



State Policy Report #17:

2007 Update on the Status of the Medicaid Prospective Payment System in the States

August 2007

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This publication was supported by Grant/Cooperative Agreement Number U30CS00209 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.

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 States also were allowed to implement an alternative payment methodology (APM) as long as it did not pay less than what FQHCs would have received under PPS and the affected FQHC agreed to the APM. Although changes in payment policies were to take effect in 2001, states were slow to implement them and most only did so after one or two years.

Since 2003, the National Association of Community Health Centers (NACHC) has surveyed annually Primary Care Associations (PCAs) regarding PPS implementation and policy in their states. The George Washington University Department of Health Policy was contracted by NACHC to examine four aspects of the PPS system from the survey: 1) payment rate structure, 2) changes in the scope of services, 3) wrap-around payments and 4) perceived impacts of the new payment program.

In 2007, all state PCAs located in the 50 states and the District of Columbia were asked to respond to this survey, and in many cases these PCAs sought and received assistance from their state Medicaid agencies in completing the survey. Eleven states (Alabama, Alaska, Delaware, Florida, Iowa, Maryland, Nebraska, New Mexico, North Carolina, Washington, and Wisconsin) did not respond to the 2007 survey. Survey responses can be found in Tables 1-12 at the end of the document. States which marked “no change” on their responses to the 2007 survey but failed to provide responses in 2006 were omitted from the corresponding table.

Findings

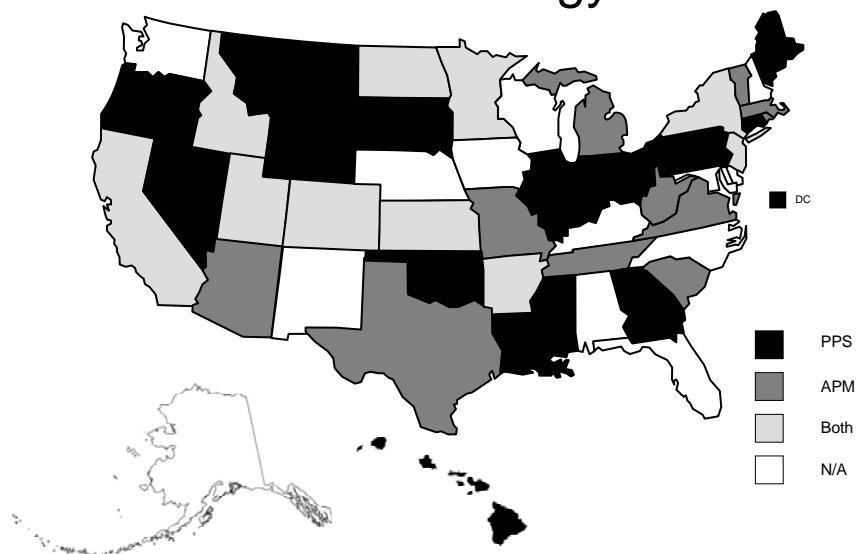
Figure 1 shows 17 of the 37 responding states and the District of Columbia are exclusively using the PPS system: Connecticut, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, and Wyoming. Four of these states lack a written policy, while South Dakota is currently working on a written policy statement (Table 1). Only New Hampshire indicates that neither PPS nor APM is in effect.

Table 2 shows which states use one all-inclusive payment rate and states with more than one PPS or APM rate. Twenty-two states and D.C. have an all inclusive rate (AZ, CA, CO, GA, IN, KS, KY, ME, MI, MN, MO, MS, MT, NV, NY, OK, SC, SD, TX, UT, VA and WY).

Seven of the PPS states report more than one rate; two of which differentiate between medical and dental rates and four have different rates for medical, dental and mental health. Ohio is the lone PPS state to have different rates for urban- and rural-based medical, dental and mental health services.

¹ Public Law No. 106-554.

Figure 1: FQHC Reimbursement Methodology



Eleven states (AZ, MA, MI, MO, RI, SC, TN, TX, VT, VA, WV) report exclusively using an alternative payment methodology (APM) and six of these states report an all inclusive payment rate. The remaining ten states (AR, CA, CO, ID, KS, MN, NJ, NY, ND, UT) use both the PPS and APM to set payment rates. Five of these PPS/APM states report an all inclusive payment rate.

Table 3 shows pharmacy services are most likely to be excluded from the payment rate, with 20 states reporting the rates are excluded. Dental, lab and x-ray services are excluded in approximately the same number of states.

Payment rates

In Table 4, states report a wide range of rates, ranging from the low of \$77 in Pennsylvania to \$315 in Minnesota (Pennsylvania uses a PPS method and Minnesota uses both APM and PPS). The number of billable visits per day also varies a great deal. Seventeen states limit the number of billable visits by the type of encounter. Kansas currently limits the number of billable visits per day to one visit, but proposed regulations will allow multiple visits with different types of providers. Only the District of Columbia reports no limitations on the number of billable visits.

Table 4 also shows all of the PPS states² use the Medicare Economic Index (MEI) as the factor of inflation. Four APM states and all PPS/APM states³ apply the MEI as well.

² Oregon was excluded from the table due to missing data across all the columns.

³ New Jersey did not provide a response to this question.

Table 5 shows states use a variety of methods and options to set rates for new starts. Eight states use a state average cost to set the rate (AZ, CT, DC, IL, NJ, OK, SD, TN); 16 states use cost of similar health centers (AZ, AR, CA, GA, HI, IL, KS, MA, MN, MS, MT, NV, NY, PA, TN, UT); 10 states use cost from centers in the same geographic area (CA, HI, ME, MS, MT, OH, OK, PA, RI, TN); and 12 states use interim cost reports to set rates (AZ, CO, ID, IN, KY, ME, MI, OH, SC, TX, VT, WY).

Most PPS states use similar health centers and similar geographic area to set rates: eight states uses similar health centers (GA, HI, IL, KS, MS, MT, NV, PA), and seven states use similar geographic areas (HI, ME, MS, MT, OH, OK, PA). Five states use state average cost to set the rate (CT, DC, IL, OK, SD) and four states use cost reports to set rates (IN, ME, OH, WY).

Change in the scope of services

Table 6 indicates 20 states have some form of a change in scope of service definition. These states use a wide variety of definitions (some are codified) a number of which are not very explicit. California's definition, for example, specifically includes an increase in service intensity attributable to change in the types of patient served. Maine, on the other hand, uses "substantial change in type of service provided" as its definition of a change in scope of service.

In addition to the 20 states with change of scope definitions, three states (LA, MN, RI) refer to other sources, such as the federal guidelines and provider manuals. Several states still lack a written definition of change in scope of service (AZ, CO, CT, GA, NV, ND, SC, SD, TN, UT, VT, VA). Two survey respondents indicate that Arizona is working on a written policy and Virginia uses a working definition despite its lack of a written policy.

The process for adjusting rates also varies significantly from state to state. For example health centers in Georgia can request a scope of service rate adjustment, despite a lack of official written policy. Michigan health centers, on the other hand, must notify the state 90 days prior to making changes. Thirty-two states require FQHCs to submit a cost report with any requests to change the payment rate.

Ten states report that, following approval, their rate becomes effective from the date the new service was added. Four states pay the new rate beginning on the date the request was approved and five states report the new rates are effective upon Medicaid's receipt of the rate change request. California is the only state that reports the rate would become effective the first day of the health center's fiscal year.

Table 8 shows only a few health centers requested a rate change in 2007. More than 75 health centers requested a rate change in 2006 and nearly all were approved (or were pending at the time the PCA submitted its survey). Rate changes ranged from the reduction of \$5 in Vermont to the increase of \$115 in Idaho for the addition of dental services. The most common reason for the rate change was the addition of dental services (AZ, ID, KS, KY, LA, MS, OH, OK, OR, RI, SD, WY).

Wrap-around Managed Care Payments

Table 9 illustrates 26 states provide wrap-around payments with 15 states paying centers on a quarterly basis. There are six states that offer monthly payments to centers. In addition to regular wrap-around payments, thirteen states reconcile payments at the end of the year. Only Colorado and West Virginia health centers appear to receive the full payment amount from the MCOs, with those MCOs then having to seek wraparound payments from their state.

Of the 26 states providing wrap around payments, 20 report significant problems with getting the correct amount paid on a timely basis. Nearly all states reporting problems with the wrap around payment system, claim delayed payments, some delayed for several years. For example, the Connecticut PCA reports that MCO's in the State are erroneously denying large numbers of claims leading to a lengthy delay and a significant disrupted cash flow at all centers.

Perceived Impacts

In Table 10, the majority of PCAs report that smaller and larger, rural, new start and special population health centers are all positively affected by the PPS rates. The same number of states report urban centers faring better and worse. Of the 17 PPS states, only four (LA, MT, NJ, OR) report all of their centers were benefited by the PPS rates. South Dakota and Maine (both PPS states) report some centers fared better and others worse under the PPS rates. Illinois and Kentucky are the only PPS states to report no classification of centers fared better. Illinois reports that smaller and rural centers were negatively affected, while Kentucky reports smaller, larger, rural, urban and new start centers fared worse under PPS. Of the states using APM and PPS, the majority report that centers using PPS are faring better than other centers in all areas except centers serving special populations where two states (MN, ND) report that centers serving special populations are being affected negatively by PPS and one state (NJ) reports those centers are being affected positively.

Table 11 shows nine PCAs (CT, HI, LA, MN, ND, OK, SD, UT, WV) report the most harmful state action or inaction is the lack of clear and written policies. Seven states (CA, CT, HI, ID, IL, MN, UT) claim the inability or process to set a new rate following a change in the scope of service to be particularly harmful to health centers. Additionally, delays in payment are reported as harmful in five states (IL, IN, MN, OR, SC). Only the Arkansas PCA indicates a need for an inflationary index that is greater than the MEI.

In general, a fair payment structure is expected to result in rates that cover the cost of care. Table 12 reflects that PCAs in seven states (IL, MO, ND, PA, RI, SD, UT) are able to work with their state to set reasonable rates and overcome problems that affect their revenue as a key element to a successful payment structure.

Conclusion

The majority of respondents report no major changes from last year, and believe that health centers are better off under the new payment structure. In fact, the survey shows states that allow

for recalculation of rates either periodically or through change of scope procedures are more likely to provide adequate payment rates. However, in some states, the problems faced by health centers appear to be beyond the issue of recalculating rates. Delays in payment, including wrap-arounds, and lack of clear guidance on change of scope policies and procedures, continue to be the biggest challenges even after seven years under the new payment program.

Table 1. State Payment Methodologies

State (N=40) *=PPS	FQHC Reimbursement Methodology			Has State Issued PPS Policy?	If yes, what document?
	PPS	APM	Both		
Arizona		X		Y	SPA published, not updated
Arkansas			X	Y	State Plan Amendment and rules, Medicaid reports that all SPAs and rules are on the CMS web site. Arkansas Medicaid posts only proposed rules for comment and "what's new" on its Web Site...Each posting is limited to 30 days
California			X	Y	California Welfare and Institutions Code Sections 14132.100-103 and California's State Medicaid Plan Amendment Regarding Federally Qualified Health Centers and Rural Health Clinics Reimbursement (Approval Date – March 8, 2004/Effective Date January 1, 2003)
Colorado			X	Y	State Rule 8.7007.B, http://www.chcpf.state.co.us/HCPF/Pdf_Bin/700fqhc.pdf
Connecticut*	X			Y	State Plan Amendment
D.C*	X			Y	State Plan
Georgia*	X			N	
Hawaii*	X			Y	http://www.hawaii.gov/dhs/main/har/har_current/17-1740.1.pdf
Idaho			X	Y	IDAPA 16.03.09.835; http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf
Illinois *	X			Y	State regulations allowed for APM rates in 2002 but none exist today so basically there is only PPS in Illinois. IL Administrative Code - 89 ILL. ADM. Code 140.463; http://www.hfs.illinois.gov/assets/053007_140.pdf
Indiana*	X			Y	Policy documents have been issued from the State Medicaid Agency
Kansas			X	Y	Revised regulations have been drafted but are in the process of internal review.
Kentucky*	X			Y	Administrative Regulation available at http://www.lrc.ky.gov/kar/907/001/055.htm
Louisiana*	X			Y	LAC 50:XI. Chapters 103-105
Maine*	X			Y	MaineCare Benefits Manual, Ch. II, Sec. 31; ftp://ftp.maine.gov/pubs/sos/cec/rcn/apa/10/144/ch101/c2s031.doc
Massachusetts		X		Y	114.3 CMR 4.00, can be found at www.state.ma.us/dhcfp
Michigan		X		Y	Medicaid Provider Manual Update; http://www.michigan.gov/documents/FQHC-03-02_79377_7.pdf
Minnesota			X	Y	Minnesota Medicaid Provider Manual – Chapter 8 www.dhs.state.mn.us
Mississippi*	X			Y	Miss. Div of Medicaid State Plan, Attachment 4.19-E; Guidelines for Reimbursement of Costs for Services to Medical Assistance Recipients for FQHCs; www.dom.state.ms.us/state_plan
Missouri		X		N	
Montana*	X			Y	Administrative Rules of Montana (ARM): 37.86.4401 (Note: Some revenue code changes have been made to improve the administration of the RHC and FQHC programs and to conform to new Medicare requirements, but no policy changes have been made)
Nevada*	X				
New Hampshire				N	Discussions to resume after July 1, 2007.
New Jersey			X	Y	New Jersey State Register June 7, 2004
New York			X	N	
North Dakota			X	N	

State (N=40) *=PPS	FQHC Reimbursement Methodology			Has State Issued PPS Policy?	If yes, what document?
	PPS	APM	Both		
Ohio*	X			Y	Chapter 5101: 3-28 of OH Administrative Code
Oklahoma*	X			Y	http://www.okhca.org/provider/policy/pdf/lib/chapter30.pdf A new version of the rules is to be implemented (Revised permanent rules passed the agency March 8,2007.
Oregon*	X			Y	OAR 410-147-0360, Oregon Administrative Rules
Pennsylvania*	X			N	
Rhode Island		X		N	
South Carolina		X		N	
South Dakota*	X			Y	In process
Tennessee		X		Y	The state uses the State Plan approved by CMS
Texas		X		Y	Texas Admin. Code. Title 1, Part 15, Ch. 355 Subsection J, Div. 14, Rule 355.8261
Utah			X	Y	Health.utah.gov , Attachment 4/19-B
Vermont		X		N	
Virginia		X		Y	State Plan Amendment
West Virginia		X			
Wyoming*	X			Y	Chapter 37; http://sos.wy.state.wy.us/Rule_Search_Main.asp
Total	18	11	10	29	

Table 2. Number and Type of Payment Rates

State (N=39) *=PPS	All- Inclusive Rate	More Than One Rate	If More Than One Rate, Separated By					Other
			Medical	Dental	Mental Health	Urban	Rural	
Arizona	X							
Arkansas		X	X	X				FFS is 90% of Delta Dental Premier Pan
California	X							By Site
Colorado	X							
Connecticut*		X	X	X	X			
D.C.*	X							
Georgia*	X							
Hawaii*		X	X	X				
Idaho		X	X	X				
Illinois *		X	X	X	X			
Indiana*	X							
Kansas	X							
Kentucky*	X							
Louisiana*		X						
Maine*	X							
Massachusetts		X	X	X	X			Add on payments for EPSDT, after-hours & weekend services & dental visits
Michigan	X							
Minnesota		X	X	X				
Mississippi*	X							
Missouri	X							
Montana*	X							
Nevada*	X							
New Jersey		X	X	X				
New York	X							
North Dakota		X	X	X				
Ohio*		X	X	X	X	X	X	By site
Oklahoma*	X							
Oregon*		X	X	X	X			On 10/1/04 rule was created to separate into medical, dental, and mental health for new starts. Existing health centers may keep their one all inclusive rate.
Pennsylvania*		X	X	X				
Rhode Island		X						Still using reasonable cost but working with the state to create a new method for calculating reasonable cost.
South Carolina	X							Medicaid Dental can file at FFS or included in the all inclusive rate
South Dakota*	X							
Tennessee		X	X	X				Optometry, Pharmacy

State (N=39) *=-PPS	All- Inclusive Rate	More Than One Rate	If More Than One Rate, Separated By					Other
			Medical	Dental	Mental Health	Urban	Rural	
Texas	X							
Utah	X							
Vermont		X				X	X	Note that the dental is paid off the Medicaid fee schedule and then cost-settled at the end of the year. The all inclusive rate covers Medical and Mental Health services. Also, to clarify about the urban/rural: VT FQHC's are paid by Medicaid at up to 125% of the Medicare upper payment limit, so their Medicaid rate tracks the urban/rural Medicaid payment differential. One VT FQHC presently has sites in both urban and rural areas, so its Medicaid all-inclusive rates vary by location.
Virginia	X							
Washington								
West Virginia		X			X	X	X	Medicare cost based rate
Wyoming*	X							
Total	22	17	13	13	6	3	3	

Table 3. Inclusion and Exclusion of Services in the Payment Rate

State (N=37) *=PPS	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Arizona	All FQHC Medicaid covered services, dental, optometry, radiology, lab			X			
Arkansas	Medical services, gynecologic visit, nutrition, mental health, child health, visual	X	X	X	X	X ⁴	
California	California's state law does not list specific services, instead it states that FQHCs are reimbursed for federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code.	In accordance with California's SPA, an FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. There are no other service exclusions (elected or otherwise from the PPS)					
Colorado	Outpatient primary care services provided by physician, PA, NP, CNM, visiting nurse, dentist, clinical psychologist, clinical social worker						
Connecticut*	Medical, dental, mental health services	X	X	X			
Georgia*	Medical			X	X	X	
Hawaii*	Dental (adults, emergency only), mental health provided by psychologist, clinical social worker or psychiatrist, licensed APRN, PA, telehealth in rural HPSA, physician services provided at site, ER, inpatient setting, patient's residence or nursing home						
Idaho	Physician services, professional counselor, dental, PT/OT, speech therapy (incidental to encounter), dietary counseling						
Illinois *	Physician services, lab, x-ray, optical, chiropractic, hospice, optometry, APN, audiologist, dental, podiatry, family planning, administration of immunizations, transportation, home health agency visits, PT/OT, speech therapy, EPSDT, renal dialysis, medical supplies, equipment, prostheses			X			
Indiana*	Medical, dental, and mental health services are reimbursed						

⁴ The cost of the above services is included. Dental services are counted as encounters for cost report settlement when the service is a face-to-face visit with the dentist.

State (N=37) *=PPS	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Kansas	Physician, Physician Assistant, advanced registered nurse practitioner, dentist, clinical psychologist, clinical social worker,	X	X				
Kentucky*	All primary care services, dental, lab, x-ray. The rate only includes limited mental health services			X			
Louisiana*	A visit is defined as face-to-face encounter with licensed practitioner, including doctors, dentists, clinical psychologists, clinical social workers, nurses practitioners, and physician assistants.			X			
Maine*	Core services provided by physician, PA, APRN, clinical psychologist, licensed social worker, licensed clinical professional counselor, asthma self-management, ambulatory services included in state plan, ambulatory diabetes education and follow-up, smoking cessation counseling, interpreter services, off-site delivery of services by health center staff, visiting nurse services	X (health center choice if carve out)	X (health center choice if carve out)	X (health center choice if carve out)			Medicare defined non-FQHC services
Massachusetts	Medical, including physician, nursing, psychiatric, licensed social worker, nutrition counseling, translation, medical social services, and "other" services	X	X	X	X	X	OB/GYN, podiatry, eye care, dermatologist and other specialists
Michigan	Medicaid covered services by provider type, hospital care						
Minnesota	Core and other ambulatory in state plan; Physician, NP, Nurse Specialist, CNM, clinical psychologist, social worker, services and supplies incident to services						Note: Costs for all of the above are included in the cost rate, but only mental health and dental are billable
Mississippi*	Dental services, optometric services, nursing facility visits, inpatient & outpatients' hospital visits, EPSDT screening, psychiatric visits, and medical services			X			

State (N=37) *=PPS	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Montana*	Core and other ambulatory in state plan; Physician, NP, Nurse Specialist, CNM, clinical psychologist, social worker, services and supplies incident to services						Note: Costs for all of the above are included in the cost rate, but only mental health and dental are billable
Nevada*	Medical			X		X	
New Jersey	Core services, dental, dental hygienist, Ob/Gyn, delivery, Norplant, vaccine injections, podiatry, eye care, chiropractic, family planning, EPSDT, HIV/AIDS, and "other" services		X	X			
New York	All Medicaid services – Medical, Dental, Clinical Psychologist, Licensed Social Work, Family Planning, Lab, X-Ray, Therapies						
North Dakota	Services associated w/ visit including lab, x-ray; prescription drugs, depends on what is in base for determining initial cost			X	X	X	
Ohio*	Physician, PA, APN, physical therapy, speech pathology, audiology, dental, podiatry, optometry, optician, chiropractic, transportation, mental health			X			
Oklahoma*	Medical (inpatient excluded – e.g. health center physician delivery for health center patient now excluded), Dental (now preventative dental only), Mental Health (including services of licensed psychologists and licensed clinical social workers (LCSWs), but now also licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs). Pharmacy is also now excluded from PPS (See the attached rules for more details).	X	X	X			

State (N=37) *=PPS	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Oregon*	Medicaid covered services, such as: Dental, routine medical office visits, immunization, tobacco cessation, delivery, maternity case management, addiction services, postpartum visits, prenatal care, outpatient mental health, medication management, ophthalmology, eye exams, PT/OT, lab and radiology.			X			Lab and radiology services were incorporated into rates as of January, 2007.
Pennsylvania*	Physician services, services & supplies incident to physician services; pneumococcal & influenza vaccine and its administration; physician assistant services; CRNP services; licensed clinical psychologist; licensed clinical social worker; dental services				If not provided by specific providers mentioned above or through licensed mental health outpatient clinic		Each FQHC has option to include or exclude services in the development of the rate as long as the service is part of the Medicaid state plan
Rhode Island	Medicaid covered services					X	
South Carolina	Ambulatory, mental health, well child visits, pre-birth check-up, podiatry, prenatal, dental	X	X	X			Nutrition, social work, health ed.
South Dakota*	All state Medicaid approved services						
Tennessee	Most only have a medical rate but some are reimbursed under a separate rate for services such as dental and pharmacy						
Texas	Physician, PA, NP, nurse midwife, visiting nurse, clinical psychologist, clinical social worker, mental health, dentist, dental hygienist, optometrist, TX Health Steps Medical Screen						
Utah	All as included in state plan, mental health only reimbursed directly if billed under Health CPT code	when provided by outside contract	when provided by outside contract		X when provided by outside contract		

State (N=37) *=PPS	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Vermont	All Medicaid state plan services are included in APM, including dental services. Note for the inclusion in the report/table: pending resolution of revisions to the Medicaid Provider Manual, it is difficult to specify other included services.	X	X	X		X	
Virginia	All covered services except pharmacy.			X			
West Virginia		X	X	X	62% of normal rate	X	
Wyoming*	Face to face encounter with a billable provider (MD, Midlevel, Psychiatrist, MSW, Dentist, Dental Hygienist, Nutritionist, Case Management (must be a license social worker)	X	X				
Total		10	11	20	4	8	

Table 4. Average Payment Rate Structure

State (N=37)	Avg. PPS/APM Rate		Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits	
	Average Rate (figure rounded to nearest dollar)	Range of Rates (figures rounded to nearest dollar)					
		Low					High
Arizona	\$139.00	\$123.00	\$163.00	N	Physician Services Index, CPI - Urban	1 per provider type, e.g. medical versus dental	
Arkansas	PPS: \$119	\$85	\$157	Y		1	Unless for different disorder/condition or if after 1st encounter patient has injury or illness requiring additional diagnosis or treatment
California	\$137.00			Y		More than one visit may be counted on the same day	See footnote ⁵
Colorado	PPS: \$130, APM: \$140	\$123	\$180	Y		1 Medical 1 Dental	
Connecticut*	Medical \$129, Dental \$120, Mental Health \$147	\$113	\$180	Y		1 visit per day	See footnote ⁶
D.C.*	\$139			Y		No limitation	
Georgia*		\$85	\$114	Y		1 Medical, 1 Dental	
Hawaii*	\$151.00			Y		1 Dental, 3 "other"	
Idaho	Medical and Mental Health: \$117 Dental \$131			Y		2 Medical, 1 Dental, 1 Mental Health	Can have 2 medical visits in one day only if have separate issues
Illinois *	Med: \$118 Dental \$92, Mental H \$49	\$84 \$76 \$35	\$127 \$101 \$54	Y		1 Medical, 1 Dental, 1 Mental Health	

⁵ [California] State law specifies the following: 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, license clinical social worker, or a visiting nurse.

⁶ [Connecticut] In the last legislative session, HB 6646 was passed and allows the Commissioner of Social Services to, consistent with federal law, make changes to the cost-based reimbursement methodology in the Medicaid program for federally qualified health centers. To the extent permitted by federal law, the commissioner may reimburse a federally qualified health center under the Medicaid program for multiple medical, behavioral health or dental services provided to an individual during the course of a calendar day, irrespective of the type of service provided.

State (N=37)	Avg. PPS/APM Rate		Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits	
	Average Rate (figure rounded to nearest dollar)	Range of Rates (figures rounded to nearest dollar)					
		Low					High
Indiana*		\$109	\$162	Y		3 visits per day	
Kansas	\$90			Y		Currently 1 visit per day-- proposed regulations will allow multiple visits with different types of health care providers	Face to face visit with the following health professionals: Physician and physician assistant, advanced registered nurse practitioner, dentist, clinical psychologist, clinical social worker, visiting nurse, registered nurse
Kentucky*		\$104	\$248	Y		1	
Louisiana*	\$121			Y			15/year
Maine*	\$122	\$98	\$135	Y		1 Med OR 1 Mental H + 1 Dental	May have all 3 only if have unforeseen emergency
Massachusetts	\$124	\$112	\$114	N	MEI with some local health care indices	1	May have multiple visits under special circumstances, see 114.3 CMR 4
Michigan	Urban \$150 Rural \$130			Y		1 Medical 1 Dental 1 Mental H	
Minnesota		\$114	\$315	Y		1	Unless another separate and distinct visit is medically necessary to treat the recipient.
Mississippi*	\$103			Y		1 Medical 1 Dental 1 Optometric 1 mental health	

State (N=37)	Avg. PPS/APM Rate		Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits	
	Average Rate (figure rounded to nearest dollar)	Range of Rates (figures rounded to nearest dollar)					
		Low					High
Montana*	\$140	\$95	\$195	Y		See footnote ⁷	
Nevada*	\$119			Y	1 per category		
New Hampshire		\$126	\$146	N/A	N/A	N/A	
New Jersey	\$129	\$124	\$132				
New York	\$145			Y	One "threshold visit" per day	Physician visits, mid-level visits, psychiatrists, clinical psychologists, clinical social workers, dentists, dental hygienists, therapy (speech, occupational, physical)	
North Dakota	\$121.27			Y	1 medical and 1 dental visit per day	Dental and mental health (when available)	
Ohio*	\$100			Y	Encounter – each type of service is billed separately regardless of whether encounters occur on same or separate days	All (transportation which is billed on a unit basis (each trip to or from service site) rather than encounter)	
Oklahoma*	\$135			Y		Multiple same day visits if for unrelated diagnoses, and generally, on an infrequent basis (specific number not provided – See rules 317:30-5-664.4)_____	
Pennsylvania*		\$77	\$135	Y	1 medical 1 dental 1 mental health		

⁷ [Montana] Encounters that take place on the same day and at a single location constitute a single visit, although the encounters were with more than one clinic or center health professional or multiple encounters with the same clinic or center health professionals. Each additional encounter with clinic or center health professionals that takes place on the same day as a medical visit to the same clinic or center constitute an additional visit if, after the first encounter: a) the patient suffers an additional illness or injury requiring additional diagnosis or treatment; b) patient has a mental health visit; c) patient has a dental visit <http://arm.sos.mt/37/37-20900.htm> (ARM 37.866.4402)

State (N=37)	Avg. PPS/APM Rate		Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits	
	Average Rate (figure rounded to nearest dollar)	Range of Rates (figures rounded to nearest dollar)					
		Low					High
South Carolina				N	the state is reviewing the possibility of changing the program		
South Dakota*	\$125			Y	1 medical visit and 1 dental visit per day	Dental and mental health (when available)	
Tennessee	\$100			Y	1 per category per day		
Texas	\$150	\$95	\$241**	Y	1 medical visit, 1 dental visit, 1 mental health per day	Multiple visits allowed if patient suffers additional illness or injury requiring additional diagnosis or treatment. EPSDT visits may also be billed on same day as another type of visit.	
Utah				Y			
Vermont	\$112			N	Cost report	1 Medical 1 Dental, 1 Mental Health day allowed up to five visits/month	
Virginia	PPS: \$91 APM: \$93			Y		1 Medical 1 Dental 1 Mental Health	All face to face encounters with a health professional (physician, physician assistants, nurse practitioner, clinical psychologist, dentist)
West Virginia	\$90			N	Increases only if Medicare cap increases		
Wyoming*	\$126			Y		2 (must be different diagnosis)	All of the above, As long as the diagnoses are different
Total				Y=30			

** This rate is an outlier. The next highest rate is \$201.

Table 5. Payment Rates for New Starts

State (N=37) *=PPS	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Arizona	Use 1 of 3 options: cost, rate of similar CHC, or state average. Rates recalculated every 3 years based on cost	Rates recalculated every 3 years based on prior 2 years cost
Arkansas	Based on average of current rates of 3 nearest health centers with similar case loads	6 months cost data, effective 1st day after 2nd fiscal cost report period
California	(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload. (B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonable similar geographic area with respect to relevant social, health care, and economic characteristics. (C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC.	
Colorado	File preliminary FQHC Cost Report w/ Department. Data from preliminary cost report used to set reimbursement for 1st year	1 year audited cost report
Connecticut*	Based on avg. rates for all FQHC's excluding Fairfield County	N/A
D.C.*	FQHC gets average rate of existing FQHCs. There is no change in initial rate annual. It is just adjusted for MEI.	
Georgia*	Rates are established by area costs	Adjusted after first year of actual services rendered
Hawaii*	Assigned 100% rate of FQHC providing similar services in similar locale. Can substitute documentation requesting different rate if believe rate is inadequate.	
Idaho	Based on estimated budget or referencing payments to other centers in same or adjacent areas.	Adjusted 2nd year Medicare cost report
Illinois *	Median rate of neighboring providers w/ similar caseloads or, if unavailable, statewide median for FQHC	Adjusted based on audited cost reports
Indiana*	Interim rate established based on current estimated cost. Final rate is determined after the first year of an audited cost report	
Kansas	A rate is used based on that of a similar health center.	The rate is established upon the settlement of the first cost report.
Kentucky*	Budget cost report for the first twelve months of operations.	At the end of the first fiscal year of the new FQHC, the cost report is audited and the rate established based on the audit.

State (N=37) *=PPS	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Louisiana*	Louisiana Register, Vol. 30, No. 10, October, 20, 2004 – The PPS per visit rate will be provider specific. To establish the baseline rate for 2001, each FQHC’s 1999 and 2000 Medicaid allowable costs, as taken from the FQHC’s filed 1999 and 2000 Medicaid cost reports will be totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. A visit is defined as a face-to-face encounter with a licensed practitioner. For those FQHCs that began operation in 2000 and have only a 2000 cost report available for determination of the initial PPS per visit rate, the 2000 allowable costs will be divided by the total number of Medicaid patient visits for 2000. Upon receipt of the 2001 cost report, the rate methodology will be applied using the 2000 and 2001 costs and Medicaid patient visits to determine a new rate.	2 year cost reports and total number of Medicaid patient visits
Maine	Initially established by reference to payments to other centers in same or adjacent areas. In absence of other centers use cost reporting.	Use MEI methods used for other centers
Massachusetts	FQHC receives class rate that it qualifies for under MA rules	
Michigan	If they have cost information, it is considered. New centers usually assigned cap based on MOA	Follow MOA agreement after have actual cost data
Minnesota	New Starts or new sites of existing FQHCs are assigned a PPS rate based on comparing the new entity with “similar” entities in service areas that are close to the new entity. In order to arrive at this rate, the state surveys the similar clinics with regard to services offered and the utilization of those services. In addition, the state places existing clinics into different “tier”, and assigned the new entity the highest rate of the clinics that fall in the same tier as the new entity. Problems with this methodology include: the massive size of the survey (12 pages); the requirement that the survey must be completed for each individual site rather than organization (many organizations have multiple sites and cannot break out the data by site); and a new start/new site’s initial PPS rate is contingent upon other clinics filling out the cumbersome survey on a timely basis. Finally, one new start in Minnesota has filed a lawsuit against the state citing the arbitrary and capricious methodology used in determining new PPS rates. The initial rate does not consider cost data.	
Mississippi*	The rate shall be calculated in amount equal to 100% of FQHC’s reasonable costs of providing Medicaid covered services. A rate is established from a FQHC in the same or adjacent area with a similar case load. In the absence of such a FQHC, the rate for the new provider will be based on projected costs. After the FQHC’s initial year, a Medicaid cost report must be filed in accordance with this plan. This cost report will be desk reviewed and a rate shall be calculated in the amount equal to 100% of the FQHC reasonable cost.	1 year cost data
Montana	Unless FQHC has current cost data, rate is set by matching a similar existing FQHC in same geographic area	2 years cost data

State (N=37) *=PPS	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Nevada*	Newly qualified FQHCs will have initial payments established either by reference to payments to other clinics in the same or adjacent areas with similar caseloads and/or scope of services.	Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, this data will be used to establish supplemental payments or recoveries from the provider and to establish a prospective per visit rate which will be adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that Center/clinic's fiscal year
New Jersey	Statewide avg for 2 years	2 years cost data
New York	The operating component is equal to peer group cost ceilings plus capital components based on capital expenditures associated with the project.	
North Dakota	New starts initially receive the current Medicare rate. After the first full fiscal year of operation a cost report is submitted and a PPS rate is calculated for the following year. No cost settlement is calculated for the start-up period.	
Ohio*	Based on nearest adjacent area that's similar or 60 th percentile of urban or rural. Initial rate is adjusted based on cost reports – effective 60 days of receipt of cost report.	Based on actual cost
Oklahoma*	In practice, new starts receive a statewide average PPS rate in their first year of service except that, again, there are different rates now for those with or without dental services – after the first year, by cost reporting methods. The State Plan amendment reads, "Federally Qualified Health Centers that enroll in Medicaid after State fiscal year 2000 will have their initial per visit rate established either by reference to payments to other Federally Qualified Health Centers in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods.	After the initial year, the per visit rate shall be established using the facility's reasonable costs inflated by the increase in the MEI."
Oregon	Based on estimated cost report	
Pennsylvania	Department will pay initial year on a per visit basis, 100% reasonable costs based on rates of other centers in same or adjacent areas; in absence of other centers will use cost report.	The next fiscal year, the rate is adjusted to reflect actual audited reasonable costs.
Rhode Island	Use rate of similar health centers in same area	
South Carolina	Based on estimated budget	6 months costs data
South Dakota*	Statewide average reconciled after 2 years to establish final PPS rate	2 years cost data
Tennessee	For new clinics, the state will use the average PPS rate for neighboring clinics with similar caseloads. If there are no such similar clinics, the State will use the average PPS rate for all clinics on an interim basis until the State can base the clinic's projected PPS rate.	
Texas	File projected cost report w/in 90 days of designation as FQHC to establish initial rate	1 year cost report with settlement
Utah	Compared to existing CHC's, rate adjusted after first year of actual data	1 year cost data
Vermont	New FQHCs and Look-alikes have an initial interim rate established based on the experience of similar health centers' rates until the filing of a first cost report.	

State (N=37) *=PPS	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Virginia	Based on estimated budget	1 year cost data
Wyoming*	Interim cost reports	1 year cost data

Table 6. Scope of Service

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Arizona	Working on written policy definition -- expect to be issued this year	New policy will describe	Y	AHCCCS Medicare CR
Arkansas	Add or delete covered services; change magnitude, intensity or character of currently offered services; change in state or federal regulatory requirement; change due to relocation, remodeling, opening a new clinic site or closing existing clinic site; change in applicable technology or medical practice; change due to recurring taxes, malpractice insurance premiums, or worker's comp premiums that were not included in base calculation	Provider submits requests for cost increase/decrease within 5 months after end of fiscal period, must identify date change occurred and detailed description, include documentation and calculations of changes and cost difference. Change must equal at least 5% total difference allowable per encounter cost and must have existed during last full 6 months of provider fiscal period. State reviews documentation, notifies FQHC within 90 days. Rate change may also be made through audit or review.	Y	State Medicaid CR
California	See footnote ⁸	Upon DHS approval of a FQHCs or RHCs request for PPS rate adjustment due to a change in the scope of services, DHS notifies the FQHC or RHC of the approval and forwards the rate adjustment information to EDS (the state intermediary). The intermediary loads the rate adjustment information into the Medi-Cal payment system and retroactive payment adjustments are then processed (the approved rate adjustment is effective from the first day of the FQHC's or RHCs fiscal year following the fiscal year in which the change in scope of services qualifying event occurred). Ongoing claims are processed and paid at the adjusted PPS rate.	Y	The Department of Health Services
Colorado	None	Request in advance. Develop and submit preliminary budget; new interim/blended budget is calculated	Y	Dept Health Care Policy and Financing CR

⁸ California's definition of change of scope of services can be found in Welfare and Institutions Code Section 14132.100(e). A change in scope of service means any of the following: (A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system, (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate. (or existing PPS rate, as specified in the SPA.) (B) A change in service due to amended regulatory requirements or rules. (C) A change in service resulting from relocated or remodeling an FQHC or RHC. (if no election is made to redetermine the PPS rate.) (D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic. (E) An increase in service intensity attributable to change in the types of patient served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations. (F) Any change in any of the services describe in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites. (G) Changes in operate costs attributable to capital expenditures associated with a modification of the scope of any other the services described in subdivisions (a) or (b), including new or expanded service facilities, regulatory compliance, or change in technology or medical practices at the center or clinic. (H) Indirect medical education adjustments and a direct graduate medical payment that reflects the costs of providing teaching services to interns and residents. (I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Connecticut*	None	None	Y	Dept. Social Services CR
D.C.*	None	None	N	
Georgia*	None	Not officially, but it can be requested in writing	N	
Hawaii*	Rate may be adjusted for increases or decrease in scope of service furnished by FQHC or RHC	Provider notifies DHS, submits documentation of substantial change, proposes adjusted rate. If DHS agrees with proposed rate, DHS will set new rate effective date of change.	N	
Idaho	Addition/deletion of new service or change in scope/intensity of services that could change clinic's total allowable cost per encounter	Budget being submitted to show increase or decrease in cost of added or deleted service; use budget to recalculate rate	Y	Medicare CR
Illinois *	Significant change resulting in inclusion of behavioral health or dental or a difference of at least 5% from current rate. PCA notes state has interpreted this to mean addition of service only.	CHC or State may initiate rate adjustment based on audited financial statements or cost reports.	Y	State Medicaid CR
Indiana*	Changes may be submitted for the following: adding services, discontinuing services, change in the type of services, relocation, remodeling, new clinic, closing clinic, federal or state regulatory requirements, and changes in site or scope of services approved by HRSA, BPHC	A change in the scope of service is submitted under the defined provisions. The change request should reflect an increase or decrease of 5% or greater to the current PPS rate that is reasonable with more than 6 months of continuation.	Y	State Medicaid Agency
Kansas			Y	Health Policy Authority
Kentucky*	Change in scope of service" means a change in the type, intensity, duration, or amount of service.	Revised cost report, which is audited. (This process is being revisited by the Primary Care Medicaid Technical Advisory Committee in an attempt to provide greater clarity and common interpretation among the Department for Medicaid Services, Auditors and Clinics.)	Y	Department for Medicaid Services
Louisiana*	Use federal definition and process, accepts federal approval of change of scope	No formal written process, still working on protocol for this	N (unless requesting approval for a change of rate)	
Maine*	Substantial change in type of service provided	Request due no later than 150 days after FQHC fiscal year end in which change occurred. FQHC submits documentation showing HRSA approved change in scope and submits cost report with a least 6 months financial data and narrative of change.	Y	Medicare CR

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Massachusetts	(1) Addition of a new service, (2) A regulatory provision that can provide an add-on to the rate for a center or group of centers to undertake special state initiatives and/or because danger of curtailment of services require a rate adjustment	(1) Not applicable because a new service (i.e. pharmacy) will be paid on its own regulation, (2) Provision in the regulation for an application and approval/disapproval process for the two “administrative relief provisions”	Y	Division of Health Care Finance and Policy CR
Michigan	See footnote ⁹	FQHC must notify state 90 days prior to making financial commitment. The Dept must approve changes before they become effective. The Dept will review rate change request within 45 days of receipt of complete documentation. Rate change may be subject to negotiation between FQHC and Dept.	N	
Minnesota	No, there is no specific definition in the state statute or rule that outlines what a change of scope is exactly for FQHCs. Rather, our Medicaid Provider Manual has “examples” which are directly excerpted here: Examples of potential PPS changes in scope of service include addition or discontinuation of: Pharmacy service; radiology services; and/or mental health services. Examples of items that are not considered PPS changes in scope of services include: increase/decrease in expenses for salaries, benefits, and supplies not directly related to a scope of service change; Increase/decrease in facility overhead or administration expenses not directly related to a scope of service change; Increase/decrease in assets not directly related to a scope of service change; and/or Expenditures for items covered by insurance.	Yes, as described in the State MA Provider Manual: In the event that an FQHC/RHC has a change in the scope of services provided, PPS rates are to be adjusted. The FQHC/RHC must provide information regarding changes in the scope of services including the budgeted costs of providing new services and any projected increase or decrease in the number of encounters due to change. Any adjustment 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 scope of services change. When determination of the revised PPS rate occurs after the revised rate’s effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.	Y	Cost reports are submitted for change of scope requests and APM. They are submitted to the Department of Human Services.

⁹ In Michigan, FQHCs at or below payment cap may request a rate change if it adds or deletes Medicaid covered services, experiences an extraordinary change in its business model, or provides services to a specialized high-need population not served by other providers in the community. A change in scope of services does not include expanding hours, adding a staff for services already provided, adding a new site with same set of Medicaid services. The new rate may not exceed capitated FQHCs that are over the payment cap may only request a rate change if it experiences an extraordinary change in its business model or provides services to a specialized high-need population not served by other providers in the community.

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Mississippi*	A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of service as follows a) the addition of a new service (i.e. dental, EPSDT, optometry) not previously provided by the FQHC; and b) the elimination of an existing service provided by FQHC. A change in the scope does mean the addition or reduction of staff to or from an existing service. Also, a change in the cost of a service is not considered a scope of service change.	To qualify for a scope of service change a facility must have at least 5% increase in cost. The FQHC must submit a Medicaid Cost report for 12 months of cost for the new service. The cost report will be desk reviewed and the new cost will be compared to the last desk reviewed Medicaid Cost Report.	Y	Division of Medicaid
Montana*	Add or delete service, change in magnitude, intensity, or character of services	Notify dept in writing of increase or decrease in scope of services. Upon provider request, Dept will determine if change qualifies as a change in scope of service and amount and effective date of rate change (increase or decrease)	Y	State Medicaid CR
Nevada*	None	See footnote ¹⁰	N	
New Hampshire	PPS/APM not in effect		Y	Medicaid
New Jersey	Addition of new FQHC covered service not in baseline or deletion of service in baseline; amended regulatory requirements or regulations; relocation, remodeling, opening/closing clinic; change in applicable technology and medical practice	FQHC notify Dept in writing at least 60 days before effective date of change and explain reason for change, submit documentation to substantiate changes and costs related to changes. The changes must be significant with substantial increase/decrease in cost. Providers may submit changes once a year (by Oct with effective date of Jan 1) or when change exceeds 2.5% of allowable per encounter rate (effective change date). Dept will notify FQHC of rate adjustment. FQHCs may appeal within 60 days of determination letter	Y	State Medicaid CR
New York	The definition applies to other facilities in addition to FQHCs. Existing regulations say that if a center adds a service or a site through the State's Certificate of Need (CON) process, the facility can apply for a rate adjustment.	Center applies for a rate appeal based on the increase in operating costs due to new capital project or program.	Y	Department of Health

¹⁰ In Nevada, each FQHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous fiscal year, adjusted by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that center/clinic's fiscal year which has been reviewed and agreed upon by the State. Documentation to support an increase or decrease in the scope of services is the responsibility of the provider.

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
North Dakota	None	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.	Y	Only start-up centers are required to submit cost reports until a PPS rate is established. PPS centers are not required to submit cost reports.
Ohio*	Addition/deletion of a new category of service; service has changed in scope, increase or decrease scope of services (5101: 3-28-09-OAC)	FQHC will get start-up rate for new category of service – 60 th percentile for rural or urban; upon receipt of cost report, PPS rate adjusted based on reasonable cost parameters	Y	Ohio Department of Jobs and Family Services
Oklahoma*	Inclusion of behavioral health benefits, dental services or a difference of at least five percent from the Center's current costs.	Center can apply for a rate change if the cost changes by more than five percent.	Y	State Medicaid Agency- Oklahoma Health Care Authority
Oregon*	See OAR 410-147-0362 (effective October 2008). A change in scope of services may occur if a FQHC has added, dropped, or expanded any service that meets the definition of a FQHC or RHC service as defined by 42 USC 1396d(a)(2)(B-C). To qualify for an adjustment, changes must result in a minimum 5% change in cost per visit. Examples of changes in the scope of services include: a change in services compared to services reported to calculate the original baseline rate, a change in types of providers, a change in the types of patient populations served, changes in operating costs, changes in technologies or medial practices, and changes in laws or regulations.	FQHCs must submit a written narrative describing change, an estimate of projected Medicaid encounters in forthcoming 12 months, a cost statement, and other documents. For anticipated changes, health centers should submit prospective costs. For unanticipated or gradual changes, health centers must provide at least six months of actual costs beginning on the date the change occurred. Upon receipt of a complete change in scope application, the Medicaid agency will review and respond to the health center with a decision within 90 days. Providers may appeal this decision in accordance with the agency's provider appeal rules. (The rule is not effective until October 2008).	Y	State Medicaid CR
Pennsylvania*	An increase or decrease in scope of services must be federally approved, covered under the State Plan & listed on the Medical Assistance Fee Schedule. Services considered are defined as distinct clinical services to include, but not limited to, physician services, licensed clinical psychologist services, licensed clinical social worker services, laboratory, pharmacy, radiology, family planning, dental & emergency services.	Provider submits to DPW the Federal approval for new or deleted services and a modified cost report reflecting change; DPW reviews change & modifies rate if approved; DPW provides written notification of decision; provider may appeal decision.	Y	Office of Medical Assistance Programs
Rhode Island	Use federal guidelines in discussion with individual health center	Rate submitted to state with explanation of what services have been added or if the	Y	Required to submit audits

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
		service area is expanded		to state
South Carolina	None	None	Y	SC Dept. of Health and Human Services
South Dakota	None	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.	Y	Annual Medicare
Tennessee	None	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.	Y	Comptroller's Office
Texas	Addition or deletion of service, change in magnitude, intensity, character of service. Includes change in provider mix, operating costs attributable to capital including new facilities, regulatory compliance, technology, or medical practice. Includes indirect medical education adjustments and graduate medical education payments. HRSA approved changes.	File cost report if seeking to adjust effective within 6 months; include data justifying change, proof of efficient operation and reason for change.	Y	Medicare CR
Utah	None	Provider submits documentation of change of scope with estimated cost. Overestimated costs will require pay-back, underestimated costs will be reimbursed.	Y	State Medicaid CR
Vermont	None	Yes Individual negotiation between the FQHC and Medicaid based on specific circumstances (i.e. adding an EMR, adding integrated behavioral health services)	Y	Medicaid cost reports are submitted to Medicaid and then audited by the regional Medicare fiscal intermediary.
Virginia	No written definition. State considers change the addition or deletion of a service	State would review actual costs from year end cost report and adjust rate.	Y	State Medicaid CR

State (N=38) *=PPS	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Wyoming*	Change in type, intensity, duration and/or amount of service. Change in cost of service by itself is not considered a change of scope.	Facility files report documenting services change and associated costs; Dept. determines if rate change is warranted and amount of any such change based on nature of the new or discontinued service and reasonableness of the facility's cost.	N	
Total			31	

Table 7. Effective Date of Adjusted Payment Rate

State (N=39) *=PPS	When Rate Change Takes Effect						Avg. Time Request to Payment
	Date New Service Added	Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Arizona	X						Average about 4-5 months, up to 1 year
Arkansas					Later of date service added or began FY		3 months
California					The approved rate adjustment is effective from the first day of the FQHCs or RHCs fiscal year following the fiscal year in which the change in scope of services qualifying event occurred		According to a survey conducted by CPCA, the state has been able to process scope of service change requests within 6 months time.
Colorado	X						Prior to new service
Connecticut*					Retroactive		6-12 months
D.C.*			X				Within 60 days
Georgia*						X	Unknown
Hawaii*					retroactive to 2004 because state and FQHC disagreed about methodology		Unknown
Idaho	X					X	1 month
Illinois *						X	unknown (appeal pending)
Indiana*					retroactive to the date the change in scope of service was fully implemented		Not applicable
Kansas	X						
Kentucky*			X				Unknown
Louisiana*					no rules/process established; deal with each on individual basis		2 remaining requests going on 3 years
Maine*	X		X				3-4 months
Massachusetts		X					
Michigan		X					45 days
Minnesota	Any adjustment 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 scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.						
Mississippi*	X					X	1 year
Missouri						X	

State (N=39) *=PPS	When Rate Change Takes Effect						Avg. Time Request to Payment
	Date New Service Added	Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Montana*	X		X				1 week to process change request plus 1-2 weeks to process payments
Nevada*							N/A (unknown because it hasn't really happened)
New Hampshire					PPS/APM not in effect		
New Jersey		X					2-3 months
New York	X					X	6-12 months
North Dakota					The first month following the date the request was submitted		Generally no more than 30 days
Ohio*					Rate adjustment effective on first day of first full month after request granted – no retroactive payments		Within 60 days of receipt of complete cost report
Oklahoma*	X		X				2 weeks
Oregon*		X					2-3 months
Pennsylvania*					Effective data consistent with begin date of service but not to precede Federal effective date		
Rhode Island	X						Average length is several months; there was change of staff this year within state and change took longer
South Carolina						X	
South Dakota*					Two year cost report required before adjustment		Generally no more than 30 days
Tennessee						X	Unknown
Texas					New service added first day of month after approved		
Utah					Application withdrawn	X	Incomplete Process

State (N=39) *=PPS	When Rate Change Takes Effect						Avg. Time Request to Payment
	Date New Service Added	Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Vermont					As negotiated by individual health center		Within the quarter
Virginia						X	
Wyoming*					Jan. 1		6 months
Total	10	4	5		15	10	

Table 8. Experience of FQHCs Seeking a Change in the Payment Rate

State (N=34) *=PPS	#/% FQHC Seeking Rate Change	#/% Approved Rate Change	Avg. Amount of change (roundest to nearest dollar/%)	Services Involved In Rate Change
Arizona	4 so far	4 so far	\$21 & 21%	Medical and dental
Arkansas	2	0		
California	FY06-77/13%	33 so far	\$21	Medical and dental
Colorado	0			
Connecticut	25%	100%	varies	All
Georgia*	1	1		
Hawaii*	1 FQHC (7.6%)	1 FQHC (7.6%)	\$8.74/visit increase	Unknown
Idaho	1	1	\$115	Dental
Illinois *	1	0		
Indiana*	1	0		
Kansas	8%	100%	Unknown	Dental/oral health
Kentucky*	50%	100%	unknown	Dental, OB/GYN and new sites
Louisiana*	3	1	unknown	addition of dental and mental health
Maine*	10 CHCs or 56%	10 approved	17%	Dental, chiropractic, mental health
Massachusetts	3	0	N/A	CHC operations related to 340B pharmacy development; urgent care; care for homeless in respite facility
Michigan	Few	50%	\$1-2 per encounter	Mostly for exceptional change in business plan
Minnesota	Unknown	Unknown	Unknown	Unknown
Mississippi*	6 CHCs or 26%	5/23%	\$5.22	HIV services, OB & GYN, Ryan White, and dental services
Montana*	0	0	N/A	N/A
Nevada*	0	0	N/A	
New Jersey	10	90%	no answer	Opening new site or adding new service; one change relating to medical technology pending
New York	10	TBD	\$3-\$20	Capital costs, making case that CHC is different from peers (to allow to move out of peer group ceiling)
North Dakota	1	0		One increased rate for physician services after changing from family practice to full service
Ohio*	unknown	100%	unknown	Dental, mental health
Oklahoma*	5	3	\$28.50	OB sites, change in types of OB/GYN services, addition of OB services and overall costs, and change in type of dental services offered (addition of dental anesthetics)
Oregon*	3	3	unknown	Expanded medical and mental health; expanded dental; change in providers.
Rhode Island	4	4	\$15-\$30	dental and service area expansion
South Dakota*	1	0		Dental
Tennessee	1	1		
Texas	0			
Utah	1	n/a	n/a	Resulted in development of APM

State (N=34) *=PPS	#/% FQHC Seeking Rate Change	#/% Approved Rate Change	Avg. Amount of change (roundest to nearest dollar/%)	Services Involved In Rate Change
Vermont	66%	100% but only on an interim	+/- \$5	As noted above, rates have been changed to adjust for temporary loss of productivity related to EMR implementation and for change in practice systems (such as behavioral health integration)
Virginia	0			
Wyoming*	1 CHC or 13%	1	\$25	Expanded medical capacity, oral health, Ryan White Title III, mental health, children's advocacy, vision

Table 9. Wrap-around Payments

State (n=40) *=PPS	Wrap-around payments to FQHCs						
	Provide payments		How often payments made	Provide at the end of the year?		Problematic process?	Why worked so well?
	Yes	No		Yes	No		
Arizona	X		Quarterly		X	Requires yearly reconciliation since quarterly payments are based on PMPM rates, not encounters	
Arkansas		X			X		
California	X			X		The Department makes an interim payment on reconciliations, but withholds 40% of the funds until the Department is able to review the reconciliation submission.	
Colorado		X				No	Receiving the wrap around payments is left up to the MCO. FQHCs receive their full FQHC reimbursement from the MCO.
Connecticut*	X		Monthly			See footnote ¹¹	
D.C.*	X		Quarterly	X		See footnote ¹²	
Georgia*	X		Monthly		X	See footnote ¹³	
Hawaii*	X		Quarterly	X		See footnote ¹⁴	
Idaho		X			X		

¹¹ [Connecticut] Very problematic. The MCO's in the state are denying large numbers of claims inappropriately and for the past two years DSS has only been paying the wrap on "clean" claims paid by the MCO's. Since 90% of the denied MCO claims are valid under Medicaid law the FQHC's have been losing out on a significant amount of money. This process has significantly disrupted cash flow at all centers.

¹² [District of Columbia] Some health centers indicate that they do not get timely payments of their wrap-around and have to call the Medicaid office repeatedly to follow-up. One health center indicated that it had not received their wrap around payment for the past years. After further investigation it appears that Medicaid did not give clear direction on the format that claims were to be submitted so providers were having their claims rejected. Medicaid is working with the health centers to resolve the issue.

¹³ [Georgia] This year has been a problem since the CMO's have taken over the Medicaid program. Late data from the plans to the state has caused a delay in payments to the centers. The State has been very helpful in resolving this issue however has caused some cash flow issues for the members

¹⁴ [Hawaii] The reconciliation has been a problem. The state is considering an APM to get the plans to do this. State reconciled 2001-2005 payments with a negotiated settlement for most health centers in December 2006. All have subsequently accepted payments. There is not yet an agreed upon method for future reconciliations.

State (n=40) *=PPS	Wrap-around payments to FQHCs						
	Provide payments		How often payments made	Provide at the end of the year?		Problematic process?	Why worked so well?
	Yes	No		Yes	No		
Illinois *	X		Monthly		X	Occasionally, MCO organizations will not report enrollment changes or the addition of an FQHC to its network resulting in payments being made to the wrong FQHC or not made at all.	Payments are generated without individual claim filings.
Indiana*	X		Monthly	X		Due to difficulty encountered with MCO data and currently no dental is available.	Although the reconciliation can be difficult, the turn around time in wrap process is beneficial to health centers
Kansas	X		Monthly	X		During a transition of managed care to a different company, not all health centers were listed on the transmission to the new entity. Therefore, data was not routed to the Health Policy Authority for that clinic. It took several months to identify the problem and rectify	
Kentucky*		X			X		
Louisiana*		X					
Maine*	X		Quarterly	X			
Massachusetts	X				X	At present, MassHealth MCOs pay MassHealth+ rates	
Michigan		X	Once a quarter		X	No, the end of the year reconciliation process has been effective.	Have the opportunity to change their payments based on projections.
Minnesota	X		Quarterly		X	See footnote ¹⁵	
Mississippi*		X			X		
Missouri	X			X		It often takes more than one year for the Medicaid office to audit the CHC cost settlement reports.	
Montana*		X			X		
Nevada*	X		Quarterly		X	It doesn't seem to be a problem	It seems to be an easy process for them to get all of the services covered and paid for.

¹⁵ [Minnesota] While the state has finally cleared a back-log of MA payments dating from 1993 – 2002, the state has yet to “finalize” and make payments from 2002 to the present day. This has created problems for CHCs during their annual audit process. Furthermore, the level of detail provided to CHCs to support the interim, quarterly payments, has been extremely inconsistent with regard to the level of detail provided. With no claims detail behind the forwarded funds, CHCs are in no position to gauge the accuracy of DHS’ payment amount.

State (n=40) *=PPS	Wrap-around payments to FQHCs						
	Provide payments		How often payments made	Provide at the end of the year?		Problematic process?	Why worked so well?
	Yes	No		Yes	No		
New Hampshire		X	N/A	N/A		N/A	N/A
New Jersey	X		Quarterly	X		The uses HMO data, which does not match FQHC data.	Regular and ongoing meetings with Medicaid have been helpful. Most of our CFOs are very familiar with the process and make periodic suggestions to improve the process.
New York	X			X		See footnote ¹⁶	
North Dakota		X			X		
Ohio*	X		Within 120 days		X		State department has a good understanding; good relationship with ODJFS
Oklahoma*	X		Quarterly		X	See footnote ¹⁷	
Oregon*	X		Quarterly payments but for services up to 9 months prior. Pilot is underway to pay on a monthly basis for services up to 3 months prior.		X	Yes, there is a delay in receiving payments under current methodology of up to 9-12 months. The pilot program is addressing this and providing payments to pilot sites on a monthly basis for services delivered 3 months prior.	

¹⁶ [New York] CHCs often face long waits for payments and unexplained denials of claims. They are sometimes denied claims for patients whose names were on the roster at the time of service. Centers also frequently face long delays in credentialing providers with plans. In late May 2007, the Department of Health sent letters announcing a new methodology for processing wrap around payments. Health centers have expressed many concerns (see attached letter) and we are presently working to resolve the myriad new issues.

¹⁷ [Oklahoma] There were two distinctly frustrating scenarios in which managed care wrap-around was difficult. One was when the State decided to no longer contract out managed care to MCOs and move to a statewide, state-administered managed care program. The problem at that time was more related to program transitions than “wrap-around policy.” The problem related to health centers ability to retain patients as the primary care provider in the change over. The second significantly difficult scenario was during the recent rule-making process due to differences in understanding how payments are to be made. However, once it was understood that health centers must be paid PPS or an APM that is at least equal to PPS for traditional claims and the wrap-around policy was restricted to managed care claims and the interim claims issues resolved, the procedures were alright. (During the rule-making process the State was paying both Traditional and Managed Care claims on the fee schedule as claims were submitted and paying a wrap monthly for both which was administratively burdensome and costly to reconcile.) Now health centers are again paid at their PPS rates as claims are processed for Traditional claims and managed care claims are paid by a wrap-around process on a quarterly basis. Otherwise, the wrap-around process seems to work relatively well.

State (n=40) *=PPS	Wrap-around payments to FQHCs						
	Provide payments		How often payments made	Provide at the end of the year?		Problematic process?	Why worked so well?
	Yes	No		Yes	No		
Pennsylvania*	X		Quarterly		X	No	PCA has worked with Office of Medical Assistance staff, individually and collectively, informally and formally, to address issues of mutual concern. There is much information sharing that generally reduces problems.
Rhode Island	X		Monthly	X		Health centers and state are working on a system so that reconciliation will be as close to zero sum as possible.	
South Carolina	X		Quarterly	X		See footnote ¹⁸	
South Dakota*		X			X		
Tennessee	X		Quarterly		X	No	Health centers report all of their paid visits for a quarter and then are reimbursed the difference between what the managed care companies paid and their rate
Texas	X		Quarterly is the goal		X	See footnote ¹⁹	
Utah	X		State makes the payment once every 120 days	X		Very slow, due to delayed/inaccurate data from MCOs	
Vermont			N/A	N/A		N/A	N/A

¹⁸ [South Carolina] Yes. There is a timing issue. The MCOs normally will provide quarter end reports forty-five days after quarter end and SC DHHS will complete this within ninety days. Therefore the process could take over four months before CHCs receive the wraparound. Also, SC DHHS has not developed a standard format to receive encounter data from the MCOs thus creating part of the current problem of MCOs submitting reports forty five days after quarter end and also there maybe some instances where the reports submitted need future correction.

¹⁹ [Texas] There are various reporting requirements and processes with each of the different health plans. Due to plans' not submitting claims correctly, health centers experience payment delays and administrative hassles. There was a recent pilot program implemented to pay HMO full encounter rate to pass through to FQHCs. Goal was to take the practice statewide. Medicaid agency has indicated it will discontinue their pilot project in this area September 1 and not implement this process further. Centers in pilot areas are experiencing difficulties in ensuring they are paid appropriately and that all parties are aware of any rate changes.

State (n=40) *=PPS	Wrap-around payments to FQHCs						
	Provide payments		How often payments made	Provide at the end of the year?		Problematic process?	Why worked so well?
	Yes	No		Yes	No		
Virginia	X		Every quarter	X		No	We work closely with our Medicaid program in Virginia to address issues that may arise, and as a result have a very cooperative arrangement with staff and administrators of the program.
West Virginia		X	Managed Care organization is responsible for wrap-around		X	Not since MC organizations took over	FQHCs receive their full FQHC reimbursement from the MCO.
Wyoming*		X					
Total	26	13		13	21		

Table 10. Impact of the State Payment System on Type of Health Center

State (N=25) *=PPS	Are some health center faring better or worse under PPS than other health centers?														Comments	
	Smaller		Larger		Rural		Urban		New Start		Special Pop.		Other			Other
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse		
Arizona	X		X		X		X		X		X				All better than before our APM	
Arkansas	X		X		X		X		X							
California	CPCA has recently coordinated development of a CFO Taskforce that will serve a liaison function with DHS staff to continue efforts to improve the current PPS system (and practices) that exist at present.															
Connecticut															See Footnote ²⁰	
Georgia*	Varies, some of each category better off and some of each worse off															
Idaho	X		X		X		X		X						New starts in frontier and poorest counties worse off	
Illinois *		X				X										
Hawaii									X				X		Older centers worse off	
Kentucky*		X		X		X		X		X						
Louisiana*	X		X		X		X		X		X	X				
Maine*		X	X			X	X		X		X					
Massachusetts	X			X				X	X							
Michigan	X			X	X			X	X		X					
Minnesota		X		X		X		X		X		X				
Montana*	X		X		X		X		X		X		X			
Nevada*	It seems to be the same across the board															
New Jersey	X		X		X		X		X		X					
North Dakota	X			X	X			X	X			X				

²⁰ Centers with fewer Medicaid Managed Care customers have it easier. Centers that have the funds to put significant additional administrative personnel in their billing department are less impacted.

State (N=25) *=PPS	Are some health center faring better or worse under PPS than other health centers?														Other Comments
	Smaller		Larger		Rural		Urban		New Start		Special Pop.		Other		
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	
Ohio*													X		
Oklahoma*					X										
Oregon*	X		X		X		X		X						
Rhode Island		X	X			X	X								
South Dakota*	X			X	X			X	X				X		
Texas		X		X		X		X	X				X		
Utah	X				X										
Total	12	6	9	7	12	6	8	8	13	3	5	5	3	1	0

Table 11. Detrimental Aspects of the State Payment System

State (n=29) *=PPS	Are there any elements in your state program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs
Arizona	All inclusive rate could be better or worse depending on the patient mix
Arkansas	No, but would like another index that is higher than the MEI to increase the PPS rates from year to year
California	Although the impact is limited, newly formed FQHCs have experienced some difficulty in securing a PPS rate. FQHCs seeking to use 3 comparable clinics have been highly scrutinized to ensure comparability. CPCA is not aware of a FQHC that has secured a rate through this process. Those health centers submitting cost reports have experienced delays in processing the cost reports. The Department has 3 years under statute to process cost reports and again only 90 days for scope of service change requests. This has resulted in a forced prioritization of scope of service change requests. According to the Department, processing a cost report typically takes approximately 12 months.
Colorado	No
Connecticut*	Inconsistency and lack of process and procedure at the State. The administration of the program is run so poorly at the state that the FQHC's don't even know how to go about requesting changes when necessary (i.e.; change of scope, re-basing if necessary, wrap around reconciliations)
D.C*	No
Georgia*	The addition of the CMO's have caused an issue with the members. Of the three plans, not all are paying the PPS rate.
Hawaii*	Change of scope methodology is too vague for FQHCs to make use of. Proposed new rules to clarify the change of scope process, require a timeframe for reconciliation and other items have been in discussion with DHS since 2004.
Idaho	The PPS process appears to discount the importance of the FQHCs in access to primary care for Medicaid and other underserved populations -- a specific issue that has not been effectively defined is a change in scope.
Illinois *	The only means available for health centers to fund expanded or enhanced services through the operating provisions of our PPS system is to create and maintain a margin on services provided. Additionally, the ability to utilize Change in Scope appeals to retroactively fund expansion or the provision of enhanced services has not been an option. Payment cycles over 70 days are not unusual although in FY07 Medicaid paid FQHCs in 30 days for children's services and 60 days for adult services. Expedited payment is available to providers that qualify.
Indiana*	Reconciliation is difficult due to frequently faulty MCO data
Kansas	All of the Above
Louisiana*	Lack of process and consistent rules for rate reconsideration
Massachusetts	Offsetting of restricted granted; 2 year review cycle; slowness in acting on administrative rate relief requests
Minnesota	<p>Lack of Medicaid payments; Medicare cap on APM program; Lack of resources at state level devoted to FQHC payments; Lack of guidelines and official methodology for basic payments, change of scope, etc.; Perception at state agency that FQHCs are "overpaid"</p> <p>Guidance and rules are extremely vague in Minnesota. Therefore, any sort of comprehensive CHC-wide understanding of the process does not exist.</p> <p>Furthermore, the processes for assigning new rates and for filing a change of scope are not transparent to CHCs. Also, one CHC's experience usually does not mirror another's experience. In other words, CHCs are being treated inconsistently in Minnesota.</p> <p>As part of the settle-up process, the state -- at times -- transmits large amounts of data to CHC CFOs to sift through and determine the accuracy of the settle-up. Often times the data is missing large numbers of claims, which is often health plan specific. This leads MNACHC to believe that the reporting on the part of health plans to our Medicaid agency is not as accurate as it should be. Our Medicaid agency has insisted that this process -- health plans reporting to the state rather than CHCs -- will not change.</p>

State (n=29) *=PPS	Are there any elements in your state program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs
Montana*	The PPS system does not work well for individuals who have extensive health issues, particularly in the dental area. There is potential for harm in how the state sets the interim rate by looking at the rate for similar/adjacent health centers because of the small number of health centers in the state and difficulty finding centers with similar characteristics. So far, this has not caused problems, but other ways to set the interim rate have not been identified.
Nevada*	None
New Hampshire	N/A
New Jersey	The wrap around process has been harmful since the state now wants to use HMO data to do Wrap around and the HMO data is clearly not as comprehensive or complete as the FQHC data. The impact is that the wrap around dollars are less than what they should be thus causing a cash flow issue. This issue is now to be resolved by a task force made up of FQHCs, HMOs, CMS and Medicaid. The first meeting is August 1, 2007.
North Dakota	Lack of written policies and procedures developed by Medicaid
Ohio*	Yes – 60 th percentile, caps unacceptable
Oklahoma*	New rules: Again, temporary administrative burden of reconciling monthly for several months for both Traditional and managed care claims – no longer required; 2007 – recalculation of rates and disagreement in what is included and what is not included in PPS reduced health center rates – some rather significantly.
Oregon*	Delay in wrap-around payments, but this issue is being addressed through the pilot program to expedite payment process.
South Carolina	SC DHHS staff changes have impacted timely reconciliation of Annual Cost Reports and quarterly wrap-around MCO reports
South Dakota*	Lack of written policies and procedures developed by Medicaid
Tennessee	No
Utah	The reconciliation process, as well as the scope change process, has been complicated by disagreement over allowable costs. Need a PPS reimbursement methodology that is clear, concise, and not subject to multiple interpretations.
Virginia	N/A
West Virginia	Use of Medicare methodology and caps as well as Medicare MH rate reductions; non-compliance with rule that PPS rate or better must be paid under APM

Table 12. Beneficial Aspects of the State Payment System

State (n=29) *=PPS	Are there any elements in your state program that you believe have been particularly helpful or beneficial to FQHCs?
Arizona	Calculation of new rates every 3 years
Arkansas	Change of Scope definition could be very helpful and beneficial to the Arkansas FQHCs if they would plan the timing of their changes consistent with the Change of Scope rules.
California	The scope of service change process significantly reinstated the cost-based reimbursement system.
Colorado	PPS has been set as the floor in Colorado. Therefore, CHCs have the ability to receive a higher reimbursement than PPS, but are not penalized for their APM going below the PPS rate
D.C.*	The increased rate is the most complete rate and is close to the true cost of care
Hawaii*	Hawaii doesn't impose any productivity screens and has a fairly generous visit/day policy.
Illinois *	When combined with hold harmless provisions, rebasing can be beneficial. Excellent relationship with state Medicaid staff.
Indiana*	Monthly wrap payments are great in assisting cash flow
Kansas	Anticipate the removal of caps/screens as well as the reimbursement of additional health professionals and more than one visit per day to be a helpful change. (This change has not yet been finalized.)
Louisiana*	None
Massachusetts	Supplemental add-ons for dental services and for after hours and weekend urgent care
Michigan	Our health centers bill inpatient visits and long term care visits using the APM. This has been useful in many communities.
Missouri	All the CHCs agreed/pledged, back when PPS passed, to our Medicaid office that they all wanted to continue cost-based and not individually pursue PPS. This partnership has been beneficial.
Montana*	The PPS system has been very beneficial for standard office type visits; the reimbursement for these services has financially benefited our organizations.
Nevada*	The FQHC's said it is set up in a simple manner so it's easy to understand
New Jersey	No
North Dakota	Access to state Medicaid staff
Ohio*	N/A
Oklahoma*	New Rules: adding mental health provider types that may provide billable encounters.
Oregon*	Change in scope definition could be very helpful to health centers ability to restore services that were cut prior to PPS (under our 1115 Waiver), as well as to adjust services to better meet the needs of populations they are serving.. Unfortunately, the new change in scope policy will not be implemented until October 2008.
Pennsylvania*	PA Medicaid provides comprehensive covered services. The implementation of PPS has been a collaborative process between PCA and State Office of Medical Assistance Programs.
Rhode Island	Our ability to work with the state has been very helpful; we are continually working to identify issues before they become problematic.
South Carolina	None
South Dakota*	Access to state Medicaid staff
Tennessee	Updating the rates to more recent year costs has been helpful
Texas	Our current methodology incentives centers to be efficient. All services are wrapped into one all inclusive rate.
Utah	Ability to negotiate APM to include in-patient physician services.
Virginia	N/A
West Virginia	An enhanced rate is better than a non-enhanced rate, but the system here is very questionable