The National Association of
Community Health Centers, Inc.

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

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Introduction

The Benefits Improvement and Protection Act of 2000 replaced the traditional cost-based reimbursement system for federally-qualified health centers (FQHCs) with a new prospective payment system.[1] States were also allowed to implement an alterative 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.[2] With little or no oversight by the federal government, the National Association of Community Health Centers began to monitor states' activities, and in 2003, contracted the George Washington University to conduct an annual survey on the status of the Medicaid prospective payment system (PPS).

The survey focuses on four aspects of the PPS system:[3] 1) payment rate structure, 2) changes in the scope of services, 3) wrap-around payments and 4) perceived impacts of new payment program. No comparison with survey results from previous years are made due to varying sample of states responding

In 2006, all state Primary Care Associations (and state Medicaid agencies) located in the 50 states, District of Columbia, and Puerto Rico were surveyed.[4] Eight PCAs did not respond to the survey (Delaware, Florida, Indiana, Kentucky, Nebraska, Nevada,

[1] Public Law No. 105-554.
[2] In addition to previous GWU/NACHC PPS surveys, see GAO, "Health Centers and Rural Clinics: State and Federal Implementation issues for Medicaid's New Payment System," June 2005.
[3] GWU IRB# 060603.
[4] Although Puerto Rico responded to the survey, it is not included in most of the tables because no payment methodology has been established to date. West Virginia did not indicate what type of payment methodology the state used.

North Carolina, and Washington).[5] Survey responses can be found in Tables 1-12 in the back of the document. The 2006 Survey document is attached following Table 12.

PPS rate structure

Figure 1 shows 19 of 42 states are using only the PPS rate system, including Alabama, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Louisiana, Maine, Maryland, Minnesota, Mississippi, Montana, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, and Wyoming[6]. However, only 13 of the 19 PPS states indicate their states have issued some form of written policy (Table 1) and five states (AL, CT, GA, PA, TN) explicitly state that they have not done so since the new PPS system became effective in 2001-02.

Figure 1. FQHC Reimbursement Methodology

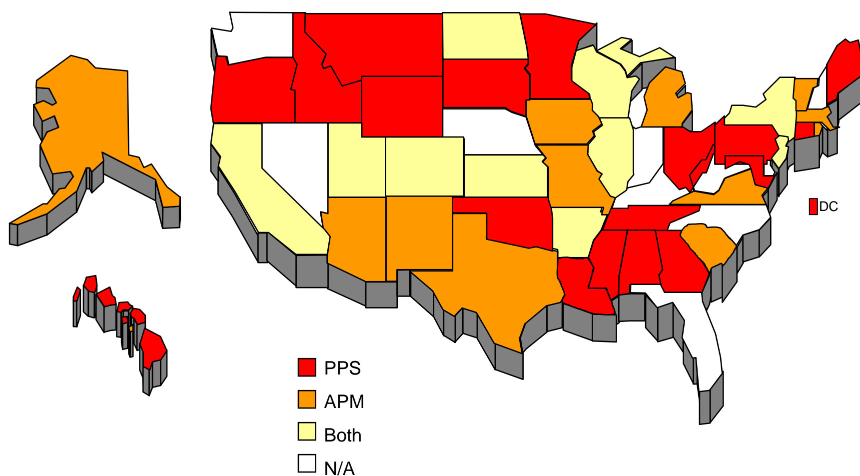

Table 2 shows whether the payment rates are inclusive or not, that is, a per visit payment rate that covers all ambulatory FQHC services. Eleven PPS states reported that the payment rate was all-inclusive. However, 8 PPS states have a number of rates based on geographical location or type of service. Ohio, for example, employs separate urban- and rural-based rates for medical, dental and mental health encounters. All PPS states use the Medicare Economic Index (MEI) as the inflationary factor (Table 4).

Twelve states reported using solely an alternative payment methodology (APM) and four of these states reported using the MEI as the inflationary factor. Five of the

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[5] Not all states are represented in all the tables due to missing or no responses to the question. Some responses have also been truncated and edited to facilitate review

[6] New Mexico indicates that the State uses the higher of the MEI of the CPI-U

APM states issued a explicit payment policy. Eight of the 12 APM states reported the rate was all-inclusive.

Ten other states reported using both PPS and APM to set rates. Of these, only Iowa, Michigan, and Virginia reported use of MEI as the inflationary factor. Eight of the ten states reported having a written policy in place. Half the states also reported the rate was all-inclusive.

In general, pharmacy, lab and x-rays were the most common services to be excluded from the payment rate. Table 3 shows 24 respondents excluded pharmacy services, 15 states excluded x-rays, and 14 excluded lab services. Four states reported excluding dental services and an additional four excluded mental health services from the rate.

Payment rates

Table 4 shows the varying rates paid to health centers. The rates range from $54 per visit in Arkansas to $248 in Wisconsin – both states using a combination of PPS and APM payment methodologies. Many states limit the number of allowable billable visits per day, depending on the type of encounter. For example, Alabama, Arizona, Arkansas, Kansas, and Massachusetts allow for one billable visit per day while Connecticut, Illinois, and Vermont allow one medical, one behavioral, and one dental visit per day. Only D.C. reported "no limitations" on billable visits.

Table 5 indicates states use a variety of methods to set rates for "new starts". States can set the rate based on state cost average (AZ, CT, DC, IL, MD, NJ, OK, SD), costs of similar health centers (AZ, AR, CA[7], GA, IL, MA, MN, MS, MT, NY, PA, TN, VT, WI), same geographic area (CA, HI, ME, MS, MT, NM[8], OH, OK, PA, RI), and interim cost reports (AZ, CO, ID, IA, ME, MD, MI, MS, ND, OH, TX, UT,VA, WY).

The PPS states predominately use geographic area and similar health centers to set rates: 12 states (AZ, AR, GA, HI, IL, MN, MS, MT, PA, RI, TN, WI) use costs of similar health centers, seven use similar geographic area (HI, ME, MD, MT, OH, OK, PA), five (ID, ME, MD, MS, OH, WY) use cost reports, and four use state cost average (CT, DC, OK, SD).

Change in Scope of Services

As demonstrated in Table 6, twenty-two (22) states have some form of a "change in scope" of service definition. As with previous PPS surveys, states use diverse definitions; some definitions are codified, others may be found in provider manuals or rely on references to federal guidelines and documents. Even after several years of PPS

[7] In addition to using the costs of similar health centers, California also uses interim cost reports and requires the health centers to finalize the rate after twelve months of operation with a final cost report (Source: California Primary Care Association).
[8] New Mexico uses same geographic area with similar scope OR actual cost data. (Source: New Mexico Primary Care Association).

implementation, four PPS states (CT, GA, TN, SD) continue to have no formal definition and three states (LA, MN, PA) refer to other sources, such as the federal guidelines and provider manuals.

In general, the specificity of the definition varies across states. Some are more explicit than others. For example, Michigan specifically excludes expansion of hours, staffing or sites as a change in service. On the other hand, Rhode Island, allows a center to provide a general explanation of its change in scope of service.

The process by which the rates may be adjusted also varies significantly from state to state. For example, without a scope of service definition, Arizona negotiates its rates. Maine allows FQHCs 150 days to request rate adjustments and they must provide at least 6 months of financial data. Michigan requires that FQHCs must first get approval 90 days prior to making changes. Thirty states require FQHCs to submit a cost report with any requests to change the payment rate.

Upon approval, 11 states reported that the rate becomes effective from the date the new service was added. Four states are paid the new rate beginning on the date the request was approved or requested (Table 7). The state can take anywhere from 30 days to two years. Only California indicated the new rate would become effective on the first day of the health centers' fiscal year. Vermont was the only state to report a negotiated effective date. Most states either did not answer or did not know when the rate change would become effective.

Table 8 shows only a few health centers actually seeking a rate change in 2006. Approximately 70 health centers requested a rate change in 2005 and nearly all were approved or pending approval. The average changes in the rate range from a reduction of $5 in Vermont due to decreased productivity to an increase of $115 in Hawaii for the addition of dental services. The most common services spurring rate change requests were dental or oral health (AZ, HI, ME, MS, MT, NM, OH, OK, RI, SD, TN, WY), followed by mental health (CT, ME, MT, OH, OK, WY), and other general/medical services.

Wrap-around Managed Care Payments

This year, a set of new questions were added to the PPS survey focused on the wrap-around payments to FQHCs. Table 9 shows 24 states provide wrap-around payments and are paid generally on a quarterly basis. Fifteen states reconcile payments at the end of the year. Twelve states (CA, IL, MD, MN, MO, OK, OR, PR, RI, SC, TX, and WV) reported significant problems with getting the correct amount paid on a timely basis. For example, Illinois, Minnesota, Maryland, New Jersey and Utah reported that delays in accurate health plan enrollment data have either led to inadequate payments or delays of up to15 months. California and Oklahoma reported some confusion in the process. Missouri indicated the reconciliation process can take years.

Perceived Impacts

In Table 10, states indicated generally that the payment program appears to work best when the rates paid actually cover the cost of care. Additionally, Arizona, California and Illinois believed that the calculation of new rates either through rebasing or change in scope of service activities were the best feature of the program. Collaboration between the state and the PCA were also deemed critical to an improved payment system.

Table 11 shows that PCAs believed the most harmful state activity was the lack of clear and written policies (HI, LA, MA, MN, ND, SD, and UT). Additionally, payment delays reportedly put health centers at financial risk (CA, MN, OR, SC, UT, and WV). Confusion around the change in scope of service policies was also cited by five state PCAs (AK, HI, ID, MN, OR). Only three states (AR, MD, PA) identified the MEI-inflation factor as a major problem.

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Conclusion

The survey found that states continue to take various approaches to structuring FQHC payment rates, implementing the process for seeking a change in the payment rate, and estimating wrap-around payments. Although most PCAs believe health centers are better off compared to cost-based reimbursement, they reported the lack of clear guidance on payment policies and payment delays as major issues to be addressed. In fact, even as states enter into their sixth year of the new payment systems, a significant number of them still have **not** clarified change in scope of service policies, improved the timeliness of payments, or better facilitated the reconciliation process. The number and magnitude of these problems now overshadow last year's top concern regarding the practical application of the MEI to adjust annual payment rates.

Table 1. State Payment Methodologies

State (N=41) *=PPS	FQHC Reimbursement Methodology			Has State Issued PPS Policy?	If yes, what document?
	PPS	APM	Both		
Alabama*	X			N	
Alaska		X		N	
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			N	
D.C*	X			Y	State Plan
Georgia*	X			N	
Hawaii*	X			Y	http://www.hawaii.gov/dhs/1740.1.pdf; http://www.hawaii.gov/dhs/ltgov/office/adminruls/
Idaho*	X			Y	IDAPA 16.03.09.144; http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf
Illinois			X	Y	IL Administrative Code - 89 ILL. ADM. Code 140.463; http://www.dpaillinois.com/lawrules/index.html
Iowa		X		N	
Kansas			X	Y	Revised regulations have been drafted but are in the process of internal review.
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
Maryland*	X			Y	PPS Regulations can be found – COMAR 10.09.08.05-1

State (N=41) *=PPS	FQHC Reimbursement Methodology			Has State Issued PPS Policy?	If yes, what document?
	PPS	APM	Both		
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				
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)
New Hampshire				N	Work is currently underway.
New Jersey			X	Y	New Jersey State Register June 7, 2004
New Mexico		X			
New York			X	N	
North Dakota			X	N	
Ohio*	X			Y	Chapter 5101: 3-28 of OH Administrative Code
Oklahoma*	X			Y	OK Administrative Code (OAK 317: 80-5-661); www.oar.state.ok.us/viewhtml/317_30-5-661.htm - PPS remains intact, reimbursement policies are approved, posted, and awaiting final system changes to take effect – expected August 1, 2006
Oregon*	X			Y	OAR 410-147-0360, Oregon Administrative Rules
Pennsylvania*	X			N	None issued yet, draft in progress
Rhode Island		X		N	
South Carolina		X		N	
South Dakota*	X			Y	In process
Tennessee*	X			N	
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

State (N=41) *=PPS	FQHC Reimbursement Methodology			Has State Issued PPS Policy?	If yes, what document?
	PPS	APM	Both		
Wisconsin			X	Y	Explanation letter mailed to FQHC's in 2001
Wyoming*	X			Y	Chapter 37; http:soswy.state.wy.us/Rule_Search_Main.asp
Total	**19**	**10**	**10**	**Y=26, N=14**	

Table 2. Number and Type of Payment Rates

State (N=41)	All-Inclusive Rate	More Than One Rate	If More Than One Rate, Separated By					Other
			Medical	Dental	Mental Health	Urban	Rural	
Alabama*	X							
Alaska	X							
Arizona	X							
Arkansas		X	X	X				FFS soon will be 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			
Iowa	X							
Kansas	X							
Louisiana*		X						
Maine*	X							
Maryland*		X	X	X		X	X	
Massachusetts		X	X	X	X			Add on payments for EPSDT, after-hours & weekend services
Michigan	X							
Minnesota*	X		X	X				
Mississippi*	X							
Missouri	X							
Montana*	X							
New Mexico	X							
New Jersey		X	X	X				

State (N=41)	All-Inclusive Rate	More Than One Rate	If More Than One Rate, Separated By					Other
			Medical	Dental	Mental Health	Urban	Rural	
New York	X							
North Dakota		X	X	X				
Ohio*		X	X	X	X	X	X	By site
Oklahoma*	X							
Oregon*	X							On 10/1/04 rule was created to separate into medical, dental, and mental health, but rule not implemented yet
Pennsylvania*		X	X	X				
Rhode Island		X						
South Carolina	X							Medicaid Dental can file at FFS or included in the all inclusive rate
South Dakota*	X							
Tennessee*		X	X					Lab, pharmacy
Texas	X							
Utah	X							
Vermont		X				X	X	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

State (N=41)	All-Inclusive Rate	More Than One Rate	If More Than One Rate, Separated By					Other
			Medical	Dental	Mental Health	Urban	Rural	
								Medicaid all-inclusive rates vary by location.
Virginia	X							
Wisconsin	X							
Wyoming*	X							
Total	**25**	**15**	**13**	**12**	**3**	**3**	**3**	

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

State (N=38)	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Alabama*	Dental and Medical as covered by Medicaid. 1 or 2 sites reimbursed for mental health that was approved under homeless program prior to becoming a health center.			X			
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	
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*		X	X	X			
Georgia*	Pregnancy, clinical social work, pre-natal case management, dental, mental health, optometry			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	Standard primary care services, optical and optometric services and supplies; chiropractic services; physical, occupational and speech therapy services; audiology, podiatric, lab services, x-rays and services provided by a psychiatrist. Separate PPS rates for Dental and Mental Health Services			X			
Iowa	All services						

State (N=38)	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
Kansas	See attachment – 30-5-118 – Services provided by the following healthcare professionals shall be covered as FQHC services: physician/physician assistant; advanced registered nurse practitioner; dentist/dental hygienists/dental assistants; clinical psychologists; clinical social workers; visiting nurse; Kan-Be Healthy nursing assessments	X	X				
Kentucky	Medicaid covered services			X			
Louisiana*	A visit is defined as face-to-face encounter with licensed practitioner, including doctors, dentists, clinical psychologists, clinical social workers, nurse 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
Maryland*	Medical, dental services (Support services like case management are NOT billable)			X	X		
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						
Mississippi*	Dental services, optometric services, nursing facility visits, inpatient & outpatients' hospital visits, EPSDT screening, psychiatric visits, and medical services			X			
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

State (N=38)	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
							health and dental are billable
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*	FQHC core services, and Medicaid covered services under state plan, including medical encounters, EPSDT, dental, family planning (after Aug. 1 see 317:30-5-660.5 definition of "core services", 661.1 to 661.6, 664.5 to 664.9 for various categories of services, listings and exclusions, and 664.10 for reimbursement policy	X	X	X	X	X	Some outside of "core" services for mental, dental. See additional explanation 317:30-5-664.1 and 664.5 to 664.8 – Other – some obstetrical e.g. delivery see 317:30-5-664.8
Oregon*	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	X	X	X			
Pennsylvania*	Physician services, services and supplies incident to services, vaccine, PA, NP, clinical psychologist, and clinical social worker services and supplies			X			
Rhode Island	Medicaid covered services	X	X	X	X	X	

State (N=38)	Services Included in PPS/APM Rate	Services Excluded from PPS/APM Rate					
		Lab	X-Ray	Rx	Mental Health	Dental	Other
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*	Medicaid covered services			some FQHCs)		some FQHCs)	
Texas	Physician, PA, NP, nurse midwife, visiting nurse, clinical psychologist, clinical social worker, mental health, dentist, dental hygienist, optometrist, TX Health Steps Medical Screen						
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	
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		
Virginia	All covered services except pharmacy.			X			
West Virginia		X	X	X	62% of normal rate	X	
Wisconsin	All services provided by Medicaid certified providers including physician, PA, NP, CNM; dental, mental health, speech, hearing, OT/PT, podiatry, chiropractic, optometry						
Wyoming*	Face to face encounter with a billable provider (MD, Midlevel, Psychiatrist, MSW, Dentist, Dental Hygienist, Nutritionist, Case Management (must be a licensed social worker)	X	X				
Total		**14**	**15**	**24**	**8**	**8**	**6**

Table 4. Average Payment Rate Structure

State (N=37)	Avg. PPS/APM Rate: Average Rate (figure rounded to nearest dollar)	Avg. PPS/APM Rate: Range of Rates (figures rounded to nearest dollar) Low	Range of Rates High	Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits
Alabama*	$114			Y		1	Dental up to age 21 reimbursed same day as another visit
Alaska	$195	$145	$247	N	Reasonable cost	1 medical 1 dental	
Arizona	APM: $130	$117	$156	N	Physician Services Index, CPI - Urban	1	
Arkansas	PPS: $116.55	$55	$157	Y		1	Unless for different disorder/condition or if after 1st encounter patient has injury or illness requiring additional diagnosis or treatment
California	$130.30			Y		1 Dental 1 Medical/Mental H California does not allow multiple encounters for a medical and mental health visit on the same day, but will reimburse two visits for a dental and medical or mental health encounter.	State law specifics 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.
Colorado	PPS: $126.32 APM: $139.50			Y		1 Medical 1 Dental	
Connecticut*	Med:$117 Dental: $111 Mental H: $136			Y		1 Medical 1 Dental 1 Mental H	
D.C.*	$132			Y		No limitation	
Georgia*	$80-109	PPS: $76	PPS: $100	Y		2	

State (N=37)	Avg. PPS/APM Rate: Average Rate (figure rounded to nearest dollar)	Avg. PPS/APM Rate: Range of Rates (figures rounded to nearest dollar) Low	Range of Rates High	Use MEI	If No MEI, factor used	Billable Visits/Day	Exceptions to Billable Visit Limits
Hawaii*	$150.75	PPS: $123	PPS: $165	Y		1 Dental 3 "other"	
Idaho*	Med and Mental Health: $110.83 Dental: $125.96			Y		2 Medical 1 Dental 1 Mental Health	Can have 2 medical visits in one day only if have separate issues
Illinois	Med: $115.82 Dental: $89.57 Mental H: $47.63			Y		1 Medical 1 Dental 1 Mental H	
Iowa		APM: $92	APM: $156	Y			
Kansas	Unknown approx. $90.00	Only one health center is using a PPS rate and that arrangement was negotiated between Medicaid and that health center		Y		1 visit per day currently. (The proposed regulations will allow multiple visits with different types of health care providers)	Face to face visit with the following health professionals.
Louisiana*	$114	$119	$121	Y			15/year
Maine*	$118			Y		1 Med OR Mental H + 1 Dental	May have all 3 if have unforeseen emergency
Maryland*				Y		An FQHC can have multiple billable visits as long as the procedure/services are different	

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				
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	Average rural: $107.02 Average urban: $128.86			Y		1 Medical 1 Dental 1 Mental H	
Minnesota*				Y			
Mississippi*	$101.16			Y		1 Medical 1 Dental 1 Optometric	All the services are billable visits if they are performed by a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting visit, clinical psychologist or clinical social worker
Montana*	$136.52	$97	$183	Y			
N.H.		$124	$144	N/A		N/A	N/A
New Mexico	$134.94						
New Jersey	$127.48	$124	$130				
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 are billed on a unit basis (each trip to or from service site) rather than encounter)
Oklahoma*	$148.85			Y		Currently 1 medical, 1 dental (After Aug. 1, more than one encounter per day for unrelated	

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				
						diagnoses (317:30-5-664.4)	
PA*	75-135			Y			
South Carolina	$106.05			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)
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			
West Virginia	$89						
Wisconsin	PPS: $248 APM: $239			Y		multiple visits allowed	As long as the diagnoses are different
Wyoming*	$126			Y		2 (must be different diagnosis)	All of the above, As long as the diagnoses are different
Total				**Y=27, N=6**			

Table 5. Payment Rates for New Starts

State (n=38)	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Alabama*	Not an issue b/c no new starts	
Alaska	In accordance with 7 AAC 43.860(l), which reads: l) A rural health clinic that enrolls during or after rural health clinic fiscal year 2000, and that (1) submits cost data for a minimum of six months during the rural health clinic fiscal year 1999 and 2000 period, may request payment at a per visit rate that is based on the submitted data; (2) does not submit cost data for a minimum of six months, will be paid a per visit rate equal to the statewide weighted average of the total Medicaid per visit payment rates made to rural health clinics; the base per visit rate will be re-determined	
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 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	1year audited cost report
Connecticut	Based on avg. rates for all FQHC's excluding Fairfield County	
D.C.	FQHC gets average rate of existing FQHCs. There is no change in initial rate annual. It is just adjusted for MEI.	
Georgia*	Based on projections and history of a similar FQHC	When data available
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	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

State (n=38)	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Iowa	Forecasted Cost Report filed	
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 200 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
Maryland*	New starts are assigned an interim rate for each of the 3 years of operation that is the average of the FQHC urban or rural rates for those years. During those first two years of that process a cost report must be filed by the new start and finalized rate developed – the third year.	
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

State (n=38)	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Montana*	Unless FQHC has current cost data, rate is set by matching a similar existing FQHC in same geographic area	2 years cost data
New Mexico	State may use MEI rate and CPI-U rate as its discretion but not less than MEI.	State has used higher CPI-U rate in 3 of the last 5 years.
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 60th 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*	Officially, as per state plan amendment, by reference to FQHCs in the same or adjacent areas, or in their absence by cost reporting methods. In practice, new starts receive state average PPS rate in initial year. Rates are individually calculated from cost reporting thereafter.	1 yr reasonable cost
Oregon*	Based on estimated cost report	
Pennsylvania*	Dept pays for initial year on per visit basis, 100% of reasonable costs based on rates of centers in same area with similar case loads or, in absence of such centers, FQHCs cost report.	1 yr audited cost report
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*	State uses avg PPS rate for neighboring clinics w/ similar caseloads. If none, use avg. rate for all clinics	Actual costs
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.	
Virginia	Based on estimated budget	1 year cost data

State (n=38)	Setting Rates for New Starts	Setting Final Rates for New Starts, if applicable
Wisconsin	Assigned PPS rate from FQHC in same or adjacent w/ similar case load.	Higher of initial PPS rate or audited rate
Wyoming*	Interim cost reports	1 year cost data

Table 6. Scope of Service

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Alabama*	Provider begins providing new service requiring significant increase in cost	Budgeted cost report requested by Medicaid's Provider Audit Program; initial encounter rate set based on info received; after year or other interval actual cost report requested; budget period settled and true encounter rate established	N	
Alaska	Add or delete service, change cost per visit by 2.5% or more, cost change directly related to new/deleted service	FQHC submit cost report to state within 120 days of end of FY when change occurred	Y	Office of Rate Review
Arizona	Working on expanded definition	Negotiated – there is no specific formula	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	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 RCHC 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	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

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
	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).			
Colorado	None	Request in advance. Develop and submit preliminary budget; new interim/blended budget is calculated	Y	Dept Health Care Policy and Financing 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	N	
Illinois	Admin code says adjustment to encounter rate only if change in scope of service results 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.	Dept. may initiate rate adjustment based on audited financial statements or cost reports; currently all appeals holding while Dept, CMS, PCA discuss change in scope of service language.	Y	State Medicaid CR

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Iowa	None	None		
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
Maryland*	Change of scope defines as a service change or a one time extraordinary circumstance.	See Page 3, Section F of attached – If an FQHC implements a change in its scope of services or if it experiences an extraordinary one-time circumstance, the FQHC or the Department may request a revision of the FQHC's prospective rate of reimbursement. Written notification must be made not later than 30 days after the implementation of the scope of services change. The cost report and supporting documentation required under this regulation shall be submitted within 90 days after the end of the first 1-year period immediately following the implementation of the scope of service change.	Y	Medicaid
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

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
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.	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.	Y	For transportation and outreach only
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.
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 not 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

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
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
N.H.			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
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.

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
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 – 60th percentile for rural or urban; upon receipt of cost report, PPS rate adjusted based on reasonable cost parameters	Y	Ohio Department of Job and Family Services
Oklahoma*	See 317:30-5-664.12 – A change in scope of services adjustment may be made when the change in scope of services includes the addition of behavioral health or dental services or would account for a 5% change in a health centers prospective payment rate.	No, * Notify Oklahoma Health Care Authority in Writing, * Eligibility within the parameters described in 11, * Effective latter of initiation of services change or application to Oklahoma Health Care Authority. The calculation itself and what is included is not explained in the rules, therefore, the answer to this question might more appropriately be "no". However, it seems that the all services are reconsidered together in calculating a change due to a change in scope of services.	Y	Medicaid Agency – Oklahoma Health Care Authority
Oregon*	None	None	Y	Only if establishing rate or rate change
PA*	Use HRSA/BPHC definition	Provider submits Federal (BPHC) approval of change and modified cost report; Dept reviews change and modifies rate if approved. Dept will provide FQHC with written notice of decision. Provider may appeal decision.	Y	State Medicaid CR
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 service area is expanded	Y	Required to submit audits 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

State (n=38)	Scope of Service Definition	Scope of Service Rate Adjustment Process	File Cost Report	Describe Cost Report (CR)
Tennessee*	None	State has worksheets to compute changes. Clinic informs state of change and provides actual cost, visit, and square footage (when applicable) allocated to new service. Change factored into 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
Wisconsin	Wisconsin is still developing a change of scope policy.	Wisconsin is still developing a change of scope policy.	Y	Division of Health Care Financing
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	
			Y=31, N=7	

Table 7. Effective Date of Adjusted Payment Rate

State (N=41)	Date New Service Added	When Rate Change Takes Effect					Avg. Time Request to Payment
		Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Alabama*	X					X	unknown
Alaska						X	One center applied for a change of scope adjustment, but the change in scope did not meet the State's change of scope definition.
Arizona	X					X	Unresolved has been over 8 months; resolved about 4-5 months
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					X	Prior to new service
Connecticut*					Retroactive		Over 1 year
D.C.*			X				Within 60 days
Georgia*						X	unknown
Hawaii*	X					X	unknown
Idaho*	X					X	1 month
Illinois						X	unknown (appeal pending)

State (N=41)	Date New Service Added	When Rate Change Takes Effect					Avg. Time Request to Payment
		Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Iowa						X	
Kansas						X	
Louisiana*					The other request has not been granted as of yet; the one center approved from an extreme circumstance		The one approved was about a week; the others have been in negotiations for almost 2 years
Maine*	X					X	3-4 months
Maryland*		X					
Massachusetts			X				
Michigan		X					45 days
Minnesota*						X	
Mississippi*	X					X	1 year
Missouri						X	
Montana*	X		X				1 week to process change request plus 1-2 weeks to process payments
New Hampshire						X	
New Mexico					Retroactive to a date determined by the state		15 months
New Jersey		X					2-3 months
New York	X					X	6-12 months
North Dakota					If approved, the first month following the date the request was submitted		Generally no more than 30 days

State (N=41)	Date New Service Added	When Rate Change Takes Effect					Avg. Time Request to Payment
		Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
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		The latter of the date the change request is received by the agency or the date of the application for the service change		1 month
Oregon*		X					2-3 months
Pennsylvania*	X					X	Unknown
Rhode Island	X				Date of federal approval		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	
Texas					New service added first day of month after approved		
Utah					Application withdrawn	X	Incomplete Process
Vermont					As negotiated by individual health center		Within the quarter

State (N=41)	Date New Service Added	When Rate Change Takes Effect					Avg. Time Request to Payment
		Date Request Approved	Date Medicaid Received Request	Beginning of FY	Other	Unknown or No Answer	
Virginia						X	
Wisconsin						X	
Wyoming*					Jan. 1		6 months
Total	**11**	**4**	**4**	**0**		**22**	

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

State (N=34)	#/% FQHC Seeking Rate Change	#/% Approved Rate Change	Avg. Amount of change (roundest to nearest dollar/%)	Services Involved In Rate Change
Alabama*	0			
Alaska	0			
Arizona	3 CHCs or 21%	2 so far, 1 still pending	Not known	Medical and dental
Arkansas	0			
California	unknown			
Colorado	0			
Connecticut*			Mental H $20	Pending mental health
Georgia*	1	1		
Hawaii*	0			
Idaho*	1	1	$115	Dental
Illinois	1	0		
Iowa	0			
Louisiana*	5	1		
Maine*	10 CHCs or 56%	8 approved, 2 pending	17%	Dental, chiropractic, mental health
Maryland*	5	5		
Massachusetts	3	1 pending	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
Mississippi*	6 CHCs or 26%	5/23%	$5.22	HIV services, OB & GYN, Ryan White, and dental services
Montana*	1 CHC or 11%	1 CHC/100%	Reduced by $0.79	Dental, mental health, and physical therapy services
New Mexico	1 CHC or 7%	1 CHC/100%	$24.00/ visit	Medical, Dental

State (N=34)	#/% FQHC Seeking Rate Change	#/% Approved Rate Change	Avg. Amount of change (roundest to nearest dollar/%)	Services Involved In Rate Change
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*	3	3	$28.50	From Medicaid agency: OB, additional sites and behavioral health; From health center: additional dental service
Oregon*	1	1	unknown	Expanded medical and mental health
Rhode Island	4	4	$15-$30	Dental and service area expansion
South Dakota*	1	0		Dental
Tennessee*	1	1		Dental
Texas	0			
Utah	1	n/a	n/a	Resulted in development of APM
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			
Wisconsin	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=37)	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			X		
Arkansas		X		X		No	CHC auditors and PCA worked together to ensure that Medicaid accepted language for SPA was fair and equitable for both parties.
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	N/A	N/A		No, since they do not have to receive the wrap-around payment.	The MCO pays CHCs their full FQHC reimbursement rate and the MCO then bills the state for the difference.
District of Columbia*	X		Every quarter	X		No	Quarterly, the OCFO checks the list in the MMIS system to verify eligibility files to calculate payment
Georgia*		X		X		1115 draft submitted to CMS; no FQHC impact	Draft being discussed
Hawaii*	X		Quarterly	X			
Idaho*		X			X		

State (n=37)	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 on a timely basis. The result is that payments sometimes are made to the wrong FQHC.	Payments are generated without individual claim filings.
Iowa	X		Usually quarterly	X		No	
Louisiana*		X	More frequently than once every 120 days		X		
Maine*	X		Quarterly	X			
Maryland*	X		Quarterly			Alternate payment has been very problematic for processing of dental claims.	
Massachusetts	X		SPA for supplemental payment to offset uncompensated care (pending)		X		Extension approved for 1 year
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	The state is in the process now of cleaning up a backlog of wrap-around payments to health centers from 1990-2002.	
Mississippi*		X			X		
Missouri	X			X		It often takes more than one year for the Medicaid office to audit the CHC cost settlement reports.	
New Hampshire		X	N/A	N/A		N/A	N/A
New Mexico	X		More frequently;	X		No	PCA developed

State (n=37)	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		
			each time the center enters a claim				process – simple form to report visits each month. Simple annual reconciliation.
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						
North Dakota		X	MCOs pay the PPS rate.			N/A	N/A
Ohio*	X		Within 120 days		X		State department has a good understanding; good relationship with ODJFS
Oklahoma*	X		Quarterly		X	There has been some confusion about the process, however, additional documentation, rule changes, training provided between OPCA and the Medicaid agency, and the developing billing manual should have or shall alleviate such situations.	OHCA has reportedly been prompt about making "wrap-around" payments to health center following the submissions of quarterly reports.
Oregon*	X		Pilot to pay more often than every 120 days		X	Yes, delay in receiving payments under current methodology 9-12 months, pilot program addressing this	

State (n=37)	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		
Puerto Rico		X	Only 2 FQHC receive payment by court order.		X	Yes, legal process since 2002.	
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		The program is currently six months behind schedule.	
South Dakota*		X	MCOs pay the PPS rate.	N/A		N/A	N/A
Tennessee*	X		Quarterly based on paid claims.		X	No	
Texas	X		Quarterly is the goal		X	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.	
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
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		Annually at best	X		The settlements and reconciliations are done only after Medicare "closes", and then Medicaid usually takes 2 years.	

State (n=37)	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		
Wisconsin	X		Depending on the FQHC, this can be monthly or quarterly	X		Not problematic	The process invovles a 2-3 day site visit, 2 weeks for completion of the paperwork.
Wyoming*		X					

Table 10. Beneficial Aspects of the State Payment System

State (n=29)	Are there any elements in your state program that you believe have been particularly helpful or beneficial to FQHCs?
Alaska	PPS removed the chaos of settlement
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	Because PPS has been set as the floor, CHCs have the ability to receive a higher reimbursement than PPS, and 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.
Iowa	Health Centers are getting higher of actual costs or the PPS rate.
Louisiana*	No
Michigan	Our health centers bill inpatient visits and long term care visits using the APM. This has been useful in many communities.
Minnesota*	No
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*	Improved reimbursement rate.
New Mexico	Wrap around reconciliation methodology and small increases when higher MEI – CPI-U inflator is used.
New Jersey	No
New York	Capitals pass through – allowing rates to go up based on capital expenditures.
North Dakota	Access to state Medicaid staff.
Ohio*	N/A
Oklahoma*	No
Oregon*	No
Pennsylvania*	Periodic meetings between PCA staff and its members with MA staff.
Puerto Rico	No
Rhode Island	Our ability to work with the state has been very helpful; we are continually working to identify issues before they become problematic.
S.C.	For 2005, the state has agreed to a new process of providing 70% of anticipated reimbursement. The final reconciliation of the cost report is to be completed soon thereafter.
S.D.*	Access to state Medicaid staff.
Texas	Our current methodology incentivizes 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	Unknown

Table 11. Detrimental Aspects of the State Payment System

State (N=26)	Are there any elements in your state program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs
Alaska	Rolling in dental to an all inclusive rate has not been good;better with FFS
Arizona	No
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 difficult 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 experience 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
District of Columbia*	No
Hawaii*	Change of scope of methodology is too vague for FQHCs to make use of. There is also a lack of clarity on whether costs can be included for substance abuse services, nutrition services, and various enabling services. Some FQHCs reportedly include some of them and others do not.
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 in our State.
Louisiana*	Not having written, set policies. Policies change periodically without advance notice.
Maryland*	The MEI
Massachusetts	Offsetting of restricted granted; 2 year review cycle; slowness in acting on administrative rate relief requests
Minnesota*	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”
Montana*	There is a 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 and other ways to set the interim rate have not been identified.
New Hampshire	N/A
New Jersey	No
North Dakota	Lack of written policies and procedures developed by Medicaid.

Ohio*	Yes – 60th percentile, caps unacceptable
Oregon*	Delay in payment, strict definition of change in scope – have to add dental or mental health services as a new line of service for change in scope to be approved/no intensity acknowledgement
Pennsylvania*	MEI not always reflective of actual cost increases – e.g. inflation greater than MEI, benefit cost increases greater than MEI, personnel costs also greater than MEI.
Puerto Rico	Yes, that CMS has no mechanism to obligate states to comply and does not penalize for non-compliance. This imposes an economic burden on CHC.
South Carolina	Slow reconciliation of year end Cost Reports.
South Dakota*	Lack of written policies and procedures developed by Medicaid.
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	The system is harmful because it has caused Medicaid to “target” FQHCs for reductions in other reimbursements and strange rules, especially regarding mental health. The state uses Medicare rate caps which punish some centers. The late payments make it difficult for the centers to stay afloat.

Table 12. Impact of the State Payment System on Type of Health Center

State (N=23)	Are some health center faring better or worse under PPS than other health centers?														
	Smaller		Larger		Rural		Urban		New Start		Special Pop.		Other		Other
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Comments
Alaska	X		X		X		X		X		X				
Arizona	X		X		X		X		X		X				
Arkansas		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.														
Georgia*	Varies, some of each category better off and some of each worse off														
Hawaii*														X	Older centers worse off
Idaho*	X		X		X		X		X						New starts in frontier and poorest counties worse off
Illinois		X				X									
Louisiana*	X		X		X			X		X	X				
Maine*		X	X			X	X		X		X				
Massachusetts		X	X				X								Based on 2001-02 prelim analysis
Michigan	X			X	X			X	X		X				
Minnesota*		X		X		X		X		X		X			
Montana*	X		X		X		X		X		X		X		
New Jersey	X		X		X		X		X		X				
North Dakota	X			X	X			X				X			
Ohio*													X		
Oklahoma*					X										
Oregon*	X		X		X		X		X						
Rhode Island		X	X			X	X								
South Dakota*	X		X		X			X	X						
Texas		X		X		X		X	X			X			
Utah	X				X										
Total	**11**	**7**	**12**	**4**	**12**	**5**	**10**	**6**	**11**	**2**	**7**	**3**	**3**	**1**	

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State/Commonwealth______

Survey Date______________

PROSPECTIVE PAYMENT SYSTEM SURVEY PRIMARY CARE ASSOCIATIONS AND STATE MEDICAID OFFICES

Please note: Like last year, we are sending one survey to PCAs and asking you to coordinate with your state Medicaid office as needed to make sure all answers are accurate and complete.

Contact Information

PCA

Name: ___________________________________

Title: ___________________________________

Phone: ___________________________________

Email: ___________________________________

State Medicaid Official

Name: ___________________________________

Title: ___________________________________

Phone: ___________________________________

Email: ___________________________________

Please note: If nothing has changed with your state's PPS/APM program since the NACHC survey last June you can put "NO CHANGE" and just answer new questions: 4a, 17a&b.

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PPS Implementation

1. Are all FQHCs in the state receiving payments under PPS or an alternative payment methodology (APM) or both? PPS APM Both

2. Has the state issued PPS rules, regulations, or policies? YES NO

2a. If YES, please identify what type of document has been issued and how to find it____

3. Do you have one all-inclusive rate or multiple rates per FQHC?
___ One all-inclusive rate per FQHC
___ More than one rate per FQHC

3a. If you have more than one rate, how are your rates separated?

___ Medical ___ Urban
___ Dental ___ Rural
___ Mental Health ___ Other (please explain)______________

4. What is the average or range of PPS/APM rate for FQHCs in your state? ___________
*If you use both a PPS and an alternative payment methodology, indicate the average PPS rate *and* average alternative rate.

4a. If your state is using an APM, is it essentially the same methodology it had used prior to the implementation of PPS, this is, is it basically a "reasonable cost" payment methodology such as is used in FQHC Medicare? If not, please summarize the methodology that the state is using as an APM. _____________________________
____
____

5. Is your state using the Medicare Economic Index (MEI) as its basis for annual rate increases? YES NO (please specify what index your state is using __________)

6. How many billable visits per day does your state allow? (For example, only one visit per day versus one medical visit and one mental health visit and one dental visit per day)

____

7. What services are FQHCs reimbursed for as part of their PPS/Alt. rate? Please be as specific as possible. For example, list dental services, licensed nutritional services, professional counselor, etc.

____

____

____

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____

____

8. Please list which of the services identified in Question 7 are treated as billable visits. In other words, which of the services that you listed in question 7 can the FQHC file a claim for as a face-to-face visit for its PPS or APM per visit rate?

____

____

____

____

9. Please list any services that are not included in the FQHC's PPS/Alt. rate:

___Lab ___ X-Ray ___Rx ___Mental Health ___Dental

Other (please specify)____

10. How are rates for new FQHCs ("new starts") established? Please note whether and when an initial rate is adjusted based on actual cost data.

____

____

____

Change in Scope of Service

11. Does your state have a definition of change of scope of services, that is, does it explain what constitutes a change in scope (for example, addition of a new service, change in service intensity, addition of a new clinic site, etc)? YES NO

11a. If YES, please describe the definition: ______________________________

____

____

12. Does your state have a process for adjusting rates due to a change in scope of service? YES NO

12a. If YES, please describe the methodology:
____
____
____

13. To what extent have FQHCs sought changes to their rates based on a change in scope of service?

13a. Number/Percent of FQHCs requesting a rate change____________________
13b. Number/Percent of FQHCs whose request has been approved____________
13c. Average amount of rate change $__________________________________
13d. Services involved in rate change requests____________________________
____

14. When does the rate change take effect?

___ When the new service was added
___ From the day the rate change request is received by the Medicaid agency
___ From the day the rate change request is approved
___ Other (please describe)____

15. What is the average length of time between when a rate change is requested and when payment based on the new rate is received by health centers?__________________________________

16. Are FQHCs required to provide cost reports to the state? YES NO

16a. If YES, to which agency?______________________________

<u>Additional Questions for PCAs Only</u>

17a. Are there any elements in your state's PPS/APM program operation you believe have been particularly helpful or beneficial to FQHCs? If so, please explain.

____
____

17b. Are there any elements in your state's PPS/APM program that you believe have been particularly harmful and/or have had an adverse impact on FQHCs?

____
____

18. Are some health centers faring better or worse under PPS than others?

	Worse	Better
a. Smaller	_____	_____

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b. Larger _____ _____
c. Rural _____ _____
d. Urban _____ _____
e. New starts _____ _____
f. Special populations _____ _____
g. Other (please specify)__________

19. In the past year has your state promulgated any regulatory or other written policy changes to PPS? YES NO

19a. If YES, please describe:____

____

Please submit a copy of your current state plan amendment related to FQHC services and payment to be included in NACHC's online clearinghouse.

Thank you for taking the time to complete this survey. Feel free to call or email Roger Schwartz at 202.296.0158 rschwartz@nachc.com with any questions.