | | | X | X | | YES | |
| **Vermont** | | X | | X | | NO. APM encounter rate is capped at 125% of Medicare encounter rate and increases as Medicare rate increases. | |

| State<br><br>N=46 | FQHC Reimbursement Methodology | | | APM Methodology | | MEI Used? | Comments |
|---|---|---|---|---|---|---|---|
| | PPS | APM | Both | Reasonable Cost | Other | | |
| **Virginia** | | | X | X | | YES | |
| **Washington** | | X | | X | | YES. Effective 4/7/2011 previously a WA-specific health care index was applied. | |
| **West Virginia** | | X | | X | | YES | |
| **Wisconsin** | | | X | X | | YES | |
| **Wyoming** | X | | | | | YES | |
| **TOTAL** | **21** | **12** | **12** | **20** | **5** | **Y=38 N=7** | |

## TABLE 2a: Service-specific Rates

| State N=45 | Does the State Pay the Same PPS/APM Rate for All Types of Services? | Services with Separate Rates | | | | How are such service-specific rates established? | Can FQHCs choose between having one all-inclusive rate or multiple service-specific rates? |
|---|---|---|---|---|---|---|---|
| | | Medical | Mental Health | Dental | Other (state licensed within scope of service) | | |
| **Alabama** | YES | | | | | | |
| **Arkansas** | NO | | | X | Pays 95% of the Delta Dental Premier Plan | Delta Dental Rates | NO |
| **California** | YES | | | | | | |
| **Colorado** | YES | | | | | | NO |
| **Connecticut** | NO | X | X | X | | Medicaid cost report | NO |
| **Delaware** | NO | | | X | | Dental is paid as fee for service based on a schedule of dental reimbursements established by the state. | NO |
| **District of Columbia** | YES | | | | | | |
| **Hawaii** | NO | X | | X | | Cost reports for 1999/2000, if service provided then, or cost reports from more recent period if established later. | NO |
| **Idaho** | NO | X | | X | | The Department sets the finalized encounter rates using the FQHC's medical/mental and dental encounter costs. | NO |
| **Illinois** | NO | X | X | X | | Cost report | NO |
| **Indiana** | YES | | | | | | |
| **Kansas** | YES | | | | | | |

| State N=45 | Does the State Pay the Same PPS/APM Rate for All Types of Services? | Services with Separate Rates | | | | How are such service-specific rates established? | Can FQHCs choose between having one all-inclusive rate or multiple service-specific rates? |
|---|---|---|---|---|---|---|---|
| | | Medical | Mental Health | Dental | Other (state licensed within scope of service) | | |
| **Louisiana** | YES | | | | | | NO |
| **Maine** | YES | | | | | | |
| **Massachusetts** | NO | X | X | X | X | Lab and Radiology on rates established by Rate Setting; Pharmacy under agreement with Medicaid; M/BH on rates established by rate setting - some by fees negotiated with BH vendor(s). Dental on Fee Scale with supplemental CHC payment | NO |
| **Michigan** | YES | | | | | | |
| **Minnesota** | NO | X | | X | | Base rates for Medical and Dental were established in 2001, based on 1999/2000 cost reports and inflated by MEI. New CHC organizations/sites and existing CHC service expansions report costs to state agency to determine rate. | NO |
| **Mississippi** | | | | | Off-site services are paid FFS rate. They include rounds, deliveries, surgeries, and home health visits. | On each FQHC's historical Medicaid costs. | NO |
| **Missouri** | NO | X | X | X | | Interim payment is made as a percentage of individual health | |

| State N=45 | Does the State Pay the Same PPS/APM Rate for All Types of Services? | Services with Separate Rates | | | | How are such service-specific rates established? | Can FQHCs choose between having one all-inclusive rate or multiple service-specific rates? |
|---|---|---|---|---|---|---|---|
| | | Medical | Mental Health | Dental | Other (state licensed within scope of service) | | |
| | | | | | | center charge schedules for CPT and HCPCS billing codes. Reasonable cost reimbursement is accomplished through a retrospective reconciliation cost report process | |
| **Montana** | YES | | | | | | |
| **Nebraska** | NO | X | | | PPS not paid for dental or mental/Behavioral Health | N/A | NO |
| **Nevada** | YES | | | | | | |
| **New Hampshire** | NO | | | X | NH has not implemented PPS/APM. However, the dept. has said they will allow BH to be billed as an encounter, but not dental | This is still being worked on. | NO |
| **New Jersey** | YES | | | | | | |
| **New Mexico** | YES | | | | | | |
| **New York** | NO | | | | Off-site visits, group therapy, some HIV services | State determined | NO |

| State N=45 | Does the State Pay the Same PPS/APM Rate for All Types of Services? | Services with Separate Rates | | | | How are such service-specific rates established? | Can FQHCs choose between having one all-inclusive rate or multiple service-specific rates? |
|---|---|---|---|---|---|---|---|
| | | Medical | Mental Health | Dental | Other (state licensed within scope of service) | | |
| **North Carolina** | NO | X | X | X | Medicaid reconciles to a "single all-encompassing composite PPS rate". | Unknown | NO |
| **North Dakota** | NO | X | | X | | Unknown | NO |
| **Ohio** | NO | X | X | X | X | interim rate is set, then submit annual cost report and the start-up rate will be adjusted accordingly | NO |
| **Oklahoma** | YES | | | | | | |
| **Oregon** | NO | X | X | X | | At the request of the FQHC a separate rate may be created based upon a specific request backed up by a cost report segregating costs between the specific service and the total remainder. | |
| **Pennsylvania** | NO | | | X | | Cost report | NO |
| **Puerto Rico** | YES | | | | | | |
| **Rhode Island** | NO | | | X | | separate cost reports | NO |
| **South Carolina** | YES | | | | | | |
| **South Dakota** | YES | | | | | | |
| **Tennessee** | NO | | | X | Optometry Pharmacy | Cost-based | YES |
| **Texas** | YES | | | | | | |

| State N=45 | Does the State Pay the Same PPS/APM Rate for All Types of Services? | Services with Separate Rates | | | | How are such service-specific rates established? | Can FQHCs choose between having one all-inclusive rate or multiple service-specific rates? |
|---|---|---|---|---|---|---|---|
| | | Medical | Mental Health | Dental | Other (state licensed within scope of service) | | |
| **Utah** | NO | | | X | | FFS rate of state Medicaid | NO |
| **Vermont** | NO | | | X | | Payments for dental care use same cost-based methodology as payments for medical care but are not subject to a cap. | NO |
| **Virginia** | NO | X | | X | OB, X-ray | Actual costs for Dental, OB, and X-ray with no cap on rate. | NO |
| **Washington** | NO | X | X | X | Each FQHC has the choice of selecting a single "blended" rate or separate rates for medical, dental and behavioral health. | Cost reports or 1999-2000 rates trended forward. | FQHCs have the option of establishing separate medical, behavioral health and dental APM rates. Pharmacy services are reimbursed as fee-for-service, but costs are included in the medical cost center of the cost report. Costs for lab and x-ray are allowable costs and incorporated within the FQHC encounter rate. |
| **West Virginia** | NO | | | X | | FFS | NO |
| **Wisconsin** | YES | | | | | | |
| **Wyoming** | YES | | | | | | |
| **TOTAL** | **Y=20 N=24** | **14** | **8** | **22** | | | **Y=2 N=23** |

## TABLE 2b: OB Services

| State<br><br>N= 42 | Does your state include OB in the FQHC PPS or APM rate? | | | | |
|---|---|---|---|---|---|
| | No | Yes, including payment for deliveries | Yes, NOT including deliveries (paid for by FFS or as part of a global rate to the center) | Yes, NOT including deliveries (paid FFS directly to provider) | Other |
| **Alabama** | X | | | | |
| **Arkansas** | | | X | | |
| **California** | | | | | Yes, however clinics have the option to carve-out OB deliveries and bill those FFS, however it is an arduous process. |
| **Colorado** | | | | | State offers ability for CHCs to get their FQ rate for ob services, and paid FFS to the center for deliveries, but CHC payment varies by CHC based on the ob services they offer and their relationship with their local hospital(s). |
| **Connecticut** | | | X | | |
| **Delaware** | | | | X | |
| **District of Columbia** | | | | | Unknown |
| **Hawaii** | | | X | | |
| **Idaho** | | | X | | |
| **Illinois** | | | | X | |
| **Indiana** | | | | | The health center receives payment by billing the Medicaid fee schedule rate and is paid for the professional services rendered by the OB. Facility fees are collected by the hospital. |

| State<br><br>N= 42 | Does your state include OB in the FQHC PPS or APM rate? | | | | |
|---|---|---|---|---|---|
| | No | Yes, including payment for deliveries | Yes, NOT including deliveries (paid for by FFS or as part of a global rate to the center) | Yes, NOT including deliveries (paid FFS directly to provider) | Other |
| **Louisiana** | | | | X | |
| **Maine** | | X | | | |
| **Massachusetts** | | | X | | |
| **Michigan** | | | X | | |
| **Minnesota** | | | | X | |
| **Mississippi** | | | | X | |
| **Missouri** | | X | | | |
| **Montana** | | | | X | |
| **Nebraska** | | | | X | |
| **New Hampshire** | | | | | There have been some changes in OB services and the way they are reimbursed. Two CPT codes have been eliminated or cut back significantly. Because we are still working with the state on this initiative, we can't definitively respond on the final outcome. |
| **New Jersey** | | | | | OB and certain GYN procedures are carved out and the center either bills the MCO directly if it is a managed care patient, or collects the fee for service payment, whichever is higher. |
| **New Mexico** | | | X | | |
| **New York** | X | | | | |
| **North Carolina** | | | X | | |

| State<br><br>N= 42 | Does your state include OB in the FQHC PPS or APM rate? | | | | |
|---|---|---|---|---|---|
| | No | Yes, including payment for deliveries | Yes, NOT including deliveries (paid for by FFS or as part of a global rate to the center) | Yes, NOT including deliveries (paid FFS directly to provider) | Other |
| **North Dakota** | | X | | | |
| **Ohio** | | | | X | |
| **Oklahoma** | | | X | | |
| **Oregon** | | X | | | |
| **Pennsylvania** | | | | | Most health centers who offer deliveries are paid their PPS rate. In the non-mandatory managed care region of the state, the health centers receive enhanced reimbursement for OB through the state's Healthy Beginnings Plus program. One health center is paid for deliveries off the fee schedule but the state is threatening to discontinue and pay PPS. PACHC is advocating that health centers be given the option of Healthy Beginnings Plus or payment off the fee schedule. |
| **Puerto Rico** | | | X | | |
| **Rhode Island** | | | X | | |
| **South Carolina** | | | X | | |
| **South Dakota** | | | X | | |
| **Tennessee** | | | X | | |
| **Texas** | | | X | | |
| **Utah** | | | X | | |
| **Vermont** | | | | | Prenatal care, delivery, and a post-partum visit are all |

| State<br><br>N= 42 | Does your state include OB in the FQHC PPS or APM rate? | | | | |
|---|---|---|---|---|---|
| | No | Yes, including payment for deliveries | Yes, NOT including deliveries (paid for by FFS or as part of a global rate to the center) | Yes, NOT including deliveries (paid FFS directly to provider) | Other |
| | | | | | bundled into a single payment if the FQHC provides all services. Services are unbundled if FQHC provider does not perform delivery. |
| **Virginia** | X | | | | |
| **Washington** | | | | | An additional payment for the delivery (delivery enhancement) is paid when a qualified FQHC provider performs a delivery for a managed care client assigned to the center. |
| **West Virginia** | | | X | | |
| **Wisconsin** | | | | | Yes to all three but in some cases have the capacity to deliver at health center, otherwise depends if provider has privileges at the hospital where delivery takes place |
| **TOTAL** | **3** | **4** | **17** | **8** | |

## TABLE 3: Types of Providers that Can Generate a PPS Encounter

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center's PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition-ist | Other: |
| **Alabama** | X | X | X | | | | | | | Physician's Assistants |
| **Arkansas** | X | | X | | X | X | | | | Tele-mental health (with a psychiatrist) is considered a face to face encounter that is a billable visit for our CHCs. |
| **California** | X | X | X | | X | X | | X | | Comprehensive Perinatal Services Provider, as defined in state regulations. |
| **Colorado** | X | X | X | | X | X | | | | Physician assistant, nurse midwife, and visiting nurse |
| **Connecticut** | X | X | X | | X | X | X | X | X | |
| **Delaware** | X | | X | | X | X | | | | Certified Nurse Midwives and Physician Assistants Also, the state does reimburse LCSWs at the PPS rate but the contracted MCOs do. |
| **District of Columbia** | X | X | X | | | | | | | Not sure which can generate PPS encounter per se, but |

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center's PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition-ist | Other: |
| | | | | | | | | | | this application lists general Medicaid provider enrollment types: https://www.dc-medicaid.com/dcwebportal/docs/providerenrollment/provider_application_2007.pdf |
| **Hawaii** | X | X | X | | X | X | | | | Optometrist, physician assistant. |
| **Idaho** | X | X | X | X | X | X | X | X | | |
| **Illinois** | X | X | X | | X | X | | | | LCPC |
| **Indiana** | X | X | X | X | X | X | X | X | | |
| **Kansas** | X | X | X | X | X | X | | X | X | |
| **Louisiana** | X | X | X | X | X | X | | | | |
| **Maine** | X | X | X | X | X | X | | X | | The RN can only generate a PPS encounter if the service is incident to services of approved and appropriate licensed practitioners. Additionally, dental hygienists can only generate a PPS encounter if they are |

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center’s PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition-ist | Other: |
| | | | | | | | | | | operating under the public health supervision model which has to be approved by the Board of Dental Examiners. |
| **Massachusetts** | X | | X | X | | | | | | |
| **Michigan** | X | X | X | X | X | X | | X | X | |
| **Minnesota** | X | X | X | | X | X | | | | Chiropractor, Nurse Practitioner, Nurse Midwife, Physician Assistant |
| **Mississippi** | X | X | X | | X | | | | | PA |
| **Missouri** | X | X | X | | X | X | | | | The providers checked above can bill Medicaid, but Missouri does not have a PPS system. |
| **Montana** | X | X | X | | X | X | | X | | PA’s, Certified Nurse Midwives, Nurse Specialists and Licensed Professional Counselors |
| **Nebraska** | X | | X | | | | | | | fa-c |
| **New Hampshire** | | | | | | | | | | This is still being worked on but the state wants to apply the PPS/APM |

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center's PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition- ist | Other: |
| | | | | | | | | | | consistent with federal law. There has been no change |
| **New Jersey** | X | X | X | | X | X | | X | | |
| **New Mexico** | X | X | X | | X | X | | | | |
| **New York** | X | X | X | X | X | X | X | X | | licensed midwifes |
| **North Carolina** | X | X | X | | X | X | | | | CNM Working on PA |
| **North Dakota** | X | X | X | | | X | | | | |
| **Ohio** | X | X | X | X | X | X | X | | | |
| **Oklahoma** | X | X | X | | X | X | | | | (Presently references exclusively Section 4231 Medicaid Manual providers) DDS; PA; CNMs; amending State Plan - in draft now - to also allow encounters payable for LPCs, LADCs, LMFTs, LBPs; certain visiting nurse services to the homebound. |
| **Oregon** | X | X | X | X | X | X | | X | | DDS MSW LMT |
| **Pennsylvania** | X | X | X | | X | X | | | | Expanded scope dental hygienist-- |

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center's PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition-ist | Other: |
| | | | | | | | | | | the Public Health Dental Hygiene Practitioner |
| **Puerto Rico** | X | X | | X | | X | | X | X | |
| **Rhode Island** | X | X | X | | X | X | | X | | DO |
| **South Carolina** | X | X | X | X | X | X | | X | | Certified Nurse Midwife, Physician Assistant, Chiropractor |
| **South Dakota** | X | X | | | X | X | | | | Physician Assistants Certified Nurse Midwife |
| **Tennessee** | X | X | X | | | | X | | | Pharmacist, Optometrist |
| **Texas** | X | X | X | | X | X | | X | | Optometrist, Physician Assistant, Certified Nurse Midwife, Licensed Marriage and Family Therapist, Licensed Professional Counselor |
| **Utah** | X | | X | | | | | | | Physician Assistant |
| **Vermont** | X | X | X | | X | X | | | | Other providers: PA, CNM. As mentioned above, VT Medicaid follows the same list of health professionals as Medicare. Visits with a |

| State | Health Care Providers Who Can Generate a PPS Encounter at the Health Center’s PPS Rate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MD | DMD | NP | RN | LCSW | Psycho -logist | Physical Therapist | Dental Hygienist | Nutrition-ist | Other: |
| | | | | | | | | | | DMD do generate an encounter, but these visits are not subject to the cap. |
| **Virginia** | X | | X | | | X | | | | |
| **Washington** | X | X | X | | X | X | | X | | Optometrist Osteopathic Physician (D.O.) LICSW reimbursed for children's behavioral health only. |
| **West Virginia** | X | X | X | | | X | | X | | |
| **Wisconsin** | X | | X | | X | X | X | X | | 7. Nursing Care to Homebound 8. Speech and Hearing 9. Occupational Therapist 10. Physical Therapist 11. Vocational Therapist 12. Optometrist 13. Podiatrist 14. Psychotherapist 15. Chiropractor Substance Abuse Services |

## TABLE 4a: Billable Encounters

| State<br><br>N=42 | State Definition of a Billable Encounter (that can generate a payment at health center rate) |
|---|---|
| **Alabama** | Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services. |
| **Arkansas** | Face-to-face |
| **California** | (g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit. (2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice. |
| **Colorado** | Visit means a face-to-face encounter between a center client and physician, dentist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist or clinical social worker providing the services set forth in 8.700.4. [Eff 08/30/2006] Available here. |
| **Connecticut** | Per the UDS definition--a face to face encounter with a licensed provider |
| **Delaware** | "Encounter" is defined as a face to face visit between a FQHC patient and any health professional whose services are reimbursed under the State Plan for the purpose of diagnosis or treatment. |
| **District of Columbia** | Visit -every patient encounter in an FQHC when one or more medical services are furnished to that patient. |
| **Hawaii** | Eligible Services (a) To be eligible for PPS reimbursement services must be: 1. Within the legal authority of an FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended; 11. Actually provided by the FQHC or RHC, either directly or under arrangements; 111. Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan; iv. Provided to a recipient eligible for Medicaid benefits; v. Delivered exclusively by licensed health care professionals (physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, or licensed dieticians); VI. Provided in an outpatient settings during business or after hours on the FQHC's or RHC's site. For full-benefit dual eligibles only, services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's home, within the limitation noted in Supplement 1 to Attachment 4.19-B, page 3 and; V11. Within the scope of services provided by the State under its fee-for-service Medicaid program and its Health QUEST program, on and after August 1994. |
| **Idaho** | An encounter is a face-to-face contact for the provision of medical, mental, or dental service between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse clinic social worker, clinical psychologist, other specialized nurse practitioner, dentist or dental hygienist. Contacts with more than one (1) discipline of health professional (medical, mental, or dental) in the same day and in the same location constitute a separate encounter (limited to three (3) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, mental, and dental health issues. |

| State<br><br>N=42 | State Definition of a Billable Encounter (that can generate a payment at health center rate) |
|---|---|
| **Illinois** | A billable encounter is defined as a face-to-face visit with a physician, physician assistant, midwife or nurse practitioner or, if the FQHC or RHC is enrolled to provide dental or behavioral health services, a dentist, licensed clinical psychologist, licensed clinical social worker or licensed clinical professional counselor, as applicable. Only services provided at the sites approved by HRSA in the FQHC Scope of Service, RHC site or the patient's place of residence are billable as an encounter. The face-to-face visit and all other ancillary services provided on a specific date of service will be reimbursed by the Department at the FQHC's or RHC's applicable (medical, dental or behavioral health) encounter rate. |
| **Indiana** | A face-to-face contact between a client and a provider of health care services who exercises independent judgment in the provision of health services to the individual client. |
| **Kansas** | A face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant, advanced registered nurse practitioner, nurse-midwife, dentist, dental hygienist with an "Extended Care Permit" per the Kansas Dental Practice Act, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. |
| **Louisiana** | **Covered Services**<br>A Federally Qualified Health Center (FQHC) provides core services in addition to other ambulatory services. The core services provided by FQHCs are comprised of the following: Physician services, Services and supplies incident to physician's services, Physician assistant services, Nurse practitioners and nurse midwife services, Services and supplies incident to the services of nurse practitioners, physician assistants, and certified nurse midwives, Visiting nurse services to the homebound, Clinical psychologist services, Clinical social worker services, and Services and supplies incident to the services of clinical psychologists and clinical social workers.<br>**Encounter**<br>A medical encounter (inclusive of mental health services) is defined as a face-to-face visit with a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Multiple medical encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.<br>A dental encounter is defined as a face-to-face visit with a dentist where dental services are rendered. Multiple dental encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit except for cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.<br>**Service Limits**<br>Only one medical encounter (inclusive of mental health encounters) per day per recipient and one dental encounter per day may be billed per recipient except in cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services shall not be arbitrarily delayed or split in order to bill additional encounters.<br>The encounter reimbursement includes all services provided to the recipient on that date of service and any services on a subsequent day incident to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service provided on subsequent lines.<br>When behavioral health services are the only services provided during an encounter, and are administered by a licensed clinical social worker or a clinical psychologist, the FQHC provider identification number must be placed as both the billing and attending provider with the appropriate modifiers and detail line procedure codes on the claim.<br>If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), it must be identified on the claims form by appending the Health Insurance Portability and Accountability Act (HIPAA) 1996 complaint modifier "GT" to the appropriate procedure code.<br>For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service. When this modifier is used, the visit is not counted in the 12 office and other outpatient visit limit for recipients 21 years of age and older.<br>**NOTE:** Professional services not covered through the Professional Services Program are not covered through the FQHC Program. |

| State<br><br>N=42 | State Definition of a Billable Encounter (that can generate a payment at health center rate) |
|---|---|
| **Maine** | 31.04-1 Core services include: A. services provided by physicians, physician assistants, advanced practice registered nurses, clinical psychologists, licensed clinical social workers, and licensed clinical professional counselors; B. services and supplies furnished as incident to services of approved and appropriate licensed practitioners. In order for incidental services to be covered, FQHC employees must perform the incidental service, unless it is an FQHC service routinely performed by contracted personnel or providers. Services provided by auxiliary personnel not in the employ of the FQHC, even if provided on the physician's order or included in the FQHC's bill, are not covered as incident to a physician's service. Thus, non-physician diagnostic and therapeutic services that an FQHC obtains, for example, from an independent laboratory, an independent licensed or otherwise qualified provider, or a hospital outpatient department are not covered FQHC services; C. visiting nurse services (as described in Section 31.04-4). 31.04-2 Ambulatory services include the following: A. Any other ambulatory service, including any incidental supplies associated with the performance of a service that is provided by the FQHC, and that is also included in the State's Medicaid Plan, are reimbursable. (These services must be provided in accordance with all applicable sections of the MaineCare Benefits Manual in order to be reimbursable.); |
| **Massachusetts** | Face to face by MD, NP, PA, RN |
| **Michigan** | A face to face medical visit with a provider who can practice independent judgment. |
| **Minnesota** | Dental Encounter: Services provided during a dental visit by a dentist. Medical Encounter: Services provided during a medical visit, including but not limited to: • Professional services • Supplies and pharmaceuticals incidental to professional services • Pharmaceuticals provided by an FQHC or a provider-based RHC in compliance with pharmacy guidelines • Obstetrical and perinatal care • Clinic visits • FQHC or RHC professional services provided to FQHC or RHC patients if covering inpatient hospital visits • FQHC or RHC professional services provided to FQHC or RHC patients if surgical services are directly provided by the center or clinic • Mental health visits provided in compliance with mental health guideline |
| **Missouri** | Not applicable. Billable encounters are determined based on the provider of the service, e.g., physician, NP, LCSW, DDS, DMD. |
| **Montana** | Visit means a face to face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services. For purposes of this subchapter, the terms of ARM 37.86.442 must be used to determine whether an encounter or series of encounters is one or more visits. |
| **Nebraska** | face to face visit with provider |
| **New Hampshire** | This is still being worked on. There has been no change |
| **New Jersey** | The encounter must be a face to face visit by a licensed provider. |
| **New Mexico** | An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual |
| **New York** | A qualifying threshold visit is one where the registered clinic patient has an encounter with a physician, physician assistant, nurse practitioner or licensed midwife for services that include comprehensive primary care. |
| **North Carolina** | "Face-to-face encounter by a physician or other health professional listed in this policy." (LCSW, licensed psychologist) |

| State<br><br>N=42 | State Definition of a Billable Encounter (that can generate a payment at health center rate) |
|---|---|
| **North Dakota** | Not available |
| **Ohio** | (A) “Billable services” for FQHCs are core and noncore services identified in rule 5101:3-28-02 of the Administrative Code which are provided in accordance with Chapter 5101:3-28 of the Administrative Code. (B) Services shall be billed on an encounter basis. An “encounter” is defined as face-to-face contact between a patient and provider(s) of covered core or covered noncore services, except for transportation services. |
| **Oklahoma** | 317:30-5-664.3. Health Center encounters (a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a PPS encounter rate. (b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the member's medical record. (c) For information about multiple encounters, refer to OAC 317:30-5-664.4. (d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include: (1) medical; (2) diagnostic; (3) dental, medical and behavioral health screenings; (4) vision; (5) physical therapy; (6) occupational therapy; (7) podiatry; (8) behavioral health; (9) speech; (10) hearing; (11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); (12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's scope of services and OHCA Administrative Rules when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements. (e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is: (1) Of a type commonly furnished in physicians' offices; (2) of a type commonly rendered either without a charge or included in the health clinic's bill; (3) furnished as an incidental, although integral, part of a physician's professional services; (4) furnished under the direct, personal supervision of a physician; and (5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic. (f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit. |
| **Oregon** | Standard Definition used in Medicare PPS. Face to Face with a provider exercising professional judgment which results in an individual documented record. |
| **Pennsylvania** | An eligible encounter is defined as a visit in which there is a face to face contact between a physician, dentist or midlevel practitioner who exercises judgment in the provision of healthcare services |
| **Puerto Rico** | It refers of what can be billed per visit. It is generated by the clinical staff or the health care provider who are licensed. |
| **Rhode Island** | "Face-to-face visit with a physician, PA, nurse practitioner, clinical social worker, clinical psychologist, dentist or dental hygienist" There is the additional requirement that services provided must be covered by the state Medicaid program. |
| **South Carolina** | A face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, |
| **South Dakota** | Not available |
| **Tennessee** | A face-to-face encounter/visit with an eligible provider. |
| **Texas** | (12) A visit is a face-to-face 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) |

| State<br>N=42 | State Definition of a Billable Encounter (that can generate a payment at health center rate) |
|---|---|
| | 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 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 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. |
| **Utah** | Face to face encounter w/billable provider |
| **Vermont** | An encounter at a FQHC/RHC is defined as a face-to-face visit between a patient and a provider. Face-to-face visits with more than one health professional for similar diagnoses, or face-to-face visits with more than one health professional of the same type, or multiple face-to-face visits with the same health professional on the same day at the same location generally constitute a single encounter. VT Medicaid follows the same list of health professionals as Medicare. Multiple encounters on the same day can occur when the patient suffers illness or injury with different diagnosis or receives a different treatment at a substantially different time of that day; or when the patients sees two different professionals to two very different diagnoses. A Medicaid encounter does not include total OB care. |
| **Virginia** | Not available |
| **Washington** | A face-to-face visit between a client and a qualified FQHC provider who exercises independent judgment when providing services that qualify for an encounter rate. |
| **West Virginia** | face to face visit with a specific set of provider types: MD/DO, NP,PA, LICSW, MS level psychologist, |
| **Wisconsin** | http://www.dhs.wisconsin.gov/aboutdhs/DHCF/MAStatePlan/ |

## TABLE 4b: Billable Encounters (con't)

| State N=45 | # of Billable Visits Per Day | Limit for # of Billable Visits Per Year? | Does the state deduct co-pays from FQHC payments? |
|---|---|---|---|
| **Alabama** | More than one; one medical and one dental | YES, 14 doctors visits per year | YES |
| **Arkansas** | More than one visit is allowed if there are different diagnoses, or different providers from the same FQHC | 12 Visits; Medical Necessity can override | NO |
| **California** | A second visit may be billed if it is a dental visit or if there is a subsequent illness or injury that necessitates an additional visit on the same day. | NO | NO |
| **Colorado** | Medical and dental are allowed on the same day, but medical and mental/behavioral health are NOT allowed. | NO | NO |
| **Connecticut** | 1 | NO | YES |
| **Delaware** | A patient can have a medical visit and a dental or behavioral health visit in the same day. | NO | NO |
| **District of Columbia** | One visit per location, but they may be able to go to another location for another service. | NO | NO |
| **Hawaii** | One for medical or optometry. One for behavioral health. One for dental. | Actually, planned for January 2012 but not yet. | NO |
| **Idaho** | More than one | NO | NO |
| **Illinois** | May provide one medical, one dental and one behavioral per day | NO | YES |
| **Indiana** | Medical Dental Behavioral health | Primary care -- no limit. Other services (vision, etc.) may require prior authorization after a specified amount of visits. Dental is capped at $1,000 per Medicaid member. | NO |
| **Kansas** | Medical, dental and behavioral health | NO | NO |
| **Louisiana** | One medical and one dental | 12 | NO |
| **Maine** | MaineCare's rule of thumb is one medical and one mental health visit; one medical and one dental; or one mental health and one dental visit per day. However, the rules can be interpreted as all three visits in one day. To play it safe, the third visit should be classified as arising due to an unforeseen emergency. Here's the language: "Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. | NO | YES |

| State N=45 | # of Billable Visits Per Day | Limit for # of Billable Visits Per Year? | Does the state deduct co-pays from FQHC payments? |
|---|---|---|---|
| | Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as a psychiatric registered nurse on the same day. An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member's record. The goal remains to treat the whole individual during one visit." | | |
| **Massachusetts** | Only one medical, but dental, some mental health (not billed under medical) are also allowed. | NO | NO |
| **Michigan** | medical, dental and behavioral health | NO | NO |
| **Minnesota** | State allows: medical/dental or behavioral/dental State does not allow: medical/behavioral Attempt to change this in 2011 MN Legislative Session was not successful. | NO | YES |
| **Mississippi** | More than one | 12 visits per year per patient unless prior approval is obtained for more than 12 | NO |
| **Missouri** | medical and mental health medical and dental | NO | YES |
| **Montana** | One Medical, one dental, one mental health. An additional Medical visit is allowed if patient suffers additional illness or injury requiring additional dx or treatment | NO | NO |
| **Nebraska** | 1 | NO | NO |
| **Nevada** | 1 | NO | YES |
| **New Hampshire** | Again, while NH has not yet implemented PPS/APM, they are looking to allow three visits in one day: medical, dental and behavioral health | NO. Again, since NH has not yet implemented this, we don't know what the final outcome will be. | NO |
| **New Jersey** | More than one, one medical, one dental, and one behavioral health | NO | NO |
| **New Mexico** | One medical, one dental, and one behavioral health | NO | NO |
| **New York** | 1 | NO | YES |

| State N=45 | # of Billable Visits Per Day | Limit for # of Billable Visits Per Year? | Does the state deduct co-pays from FQHC payments? |
|---|---|---|---|
| **North Carolina** | medical, behavioral health and dental | Mandatory services limit: 22. Exceptions: EPSDT eligible kids, recipients under age 21, recipients enrolled in CAP and pregnant recipients receiving pregnancy care | NO |
| **North Dakota** | One medical and one dental per day | NO | YES |
| **Ohio** | Medical Dental Speech Mental Physical Transportation Vision Podiatry Chiropractic | YES | NO |
| **Oklahoma** | More than one for unrelated diagnosis; could be within same category of service; otherwise, medical, dental, behavioral health separately may qualify for unrelated diagnosis | NO | NO |
| **Oregon** | One Each Day for Medical One Each Day for Dental One Each Day for Mental Health | NO | NO |
| **Pennsylvania** | One for medical, dental and behavioral permitted per day | NO | NO |
| **Puerto Rico** | More than one | NO | NO |
| **Rhode Island** | one medical one dental one behavioral health (there are still a few kinks in the system that are being worked out) | NO | NO |
| **South Carolina** | Medical; Mental/Behavioral health; Dental; Podiatry; Vision | Mental Health annual visit cap = 12 Family Planning annual visit cap = 8 | YES |
| **South Dakota** | 1 Medical, 1 dental | Dental visits limited to 3 per year Medical visits not limited | YES |
| **Tennessee** | One per day per type of service | NO | NO |
| **Texas** | Up to five different combinations of medical and "other health visits." Each must have a different diagnosis. | Family planning visits under the Women's Health Waiver are limited to 3 visits per year. | NO |
| **Utah** | 1 | NO | YES |
| **Vermont** | If 2nd visit is for something substantially different from first visit, the 2nd visit is billable. | 5 physician encounters per month (with an exception for visits with diagnosis of opiate dependency) | YES |
| **Virginia** | 1 | NO | NO |
| **Washington** | one visit/day for medical/behavioral health additional visit okay for dental | NO | NO |
| **West Virginia** | One | YES, for behavioral health - 10 visits | YES |
| **Wisconsin** | More than one | NO | YES |

| State<br>N=45 | # of Billable Visits Per Day | Limit for # of Billable Visits Per Year? | Does the state deduct co-pays from FQHC payments? |
|---|---|---|---|
| **Wyoming** | More than one | NO | YES |
| **TOTAL** | **More than one=37**<br>**One=7** | **12** | **16** |

## TABLE 5a: Scope of Service Definition

| State<br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| **Alabama** | NO | |
| **Arkansas** | Addition or deletion of FQHC-covered service (dental, mental health, etc.); Change in magnitude, intensity, or character of currently offered FQHC-covered services; Adding or deleting specialties or specialists, adding or deleting HIV services or chronic disease treatments, etc.; Change in state or federal regulatory requirements-Mandated revisions in types or numbers of professional staff, changes in support service equipment or personnel, ;Changes due to relocation, remodeling, opening or closing a new site; Change in applicable medical technologies and medical practices | Eliminate the 6-month requirement that the scope of service change must have existed during the last full 6 months of the fiscal period; Eliminate "scope of service" adjustment that will be effective on the later of the first date that the scope of services changed or the beginning date of the just completed current fiscal period. |
| **California** | YES | NO |
| **Colorado** | NO | Yes, we'd like to have a definition. Our current change scope process is related to our APM rate, not PPS. We'd like our change in scope process to be for our PPS rate, and in state regulations. |
| **Connecticut** | NO | |
| **Delaware** | A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment. A change in the cost of service alone is not considered a change in the scope of service. Significant increases or decreases to the magnitude, intensity or character of service offered by the FQHC attributable to changes in the types of patients served shall qualify, such as services to patients with HIV/AIDS or other chronic disease, or the homeless, elderly, migrants, or other special populations. | NO |
| **District of Columbia** | Increase or decrease in scope of services -A change in the type, intensity, duration, and/or amount of services. A change in the cost of a service, in and of itself, is not considered a change in the scope of services. | YES |
| **Hawaii** | Change in scope includes any of the following only if these changes result in a change in type intensity, duration or amount of service, or any combination therein: i. Addition of new services not incorporated in the baseline rate or deletion of services incorporated in the baseline rate; 11. Changes necessary to maintain compliance with amended state or federal requirements or; 111. Changes resulting from relocation; IV. Changes resulting from the opening of a new service location; v. Changes in | |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| | the type, intensity, duration or amount of service caused by changes in technology and medical practice used; VI. Increase in service intensity, duration, or amount of service resulting from the changes in the types of patients served, including, but not limited to, populations with HIVIAIDS, or other chronic diseases, or homeless, elderly, migrant or other special populations; V11. Changes resulting from a change in the provider mix of a FQHC, RHC or an affiliated site; Vlll. Changes in the scope of a project approved by the HRSA, where the change affects a covered service, as described below; IX. Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, described below, including new or expanded service facilities, regulatory compliance measure~, or change in technology or medical practices at the FQHC or RHC. | |
| **Idaho** | After an FQHC obtains approval for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the FQHC must request the Department to review the encounter rate(s) for the FQHC. The review will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by an FQHC that could change an FQHC's total cost per encounter. The FQHC must request the Department to review the encounter rate(s) within sixty (60) days after the FQHC has gained approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. (4-2-08) b. When an FQHC does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change the FQHC's scope of services, the FQHC must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s) for the FQHC. The Department will review the request for a change in intensity within 60 (sixty) days of the planned change in intensity of services. | |
| **Illinois** | "...the inclusion of Behavioral Health Services or dental services or a difference of at least five percent from the Center's current rate." | The threshold should be less than 5%. |
| **Indiana** | 1. The center or clinic has added or has discontinued any service that: a. Meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C), and b. Is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary. 2. The center or | NO but the 5% threshold is difficult to meet. |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| | clinic has experienced a change in the type, intensity, duration and/or amount of current services as described in number one above. 3. The center or clinic has experienced a change in services, as described in number one above, due to the relocation, remodeling, opening of a new clinic site or closing of an existing site. 4. A change due to federal or state regulatory requirements. 5. A change in sites or scope of services that are approved by the Health Resources and Service Administration (HRSA), Bureau of Primary Health Care. | |
| **Iowa** | | |
| **Kansas** | NO | |
| **Louisiana** | Change in Scope and addition, removal and relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the baseline rate. | NO |
| **Maine** | An FQHC request for a rate adjustment due to a substantial change in the type of service provided (equivalent to a change in scope of project) must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the change in scope occurred. The FQHC will be required to submit documentation showing that the Health Resources and Services Administration (HRSA) had approved its change in scope of project, and a cost report reflecting at least six (6) months of financial data and narrative documenting the change. The Department will respond to the Health Center's request for a rate adjustment within sixty (60) days. If the Department determines that a related rate adjustment is warranted, the incremental cost per encounter from this change may be added to the calculations that set the existing rate, and a new rate may be established. This new rate will be based on the reasonable costs associated with the CMS-approved changes as determined by the Department, and will become effective on the date the change of scope was implemented by the FQHC. An FQHC change in scope of service may also be based on a change specifically approved by the Commissioner of the Department of Health and Human Services. | de-link the scope of service review process from the HRSA scope of project approval and broaden the events that can trigger a scope of service increase to include the intensity of services provided as well as investment in HIT and other technology (e.g., telemedicine) |
| **Massachusetts** | No definition of change of scope, but Regulation 114.3 CMR 4 has a provision for increases to the rate (1) if services need to be expanded to meet need in an area and (2) if the CHC and the state agree on an initiative that would increase costs. | |
| **Michigan** | YES | |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
| --- | --- | --- |
| **Minnesota** | Change in Scope of Services. If an FQHC/RHC has a change in the scope of services provided, PPS rates are to be adjusted. The FQHC/RHC must: • Complete the PPS Rate Adjustment for Scope of Service Change form (DHS-4561), • Provide historical and budgeted cost information showing the facility's expenses prior to and after the change in scope of services and the last two audited financial statements • Provide the projected increase or decrease in the number of encounters due to the change Note: Some services do not require a face-to-face visit with an FQHC/RHC provider, e.g., laboratory, x-rays, pharmacy, etc., and may not affect the number of encounters. Examples of changes in scope of services include addition or discontinuation of one of the following: • Pharmacy services (PDF) • Radiology services (PDF) • Mental health services (PDF) • Dental services (PDF) Examples of items that are not considered changes in scope of services include: • Increase/decrease in expenses for salaries, benefits, and supplies not directly related to a change in the scope of services • Increase/decrease in facility overhead or administration expenses not directly related to a change in the scope of services • Increase/decrease in assets not directly related to a change in the scope of services • Expenditures for items covered by insurance not directly related to a change in the scope of services | Overall, would like a more transparent process that clearly outlines the process along with the timeline for the state to determine rate and an appeals process. The definition would change to the following (which the PCA is proposing to the state Medicaid agency very soon): A change of scope-of-services is defined as: • The addition of a new FQHC/RHC service that is not incorporated in the baseline prospective payment system (PPS) rate • The deletion of an FQHC/RHC service that is incorporated in the baseline rate. • A change in service due to new or amended Federal or State statutes, rules, regulations or standards • A change in service due to the relocating or remodeling of an FQHC or RHC site • A change of provider mix • A change in operating costs attributable to the purchase, implementation and maintenance of electronic health record and practice management systems and participation in Federal and/or State health information networks and/or exchanges. • A change in types of services due to a change in applicable medical technology and/or medical practice, such as certification as a primary care medical home by the center or clinic. • An increase or decrease in service intensity attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations. A change in service intensity includes increases or decreases associated with the provision of interpretative services. • Any changes in any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code • Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic. • Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents. • Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA). |
| **Mississippi** | | NO |
| **Missouri** | NO | |
| **Montana** | ...the addition or deletion of a service or a change in the magnitude, intensity or character of services provided by an FQHC or RHC or one of their sites. The increase or decrease in the scope of service must be reasonably expected to last at least one year. The term includes, but is not limited to a) an increase or decrease in intensity attributable to | |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| | changes in the types of patients served, including but not limited to HIV/AIDS, the homeless, elderly, migrant or other chronic diseases or special populations; b) any changes in services or provider mix provided by FQHC or RHC or one of their sites; c) increases or decreases in operating costs that have occurred during the fiscal year and that are attributable to regulatory compliance; and d) any approved changes in scope of project as defined by the health resources and service administration (HRSA). | |
| **Nebraska** | NO | |
| **New Hampshire** | NO. Again, the state is working with us on factoring change of scope into the discussion about how the rates would be calculated | |
| **New Jersey** | The definition is one that includes changes in sites, services, medical technology, and regulated changes. The problem is that the State of NJ keeps trying to apply caps and screens to the methodology. | Yes, We are working on that now and hope to have a new proposed draft by end of year. |
| **New Mexico** | Change in Scope of Services Once the PPS Rates are determined as outlined in this section, adjustments to those rates will reflect changes in the scope of services will be made upon the written request of the provider and approval by MAD. **A** provider's request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider's fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.<br>A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC's and RHC's fiscal period, MAD may require the FQHC and RHC to submit and additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.<br>MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a change in scope of service. MAD'S final determination will be communicated to | Definition is problematic in that rates were established over 15 years ago and calculation is difficult if not impossible. |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| | the FQHC and RHC in writing. | |
| **New York** | Must be part of a CON and only done for expansion or new services. Must also be recognized by CMS as part of the FQHC's scope. | We would like to see an expansion of definition to include changes outside of the CON process, for example changes in service delivery. |
| **North Carolina** | Added new service or omitted service | NO. But we would like clarification on when it needs to be updated. |
| **North Dakota** | NO | |
| **Ohio** | (A) Definitions. (1) "Change in scope of service" means: (a) The addition or deletion of a new category of service as described in paragraph (B) of this rule; or (b) The department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule. (2) "Category of service" means the following different types of services: (a) Medical, as defined in Chapter 5101:3-4 of the Administrative Code; (b) Dental, as defined in Chapter 5101:3-5 of the Administrative Code; (c) Mental health, as defined in rule 5101:3-8-05 and 5101:3-4-29 of the Administrative Code; (d) Physical therapy, as defined in rule 5101:3-8-02 of the Administrative Code; (e) Podiatry, as defined in Chapter 5101:3-7 of the Administrative Code; (f) Optometry, as defined in Chapter 5101:3-6 of the Administrative Code; (g) Chiropractic, as defined in Chapter 5101:3-11 of the Administrative Code; (h) Speech pathology and audiology, as defined in Chapter 5101:3-13 of the Administrative Code; and (i) Transportation, as defined in Chapter 5101:3-15 of the Administrative Code. (3) "Increase or decrease in the scope of services" means the addition or deletion of a category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule. | YES |
| **Oklahoma** | 317: 30-5-664.12 (b) Scope of service adjustments. If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made only if the change in the scope of services results in the inclusion of behavioral health services or dental services or a difference of at least five percent from the Center's current costs (other than overhead). The OHCA may initiate a rate adjustment, base on audited financial statements or cost reports, if the scope of services has been modified to include behavioral health services or dental services or would otherwise result in a change of at least five percent from the Center's current rate. If a new rate is set, the rate change | Changing to more specifically define qualifying events and change cost threshold percentage to lower percentage for increases in scope and higher percentage for decrease in scope. |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
|---|---|---|
| | takes effect on the latter of the change of services date or the date of application to the OHCA for rate change. (Amending change in scope requirements/process with a State Plan Amendment in draft currently). | |
| **Oregon** | 5% Cost per visit change due to changes in: intensity, service mix, delivery | |
| **Pennsylvania** | A change in scope of service(s) involves the addition of a service that was never provided before or the discontinuance of an existing service. | We would like to see the definition expanded to include addition of new sites, changes in intensity, new technology, and any significant change that impacts the cost of services. |
| **Puerto Rico** | NO | |
| **Rhode Island** | "Material impact on cost of service delivery" such changes may include a change in organizational structure, a change in practice, or change in primary/specialty care. | We would like the definition clarified, together with a specified process to negotiate a change in scope of services rate adjustment |
| **South Carolina** | NO | |
| **South Dakota** | NO | |
| **Tennessee** | Addition of new services and addition of new clinic sites can constitute a change in scope. | We would like a clearer definition that outlines a more defined process. |
| **Texas** | (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). | |
| **Utah** | State record indicates that a change can be made with an increase of >1% or >$1 increase of total charges | |
| **Vermont** | NO I surveyed some FQHCs who have gone through this process. No actual definition was cited. Changes in location require a "change application." This is a simple and straightforward form. There doesn't seem to be a process for the addition of a new service. | |

| State<br><br>N=43 | Scope of Service Definition | Would Like to See Definition Changed? How? |
| --- | --- | --- |
| **Virginia** | NO | |
| **Washington** | Change of scope: "a change in the type, intensity, duration and/or amount of services. A change in scope of service will occur if: (1) the center adds or drops any service that meets the definition of FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment. | Needs to specify how intensity, duration and/or amount of services would be considered. |
| **West Virginia** | NO | |
| **Wisconsin** | NO | |
| **TOTAL** | **Y=26 N=16** | **Y=15 N=6** |

## TABLE 5b: Scope of Service Rate Adjustment Process

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| **Alabama** | The facility must supply a budgeted cost report to get a rate change, and then submit an actual cost report after the budget period is over. The budget period must be at least 6 months. The final cost report is then compared to the budgeted cost report and a settlement is made. The rates then start at the final cost report rate. | NO |
| **Arkansas** | The process is explained in the State Plan Amendment. Scope of service adjustment must be requested within five months after the end of the fiscal period. The request must identify the beginning date that the change occurred and include detailed description of the change and costs incurred. Arkansas Medicaid will notify the organization within 90 days. The scope of service adjustment must result in at least a 5% difference in the encounter cost. The scope of service change must have existed during the last full six months of the fiscal period. scope of service" adjustment that will be effective on the later of the first date that the scope of services changed or the beginning date of the just completed current fiscal period. Scope of service adjustments can be applied cumulatively, if necessary to meet the 5% threshold. The effective date is determined based on the last change that puts the adjustment over the threshold. The same scope of service change can only be used once. Scope of service adjustment is calculated by comparing the actual per encounter cost for the fiscal period with the per encounter cost not including the scope of service change. The dollar difference, if implemented, is added to the PPS rate for the fiscal period. | Made easier |
| **California** | YES | Yes - we would like to have standards in the level of scrutiny that state auditors can give to applications, including standards around what information can be requested, how productivity screens can/cannot be applied, etc. |
| **Colorado** | The process for changes in scope, based on current practice with the state's Medicaid auditor, is the following: Colorado does a blended rate calculation. The provider submits the costs/encounters for the new site or service by either completing the cost report forms or submitting a budgeted report showing the same data. The current encounter rate and the estimated rate for the new site or service is averaged together to determine the new blended encounter rate. | Yes, our current change scope process is related to our APM rate, not PPS. We'd like our change in scope process to be for our PPS rate, and in state regulations. |
| **Connecticut** | Per request of the center with an updated Medicaid cost report required. This can take up to two years to process. | To regular COLA |
| **Delaware** | Changes require submission of a cost report. A minimum of three (3) months operational and cost experience must be demonstrated within the cost reporting year to establish that the change was not temporary. The net effect of all qualifying changes in scope of service must demonstrate to DMAP the likelihood of at least a 2.5% | Unsure since it is so rarely used |

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | annual difference in Medicaid allowable costs compared to the costs used to compute the last approved PPS rate. | |
| **District of Columbia** | For services provided in fiscal year 2002 and in each fiscal year thereafter, the prospective rate will be computed by taking the FQHC's prospective rate that was in effect in the previous fiscal year and (1) increasing the rate by the applicable inflation factor for that fiscal year and (2) adjusting the rate to take into account any increase or decrease in the scope of such services furnished by the FQHC during the fiscal year. The amount of the adjustment shall be at a negotiated rate and the District shall implement a revision to an FQHC's rate not later than 90 days after the establishment of the negotiated rate. The FQHCS are responsible for reporting to the District an increase or decrease in the scope of services and the starting date of such a change. The District will specify the reporting format and content. | NO |
| **Hawaii** | (a) PPS rates may be adjusted for changes in the scope of services provided by an FQHC or RHC upon submission of a written notice to the Department specifying the changes in scope of service and the reasons for those changes within 60 days of the effective date of the changes. If the written notice is greater than 60 days after the effective date of changes the Department will consider the effective date of change of scope of services to be the notification date. (b) An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit data/documentation/schedules that substantiate any changes in services and the related adjustment of reasonable costs following Medicare principles of reimbursement. (c) An FQHC or mc requesting a rate adjustment for changes in scope of service must submit a projected adjusted rate within 150 days of the changes. The projected adjusted rate is subject to approval by the Department and shall be calculated based on a consolidated basis, including both costs included in the base rate and additional costs, provided that the FQHC's or mc's baseline PPS rate was calculated based on consolidated costs. (d) Within one hundred twenty days of receipt of the projected adjusted rate and all additional documentation requested by the Department, the Department shall notify the FQHC or mc of its acceptance or rejection of the projected adjusted rate. The Department will reduce the projected adjusted rate by twenty percent of the difference between the FQHC's or mc's previously assigned PPS rate and the projected adjusted rate to eliminate the reporting of cost increases not related to a qualifying scope change. Upon approval by the Department, the FQHC or RHC will be paid the reduced projected adjusted rate effective from the date of the change in scope of services through the date that a rate is calculated based on the submission of cost reports for the first full fiscal year which include the | No. Got it changed only about a year ago. |

| State<br>N=43 | Scope of Service<br>Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | change in scope of service. (e) The Department will review the calculated rate of the first full fiscal year cost report if the change of scope in service is reflected in more than six months of the report. For those FQHCs or RHCs in which the change of scope of services is in effect for less than six months, the next full year cost report is also required. The Department will review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report will be adjusted to the MEI of the second year report. Each report will be weighted based on the number of patient encounters. (f) The PPS rate will be adjusted following review of the cost reports and supporting documentation by the Department or its designated agent. (g) Payment adjustments will be made for the period from the effective date of the change in scope of services through the date of the final adjustment of the PPS rate. (h) To qualify for rate adjustment, a change of scope must be a change in type, intensity, duration or amount of service, or any combination therein. A change in cost alone, in and of itself will not be considered a change in scope of service. | |
| **Idaho** | Yes, in rules. | NO |
| **Illinois** | NO | By broadening the instances that could trigger a rate change and having a written process for requesting a change. |
| **Indiana** | http://in.mslc.com/uploadedFiles/FQHC-RHC%20Change%20in%20Scope%20of%20Service%20Guidelines%20and%20Form.pdf | The cost related to a change in the scope of service must account for an increase or decrease to the existing PPS rate of 5% or greater. Changing the 5% threshold to a 3% threshold would be more realistic for help health centers. |
| **Kansas** | Must provide an updated cost report | There is none at the state level |
| **Louisiana** | YES | |
| **Maine** | An FQHC request for a rate adjustment due to a substantial change in the type of service provided (equivalent to a change in scope of project) must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the change in scope occurred. The FQHC will be required to submit documentation showing that the Health Resources and Services Administration (HRSA) had approved its change in scope of project, and a cost report reflecting at least six (6) months of financial data and narrative documenting the change. The Department will respond to the Health Center's request for a rate adjustment within sixty (60) days. If the Department determines that a related rate adjustment is warranted, the incremental cost per encounter from this change may be added to the calculations that set the existing rate, and a new rate may be established. This new rate will be based on the | NO |

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | reasonable costs associated with the CMS-approved changes as determined by the Department, and will become effective on the date the change of scope was implemented by the FQHC. An FQHC change in scope of service may also be based on a change specifically approved by the Commissioner of the Department of Health and Human Services. | |
| **Massachusetts** | No definition of change of scope, but Regulation 114.3 CMR 4 has a provision for increases to the rate (1) if services need to be expanded to meet need in an area and (2) if the CHC and the state agree on an initiative that would increase costs. | NO |
| **Michigan** | The policy in our Medicaid Policy Manual hasn't changed since last year. Please let me know if you need another copy. | NO |
| **Minnesota** | Calculating Rate Adjustment for Change in Scope of Services. MHCP uses the same Medicare formula employed on the Form CMS-222, as modified for MA covered services, and used to establish PPS rates for January 01, 2001. It is necessary to identify the 1999 and 2000 costs used to calculate the PPS rate. For each year prior to the year of the change, these costs are inflated by the Medicare Economic Index (MEI). The inflated costs are then adjusted for budgeted costs and resulting increase or decrease in encounters, related to the change in scope of services and the rate impact of the change is determined. Since the costs are distributed amongst all of the encounters, there are instances in which the PPS rate decreases. Detailed worksheets (Excel) are available to enable FQHC/RHC's to calculate the impact of a change in the scope of services. If a provider does not have a record of the 1999 and 2000 costs used to establish their PPS rate, they can be obtained from the Payment Policy Section. Adjustments to the clinic's PPS rate for changes in the scope of services will be effective on the first day of the month following the change in scope of services. A "look back" will be conducted after the new services have been in place for a year. The PPS rate will be revised according to the actual costs and encounters directly related to the change in scope of services. When determination of the revised PPS rate is completed, retroactive adjustments for paid claims will be made by MHCP back to the effective date of the revised rate. | PCA is requesting a more transparent process that outlines the exact process to file a change of scope along with expanding the definition of what constitutes a change of scope. In addition, having a timeline for the state to determine the new rate along with an appeals process would be helpful. |
| **Mississippi** | | NO |
| **Missouri** | NO | N/A |
| **Montana** | New Rate = (Present PPS Rate x Present number of visits in 12 month period prior to change) + Expected change in costs divided by (Present visits + Expected change in visits) | NO |

| State<br>N=43 | Scope of Service<br>Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| **Nebraska** | NO | N/A |
| **New Hampshire** | Not yet--this is likely to be one of the outcomes of our work with the state on implementation | We want to have changes In Scope factored into the PPS/APM implementation to ensure that the FQHCs receive adequate reimbursement |
| **New Jersey** | It is a long complicated formula that each center must use with the starting part being the base rate with allowances made for incremental costs due to the incremental cost of the new site or service. | We are working on a new methodology with the Medicaid staff. |
| **New Mexico** | Only two applications have been made and the process was more or less a negotiation of a reasonable increase based on data submitted. | Definition and process are both problematic. |
| **New York** | It's part of the CON. The process is detailed out in regulation. | UNSURE |
| **North Carolina** | Unknown | NO |
| **North Dakota** | Center provides information regarding the change in scope that includes an explanation of the new service that was not covered at the time the PPS rate was established and the fiscal impact of the change. The state reviews the information and if approved the additional cost is added to the PPS rate. | NO |
| **Ohio** | Yes but impossible to meet the conditions | YES |
| **Oklahoma** | Written request and supporting documentation to reevaluate entire current singular rate. Do not have a current application package - in plans to develop a more standardized procedure. | Yes, more standardized process with instructions. Clarity about method. |
| **Oregon** | Document the underlining change and then document the change rate due to these changes. | NO |
| **Pennsylvania** | Yes, in policy. Health centers must submit the federal approval for new or deleted services and a modified cost report reflecting the change. The Department of Public Welfare can then change the rate--up or down. We have requested that health centers be given the following options when adding a service: 1- Add the service without a change in rate 2- Add the service with the right to retain the current rate after impact analysis 3- Add the service with a change in rate 4- Have the right to rescind the request for a rate re-calculation at any time during the process. | |
| **Puerto Rico** | NO | Sure, if is for better. In PR the method changed, now is more specific for the codes and more detailed. |
| **Rhode Island** | NO | YES |
| **South Carolina** | NO | N/A |

| State<br>N=43 | Scope of Service<br>Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| **South Dakota** | NO | Yes, need written procedure on how to request a change in scope. |
| **Tennessee** | From the State Plan ~ "The State has worksheets in place which will compute the changes in scopes of services. Clinics first inform the state that they have a change and provide actual costs, visits, and (if applicable) square footage allocated to the new services. The change in costs will then be factored into an adjusted PPS rate. | |
| **Texas** | (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. | YES |
| **Utah** | State plan | NO |
| **Vermont** | NO | NO |
| **Virginia** | Rates are based on cost reports, submitted to accounting firm. Additional sites under the same Tax ID are generally given the same rate. | Has not been discussed as an issue. |
| **Washington** | If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost-per-encounter detailed in the center's most recent rebasing. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by | Yes. The department considers a federally qualified health center (FQHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered Medicaid services. A change in scope of service means any of |

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | increasing it by the average statewide cost-per-encounter as detailed in the most recent rebasing of other centers that provide the service. Once the center can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost-per-encounter to establish a final encounter rate. The new encounter rate(s) will be effective on the date the new service was fully implemented and available. | the following: (a) A change in the type of service is defined as: (i) The addition of a new FQHC service that is not incorporated in the baseline PPS or APM encounter rate, or a deletion of an FQHC service that is incorporated in the baseline PPS or APM encounter rate. (ii) The addition or deletion of a covered Medicaid service under the State plan. (b) A change in the intensity, duration and/or amount of services is defined as: (i) A change in services due to a change in applicable technology and/or medical practice utilized by the FQHC. (ii) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations. (iii) Any changes in the provider mix of the FQHC or one of its sites. (iv) Changes in operating costs attributable to capital expenditures associated with a modification of any of the services provided by the FQHC, including new, expanded or renovated service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic. (v) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents. (vi) Any changes in the FQHC's scope of project approved by the federal Health Resources and Service Administration (HRSA) not addressed elsewhere in this definition. (2) The following additional provisions apply to a request for a change in scope of services: (a) No change in costs alone shall be considered a change in scope of service. To qualify for an adjustment to the encounter rate the increase or decrease in costs must be due to a change in the type, intensity, duration, or amount of services, or any combination thereof and the costs claimed are allowable under OMB Circular A-122 or A-87 as applicable to the particular organization. (b) An FQHC may request one change in scope adjustment per calendar year. (c) The adjusted encounter rate for a change in the type of services shall be effective on the date the change of scope of service is effective. (d) The encounter rate adjustment methodology for a change in the type of services shall be at the option of the FQHC and shall include the following options: (i) As part of the adjustment process, an FQHC may opt to convert from an all-inclusive encounter rate to a set of service specific (unbundled) rates or from unbundled rates to an all-inclusive rate; (ii) If the change in scope is due to an increase or addition in the type of service(s), the FQHC may opt for an adjustment to its rate(s) on an interim basis; in such a case, the State will adjust the |

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | | current encounter rate by an interim cost-per-encounter (using a statewide average of the other FQHCs that provide the service); this interim rate will be reconciled to final rates as determined by a desk review of the Medicaid cost report to determine if the costs are reasonable and necessary and shall be retroactive to the date the new service was fully implemented and available; (iii) To determine the final rate adjustment for the addition of a type of service a center may opt for: (A) An adjustment to the encounter rate by rebasing that rate using all allowable costs on either an all-inclusive or service specific (unbundled) basis as specified on a Medicaid cost report submitted to the State for that purpose; or, (B) An incremental adjustment to the all-inclusive encounter rate or the development of service specific encounter rates based on a Medicaid cost report reflecting a full year of costs of providing the added service and the proposed incremental adjustment to the current all-inclusive or service-specific (unbundled) encounter rate(s) submitted to the State. (iv) To determine the final rate adjustment for the elimination of a type of service for FQHCs with an all-inclusive rate, the FQHC will be required to submit a Medicaid cost report for its most recent complete fiscal year prior to the scope change to the State. Using this Medicaid cost report, the FQHC will calculate two all-inclusive encounter rates: one with the costs and encounters of the discontinued or decreased service, and one without the costs and encounters of the discontinued service. The State will perform a desk review and will calculate the percentage difference between these two rates, and then apply the percentage difference to the FQHC's encounter rate to derive a new base encounter rate. The new base encounter rate will then be trended forward using the appropriate annual trend factor to determine the FQHC's new all-inclusive encounter rate. To trigger a rate adjustment attributable to a decrease in type of services the FQHC's encounter rate(s) must be significantly affected by the decrease. For purposes of rate adjustment, significantly affected is defined as a decrease in costs of at least 2.5% per encounter. The decreased rates will be effective on the first day of the fiscal year after the decrease. For centers with service-specific (unbundled) rates, the State will no longer reimburse the rate for the elimination of a service if it has been eliminated completely. (e) The adjustment methodology for changes in the intensity, duration, and/or amount of services will be addressed by adjusting the all-inclusive or service specific (unbundled) encounter rate(s) (at the option of the FQHC) using all allowable costs to determine the appropriate rate as specified |

| State N=43 | Scope of Service Rate Adjustment Process | Would you like to see a change in scope process changed? How? |
|---|---|---|
| | | on a Medicaid cost report submitted to the State for that purpose. The adjusted rates shall be retroactive to the first day of the FQHC's fiscal year for which cost data is submitted to support the adjustment. (3) FQHCs must: (a) Notify the department's FQHC program manager in writing no later than one year after the change(s) in scope occurred, at the address published in the department's FQHC Billing Instructions, of any changes in scope of service; and (b) Provide the department with all requested documentation pertaining to the change in scope of service. (4) The department must: (a) Respond with a decision regarding the FQHC's application for a rate adjustment within 90 days of receipt. If the department does not respond within 90 days, the rate adjustments proposed by the FQHC will take effect retroactive to the date that the change(s) in scope occurred. (b) Adjust the encounter rate(s) upon acceptance of the FQHC's application for the change in scope of service as specified above. |
| **West Virginia** | NO | WV Medicaid needs to establish guidelines for CHCs to request a change a scope. |
| **Wisconsin** | NO | NO |
| **TOTAL** | **Y=29 N=12** | **Y=17 N=15** |

## TABLE 6: Cost Reports

| State<br>N=43 | Are FQHCs required to provide cost reports to the state? | | | |
|---|---|---|---|---|
| | Yes | If yes, why? Would you like the state to eliminate them? | No | If no, how did you get the state to eliminate these? |
| **Alabama** | | | X | N/A |
| **Arkansas** | X | State Plan Amendment reconciliation at end of the Year. Would not like to see them eliminated. | | |
| **California** | X | N/A | | |
| **Colorado** | X | Rates are based on current costs. Would not like them eliminated. | | |
| **Connecticut** | X | They are requested not required. Would like to see them eliminated | | |
| **Delaware** | X | Ostensibly to justify annual PPS rates but rates appear to be established before cost reports are received and reviewed. Would like to see them eliminated. | | |
| **District of Columbia** | | | X | They provide uncompensated care reports to DOH; DHCF does not require cost reports... But they submit Medicare Cost Reports to CMS. |
| **Hawaii** | | | X | Cost reports are required only for changes of scope. The state didn't want them after PPS was implemented. |
| **Idaho** | | | X | The IPCA has not received a Board request to pursue elimination of cost reporting. |
| **Illinois** | X | In the past, cost reports were used to update the rates. We would not like them eliminated. | | |
| **Indiana** | X | It's required. Would not like to see them eliminated. | | |
| **Kansas** | X | To determine their reimbursement rate. Whether we would want them eliminated would depend upon what system would replace them. | | |
| **Louisiana** | X | Only for a change in scope | | |
| **Maine** | | | X | To be clear, FQHCs don't have to file Medicaid cost reports annually, but they must submit their Medicare cost report within 150 days of their fiscal year end, as well as a cost report with any scope of service change. We got the state to eliminate the annual Medicaid cost report on the basis of the language in the Benefits Improvement Act that provided for PPS. |
| **Massachusetts** | X | State uses them to determine rates. We do not want them eliminated but we would like the state to use the FQHC Medicare | | |

| State<br><br>N=43 | Are FQHCs required to provide cost reports to the state? | | | |
|---|---|---|---|---|
| | Yes | If yes, why? Would you like the state to eliminate them? | No | If no, how did you get the state to eliminate these? |
| | | Cost Report which is very similar | | |
| **Michigan** | X | The cost reports indicate the revenue and billable encounters to the Medicaid managed care agencies. At this point, data from the Medicaid Managed Care companies is not reliable enough and we would have concern this could negatively impact the reimbursement. | | |
| **Minnesota** | X | Part of rate determination process for change of scope and new sites. Unknown if we would want them eliminated. | | |
| **Mississippi** | X | They provide the Medicare cost report only for needed desk audits. There is no reconciliation. We would not want them eliminated as it stands now. | | |
| **Missouri** | X | So the state reconciles interim payments to reasonable cost. We would not want them eliminated. | | |
| **Montana** | | | X | Never required (except for initial rate setting) |
| **Nebraska** | X | Mandate, prior to 2010 used cost settlement vs. pps. Would be great to eliminate, but it does help us see our costs | | |
| **New Hampshire** | X | They have been required to provide cost reports to the state up until now because PPS/APM has not been implemented. Our FQHCs want to ensure adequate and fair reimbursement--but right now cost reporting is the status quo, which they want to maintain until PPS/APM is implemented. | | |
| **New Jersey** | X | They provide their Medicare cost reports with certain lines added in to account for Medicaid costs. This subscripted Medicare report was approved by CMS. Would not like to eliminate them. | | |
| **New Mexico** | | | X | Cost Reports were not considered necessary given the PPS methodology. |
| **New York** | X | We are licensed in New York State as Article 28 health care facilities. The cost reports are also used to determine indigent care funding amounts and other rates. Unsure if we would like them eliminated. | | |
| **North Carolina** | X | FQHCs with cost-based reimbursement provide for reconciliation. No use for FQHCs using PPS. We would like them eliminated. | | |

| State<br>N=43 | Are FQHCs required to provide cost reports to the state? | | | |
|---|---|---|---|---|
| | Yes | If yes, why? Would you like the state to eliminate them? | No | If no, how did you get the state to eliminate these? |
| **North Dakota** | X | To provide documentation of expenses. | | |
| **Ohio** | | | X | |
| **Oklahoma** | X | Annual cost reports have not been acted upon. Seemingly to ensure payment covers costs, State can check if change in scope of services applicable. We would like to see them eliminated except for change in scope applications. | | |
| **Oregon** | | | X | They lacked the staff to review cost reports at the start of PPS so they never started. |
| **Pennsylvania** | | | X | Annual cost reports became unnecessary after PPS rates were established and decisions were made to increase the rates annually by the MEI and to change rates at other times only with the addition or deletion of a service (when a modified cost report is required). |
| **Puerto Rico** | | | X | |
| **Rhode Island** | X | Used to set encounter rates. | | |
| **South Carolina** | X | Used to set encounter rates. Would not like to see them eliminated. | | |
| **South Dakota** | X | To document the costs of the Health Center to provide services. | | |
| **Tennessee** | X | It's stipulated in the State Plan Amendment. We would not like them eliminated. | | |
| **Texas** | X | To allow the state to rebase rates to straight PPS methodology. We would not like to see them eliminated because they serve to help centers assess whether they need rate adjustments. | | |
| **Utah** | X | Only FQHCs on the APM are required. Would not like to see them eliminated. | | |
| **Vermont** | X | Cost reports are necessary for the APM. Would not like them eliminated. | | |
| **Virginia** | X | Required as specified in regulations from 2002. Eliminating cost reports has not been discussed. | | |
| **Washington** | X | Periodic rebasing is required by the State Plan. Would like to see them eliminated. We'd also like to see annual reconciliation eliminated. | | |

| State<br><br>N=43 | Are FQHCs required to provide cost reports to the state? | | | |
|---|---|---|---|---|
| | Yes | If yes, why? Would you like the state to eliminate them? | No | If no, how did you get the state to eliminate these? |
| **West Virginia** | X | Used to establish the Medicaid rate (APM). Would like to eliminate them if we could establish a fair PPS rate. | | |
| **Wisconsin** | X | It is required for payment. We would not like them eliminated. | | |
| **TOTAL** | **32** | **Y=7 N=15** | **11** | |

## TABLE 7a: Timing of Rate Changes

| State N=43 | When Rate Change Takes Effect | | | | Average Time from Request to Payment |
|---|---|---|---|---|---|
| | Day New Service Is Added | Date Medicaid Received Request | Date Request Approved | Other / Unknown | |
| **Alabama** | | | | The rate adjustment starts the next month after the budgeted cost report is received and desk reviewed. The new rate starts after the settlement has been finalized with a lump sum adjustment from that time back to the beginning of the budget period. | It will start the first of the next month if it was received before the 20th of the previous month. |
| **Arkansas** | | | | Beginning of Fiscal Year after Approval. | Undetermined |
| **California** | | | | UNKNOWN | Significant delays are common. This is a major frustration by health centers in our state. |
| **Colorado** | X | | | Rate changes are effective 120 days after each FQHC's fiscal year end, and are based on each FQ's annual Medicaid cost report. | Approximately 30 days |
| **Connecticut** | | | X | | Two years |
| **Delaware** | | | X | | Unknown for change of scope. Annual cost reports are due June 30 with new rates established effective July 1 |
| **District of Columbia** | | | | The amount of the adjustment shall be at a negotiated rate and the District shall implement a revision to an FQHC's rate not later than 90 days after the establishment of the negotiated rate. | The amount of the adjustment shall be at a negotiated rate and the District shall implement a revision to an FQHC's rate not later than 90 days after the establishment of the negotiated rate. |

| State N=43 | When Rate Change Takes Effect | | | | Average Time from Request to Payment |
|---|---|---|---|---|---|
| | Day New Service Is Added | Date Medicaid Received Request | Date Request Approved | Other / Unknown | |
| **Hawaii** | | | | When the new service was added unless the FQHC notifies the Dept. more than 60 days after the service starts. Then this change will be effective no sooner than the date of notification. | UNKNOWN |
| **Idaho** | X | | | | 2 years |
| **Illinois** | | | | UNKNOWN | N/A |
| **Indiana** | | | X | | Ideally, it should take 6 months of health center data to establish a new change of scope rate (this process should take a few months) but sometimes this process is longer. |
| **Kansas** | | X | | | Approximately 60 days, but varies |
| **Louisiana** | | X | | | N/A none yet requested, submitted and approved. |
| **Maine** | X | | | | It's been a few years since the last scope of service was filed, but it generally takes between 60 and 90 days |
| **Massachusetts** | | | X | | About 1 month |
| **Michigan** | X | | | | It is based on whether or not additional information is required, but generally within 3 months of receiving the necessary information. |

| State N=43 | When Rate Change Takes Effect | | | | Average Time from Request to Payment |
|---|---|---|---|---|---|
| | Day New Service Is Added | Date Medicaid Received Request | Date Request Approved | Other / Unknown | |
| **Minnesota** | | | | Not clearly outlined in rules or regulation. | UNKNOWN |
| **Mississippi** | | | | January 1st of each calendar year. | 60 days |
| **Missouri** | | | | N/A | N/A |
| **Montana** | | X | | | 30-60 days |
| **Nebraska** | | | | UNKNOWN | UNKNOWN |
| **New Hampshire** | | | | we won't know until we come to agreement with the state | this is an issue we are working on with the state |
| **New Jersey** | X | | | | 5 years |
| **New Mexico** | | | X | | 3-6 months |
| **New York** | X | | | | 3-6 months |
| **North Carolina** | | | | Beginning of health center's FY | ~ 6 mo |
| **North Dakota** | | | | The first month following the date the request was submitted | Generally no more than 30 days |
| **Ohio** | | | | 1st day of 1st full month after request granted; or within 60 days of completed cost report (depends upon method selected) | N/A |
| **Oklahoma** | | | | The latter of when the service is added or the date of application to the State for rate change. | NO CHANGE |
| **Oregon** | | | | Start of Quarter after approval of Change in Scope Application. | Depends upon when submitted. If application submitted just before start of quarter, services 10 days after submission may be included. If submitted at start of quarter there is |

| State N=43 | When Rate Change Takes Effect | | | | Average Time from Request to Payment |
|---|---|---|---|---|---|
| | Day New Service Is Added | Date Medicaid Received Request | Date Request Approved | Other / Unknown | |
| | | | | | a 90 day wait. Actual payment is delayed in either case for 90 to 270 days after date of service. |
| **Pennsylvania** | | | | From the date HRSA approval of the change in scope | Not tracked |
| **Puerto Rico** | | | | N/A | N/A |
| **Rhode Island** | | | | following a merger | UNKNOWN |
| **South Carolina** | | | | N/A | N/A |
| **South Dakota** | | | | After receiving 2 years of cost reports | Generally no more than 30 days |
| **Tennessee** | X | | | | 1 year |
| **Texas** | | | | First day of the month after approved. | Variable |
| **Utah** | | | | N/A | N/A |
| **Vermont** | | | X | | According to one FQHC CFO, the process for this has changed over the years and now what happens is the FQHCs' Cost Report is filed; based on this NGS does a 'recalculation of the Interim Reimbursement Rate' and sends a request off to DVHA to adjust the FQHCs' rate. It's a long process from start to finish. E.g., an FQHC's cost report might be due May 31st |

| State<br>N=43 | When Rate Change Takes Effect | | | | Average Time from Request to Payment |
|---|---|---|---|---|---|
| | Day New Service Is Added | Date Medicaid Received Request | Date Request Approved | Other / Unknown | |
| | | | | | and they usually send the letter to DVHA to make the adjustment in January/February of the following year and VT Medicaid makes the adjustment usually March/April. So for instance one FQHC's current rate which was implemented on March 1 2011 is based on Costs from the 2009 cost report. |
| **Virginia** | | | | UNKNOWN | UNKNOWN |
| **Washington** | X | | | | UNKNOWN |
| **West Virginia** | | | | N/A | N/A |
| **Wisconsin** | | | | N/A | Annually, but in some cases quarterly if doing interim reports |
| **TOTAL** | **8** | **3** | **6** | | |

## TABLE 7b: Health Centers Seeking Rate Changes

| State | Number of FQHCs Seeking Rate Change | Number That Approved Rate Change | Average Amount of Change (round to nearest dollar/percentage) | Services Involved In Rate Change |
|---|---|---|---|---|
| **Alabama** | No change | No change | No change | No change |
| **Arkansas** | Not available | Not available | Not available | Not available |
| **California** | NOT AVAILABLE | NOT AVAILABLE | NOT AVAILABLE | NOT AVAILABLE |
| **Colorado** | n/a | n/a | n/a | n/a |
| **Connecticut** | 50% | 50% | 20% | Mostly dental |
| **Delaware** | It is extremely rare to request this. FQHCs must submit a cost report annually anyway. | N/A | N/A | N/A |
| **District of Columbia** | No change | No change | No change | No change |
| **Hawaii** | Unknown | Unknown | Unknown | unknown |
| **Idaho** | 1 | 1 | Unsure | unsure |
| **Illinois** | 1 | 0 | n/a | n/a |
| **Indiana** | 2 | 1 | unsure | addition of new services; new site added |
| **Kansas** | Unknown | Unknown | Unknown | unknown |
| **Louisiana** | 1 | 0 | 0 | N/A |
| **Maine** | 15 of 18; 83% | 15 of 18; 83% | 23.3% | behavioral health; oral health; new location(s); addition of specialist (e.g., psych) |
| **Massachusetts** | 2 | 2 | 2% | pharmacy, after-hours coverage |
| **Michigan** | around 3 more requests this year | all have been approved or are in the process | 10% | obstetrical and dental services have been the majority |
| **Minnesota** | Unknown | Unknown | Unknown | unknown |

| State | Number of FQHCs Seeking Rate Change | Number That Approved Rate Change | Average Amount of Change (round to nearest dollar/percentage) | Services Involved In Rate Change |
|---|---|---|---|---|
| **Mississippi** | 9, 43% | 8 approved, 38% | 7% | OB, dental and HIV |
| **Missouri** | n/a | n/a | n/a | n/a |
| **Montana** | 1/15 - 7% | 1/1 100% | 27% | New service sites |
| **Nebraska** | NO CHANGE | NO CHANGE | NO CHANGE | NO CHANGE |
| **New Hampshire** | all FQHCs are working towards PPS/APM implementation | all FQHCs are working towards PPS/APM implementation | all FQHCs are working towards PPS/APM implementation | all FQHCs are working towards PPS/APM implementation |
| **New Jersey** | 50% | 3 | Unsure | new sites were added |
| **New Mexico** | 2 | 2 | 20% | Dental/Hospital Call |
| **New York** | less than 10% | most that request are approved | n/a | expansions and new services |
| **North Carolina** | No change | No change | No change | No change |
| **North Dakota** | No change | No change | No change | No change |
| **Ohio** | 0 | 0 | 0 | 0 |
| **Oklahoma** | No change | No change | No change | No change |
| **Oregon** | No change | No change | No change | No change |
| **Pennsylvania** | Not tracked | Not tracked | Not tracked | Not tracked |
| **Puerto Rico** | n/a | n/a | n/a | n/a |
| **Rhode Island** | unknown precisely; 1 granted following a merger | Unknown | Unknown | unknown |
| **South Carolina** | n/a | n/a | n/a | n/a |
| **South Dakota** | 1 of 6 or 16.667% | still pending with State | still pending with State | unsure |

| State | Number of FQHCs Seeking Rate Change | Number That Approved Rate Change | Average Amount of Change (round to nearest dollar/percentage) | Services Involved In Rate Change |
|---|---|---|---|---|
| **Tennessee** | 2 | 1 | Separate rate for dental & Rx | Dental & Rx |
| **Texas** | 100% of Texas FQHCs were rebased in 2010 | n/a | n/a | n/a |
| **Utah** | No change | No change | No change | No change |
| **Vermont** | No change | No change | No change | No change |
| **Virginia** | NOT AVAILABLE | NOT AVAILABLE | NOT AVAILABLE | NOT AVAILABLE |
| **Washington** | A few | None | n/a | n/a |
| **West Virginia** | n/a | n/a | n/a | Currently in litigation to address the APM/cost-based reimbursement methodology |
| **Wisconsin** | No change | No change | No change | No change |

## TABLE 8a: Wrap-around Payments to FQHCs

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **Alabama** | | | X | | | | NO | |
| **Arkansas** | | | X | | | | | |
| **California** | X | | | Each time the center files an individual claim | X | | Yes, The state has up to 3 years to finalize reconciliation. They are only required to give 60% to the health center up front and hold the remaining 40%. In the past they used to finalize most of these within a year. In the last couple years it has taken closer to 3 years in many instances which has hurt financial stability. | |
| **Colorado** | X | | | We don't know, since the state is making these payments to the HMOs. | | X | NO | Colorado is the state where CHCs get their rate upfront with the state making the HMO whole. |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **Connecticut** | | X | | Each time the center files an individual claim | | X | Yes, Litigated twice and prevailed both times | |
| **Delaware** | | X | | N/A | | | No | Delaware does not do wraparound. |
| **District of Columbia** | X | | | Once every 90 days | | X | No | N/A |
| **Hawaii** | | | X | | | | | |
| **Idaho** | | | X | | | | | |
| **Illinois** | X | | | The wrap payments are vouchered each month but given the instability of Medicaid payment cycles the payments are not made on a consistent basis. | | X | Yes, The state has held up to 5 months worth of payments in times of cash flow crises. | |
| **Indiana** | X | | | Once every 30 days | X | | Current process for year-end reconciliations can take up to 2 years. | |
| **Kansas** | X | | | Annually | X | | Yes, It has taken many months for CHCs to get their wrap-around payments, but the process has improved | |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| | | | | | | | significantly this year. | |
| **Louisiana** | | | X | | | | | |
| **Maine** | | | X | | | | | |
| **Massachusetts** | | X | | N/A | | | No | N/A |
| **Michigan** | X | | | Once every 90 days | X | | Yes, The process isn't as quick as most health centers would like, which creates a cash flow issue. | |
| **Minnesota** | X | | | Once every 120 days | X | | Yes, Since 2001, there have been 2 significant delays whereby payments to CHSs were delayed for 5 years and totaled $5 million each time. In 2011, 6 CHCs prevailed in a federal lawsuit to direct the state to comply with federal law with regards to timely payments. | |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **Mississippi** | | X | | | | X | NO | n/a |
| **Missouri** | X | | | Once every 90 days | X | | NO | Health centers invoice MO HealthNet for the difference between the amount paid by the Medicaid managed care plan and the amount the health centers would receive if paid directly by MO HealthNet. MO HealthNet pays quarterly and timely. |
| **Montana** | | | X | | | | | |
| **Nebraska** | | | X | N/A | | X | Yes, They used to prior to 2010 and it took forever (3-5 years) but then got better over time | |
| **New Hampshire** | | | X | | | | | |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **New Jersey** | X | | | Every 120 days | | X | NO | NJ has paid consistently every quarter even though they cannot reconcile the claim to the faulty HMO data. |
| **New Mexico** | X | | | Monthly | X | | NO | We designed it and state was reasonable. |
| **New York** | X | | | Each time the center files an individual claim | X | | Yes, One major issue is you must receive payments from the MCO before being able to bill wrap payment to state. | |
| **North Carolina** | | | X | | | | | |
| **North Dakota** | | | X | | | | | |
| **Ohio** | X | | | Each time the center files an individual claim | | X | NO | state has been cooperative turnaround on wrap claim is less than 10 days |
| **Oklahoma** | | | X | | | | | |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **Oregon** | X | | | Quarterly Wrap Around Reports are filed with the State for services delivered 9 months earlier. | | X | Yes, The 9 month delay in payment was a burden on many FQHCs. The state allows exemptions to the waiting period upon specific request. In these cases the payment is delayed for only 90 days. | |
| **Pennsylvania** | X | | | Once every 90 days | X | | Yes, The state failed to do an annual reconciliation for many years, but did retrospective settlement of those years for all health centers this past year (for some health centers, as many as 11 years). The state has verbally committed to annual reconciliation from this point forward. | |
| **Puerto Rico** | | X | | N/A | | X | Yes, It has been a long and expensive process for the centers and | |

| State<br><br>N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| | | | | | | | the state, 7 years of litigation. The centers are trying to implement a prospective payment system because the payments do not come automatically. The current process is failing to comply with the law and causes higher costs. | |
| **Rhode Island** | X | | | Once every 30 days | X | | Yes, reconciliation process is complicated, confusing and muddled, leading to large overpayments or underpayment s, and frequent swings between the two extremes | |
| **South Carolina** | X | | | Once every 90 days | X | | Yes, Delays; Outdated rates used as basis for settlements; Typically takes 2-8 quarters for complete settlement. | |

| State<br>N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state “reconcile” or “settled-up” payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| **South Dakota** | | | X | | | | | |
| **Tennessee** | X | | | Once every 90 days | | X | Yes, Health Centers in Tennessee have had issues with the timeliness of wrap-around payments. In some instances wrap-around payments have been delayed several months. | |
| **Texas** | X | | | Once every 90 days | X | | Yes, Time consuming, administrative burden. The state eliminated wrap around payments to health centers altogether as of September 1, 2011. | |
| **Utah** | X | | | Once every 90 days | X | | Yes, Delays and inconsistent process in determining allowable costs and carve-outs such a grant funding that may be used for uninsured patients | |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? Yes | Provide Payments? No | Provide Payments? No managed care enrollees | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? Yes | Does the state "reconcile" or "settled-up" payments at the end of year? No | Problematic process? | Why did it work well? |
| **Vermont** | | | X | N/A | | | NO | There isn't a wrap-around process. |
| **Virginia** | X | | | Once every 120 days | X | | NO | We work to maintain a working relationship with Medicaid staff to resolve any issues before they become problematic. |
| **Washington** | X | | | Once every 30 days | X | | Yes, Incredibly time-consuming, complex and expensive. We contract with a consultant who spends numerous hours working with state rates staff and their actuary. We have been working on the 2009 reconciliation for the last 10 months or more! | |
| **West Virginia** | | X | | | | X | Yes. final settlements are years behind | |
| **Wisconsin** | X | | | Varies monthly to quarterly | X | | NO | Our FQHCs have a long standing and positive |

| State N=43 | Wrap-around payments to FQHCs Treating Medicaid Managed Care Enrollees | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provide Payments? | | | Payment Frequency | Does the state "reconcile" or "settled-up" payments at the end of year? | | Problematic process? | Why did it work well? |
| | Yes | No | No managed care enrollees | | Yes | No | | |
| | | | | | | | | relationship with our auditor |
| **TOTAL** | **23** | **8** | **14** | | **16** | **12** | **Y=19 N=13** | |

## TABLE 8b: Wrap-around Payments to HMOs

| State<br>N=32 | Is your state making "wrap-around" payments to HMOs for Managed Care Enrollees, rather than the health centers? | | | |
|---|---|---|---|---|
| | Yes | If yes, how often are these "wrap-around" payments made? | No | If no, is your state considering this change? |
| **California** | | | X | |
| **Colorado** | X | We don't know, since the state is making these payments to the HMOs. | | |
| **Connecticut** | X | Each time the center files an individual claim | | |
| **Delaware** | X | NA | | |
| **District of Columbia** | | | X | The FQHC's would prefer to be made whole directly via the MCO's, but the overall managed care contract process continues to be an issue. |
| **Illinois** | | | X | |
| **Indiana** | | | X | |
| **Kansas** | | | X | |
| **Louisiana** | | | X | |
| **Massachusetts** | X | N/A | | |
| **Michigan** | | | X | |
| **Minnesota** | | | X | |
| **Mississippi** | X | N/A | | |
| **Missouri** | | | X | Not that we are aware of. |
| **Nebraska** | | | X | |
| **New Jersey** | | | X | Yes out state is considering this change. However the denial rate from the HMOs hovers around 20-30% each month. Until that situation is corrected, then this proposal is not doable. |
| **New Mexico** | | | X | |

| State<br><br>N=32 | Is your state making “wrap-around” payments to HMOs for Managed Care Enrollees, rather than the health centers? | | | |
|---|---|---|---|---|
| | Yes | If yes, how often are these “wrap-around” payments made? | No | If no, is your state considering this change? |
| **New York** | | | X | No |
| **North Carolina** | | | X | Yes, it is under consideration. |
| **Ohio** | | | X | Possibly |
| **Oregon** | | | X | |
| **Pennsylvania** | | | X | |
| **Puerto Rico** | | | X | |
| **Rhode Island** | | | X | It has been discussed, but unknown whether the state is considering this change in methodology |
| **Tennessee** | | | X | Yes |
| **Texas** | | | X | This legislative session, the state eliminated wrap payments to FQHCs and will instead pay the entire encounter rate up front to the HMOs. This will begin September 1, 2011 for those FQHCs participating in the managed care program. |
| **Utah** | | | X | No - was not considered in recent 1115 waiver proposal |
| **Vermont** | | | X | No HMOs in Vermont. |
| **Virginia** | | | X | No change being considered. |
| **Washington** | | | X | |
| **West Virginia** | | | X | The issue of wrap-around is part of litigation |
| **Wisconsin** | | | X | Not that we know of |
| **TOTAL** | **5** | | **27** | |

## TABLE 9: Impact of PPS/APM on FQHCs

| State<br>N=42 | PPS/APM Program Impact on FQHCs | |
|---|---|---|
| | Are there any elements in your state's PPS/APM program that you believe have been particularly helpful or beneficial to FQHCs? | Are there any elements in you state's PPS/APM program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs? |
| **Arkansas** | Yes-Definition for allowable application for change in scope | No |
| **California** | EHR as a triggering event | 3 year reconciliations, ambiguity around allowable costs and offsite encounters, utilization controls, etc. |
| **Colorado** | APM rate reflects CHC actual or reasonable costs. | Yes, including (1) there is no change in scope process associated with our PPS rate, (2) our rate calculation still uses the old HRSA productivity screen, and (3) in September 2009 our rates were cut to the midpoint between our APM and PPS rates as part of budget cuts. |
| **Connecticut** | OB deliveries on FFS | Delays in resolving methodology which required litigation |
| **Delaware** | Delaware simply gets the PPS rate and doesn't have to worry about wraparound. Also, dental is fee for service and may pay more in the long run than a dental PPS rate would. | LCSW services not reimbursed through straight state Medicaid. There is no reimbursement for enabling and outreach services. Expensive specialists such as OB/GYNs need to be reimbursed at a higher rate for in office procedures. |
| **District of Columbia** | Unsure | Unsure |
| **Hawaii** | The new change of scope rules. The relatively generous number of visits/day. | State has passed responsibility of full PPS payment to managed care plans and that has reduced cash flow and implementation and reconciliation has had some bumps. |
| **Idaho** | The PPS process is working for our members. | No |
| **Illinois** | No | Lack of a real change of scope policy/procedure. |
| **Indiana** | Medicaid offers the opportunity for FQHCs to comment on encounter codes that they feel should be added to the FQHC encounter codes each year. | Once PPS rate is set, it cannot be changed (unless through a change of scope). If possible to have an entire re-basing of PPS rate due to extraordinary circumstances, that would help some. Also, when PPS rates were established 7/1/02 using 1999 & 2000 cost reports, state did not inflate all periods up to 7/1/02 effective date. |
| **Kansas** | No | No |
| **Louisiana** | | 1. Lack of clarification on the change in scope and change in rate structure associated with such<br>2. Process for the PPS (previously called APM) rate assignment for all satellites and new starts has never had CHC buy-in and review |
| **Maine** | Allowance for LCPCs to bill as core providers; the scope of service change process; reimbursement of multiple visits; full wrap on duals (except for QMBs | The legacy of the cap in use in 1999 and 2000 continues to haunt a couple of health centers that haven't filed for a scope of service change; also, the state's methodology for |

| State<br><br>N=42 | PPS/APM Program Impact on FQHCs | |
|---|---|---|
| | Are there any elements in your state's PPS/APM program that you believe have been particularly helpful or beneficial to FQHCs? | Are there any elements in you state's PPS/APM program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs? |
| | which pay just up to Medicare amount) | assigning a rate to a new health center lacks legitimacy and is tainted by the decade old cap. |
| **Massachusetts** | Add-ons to the rate for EPSDT and after-hours urgent care have been helpful and to some extent allow centers which incur these costs to get higher reimbursement | The major difference between the state and the FQHC Medicare Cost Report process is that the state offsets grant funding, resulting in a lower rate; (2) Although the rate cap is higher than the Medicare cap (based on a percentile of actual) it affects the higher cost CHCs. |
| **Michigan** | No | The state still isn't requiring the QHPs to pay for all FQHC services and when the plans don't pay it the State has refused to apply wrap around rates. |
| **Minnesota** | No | Yes. The entire system is extremely labor intensive for CHC staff as they need to sift through vast amounts of data from the state. In addition, the data transferred from the managed care plans to the state (which are the basis of the payments), has often been incomplete and inaccurate. |
| **Mississippi** | Yes, not having to file Medicaid cost reports and no reconciliation requirements | No |
| **Missouri** | The APM assures reasonable cost reimbursement and scales to health center growth and decline. MO HealthNet continues to reimburse for inpatient services even though it is not required. | MO HealthNet imposes a 30% cap on administrative costs AND does not allow HIT costs to be considered direct health care costs. During implementation of EMRs, the lowered productivity coupled with the up-front training costs reduces the EMR costs recoverable through the cost report reconciliation process. In addition, private grants and some contracts from state agencies are offset against cost on the cost reports. |
| **Montana** | Change of scope options | No |
| **Nebraska** | Now that we are PPS the money flows better. | N/A |
| **New Hampshire** | N/A | N/A |
| **New Jersey** | Quarterly wrap around has been helpful. | Change of scope has been harmful since we have added sites and not received a higher rate for those sites. This is due to NJ Medicaid wanting to use caps and screens when calculating the new rate. We have flatly denied that approach which is why so many change of scope applications are still sitting. |
| **New Mexico** | Monthly Wrap Around Process very Beneficial | |
| **New York** | n/a | Yes, we currently have litigation pending. Call for more details. |

| State<br>N=42 | PPS/APM Program Impact on FQHCs | |
|---|---|---|
| | **Are there any elements in your state's PPS/APM program that you believe have been particularly helpful or beneficial to FQHCs?** | **Are there any elements in you state's PPS/APM program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs?** |
| **North Carolina** | No | Waiting for rate change at the beginning of FY. |
| **North Dakota** | Access to state Medicaid staff | None |
| **Ohio** | 9 different PPS rates for different services, each billable on same day (as applicable) | Caps and screens |
| **Oklahoma** | PPS payments in full as claims are adjudicated versus managed care wrap-around process. | Lack of clear, consistent billing instruction. Cost threshold limitations and reporting - e.g., some devices are very expensive and health centers have to endure the expense to do what patients need until they meet cost threshold to increase rate. Method of applying split FFS restorative and PPS preventive dental can complicate patient services planning (if do both preventive and restorative services one trumps the other on the payment side). |
| **Oregon** | Our Change in Scope Policy works very well. | The Medicaid as secondary payor to Medicare policy limiting Medicaid payment to 20% of Medicare charges was particularly harmful. |
| **Pennsylvania** | Automatic MEI adjustment | PPS for OB and gyn surgeries; restriction on rate changes except when a service is added or deleted |
| **Puerto Rico** | No | Yes |
| **Rhode Island** | No | very complicated |
| **South Carolina** | Offers the ability to communicate annual cost increases that could affect encounter rate. | State imposed 30% Administrative Cap; Grant offsets; Delays on rate settlements; Delays in wrap payment settlements; No final rule on PPS rates or scope changes |
| **South Dakota** | Access to state Medicaid staff | Lack of written policies and procedures developed by Medicaid |
| **Tennessee** | For those CHCs who receive their payments in a timely fashion, they appreciate the predictability of payments. | Updating to costs from 2004-2005 & 2005-2006. |
| **Texas** | The increase factor of MEI+0.5% aids our ability to keep FQHCs whole and ensure grant funding does not supplement costs associated with Medicaid enrollees. | N/A |
| **Utah** | No | Inconsistent rules by state Medicaid auditors |
| **Vermont** | VT FQHCs like that the APM is cost-based, is comprehensive, and that a control for inflation (the link to the Medicare rates) is built in. | The cap isn't high enough for many FQHCs. |

| State<br><br>N=42 | PPS/APM Program Impact on FQHCs | |
|---|---|---|
| | Are there any elements in your state's PPS/APM program that you believe have been particularly helpful or beneficial to FQHCs? | Are there any elements in you state's PPS/APM program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs? |
| **Virginia** | No | There is some concern that the cap on FQHC rates has negatively impacted low cost providers. |
| **Washington** | Use of the health care index (developed for WA by IHS Global Insights) was very beneficial compared to the MEI. However, that has now been replaced with the MEI due to state budget shortfalls. One time (following APM development) voluntary rebasing was beneficial to almost 50% of our health centers. | Return to MEI. Annual reconciliation. Failure to reimburse for behavioral health visits. Change of scope process. |
| **West Virginia** | No | The overall cost-based reimbursement is problematic, since it is a copy of the Medicare cost report without any adjustment for caps/screens, services |
| **Wisconsin** | No | No |

## TABLE 10: CHANGES TO PPS/APM

| State<br>N=42 | In the past year, has your state promulgated any regulatory or other written policy changes to PPS? | | | Are changes to PPS/APM currently being explored? | | |
|---|---|---|---|---|---|---|
| | Yes | No | If yes, what is the policy change? | Yes | No | If yes, what is the status of the discussion? Who is leading the discussion? |
| **Arkansas** | | X | | X | | State applying for CMS innovations grant for episodes of care-bundled payment |
| **California** | | X | | | X | |
| **Colorado** | | X | | X | | As noted previously, CHCs began receiving the midpoint of their APM and PPS rate in September 2009. CCHN is currently exploring with FTLF, and our state Medicaid agency changes to our pharmacy and change is scope processes. |
| **Connecticut** | | X | | | X | |
| **Delaware** | | X | | | X | |
| **District of Columbia** | | X | | | X | |
| **Hawaii** | X | | In January 2011 State required to plans to make full payment. State is involved in reconciliation only for changes in scope. | | X | |
| **Idaho** | | X | | | X | |
| **Illinois** | | X | | | X | |
| **Indiana** | | X | | | X | |
| **Kansas** | | X | | | X | |
| **Louisiana** | | X | | | X | |
| **Maine** | X | | Clarification to the wrap payment for duals | | X | |
| **Massachusetts** | | X | | X | | Expanding the 114.3 CMR 4 additional payment regulations to include medical education costs; obtaining an add-on for the costs of in-hours urgent care. |

| State<br><br>N=42 | In the past year, has your state promulgated any regulatory or other written policy changes to PPS? | | | Are changes to PPS/APM currently being explored? | | |
|---|---|---|---|---|---|---|
| | Yes | No | If yes, what is the policy change? | Yes | No | If yes, what is the status of the discussion? Who is leading the discussion? |
| **Michigan** | | X | | | X | |
| **Minnesota** | | X | | X | | Change of scope and same day medical/mental health encounter discussions driven entirely from the health centers. Also, as ACOs are rolled out in MN in January 2012, there are concerns about waivers and PPS as well. |
| **Mississippi** | | X | | | X | |
| **Missouri** | X | | | X | | MO HealthNet filed a rule amendment to exclude HIT Meaningful Use incentive payments and supplemental payments for Health Home services to chronically ill patients from cost offset. |
| **Montana** | X | | | X | | Possibilities for EHR change of scope -- health centers--just beginning, initial reaction from state has been negative |
| **Nebraska** | | X | | | X | |
| **New Hampshire** | | X | Although the state came up with some tentative policy decisions---we have not come to final agreements on the project. | X | | Yes--implementation would be different. |
| **New Jersey** | X | | Yes...but the regs were withdrawn. | X | | Medicaid wants the HMO to pay the wrap around. In addition, the issue of caps and screens is still being hotly debated. |
| **New Mexico** | | X | | | X | |
| **New York** | | X | | X | | |
| **North Carolina** | X | | Application of MEI to PPS not active until start of FQHCs new FY. Applies for rate adjustments for scope of services, too. | | X | |
| **North Dakota** | | X | | | X | |
| **Ohio** | | X | | X | | |
| **Oklahoma** | X | | Amending providers in or out of PPS payment, amending definition of FQHC services for State FQHC PPS purposes, | X | | |

| State<br><br>N=42 | In the past year, has your state promulgated any regulatory or other written policy changes to PPS? | | | Are changes to PPS/APM currently being explored? | | |
|---|---|---|---|---|---|---|
| | Yes | No | If yes, what is the policy change? | Yes | No | If yes, what is the status of the discussion? Who is leading the discussion? |
| | | | amending definition of allowable places of services for PPS payments, reviewing method of change in scope process. | | | |
| **Oregon** | | X | | X | | Developing an APM jointly between the State and the FQHCs to enable implementation of Primary Care Home. |
| **Pennsylvania** | X | | Changed policy to pay for an FQHC "dental encounter" rather than a "dental service" | X | | We are urging the option of payment off the fee schedule for OB and GYN surgeries and the request is currently under consideration. |
| **Puerto Rico** | | X | | | X | |
| **Rhode Island** | | X | | X | | Slow conversation driven mostly by CHCs. Ongoing, and will probably heat up again in the Fall. |
| **South Carolina** | | X | | X | | Engaged in comp analysis between existing APM rates and proposed PPS. |
| **South Dakota** | | X | | | X | |
| **Tennessee** | | X | | X | | The discussion was first initiated by Health Centers trying to find a way to improve the timeliness of payments. The main policy change being explored is claim-by-claim reimbursement. The MCOs will pay the wrap-around payment and invoice the state for costs. |
| **Texas** | X | | In January, the state issued a final rule that made several changes to the PPS system. (1) The annual increase to the APPS rate was reduced from MEI+1.5% to MEI+0.5%. (2) FQHCs are now allowed to reselect APPS or PPS each time the state amends the APPS reimbursement methodology. (3) The process for establishing an initial interim reimbursement rate for new FQHCs was amended. | | X | |
| **Utah** | | | | | X | |
| **Vermont** | X | | A state plan amendment proposed significant reductions to the 340B dispensing fees for participating FQHCs. This | | X | |

| State<br><br>N=42 | In the past year, has your state promulgated any regulatory or other written policy changes to PPS? | | | Are changes to PPS/APM currently being explored? | | |
|---|---|---|---|---|---|---|
| | Yes | No | If yes, what is the policy change? | Yes | No | If yes, what is the status of the discussion? Who is leading the discussion? |
| | | | amendment was withdrawn and resubmitted with a more appropriate dispensing fee but more complex administrative and reporting requirements. | | | |
| **Virginia** | | X | | | X | |
| **Washington** | | | Proposed state plan amendment submitted to CMS on June 8, 2011: For services provided from April 7, 2011 through June 30, 2011, each FQHC will have the choice of receiving either its PPS rate or a rate determined under a revised APM. The revised APM will be the center's PPS rate for calendar year 2011 inflated by 5%. For services provided on and after July 1, 2011, each FQHC chooses between its PPS rate or a revised APM: for clinics that rebased their rate effective January 1, 2010, their allowed costs per visit during the cost report year inflated by the cumulative percentage increase in the MEI between the cost report year and 2011. For clinics that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new clinic or type of service) inflated by the cumulative percentage increase in the IHS Global Insight Index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2008 through 2011. The rates will be inflated by MEI effective January 1, 2012, and each January 1 thereafter. | X | | The state has submitted a concept paper to the Centers for Medicaid and Medicare Innovation. Included in the concept paper is changing to per capita payments for managed care wraparound payments--no annual reconciliation required. |

| State<br><br>N=42 | In the past year, has your state promulgated any regulatory or other written policy changes to PPS? | | | Are changes to PPS/APM currently being explored? | | |
|---|---|---|---|---|---|---|
| | Yes | No | If yes, what is the policy change? | Yes | No | If yes, what is the status of the discussion? Who is leading the discussion? |
| **West Virginia** | X | | Medicaid agreed to change behavioral health reimbursement from 62.5% to 100% | X | | Lawsuit filed in February 2011, argument heard by judge in April 2011, waiting for opinion |
| **Wisconsin** | | X | | | X | |
| **TOTAL** | **11** | **29** | | **18** | **24** | |