Guidehouse

Alaska Medicaid Rate Evaluation

Federally Qualified Health Centers (FQHC)

Presented to:

Alaska Department of Health

Presented by:

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A. Executive Summary

The Alaska Department of Health (DOH) engaged Guidehouse to conduct a rate evaluation of payments and reimbursement methodologies across a range of services covered under Medicaid. Guidehouse evaluated rates for behavioral health, rates for long-term services and supports (LTSS), rates for Federally Qualified Health Centers (FQHCs), and reimbursement-related issues impacting medical transportation in Alaska. This report focuses exclusively on FQHC reimbursement; rate evaluation findings and recommendations for the other programs under review are released in separate reports.

FQHC rate methodologies must align with federal requirements, including that a Prospective Payment System (PPS) rate be adjusted to take into account any increase or decrease in the scope of service furnished by the FQHC during the fiscal year, known as a "Change in Scope" (CIS). This report presents our opportunity analysis and recommendations for a one-time Catch-Up and an ongoing CIS methodology for PPS rate updates for Alaska's FQHCs.[1] Guidehouse compiled data from Medicare cost reports, supplemental data surveys and other State-provided data to perform the analysis. During the rate evaluation process, Guidehouse met with DOH on a biweekly basis and held four stakeholder engagement meetings which helped Guidehouse understand provider perspectives and adjust the rate methodology development to align with feedback.

The rationale for Guidehouse's proposed Catch-Up CIS PPS approach, as well as the additional rate and policy recommendations supporting it, is grounded in two significant findings that these recommendations are intended to address:

Finding 1 (FQ-F1): Many FQHCs have modified their service offerings over the past two decades. Those changes may not be reflected in their current PPS rates, but most providers have rates that reflect more recent cost data through the Alternative Payment Methodology (APM) rate.

Finding 2 (FQ-F2): FQHC providers report that they are experiencing service delivery challenges, some of which may be partially addressable through Medicaid policy revisions.

In response to these findings, Guidehouse developed a model to quantify a Catch-Up CIS PPS rate specific to each of the FQHC providers reviewed. The model utilized a bottom-up approach in which Guidehouse relied on the appropriate costs and visits as reported in providers' Medicare cost reports. Guidehouse then layered into the model additional visits not included in the Medicare cost reports as reported by FQHCs. Guidehouse requested audited financial statements and additional supplemental data from the FQHCs to further validate the expenses as well as medical and mental health visit data (where applicable), along with collecting feedback on service delivery challenges experienced by the FQHCs.

[1] Guidehouse's review and analysis did not include Tribal FQHCs (TFQHCs) operated by Tribal Health Organizations, which are allowed to enroll as a separate provider type in Alaska and have opted to receive the All-Inclusive Rate (AIR), or encounter rate, calculated annually by the Indian Health Service (IHS) and published in the Federal Register, distinct from other FQHCs. TFQHC funding and payment methodologies fall outside the scope of Guidehouse's evaluation.

Recommendations and Fiscal Impact

Guidehouse formulated three related recommendations, which are contingent on federal approval, addressing FQHC rates. Guidehouse's recommendations include a proposal for a one-time Catch-Up CIS that will rebase PPS rates for those FQHCs with a qualifying CIS. Additional recommendations address the need for DOH to clarify CIS requirements to define a process for future CIS requests and to provide additional resources to support FQHC participation in the Catch-Up CIS opportunity.

Recommendation 1 (FQ-R1): Alaska Medicaid should consider implementing a Catch-Up Change in Scope rate adjustment to better align FQHC PPS rates with the current scope of services delivered by each FQHC.

Recommendation 2 (FQ-R2): Alaska Medicaid should consider offering enhanced technical assistance to FQHC providers interested in the opportunity to update their PPS rates with a one-time Catch-Up Change in Scope.

Recommendation 3 (FQ-R3): Alaska Medicaid should consider establishing a transparent Change in Scope policy that provides a clear definition of the changes in the type, intensity, duration, or quantity of services that potentially qualify for a CIS.

Guidehouse developed a fiscal impact analysis that utilized claims data, current FQHC encounter rates, and the proposed Catch-Up CIS PPS rates utilized in the financial model. The fiscal impact compares the financial impact on State expenditures with and without the Catch-Up CIS rates. Guidehouse then incorporated Alaska Medicaid's weighted average federal match into the fiscal impact to estimate between **$2.9 million and $5.3 million impact in total or between $800 thousand and $1.5 million in State share annually**, depending on how many providers choose to participate in the opportunity**.**

The analysis indicates **implementation of the projected rates would result in a 17 percent funding increase for the non-tribal FQHC program overall.** Guidehouse also considered the potential expense of our other rate and policy recommendations for DOH to consider, there may be additional administrative costs incurred from enhanced technical support, depending on the number of providers receiving support and the level of assistance required.

B. Introduction and Background

B.1. Federally Qualified Health Center (FQHC) Encounter Rates

FQHCs are community-based health care providers that offer a range of services including primary and behavioral health care, often but not always in underserved areas. FQHCs must provide primary and preventative care services but may offer other services included in a state's Medicaid plan, such as dental, behavioral health, and vision services. FQHCs are paid using an encounter rate, which is a single rate paid for all services provided to one patient in one day[2]. Encounters must occur one-on-one between a patient and an FQHC provider, which can include physicians, physician assistants, nurse practitioners, clinical psychologists, clinical social workers, registered dieticians, or other allied health professionals. All services must be delivered within providers' scope of practice.

B.2. Prospective Payment System (PPS)

The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) requires all state Medicaid agencies to establish a baseline PPS rate for each FQHC. The PPS rate establishes a baseline rate for each FQHC according to the methodology required under BIPA. As required by BIPA, the PPS rate is calculated as 100% of a facility's total reasonable costs divided by total encounters during state fiscal years 1999 and 2000, resulting in an average encounter rate. States are required to update the PPS rates annually for inflation and based on changes in the scope of services provided to patients. For annual inflation, states are required to use the Medicare Economic Index (MEI) for rate updates. The MEI is the Centers for Medicare & Medicaid Services (CMS)-published index used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services.

At the time of analysis, five of the fourteen FQHCs in Alaska were paid via the PPS rate, and two of those five were in the process of transitioning to an alternative rate as discussed in Section B.4 of this report. Since the time of analysis, two providers have formally transitioned to the APM.

B.3. Change in Scope Rules

Federal statute, SSA Sec. 1902. [42 U.S.C. 1396a] requires states to adjust FQHC PPS rates to "take into account any increase or decrease in the scope of such services furnished by the center or clinic." However, federal statute does not define how states should interpret an "increase or decrease in the scope" and CMS guidance on how to define "changes in scope" for FQHCs is limited. In 2001, CMS issued guidance that a CIS of services is a change in the type, intensity, duration, or quantity of services. It also clarified that a change in the scope of FQHC services always occurs when a facility adds or removes any service that meets the definition of an FQHC or Rural Health Clinic (RHC) service, as provided in section 1905(a)(2) (B) and (C), and the service is a covered Medicaid service under the State Plan. However, a change in the cost of a service is not considered in and of itself a change in the scope of services. Finally, CMS clarified that state

[2] On rare occasions providers may be allowed to bill two separate visits in a single day.

agencies must include the cost of new FQHC services even if these services do not require a face-to-face visit with an FQHC provider, (e.g., laboratory, x-ray, drugs, outreach, case management, transportation, etc.)[3]

B.4. Alternative Payment Methodology (APM)

In addition to the PPS rate, which can be adjusted with a CIS, states may also establish an Alternative Payment Methodology (APM) under BIPA as long as the reimbursement is equal to or greater than the PPS rate and the FQHC consents to receiving the APM rate. If an FQHC receives less reimbursement than it would have been eligible for under the PPS rate, the facility must receive the difference as part of an additional payment. CMS requires approval of APMs through a state plan amendment. All states that operate managed care programs and pay FQHCs an APM encounter rate must calculate the difference between the APM and PPS annually and make supplemental payments to FQHCs if the APM is lower than the PPS. For inflation of the APM, states have the option of using the MEI or an FQHC-specific market-based update developed by CMS.

Nine FQHCs in Alaska have opted into the APM rate, with two more FQHCs currently in the process of transitioning to an APM. Alaska's APM rate is a provider-specific, cost-based methodology designed to allow FQHCs to be reimbursed for the actual costs of providing services. It allows FQHCs to undergo a review of their Medicare cost reports at least every four years to establish a new APM rate. In interim years, the APM is subject to inflationary adjustments.

B.5. Guidehouse Rate Evaluation and Role

Prior to this rate evaluation and opportunity assessment, DOH and the Alaska Primary Care Association (APCA), which represents the State's FQHC providers, had begun discussing APCA's concerns about FQHC reimbursement and policy. Some of APCA's requests included changes to:

- The inflation factors used to calculate rates
- The base data and effective dates of interim and final PPS rates for new FQHCs
- The process for providers transitioning from PPS-based rates to APM-based rates, such as quicker and clearer processes
- The CIS process and timing, including an expanded definition of what qualifies for a CIS and more clarity around the process

Over the course of many discussions, DOH responded to several of APCA's concerns.

As a result of the conversations between DOH and APCA, Guidehouse was tasked with evaluating the opportunity to implement modifications to the existing CIS methodology and to submit a report detailing subsequent recommendations and considerations to reflect options for updating the methodology. To accomplish this, Guidehouse and DOH drafted a proposed conceptual CIS definition that relied on input from APCA and the FQHCs. More information about the conceptual proposal can be found in Section E.2.2 of this report. Using this proposed definition, Guidehouse

[3] NACHC, BIPA PPS FCHC/RHC Q&A

collected cost reports and released a supplemental data survey for FQHCs to complete, along with a requested CIS form reporting supporting documentation to inform DOH on each FQHC's costs to deliver services.

When establishing encounter-based rates for FQHCs[4], we relied on cost reports and supplemental surveys to capture relevant cost and utilization data, supporting providers to complete the cost reports, collecting, reviewing, and analyzing the cost information, developing a rate model, and calculating rate recommendations. This report is intended to describe the methodology and data sources that Guidehouse used and to present our resulting recommendations.

[4] Guidehouse's review and analysis did not include Tribal FQHCs (TFQHCs) operated by Tribal Health Organizations, which are allowed to enroll as a separate provider type in Alaska and have opted to receive the All-Inclusive Rate (AIR), or encounter rate, calculated annually by the Indian Health Service (IHS) and published in the Federal Register, distinct from other FQHCs. TFQHC funding and payment methodologies fall outside the scope of Guidehouse's evaluation.

C. Findings and Recommendations

C.1. Findings and Considerations

Guidehouse requested CIS forms from FQHCs (discussed further in Section E) to collect information about the changes in scope that have occurred since the time period when DOH originally set their PPS rates. Guidehouse requested this information to better understand the types and magnitude of changes that providers experienced over the last several years, given that many providers had not previously notified DOH of a CIS event. In total, nine of the fourteen FQHCs submitted changes of scope forms. Submissions included changes that spanned as far back as 2017 and as recent as 2025. Due to the time period of the data Guidehouse had available, only changes in scope up to 2024 were included in our rate calculations and fiscal impact. Provider submissions covered several types of changes, some of which would qualify for a CIS rate update and some of which would not qualify in alignment with the proposed conceptual CIS definition described in Appendix A. Reported events included events that would likely qualify for a CIS rate update under the CIS definition described in Appendix A and events that would likely not qualify.

- **Reported events that would likely qualify for a CIS rate update under the CIS definition described in Appendix A:**
    - Addition of new services (e.g., dental services)
    - Removal of services (e.g., nutrition services)
    - Implementation of Electronic Health Record systems
    - Change in population intensity (e.g., closing of elderly care options in the geographic area led to a large increase in the elderly population served)
- **Reported events that would likely not qualify for a CIS rate update under the CIS definition described in Appendix A:**
    - Hiring new staff
    - Purchase of replacement equipment
    - Closing clinic locations

Although PPS rates may not reflect the sum of the changes reported by FQHCs, providers who are on the APM are currently receiving higher rates that are regularly updated to reflect more recent cost data, including the costs associated with their CIS.

Finding 1 (FQ-F1): Many FQHCs have modified their service offerings over the past two decades. Those changes may not be reflected in their current PPS rates, but most providers have rates that reflect more recent cost data through the Alternative Payment Methodology (APM) rate.

Guidehouse's supplemental data survey, discussed in Section E, offered providers the opportunity to submit additional qualitative feedback on their challenges with FQHC service delivery, changes in cost, and any further contextual information to support the reimbursement evaluation.

Many providers noted significant workforce challenges. FQHCs described concerns with recruitment and retention, as well as competitive pay, especially compared to other providers or industries. Some also explained that attracting staff to rural locations is challenging and can result in overreliance on temporary staff, which impacts patients by creating disruptions in continuity of care.

In addition, providers noted that inflation and increased costs have created difficulties that existing payment rates do not cover. Some providers experience financial insecurity due to limitations on Medicaid service coverage, such as the annual cap on dental benefits for adult Medicaid patients. Providers also observed increases in cost for supplies, electricity and fuel, insurance, and pharmaceuticals and vaccines. Providers stated that supply chain disruptions have likewise impacted their business.

Finding 2 (FQ-F2): FQHC providers report that they are experiencing service delivery challenges, some of which may be partially addressable through Medicaid policy revisions.

Lastly, the FQHCs expressed several concerns with existing Medicaid administrative processes. Providers noted difficulties with getting timely and accurate Medicaid eligibility redeterminations for their patients and the significant administrative burden to seek approval for booking patient travel for their patients. They also noted concerns with adhering to Medicaid 1115 Waiver regulations, difficulties with pursuing APM reimbursement, the desire to have encounters involving clinical pharmacists trigger an FQHC encounter. Lastly, one FQHC provider requested that DOH incorporate CMS Chronic Care Management billing codes into FQHC reimbursement.

Given that the majority of feedback noted concerns in reimbursement, it is important to consider this feedback to support our recommendations. All recommendations are subject to CMS approval.

C.2. Recommendations

Guidehouse recommends that DOH implement a Catch-Up CIS opportunity to confirm that the historical needs and circumstances of FQHCs are adequately addressed. This Catch-Up CIS would offer providers the opportunity to seek reimbursement for changes in their organization that have occurred since their PPS rates have been established to present. Providers have noted they frequently have not sought out a PPS rate update when they experience a CIS due to confusion and administrative burden with existing CIS reporting processes. Therefore, Guidehouse recommends that DOH offer a one-time opportunity for providers to "catch up" on submitted formal CIS requests and seek an update to their base PPS rate. This Catch-Up CIS PPS rate would be effective on a go-forward basis from the date of regulation implementation but would not be applied retroactively to historical claims.

Recommendation 1 (FQ-R1): Alaska Medicaid should consider implementing a Catch-Up Change in Scope rate adjustment to better align FQHC PPS rates with the current scope of services delivered by each FQHC.

Seeking provider buy-in will be crucial for DOH in moving forward with this initiative, as FQHC support and cooperation will facilitate a smoother transition and implementation process.

Likewise, providers who want to participate will need to work closely with DOH or its designee to submit and refine data. Engaging providers early on and incorporating their feedback will help in creating a CIS that is both practical and beneficial for all stakeholders involved.

The CIS should reflect at least 10 years of changes to capture the majority of changes, but DOH may also consider allowing providers to submit changes going back to the time of development of their initial PPS rates. While the new rate would capture any CIS that occurred over the last several years, we recommend that the new rate be implemented prospectively on a go-forward basis. This would be consistent with Alaska statute 44.62.240 providing that regulations can only have prospective effect under state law. This comprehensive approach will allow the catch up to be most relevant and effective in addressing historical challenges going forward. Providers should be given at least three months to indicate their interest and submit their one-time Catch-Up CIS request after the supporting regulatory changes are promulgated. Additionally, they should include at least two years of data with their CIS submission to provide a robust foundation for the rate changes being proposed.

Implementing this CIS will require updates to existing regulations to accommodate the new scope and requirements. The State may also consider updating its state plan language to align with the changes and demonstrate consistency across all regulatory documents. These updates will help in creating a cohesive framework that supports the successful implementation of the CIS.

Guidehouse estimates that implementing this change will cost Alaska Medicaid between $800 thousand and $1.5 million in State funds, which would yield an increase in FQHC reimbursement by a total of between $2.9 million and $5.3 million annually. For more information on fiscal impact, please refer to Section H.

Federal guidelines require that DOH make the CIS option available to all FQHCs. However, for providers opting into the APM, the PPS serves as a minimum rate but typically does not keep up with rising medical costs even with annual inflationary adjustments. Recognizing that submission of data and materials to update PPS rates may be administratively burdensome, several providers that have already opted into the APM rate may choose not to opt into the CIS PPS update if they do not find the ongoing financial benefit to be significant. Nine of the fourteen FQHCs have opted into the APM rate, thus limiting the range of financial benefits from a negligible rate increase (for those whose APM is higher than the calculated PPS rate) to a 20 percent rate increase. Of the providers already on the APM, two providers did not submit supplemental encounter data, so rate increases may be overestimated. The other providers would receive a 15 percent rate increase or lower with a Catch-Up CIS rate update.

Three providers still rely on the PPS rate for reimbursement. These providers are most likely to see the strongest financial gains in submitting a CIS rate update. While Guidehouse was unable to calculate a fiscal impact for providers with blank CMS cost reports, Guidehouse estimates significant rate increases of over 100 percent for the one PPS provider who does have a cost report. Based on this analysis, DOH could reasonably assume that the other two PPS providers would see similar rate increases as well.

Three of these providers serve predominantly rural areas of Alaska and operate as the primary healthcare clinics in their areas. If these providers opted into a Catch-Up CIS PPS rate, additional funds would be targeting Alaskans with otherwise limited access to care.

Recommendation 2 (FQ-R2): Alaska Medicaid should consider offering enhanced technical assistance to FQHC providers interested in the opportunity to update their PPS rates with a one-time Catch-Up Change in Scope.

The Department of Health (DOH) should offer technical assistance to providers that struggle with existing processes such as requests to transition to an Alternative Payment Methodology (APM). This enhanced support may prove helpful for providers to navigate complex regulatory requirements and to request payment methodologies appropriate to their needs, for example. By providing guidance and resources, DOH or their designee can help providers overcome barriers and improve their understanding of these processes, ultimately leading to more accurate and timely submissions.

Technical assistance can result in increased rates for providers, particularly those serving rural or in-need populations. These providers often face unique challenges and may lack the resources or expertise to effectively manage the administrative aspects of their operations. DOH's support may help providers take advantage of the CIS opportunity they are offered, further improving their financial stability and enabling them to continue delivering high-quality care to their communities. This support can also help reduce disparities in healthcare access and outcomes, as providers in underserved areas will be better equipped to meet the needs of their patients.

In addition, technical assistance can foster a stronger partnership between DOH and healthcare providers. By demonstrating a commitment to supporting providers and addressing their specific needs, DOH can build trust and encourage greater collaboration. This collaborative approach can lead to more effective and sustainable solutions for the healthcare system as a whole, benefiting both providers and patients. Ultimately, by investing in the success of providers, DOH can help create a more resilient and equitable healthcare system. It should be noted, however, that DOH's Office of Rate Review serves as the auditing entity for FQHC cost reports and therefore cannot offer technical assistance in relation to the completion of a cost report.

Guidehouse believes that three providers may benefit from this enhanced technical assistance if given the opportunity. In particular, the providers who may benefit from one-on-on support are those who have experienced administrative challenges in moving to an APM. Depending on the number of FQHCs included, the intensity of their support needs, and the type of organization offering the assistance, costs for interested FQHCs seeking individualized technical assistance may cost up to $200,000 in total.

Recommendation 3 (FQ-R3): Alaska Medicaid should consider establishing a transparent Change in Scope policy that provides a clear definition of the changes in the type, intensity, duration, or quantity of services that potentially qualify for a CIS.

In addition to the one-time, Catch-Up CIS, Guidehouse recommends that DOH implement a clear and concise definition (such as the one found in Appendix A) for what a CIS would include going forward. The intent is to create a more streamlined and efficient process that accurately reflects the evolving needs and circumstances of healthcare providers. By establishing a well-defined CIS, DOH can confirm that all stakeholders have a common understanding of the criteria and requirements, which will facilitate more effective implementation of changes and may help providers request changes in real time as they occur going forward, without having to wait for

another, unplanned Catch-Up opportunity or an APM rebase. Providers should be given at least three months to submit the request for a rate update to DOH after a change in scope event.

To support the implementation of the new CIS definition, Guidehouse recommends that DOH conduct provider education, such as recorded information sharing sessions, to train providers on the new definition and DOH expectations for submission going forward. This recording could be made available on DOH's publicly accessible website to support providers who may choose to submit a CIS request in the future. In addition, we recommend that DOH posts the finalized definition on their publicly accessible website to offer a user-friendly reference for providers. This educational initiative would help facilitate keeping providers well-informed and prepared to comply with the updated requirements, thereby facilitating a more efficient and useful CIS process.

Guidehouse anticipates this recommendation would be of minimal cost to Alaska Medicaid, as it could be absorbed within normal administrative workflow. Given that providers would only be able to submit a request for a CIS rate update when they experience a substantial change in scope conforming to the proposed CIS definition, we anticipate any associated rate update work to be dispersed over time in response to provider submissions. However, overall administrative cost to the State may depend on the relative expansiveness of the final implemented CIS definition.

D. Stakeholder Engagement

D.1. Communications and Provider Technical Support

As a key component of this engagement, Guidehouse solicited stakeholder input through engagement with state staff, FQHC providers and APCA. Guidehouse's comprehensive stakeholder engagement improved our understanding of stakeholders' perspectives and facilitated a cost reporting and rate methodology development process more responsive to the needs of Alaska's FQHC providers and stakeholders.

Guidehouse held four (4) meetings with APCA and its represented providers as part of the stakeholder engagement.

- November 11, 2024: Onsite meeting between Guidehouse and APCA
- December 2, 2024: FQHC Introduction to Guidehouse Rate Study team to introduce FQHCs to Guidehouse and to describe the rate study process
- January 16, 2025: FQHC Rate Study Kick Off Meeting to discuss data requests and detail the rate study process
- August 6, 2025: Final FQHC Meeting to discuss the data that was collected, the process to develop the rate model and fiscal impact, recommendations, and next steps

In addition to direct provider outreach, Guidehouse furnished individual technical assistance as requested by particular FQHCs. The technical assistance sessions provided FQHCs with the opportunity to ask questions related to the data request and any other questions they had pertaining to the engagement.

During our rate development, Guidehouse provided FQHCs with a dedicated email inbox specifically to communicate with FQHCs and submit a supplemental data survey. The email inbox allowed providers to reach out directly to Guidehouse with questions and data submissions.

D.2. Data Reporting

Guidehouse worked one-on-one with each individual FQHC via email and phone to support FQHCs as they collected the requested data as well as to verify the accuracy of reported data following submission. Table 1 below is a high-level summary of direct provider outreach conducted by Guidehouse, which does not include a broader range of individual technical assistance emails and meetings with providers. Guidehouse tailored the emails and phone calls to each individual FQHC, resulting in over one hundred direct emails and phone calls with providers.

Guidehouse initially shared the data request on March 7, 2025, with a target for providers to submit their information by April 4, 2025. In response to APCA feedback and provider requests for additional time to complete the survey, Guidehouse extended the survey deadline several times, first to April 18, 2025, then to April 30, 2025, then again to May 16, 2025. Guidehouse communicated these extensions and offered opportunities for one-on-one technical assistance through phone calls and email channels, as described in Table 1. Guidehouse continued to accept data submissions until May 30, 2025, giving providers over two months to complete the supplemental survey.

Table 1: Direct Provider Outreach Conducted by Guidehouse

Date	Outreach	Communication Type
11/21/2024	APCA, DOH, and GH meeting	On Site Meeting
12/2/2024	Introductory meeting with FQHCs	Teams Meeting
1/16/2025	Rate evaluation kick-off meeting	Teams Meeting
3/7/2025	Initial data request	Email
4/2/2025	Reminder about 4/4 reporting deadline	Email
4/3/2025	Reminder about 4/4 reporting deadline	Phone
4/4/2025	Reminder about 4/4 reporting deadline/offer for extension	Email
4/11/2025	Offer for reporting deadline extension to 4/18	Email
4/23/2025	Offer for reporting deadline extension to 4/25-4/30	Email
5/8/2025	Offer for reporting deadline extension to 5/16	Email
5/13/2025	Confirmation of reporting deadline extension to 5/16	Phone
5/14/2025	Reminder about 5/16 reporting deadline	Email
8/6/2025	Final Meeting with FQHCs	Teams Meeting

E. Data Sources

E.1. Overview of Data Sources

Guidehouse relied upon a variety of data sources to determine the cost of implementing a Catch-Up CIS PPS rate update. Guidehouse drew from CMS Cost Reports, audited financial statements, supplemental data submitted by both providers and DOH, claims data, and the Medicare Economic Index. In the section below, we describe in detail the sources used in the rate development process.

E.2. Provider Cost Reports

E.2.1. Medicare CMS-224 Cost Reports and Audited Financial Statements

Guidehouse downloaded FQHC CMS 224-14 cost reports available through CMS's Healthcare Provider Cost Reporting Information System (HCRIS) database. Providers also submitted PDF cost reports directly to Guidehouse in instances in which information was not available from HCRIS. Guidehouse used CMS cost reports from provider fiscal years ending in 2022, 2023, as well as 2024 when available. Guidehouse used a two-year average of the two most recent years available to determine rates.

Additionally, providers submitted audited financial statements from the same years for comparison and validation purposes. To review data accuracy and completeness, Guidehouse reconciled the total operating expenses listed in Worksheet F-1, Column 4, Line 17 of the CMS Cost Reports with the total operating expenses listed in the audited financial statements for each corresponding year. In two instances, provider CMS cost reports were blank, requiring Guidehouse to rely on the reported visits submitted in the supplemental data survey and the total operating expenses included in the audited financial statements as a proxy to determine an estimated PPS rate.

E.2.2. Supplemental Data Survey

While CMS cost reports serve as robust sources of FQHC cost information, not all the information required by Guidehouse was readily available in that source. Specifically, some FQHC encounters, such as telehealth and dental visits, are not captured in existing cost reports. To account for this deficit, Guidehouse created and distributed a supplemental data survey collecting visit volumes for medical, mental health, telehealth, dental and other visits.

In some cases, FQHCs did not complete the supplemental data survey. In those instances, Guidehouse sought prior year encounter data from DOH. If historical encounter data was not available, Guidehouse documented those providers and relied upon the encounters reported in the cost report. In those cases, rates may be overestimated as the costs reflect more services than the visits. Where supplemental data was available, Guidehouse compared the visit data provided in the supplemental data surveys with the Medicare Cost Reports received and incorporated the telehealth, dental and other visits (if applicable) into the FQHC rate model.

In addition to collecting the encounter data, Guidehouse used the supplemental data survey to offer the FQHCs an opportunity to share feedback pertaining to challenges or obstacles they have experienced impacting service delivery, recent cost increases, and other pertinent qualitative information. To support gathering of qualitative feedback, Guidehouse submitted the following prompts:

- Please describe any challenges or obstacles that your facility is experiencing that impact delivery of service
- Please describe any recent increases in costs for example salary increases, staff retention bonuses, insurance premium increases, etc.
- Is there anything else you would like us to know?

To collect appropriate and correct data on which clinics might qualify for a CIS, Guidehouse helped DOH draft a conceptual proposal to outline a revised definition and examples of potential changes in the scope of services. Guidehouse and DOH used input from APCA to create the conceptual proposal and shared it with providers for feedback and to support the rate evaluation. As part of the supplemental survey, Guidehouse also requested a CIS form from FQHCs to demonstrate the changes in scope that have occurred since the time DOH set their initial PPS rates. The conceptual proposal can be found in Appendix A.

E.3. Claims Data

DOH provided claims data from 2023 to 2025 year-to-date. Guidehouse used the claims data as a basis for Medicaid encounters. Guidehouse also used two-year average with 2023 and 2024 claims utilization as a basis for estimated 2026 utilization. Guidehouse did not assume any changes to volume between the base data and the rate year.

E.4. Inflation Factors

In the FQHC rate development and fiscal impact, Guidehouse used the publicly available Medicare Economic Index (MEI) to determine inflation from the base period to the rate period. To calculate the FQHC rates, the total reimbursable cost of services for 2022, 2023 and 2024 (where applicable) were inflated to the 2025 base year using the rates reflected in table 1. To estimate rate year fiscal impact, Guidehouse used a three-year MEI average to inflate calculated 2025 rates to the 2026 rate year.

Table 2: MEI Inflation Factors Used in Analysis

Year	MEI Inflation Factor
2022	2.1%
2023	3.8%
2024	4.6%
2025	3.5%

F. Peer State Comparisons

F.1. Overview

Guidehouse conducted an environmental scan of other state Medicaid programs' FQHC state plan and regulatory language regarding options to update the PPS rate and/or implement a second alternative payment methodology (APM).

F.2. Environmental Scan Methodology

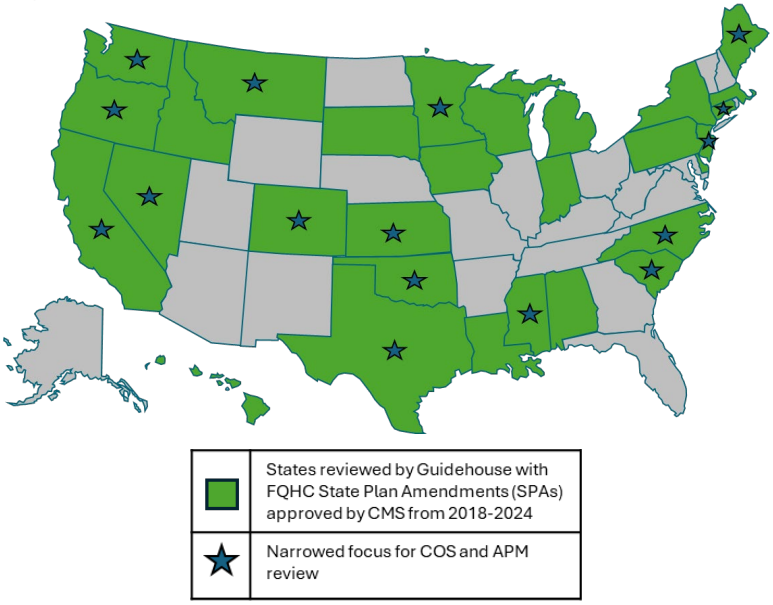
DOH requested examples of how other states support changes to FQHC rates. Guidehouse reviewed other states' administrative rules and CMS-approved state plan language that addressed FQHC "changes in scope" language. Specifically, Guidehouse reviewed relevant language on the following topics identified by DOH:

1. Defining CIS
2. Time Period to Request CIS
3. Minimum Threshold Requirements
4. CIS Data Requirement and Review Timeline
5. Adjusted Rate Effective Date

In addition, our team conducted a review of other state Medicaid programs' FQHC state plan language regarding options to update and/or implement a second APM.

To support this request, Guidehouse reviewed all the FQHC state plan amendments (SPA) approved by CMS from 2018 to 2024. Please refer to Figure 1 for a comprehensive list of states with SPA language reviewed by Guidehouse.

Figure 1: States Guidehouse Reviewed for Environment Scan



For our research on CIS, Guidehouse focused on the following states: California, Colorado, Connecticut, Kansas, Minnesota, Mississippi, Nevada, New Jersey, Oklahoma, Oregon, Texas, South Carolina, and Washington. For our research on "rebasing" the PPS using an APM, we focused on the following states: Colorado, Maine, Minnesota, Montana, North Carolina, New Jersey, and South Carolina.

For a full inventory of Guidehouse's research on specific regulatory and SPA language from other states, please refer to Tables 4 through 10 in Appendix B.

F.3. Peer State Findings

F.3.1. Change in Scope Findings

Defining CIS

States generally define a change in scope as a modification in the type, intensity, duration or amount of services. Common elements include:

1) Addition or deletion of new FQHC services, including those not requiring face-to-face visits
2) Changes resulting from remodeling, relocation or new facilities
3) Changes due to technology or medical practice updates
4) Changes in patient population served that affect service intensity
5) Changes in provider mix or operating costs related to capital expenditure or regulatory compliance

This aligns closely with Alaska's proposed CIS definition as defined in Appendix A.

Time period to request CIS

The time-period to request a change in scope varies by state but generally falls within a specific time frame after the fiscal year in which the change occurred or after the cost report for the fiscal year in which the change occurred is settled. For instance, California allows requests once after the fiscal year within 150 days of the beginning of the fiscal year. Colorado requires applications within 90 days of the end of the fiscal year. Some states require notification of the change within a specific time frame after the change itself occurred. For example, Nevada requires notification within 60 days of the change effective date. As part of FQ-R1 and FQ-R3, Guidehouse is recommending that Alaska offer providers at least three months (90 days) after regulatory changes are promulgated for providers to participate in the one time Catch-Up CIS process and that providers be given at least three months (90 days) after a future scope change occurs to notify DOH and request a rate update.

Minimum Threshold Requirements

The peer states we reviewed require a minimum cost change of anywhere between 1.75 percent and 5 percent to qualify for a CIS rate update. Alaska currently requires a minimum cost threshold of 2.5 percent, which falls within the range we see in peer states.

CIS Data Requirements

The change in scope of data requirements vary by state. For example, Connecticut allows FQHC's to provide their Medicaid cost report, audited financial statements and other relevant documentation for a change in scope request and should expect a decision within 120 days after their request was submitted. Other states require the same or similar data requirements in the form of cost reports, detailed trial balances narrative descriptions and schedules which substantiate the increase/decrease in services and costs.

Rate Effective Dates

Peer states offer a wide range of rate effective dates, with some states offering retroactive rate adjustments to the start of the fiscal year in which the request is submitted and others offering rate adjustments that take place after the rate is calculated. Alaska's rate effective date is not currently defined in regulation. State statute, AS 44.62.240, requires that a change to regulation, which this would be since these rates are in regulation, be prospective only.

F.3.2. Second APM Findings

Guidehouse conducted an environmental review of other state Medicaid programs' Federally Qualified Health Center (FQHC) State Plan Amendment (SPA) language regarding options to update and/or implement a second APM. Guidehouse reviewed FQHC SPAs approved by CMS from 2018 to 2024. Below are approaches seven states utilized that implemented rebasing APMs.

- **Colorado:** Utilized the lesser of two calculated rate options: 1) uses current annual costs and visits from the most recent audited Medicaid cost report and inflates that figure by the MEI and 2) Calculates the weighted average of the FQHC's costs and visits for the past 3 years.
- **Maine:** Used 2018-2019 cost report data for in-scope MaineCare covered FQHC services to calculate costs for two years and divided by encounters and applies any approved changes in scope and MEI for inflation with annual adjustments starting July 2024.
- **Minnesota:** Rebased every two years using cost reports from three and four years prior, inflates rates annually until the next rebase using FQHC MEI minus productivity adjustments, and includes allowable graduate medical education costs.
- **Montana:** Rebased rate based on current cost reports for the previous two years. Annual increases utilize primary care MEI and Change in Scope.
- **North Carolina:** Set APM rates every three years based on Medicaid allowable costs and encounters from two years prior and inflated using the greater of Medicare FQHC Market Basket or CPI for medical care and adjusted for changes in scope with a 13% multiplier.
- **New Jersey:** Rebased rate based on Medicare base PPS payment rate and the FQHC geographic adjustment factor plus $19.35 The rate is adjusted for any changes in scope.
- **South Carolina:** Rebased using 2021 cost reports. The cost reports were adjusted to cap increase in overhead cost and to include productivity minimums based on practitioner type. Trended costs to 2023 using the Global Insight 2022 Quarter 3 Forecast.

G. Rate Methodologies and Components

G.1. Overview of Rate Methodologies

FQHCs hold a unique position within Medicaid provider types. Unlike most provider types for which states have broad discretion in determining the method and amount of payment, payment methodologies and rates for FQHCs are mandated in and governed by Federal Statute. As described in Section B, BIPA enacted a PPS that requires states to pay FQHCs a cost-based rate with annual updates for inflation and substantial changes in scope of service. Given that this analysis is intended to explore a Catch-Up CIS, the methodology described below is reflective of PPS rate development and is subject to CMS approval.

G.2. Rate Methodology Process

To calculate a State Fiscal Year (SFY) 2026 cost per visit amount that reflects current cost of any scope changes, Guidehouse developed the model as follows:

Based on the HCRIS data, and utilizing SFY 2022, 2023 and/or 2024 (where applicable) for the FQHCs, Guidehouse calculated the direct healthcare costs using the sum of the total direct care service costs located on Worksheet A, Column 7, Line 37 and the total enrolled ambulatory service costs located on Worksheet A, Column 7, Lines 50 and 70. The subtotal for the direct healthcare costs were added to the total non-reimbursable costs located on Worksheet A, Column 7, Line 80 to get the total costs excluding overhead. The ratio of the direct healthcare costs to total costs, excluding overhead, provided the reimbursable percentage of overhead costs. This number was multiplied by the total overhead costs, located on Worksheet A, line 13, to get the overhead applicable to reimbursable services. The total reimbursable cost of services equals the sum of the overhead applicable to reimbursable services and the direct healthcare costs.

Based on the Medicare Economic Index (MEI), the total reimbursable cost of services for 2022, 2023 and/or 2024 (where applicable) were inflated to the 2025 base year. Guidehouse then added together the costs for the two most recent years of cost reports.

Guidehouse harnessed the CMS Cost Reports for the medical and mental health visits located on Worksheet S-3, Column 5, Lines 2 and 4. Guidehouse used the supplemental data survey to reconcile the medical and mental health visits to the Medicare Cost report data and to incorporate the telehealth, dental and other visits into the rate model. In certain instances, DOH provided Guidehouse with telehealth, dental and other visits for specific FQHCs. Guidehouse calculated total visits for each FQHC and divided the total inflated costs by the total visits to calculate a proposed Catch-Up CIS PPS encounter rate. Guidehouse inflated the final rate to 2026 using a three-year average MEI inflation factor of 3.97% to estimate SFY 2026 rates.

For two facilities, CMS Cost Report data was unavailable or missing. As a result, Guidehouse utilized FQHCs' audited financial statements to estimate their costs, while relying on their supplemental data surveys to obtain the number of visits needed to estimate their rate. This alternate methodology offered a proxy for the estimated PPS rate for these providers.

H. Fiscal Impact Estimates

H.1. Fiscal Impact Overview

The Fiscal Impact analysis is a crucial process employed to evaluate how projected rate recommendations will impact total spend. This meticulous approach involves several key components and methodologies to facilitate accurate projections and informed decision-making.

As discussed in Section G, Guidehouse determined rate estimates for providers to reflect any changes in their scope of services since their initial PPS rate calculation. Guidehouse inflated existing rates and the Catch-Up CIS proposed rates by a three year average MEI inflation factor of 3.97% to estimate SFY 2026 rates. Guidehouse used an average of SFY 2023 and 2024 encounters as a basis for estimated SFY 2026 utilization, with no projected volume differences. We then multiplied the projected utilization by the calculated rates with and without the CIS. The difference between the two reimbursement levels represents additional funds that DOH would need in order to support implementation of a Catch-Up CIS PPS rate. This analysis uses an aggregate Federal Medical Assistance Percentage (FMAP) of 71.3% based on a weighted average of FMAP by member. FMAPs for target populations (Medicaid expansion population, the Children's Health Insurance Program (CHIP), and breast/cervical cancer) have higher match rates, as do Indian Health Services (IHS) members who utilize clinics with care coordination agreements in place. All other members receive the standard Federal Fiscal Year (FFY) 2026 FMAP for Alaska.

Table 3 describes the anticipated total annual fiscal impact for the Catch-Up CIS. The upper bound included in the table assumes that all providers would take advantage of the Catch-Up CIS opportunity while the lower bound included in the table assumes that only providers who were on the PPS at the time of analysis would request a Catch-Up CIS PPS rate update. This table does not include providers with blank or "zeroed-out" cost reports.

Table 3: Total Annual Fiscal Impact

Category	Estimated Medicaid Expenditures without CIS	Estimated Maximum Medicaid Expenditures with CIS	Projected Lower Bound: State	Projected Upper Bound: State	Projected Lower Bound: Fed & State	Projected Max: Fed & State
Total	$32,070,000	$37,390,000	$800,000	$1,530,000	$2,870,000	$5,320,000

The analysis assumes that all providers experienced a valid and approvable CIS since their initial PPS rates were set, although Guidehouse is unable to confirm that providers who did not submit supplemental CIS forms would qualify. This analysis also assumes no change to the existing PPS and APM rates beyond MEI inflation.

Per federal requirements, in all cases providers will receive the higher of the PPS or the APM rate, if they have one. Any clinics for whom the inflated APM rate would be higher than the calculated Catch-Up CIS PPS rate would not be financially impacted by the proposed Catch-Up CIS.

In total, for DOH to implement the Catch-Up CIS rate, it would cost between $800 thousand and $1.5 million in state funds and would result in between $2.9 million and $5.3 million of new funds distributed to providers annually. This estimate does not account for any additional inflation or CIS rate updates in future years.

We also recognize that the impact may be quite small for several providers, who may choose not to participate in the Catch-Up CIS option. Therefore, we believe that the $1.5 million expected state share impact is the upper bound of expected costs within the first year of the program update.

I. Appendix

Appendix A: Conceptual Proposal for FQHC Change in Scope Definition

The Department of Health (DOH) is exploring a potential update to the state's definition of a change in scope of services for Federally Qualified Health Centers (FQHCs). In discussions with the Alaska Primary Care Association (APCA), the Department determined that establishing a non-exhaustive list of examples of changes in scope of services would be helpful in providing guidance to FQHCs interested in requesting a change in scope.

This Appendix presents a conceptual proposal outlining a revised definition and proposed examples of changes in scope of services. It is intended solely for discussion purposes and does not represent a final policy or determination. Any formal changes, including a State Plan Amendment (SPA) as necessary, will follow the applicable standard rulemaking process, including opportunities for public comment and stakeholder engagement, and would be subject to CMS approval.

For FQHCs, a change in the scope of services may be defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change of the scope of services.

The following examples are offered as guidance to help FQHCs understand the types of changes that may be recognized as part of the definition of a change in scope of services, however, any change would be subject to approval by the Department. Examples include, but are not limited to, the following:

a) The addition or deletion of a new FQHC or RHC service (such as adding or deleting dental services, another health professional service, or other Medicaid covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays, care management, or outreach) that is not included in the existing prospective payment system reimbursement rate.

b) A change in the type, intensity, duration and/or amount of service due to amended regulatory requirements or rules. Examples include but are not limited to:

   - The State amends the State Plan to remove a Medicaid covered service that is included in some FQHCs' existing prospective payment system reimbursement rate.
   - Changes in laws or regulations related to patient privacy.

c) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic. Examples include but are not limited to the implementation of new electronic health record or practice management systems; the implementation of integrated primary care-behavioral health or patient- centered medical home models; and the integration of specialist services into primary care or behavioral health visits.

d) An increase in the intensity of a service attributable to significant changes in the types of patients served, including, but not limited to, a significant increase in the populations with

HIV or AIDS, other chronic diseases, homeless, elderly populations, seasonal workforce, or other special populations.

e) A change in the scope of a project approved by the Health Resources and Services Administration (HRSA) where the change impacts a covered Medicaid service included within the FQHC PPS.

Examples of items that are NOT considered changes in scope of services include:

- A change in scope of services does not mean the addition or reduction of staff to or from an existing service.
- A change in the cost of a service is not considered in and of itself a change of the scope of services. This includes, but is not limited to, increases or decreases not directly related to a change in scope of services for:
    - Salaries, benefits, and supplies.
    - Facility overhead or administrative expenses.
    - Assets.
- A change in office hours.
- A change in office location or office space.
- A change in the number of patients served or the number of encounters provided.
- A change in reimbursement methodology (i.e. a provider changing billing services from fee for service to under the FQHC benefit or from the FQHC benefit to under fee for service).

Appendix B: Change in Scope and Second APM Examples by State

The following lists provide examples of other states' State Plan and administrative rules language. Guidehouse researched the following topics, which can be found below in this Appendix:

- How states define changes in scope
- How states define the time period providers have to request a CIS
- Language states use as Minimum Threshold Requirements to trigger a CIS
- How states require data submission and the timeline they conduct reviews for changes in scope
- How states determine the effective date for new rates
- States with APMs
- How states use an APM as the vehicle to rebase the PPS

For the first four, Guidehouse focused on the following states: California, Colorado, Connecticut, Kansas, Minnesota, Mississippi, Nevada, New Jersey, Oklahoma, Oregon, Texas, South Carolina, and Washington. For items 9 and 10, we narrowed the scope to approved SPAs with language related to "rebasing" the PPS using an APM: Colorado, Maine, Minnesota, Montana, North Carolina, New Jersey, and South Carolina.

It is important to note that while the text below reflects the exact formatting and vernacular in the state SPAs, we excluded non-relevant SPA language related to managed care payments, value-based payments, and reconciliation language for APM payments are less than PPS payments, temporary COVID-19 policies and specific Tribal FQHC payments.

Key Elements from Other States: Defining Change in Scope

California[5]- *State Plan Language*

> Subject to the conditions set forth in subparagraphs(a) through(d), inclusive of paragraph (1), a change in scope-of-service means any of the following:
>
> (a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other MediCal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.
>
> (b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

[5] DHCS California, State Plan 4.19B

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) An increase in the intensity of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites.

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C. l.

Colorado[6] - *State Plan Language*

A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC, subject to all of the following:

a. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

b. The reported cost adheres to the reasonable cost principles set forth in 42 CFR §413 and 45 CFR §75.

c. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

Mississippi[7] - *State Plan Language*

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services shall occurs if:

[6] CMS, State Plan Amendment (SPA) CO#: 18-0014
[7] CMS, State Plan Amendment (SPA) MS#:18-0012

(1) the FQHC has added or has dropped any services that meets the definition of an FQHC service as provided in section 1905(a)(2)(B) and (C) of the SSA; and,

(2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the FQHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

New Jersey[8] - *State Plan Language*

The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the clinic during that fiscal year. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

The state will implement scope of service changes as follows:

(i) the addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate;

(ii) a change in scope of service due to amended regulatory requirements or regulations;

(iii) a change in the volume or amount of services as a result of relocation, remodeling, opening a new clinic or closing an existing clinic site.; and/or

(iv) a change in scope of service due to changes in technology and medical practice.

Oklahoma[9] - *State Plan Language*

A change in scope-of-service means any of the following:

(a) The addition of a new FQHC service (such as adding medical, dental, or behavioral health services or another health professional service), or deletion of SoonerCare covered services that are included in the existing prospective payment system reimbursement rate.

(b) A change in service due to amended regulatory requirements or rules.

(c) A change in service resulting from either remodeling an FQHC or relocating an FQHC if it has not elected to be treated as a newly qualified clinic.

(d) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

[8] CMS, State Plan Amendment (SPA) NJ#20-0015
[9] CMS, State Plan Amendment (SPA) OK#: 21-0007

(e) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services provided, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(f) A change in the scope of a project approved by HRSA where the change impacts a covered service.

Oregon[10] - *Admin Rules Language*

The Centers for Medicare and Medicaid Services (CMS) defines a "change in scope of services" as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS' broad definition of change in scope of services allows the Division the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements "type," "intensity," "duration," and "amount" and procedures for implementing these adjustments. This rule defines the Division's policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC § 1396d(a)(2)(B)–(C).

A change in the cost of a service is not considered in and of itself a change in the scope of services. An FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers' services.

The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

   A. Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

[10] OregonLaws, OAR 410-147-0362 Change in Scope of Service

B. Services that do not require a face-to-face visit with an FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case-management, supportive rehabilitative services, and enabling services.)

b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

   A. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

   B. The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

      i. If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

      ii. If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center;

d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

e) A change in applicable technologies or medical practices:

   A. Maintaining electronic medical records (EMR);

   B. Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

   C. Updating practice management systems;

f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

   A. Changes in laws or regulations affecting health center malpractice insurance;

   B. Changes in laws or regulations affecting building safety requirements; or

   C. Changes in laws or regulations relating to patient privacy.

The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3)–(5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or

(e) A change in the number of patients served.

South Carolina[11] - *State Plan Language*

The baseline PPS rate or the APM PPS rate will be adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in the cost of a service is not considered in and of itself a change in the scope of services. A change in scope will be defined as:

- A change in the type, intensity, duration, and/or amount of services or;
- Adding a South Carolina Medicaid service that was not included in the baseline PPS rate or APM PPS rate calculation or;
- Deleting a South Carolina Medicaid service that was included in the baseline PPS rate or APM PPS rate calculation or;
- Incurring a minimum five percent (5%) cost increase in overhead costs or direct medical costs as a result of the acquisition of or implementation of a singular project or equipment purchase that is not covered by any of the other scope of service change criteria.

Texas[12] - *Admin Rules Language*

Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope. A change in scope provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites.

(A) A change in scope includes:

i. an increase in service intensity attributable to changes in the types of patients served, including but not limited to, patients with HIV/AIDS, the homeless, the elderly, migrants, those with other chronic diseases or special populations;
ii. any changes in services or provider mix provided by an FQHC or one of its sites;
iii. changes in operating costs that have occurred during the fiscal year and which are attributable to capital expenditures, including new service facilities or regulatory compliance;

[11] CMS, State Plan Amendment (SPA) SC #: 16-0005
[12] Texas Administrative Code, RULE §355.826 Federally Qualified Health Center Services Reimbursement

iv. changes in operating costs attributable to changes in technology or medical practices at the FQHC;
v. indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or
vi. any changes in scope approved by the Health Resources and Service Administration (HRSA).

Key Elements from Other States: Time Period to Request Change in Scope

California[13] - *State Plan Language*

> An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

Colorado[14] - *State Plan Language*

> A FQHC must apply to the Department by written notice within ninety (90) days of the end of the fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC' s annual cost report.
>
> The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate- setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC' s fiscal year end.

Mississippi[15] - *State Plan Language*

> An FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC's first full fiscal year of operation with the change in scope of services.

Nevada[16] - *State Plan Language*

> The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP.

[13] DHCS California, State Plan 4.19B
[14] CMS, State Plan Amendment (SPA) CO#: 18-0014
[15] CMS, State Plan Amendment (SPA) MS#:18-0012
[16] CMS, State Plan Amendment (SPA) NV #:24-0015

New Jersey[17] - *State Plan Language*

> Providers must follow the Change in Scope of Service Application Requirements, as specified in State regulation. Providers must notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.
>
> Providers may submit requests for scope of service changes either:
>
> 1) once during a calendar year, by October 1, with an effective date of January 1 of the following year; or
> 2) when the scope of service change(s) exceed(s) 2.5% of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change in scope that exceeds the 2.5% minimum threshold for a mid-year adjustment.

Key Elements from Other States: Minimum Threshold Requirements

California[18] - *State Plan Language*

> The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold will be applied to the average per visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

Colorado[19] - *State Plan Language*

> The net change in the FQHC' s per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change."
>
> The Department will calculate the difference between the current PPS rate and the adjusted PPS rate and verify that the adjusted PPS rate meets the 3% threshold described in Paragraph 20d above. If it does not meet the 3% threshold, no scope- of service rate adjustment will be implemented.

[17] CMS, State Plan Amendment (SPA) NJ#20-0015
[18] DHCS California, State Plan 4.19B
[19] CMS, State Plan Amendment (SPA) CO#: 18-0014

Minnesota[20] - *Admin Rules Language*

> If a FQHC or RHC has a change in the scope of services provided, resulting in a medical or dental rate change greater than plus or minus 2.5 percent, the DHS Payment Policy staff will adjust the PPS or APM IV rates.

Mississippi[21] - *State Plan Language*

> The change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of service took place.
>
> The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of services took place."

New Jersey[22] - *State Plan Language*

> When the scope of service change(s) exceed(s) 2.5% of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change in scope that exceeds the 2.5% minimum threshold for a mid-year adjustment.

Oregon[23] - *Admin Rules Language*

> Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3)–(5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

South Carolina[24] - *State Plan Language*

> Incurring a minimum five percent (5%) cost increase in overhead costs or direct medical costs as a result of the acquisition of or implementation of a singular project or equipment purchase that is not covered by any of the other scope of service change criteria.

[20] Minnesota, Federally Qualified Health Center and Rural Health Clinics
[21] CMS, State Plan Amendment (SPA) MS#:18-0012
[22] CMS, State Plan Amendment (SPA) NJ#20-0015
[23] OregonLaws, OAR 410-147-0362 Change in Scope of Service
[24] CMS, State Plan Amendment (SPA) SC #: 16-0005

Change in Scope Data Requirement and Review Timeline

Colorado[25] - *State Plan Language*

> A FQHC must apply to the Department by written notice within ninety (90) days of the end of the fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC' s annual cost report. For a scope- of-service rate adjustment to be considered, the change in scope of service must have existed for at least a full six (6) months. Only one scope- of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.
>
> The documentation for the scope- of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope- of-service rate adjustment must submit the following to the Department:
>
> a. The Department' s application form for a scope- of-service rate adjustment, which includes:
>
> i. The provider number(s) that is/are affected by the change(s) in scope of service;
>
> ii. A date on which the change(s) in scope of service was/were implemented;
>
> iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change; and
>
> iv. An attestation statement;
>
> b. The Department' s data section form for a scope- of-service rate adjustment;
>
> c. Detailed documentation and/ or cost reports that substantiate the data in the aforementioned forms; and,
>
> d. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, this may delay implementation of any approved scope- of-service rate adjustment.

Connecticut[26] - *State Plan Language*

> An FQHC shall file a preliminary cost report to support its request for a rate adjustment not later than 90 days after the date on which the FQHC submitted its request for a rate adjustment.
>
> (6) If a FQHC has received approval for a change in scope of project from HRSA for which it seeks a rate adjustment for a change in scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the FQHC has received approval from HRSA for the change in scope of project. The FQHC shall submit all documentation submitted to HRSA regarding the change in scope of project.

[25] CMS, State Plan Amendment (SPA) CO#: 18-0014
[26] CMS, State Plan Amendment (SPA) CT#: 16-0015

(7) If a FQHC is not required to file a change in scope of project with HRSA but plans an increase or decrease in services or sites to be offered by the FQHC that result in a change to the FQHC's scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the end of the FQHC's fiscal year. A FQHC shall submit all documentation required or requested by the department with respect to the change in scope of service.

(8) Based upon the Department's review of a variety of factors and documents, including, including not limited to the FQHC's original scope of project, subsequent amendments to the scope of project, cost reports and audited financial statements, the Department may initiate a review of an FQHC to determine whether there has been a change in the scope of services by notifying the FQHC in writing and requesting documentation with respect to the scope of services. An FQHC shall submit all requested documentation not later than ninety days after receipt of written notification from the Department.

(9) In making its determination with respect to whether an FQHC's encounter rate may be adjusted based upon a change in scope of services, the department shall review the following:

(A) The FQHC's Medicaid cost report;

(B) The FQHC's audited financial statements; and

(C) Any other documentation relevant to the change in scope of services.

(10) The department shall issue a decision on a request for an adjustment to the FQHC's encounter rate not later than 120 days after the date on which the FQHC submits the request to the department.

Mississippi[27] - State Plan Language

The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC PPS rate as a result of the change in scope of services. The Division of Medicaid will require the FQHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred.

[27] CMS, State Plan Amendment (SPA) MS#:18-0012

Nevada[28] - *State Plan Language*

> An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principles of reimbursement.
>
> An interim rate will be determined using the first three months of actual cost data available from the provider if requested by the provider as they believe their costs will greatly exceed the current average rates, otherwise the current average of existing base rates for FQHC/RHCs for similar services will be used as a more expeditious means of setting an Interim Rate.
>
> After a full year of providing the services related to the change in scope, an analysis will be performed on the actual reasonable costs for a full year of service and an adjustment will be made to the PPS /MVSSAPM.

New Jersey[29] - *State Plan Language*

> Providers must notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.
>
> Providers must submit documentation/schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes must be significant with substantial increases/decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate.

Washington[30] - *State Plan Language*

> For retrospective change in scope, an FQHC submits actual data of twelve months documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the FQHC is seeking to adjust its rate based on that change.

Key Elements from Other States: Adjusted Rate Effective Date

California[31] - *State Plan Language*

> Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

[28] CMS, State Plan Amendment (SPA) NV #:24-0015
[29] CMS, State Plan Amendment (SPA) NJ#20-0015
[30] CMS, State Plan Amendment (SPA) WA#: 15-0025
[31] DHCS California, State Plan 4.19B

Colorado[32] - *State Plan Language*

> The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.

Kansas[33] - *State Plan Language*

> Any rate change would be implemented on the first of the month following the KDHE decision.

Mississippi[34] - *State Plan Language*

> Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

Nevada[35] - *State Plan Language*

> The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP.

Oregon[36] - *Admin Rule Language*

> The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):
>
> The Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

Washington[37] - *State Plan Language*

> If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the application with the agency. The State will notify the center of a decision within 90 days of receiving completed application.

[32] CMS, State Plan Amendment (SPA) CO#: 18-0014
[33] CMS, State Plan Amendment (SPA) KS: 22-0004
[34] CMS, State Plan Amendment (SPA) MS#:18-0012
[35] CMS, State Plan Amendment (SPA) NV #:24-0015
[36] OregonLaws, OAR 410-147-0362 Change in Scope of Service
[37] CMS, State Plan Amendment (SPA) WA#: 15-0025

Key Elements from Other States: APM State Plan Example Language

Colorado[38]

10. All participating FQHCs, including freestanding and hospital-based centers, are required to file annual cost reports with the Department. Audited cost data from these reports will be used to set yearly FQHC reimbursement rates under an alternative payment method. The Department will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries.

14. The calculation methodology of the APM rate for both freestanding and hospital-based FQHCs is the same, and each FQHC will have its own rates calculated. The Department' s hired cost report auditor will determine each FQHC' s APM rates by utilizing the following steps:

a. Physical Health Rate

   Step 1: Calculate the Current Year Inflated Physical Health Rate. The Current Year Inflated Physical Health Rate is calculated by using the FQHC' s current annual costs and visits from the most recent audited Medicaid cost report for physical health services and associated administrative costs and inflating that figure by the MEI inflation factor.

   Step 2: Calculate the Inflated Physical Health Base Rate. The Physical Health Base Rate is calculated by taking a weighted average of the FQHC' s costs and visits for the past three years. The Physical Health Base Rate is recalculated every year, and is inflated by the MEI to get the Inflated Physical Health Base Rate.

   Step 3: Calculate the lower of the rate determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the Physical Health APM rate, is calculated as the lesser of the Current Year Physical Health Inflated Rate and the Inflated Physical Health Base Rate.

   Step 4: Effective July 1, 2020, adjust the Physical Health APM rate based on the FQHC' s quality modifier.

   Step 5: The FQHC will be reimbursed the Physical Health APM rate for physical health services.

b. Specialty Behavioral Health Rate: The Specialty Behavioral Health rate shall be calculated utilizing the same methodology described in 14. a Physical Health utilizing costs and visits from the most recent audited cost report for specialty behavioral health services and associated administrative costs.

c. Dental Rate: The Dental rate shall be calculated utilizing the same methodology as described in 14. a Physical Health using costs and visits from the most recent audited cost report for dental services and associated administrative costs. The Dental Rate shall not be adjusted by the FQHC' s current quality modifier as described in Step 4.

[38] CMS, State Plan Amendment (SPA) CO#: 18-0014

Maine[39]

b) Alternate Payment Methodology (APM)

Effective March 1, 2023, an FQHC is eligible to receive an APM for the provision of FQHC services under an alternative payment methodology that is agreed to by the State and the center or clinic and results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under the PPS, compared annually.

The APM was developed using one hundred percent (100%) of the average of their reasonable costs of providing in-scope MaineCare-covered FQHC services within fiscal years 2018 and 2019. The Department then accounted for any Change in Scope requests that had been approved by the Department between fiscal years 2020 and 2022 and inflated by the federally qualified health center market basket percentage published by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services. This index will also be used for annual inflation adjustments beginning July 2024 and each July thereafter.

Minnesota[40]

The encounter rate shall be computed based on the clinic's allowable base year(s) costs divided by the number of qualifying encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practitioner eligible to independently bill for the services provided.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing.

Clinic encounter rates shall be rebased every two years using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

Treatment of Health Care Education Program Costs

A clinic's costs related to participation in health care education programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants received to compensate training facilities for a portion of the clinical training costs.

[39] CMS, State Plan Amendment (SPA) ME#: 23-0003
[40] CMS, State Plan Amendment (SPA) MN#: 21-0013

Montana[41]

> Effective July 1, 2019, FQHCs can elect to be reimbursed under an Alternative Payment Methodology (APM). The APM is intended to ensure the FQHCs' PPS rates accurately reflect the cost of the current services provided. The Department will calculate a per- visit rate derived from current cost, using current cost reports for the previous two years. Cost data from these reports will be used to set reimbursement rates under the alternative payment method. The Department will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries....
>
> For services furnished during fiscal year 2021 or a succeeding fiscal year, the payment for such services will be in an amount (calculated on a per visit basis) that is equal to the amount of the APM per visit rate for the preceding fiscal year:
>
> 1) increased by the percentage increase in the MEI applicable to primary care services for that calendar year; and
> 2) adjusted to take into account any change in the scope of services furnished by the center during that fiscal year.

North Carolina[42]

> (B) The APM per visit rate for each individual FQHC will be determined triennially each July 1st based on the following methodology:
>
> 1. For the first year of each triennial period:
>   a. the sum total of Medicaid allowable costs for covered services from the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., the provider's fiscal year end 2021 cost report shall serve as the basis for the APM rate beginning July 1, 2023). Medicaid allowable costs for purposes of calculating the APM rate shall exclude the following non-Core Service costs, which are separately reimbursable:
>   i. Pharmacy services (Attachment 4.19B, Section 12, Pages 1a and 2)
>   ii. Physician-provided services at a hospital inpatient and outpatient location (Attachment 4.19B, Section 5, Page 1)
>   iii. Diagnostic Laboratory Services (Attachment 4.19B, Section 3, Page 1)
>   b. Divide Medicaid allowable cost by the total number of Medicaid face to face encounters (Core Service, Well Child (NC Health Check), and Dental visits) to determine a base year Medicaid cost per encounter.

[41] CMS, State Plan Amendment (SPA) MT#: 19-0007
[42] CMS, State Plan Amendment (SPA) NC#: 23-0022

c. Inflate the base year Medicaid cost per encounter amount from the prior step to July 1st of the current year by compounding the months between the end of the fiscal year for the FQHC's cost report (as described in subparagraph (6)(B)1.a) through July 1st of the current year. The inflationary factor shall be the greater of:

    i. The Medicare FQHC Market Basket; or

    ii. The Consumer Price Index (CPI) for medical care.

d. Multiply the Medicaid cost per encounter from the prior step by one and thirteen one hundredths (1.13).

2. Annually on July 1st for the second and third years of each triennial period:

    a. Adjust the previous year's APM rate to account for any increase (or decrease) in the scope of services in the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., APM rates beginning July 1, 2024, shall consider changes in scope of service from the provider's Medicaid cost report period ended in calendar year 2022); and

    b. Inflate the amount by the greater of:

        i. The Medicare FQHC Market Basket; or

        ii. The CPI for medical care.

3. In the first year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)1. For the second and third year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)2.

4. FQHC's that are newly qualified or fail to submit a cost report by the beginning of the triennial period will preliminarily receive a "like provider" APM rate established by reference to rates paid to other FQHCs with a similar scope of services and caseload in the closest geographical proximity.

    a. FQHCs meeting these criteria will default to a like provider APM rate but will have the opportunity to elect the PPS rate described in subparagraph (1).

    b. For FQHCs that submit a full 12-month Medicaid cost report by March 1 of a year during the triennial period, the Division will calculate a center-specific APM rate to be applied on a prospective basis beginning with the start of the next state fiscal year.

    c. FQHCs that submit the required cost report during the triennial period will remain subject to the same triennial cycle as other FQHCs in subsequent years (i.e., submitting a cost report in the middle of a triennial period does not start a unique triennial period for that FQHC; the FQHC would still be required to submit a subsequent cost report within the same timeframe as other FQHCs prior to the start of the next statewide triennial period).

New Jersey[43]

A. Effective on or after service dates on or after October 1, 2020, FQHCs providing services to Medicaid/NJ Family Care fee-for-service beneficiaries who elect to be paid under this methodology, shall be reimbursed with the Alternative Payment Methodology III (APM III).

1) The APM III will pay a rate equivalent to 100 percent of the Medicare FQHC base payment rate, adjusted for each FQHC based on the facility's location (referred to as FQHC geographic adjustment or FQHC GAF) plus $19.35 in accordance to Section 1834(o)(1)(A) of the Social Security Act.
2) FQHCs located in following counties are considered Northern Jersey (Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren. FQHCs located in the following counties are considered Rest of Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem)
The FQHC APM III rate will be calculated as follows: (Medicare Base PPS payment rate x FQHC GAF) + $19.35 = APM rate
3) The alternative methodology encounter rate shall be updated annually using the MEI (as defined in section 1842(i)(3) of the Social Security Act) and the FQHC geographic adjustment factor....
4) The alternative methodology encounter rate may be adjusted for a change in scope of services (as defined in Section III)

South Carolina[44]

Effective for services provided on and after July 1, 2023, the APM PPS methodology is updated as described below:

Fiscal year ending 2021 cost reports were used as the base year.

The overhead cost limit increased from no more than 30% to the 75th percentile of all FQHCs under the APM methodology.

The minimum productivity levels employed to determine the payment rates – physicians shall be 3,160 patient visits per year; mid-level practitioners shall be 2,585 patient visits per year; and OB/GYN physicians shall be 3,160 patient visits per year.

Next, in order to trend the FY 2021 data to the payment period beginning July 1, 2023, the Medicaid Agency employed the use of the midpoint to midpoint trending methodology using the IHS Global Insight 2022 Quarter 3 Forecast.

[43] CMS, State Plan Amendment (SPA) NJ#: 20-0015
[44] CMS, State Plan Amendment (SPA) SC#: 23-0007

Key Elements from Other States: APM to Rebase PPS

Table 4: APM to Rebase PPS

State	Methodology	Rebasing Schedule	Years of Data	Inflation Factor and Adjustments	Other
Colorado	Calculated two rates: 1. Rate calculated using current annual costs and visits from the most recent audited Medicaid cost report and inflating that figure by the MEI inflation factor. 2. Rate calculated using weighted average of the FQHC' s costs and visits for the past three years The lesser of the two rates is the new APM rate.	Annual	1 or 3 years	MEI	Separate rates for physical, behavioral, and dental healthcare
Maine	Used 2018 and 2018 cost report data for in-scope MaineCare covered FQHC services to calculate costs for two years and divide by encounters, applied change in scope and FQHC MEI.	None	2 years	Annual increases using FQHC MEI and change in scope	
Minnesota	Clinic's allowable base years costs divided by the number of qualifying encounters in the base years. Rebased every two years using fiscal years that are three and four years prior to the rebasing year.	2 years	2 years	Annual increase using FQHC MEI, less the productivity adjustment	Include GME allowable costs.

State	Methodology	Rebasing Schedule	Years of Data	Inflation Factor and Adjustments	Other
Montana	Rebased rate based on current cost reports for the previous two years.	None	2 years	Annual increase using primary care MEI and change in scope	
North Carolina	Medicaid allowable costs divided by Medicaid encounters inflated by FQHC MEI or CPI for Medical care. The Medicaid cost per encounter is then multiplied by (1.13)	3 years	1 year	Annual increase using FQHC MEI or Consumer Price Index (CPI) for medical care and change in scope	Dental claims eligible for wraparound payments
New Jersey	Medicare Base PPS payment rate x FQHC Geographic Adjustment Factor (GAF) + $19.35	Annual	N/A	MEI and geographic adjustment	Rate adjusted for change in scope
South Carolina	Rebased using 2021 cost reports. Capped increase in overhead cost. Included productivity adjustments. Trended costs to 2023 using the IHS Global Insight 2022 Quarter 3 Forecast.	None	1 year	IHS Global Insight 2022 Quarter 3 Forecast	Rate adjusted for change in scope. Productivity adjustments