

South Dakota Department of Social Services (DSS) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services Rate Study

Stakeholder Workgroup Session

June 26, 2025

Agenda

Introductions & Project Overview	3-4
Purpose of Presentation	5-6
Rate Reform & Policy Review Process	7-9
Provider Survey	10-13
Questions for Discussion	14-21
Contact Information & Next Steps	22-23



Introductions & Project Overview

The background is a solid blue color with various geometric shapes scattered across it. These shapes include solid blue squares and rounded rectangles of different sizes and shades of blue, as well as white-outlined squares and rounded rectangles. The shapes are arranged in a way that creates a sense of depth and movement, with some appearing to overlap others.

Introductions & Project Overview

Public Consulting Group LLC (PCG) partnered with the South Dakota Department of Social Services (SD DSS) in March 2025 to conduct a comprehensive rate study of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

The goals of this project include the following:

- Performing an in-depth **analysis of current reimbursement policies**
- Evaluating existing **changes in scope of services** policies and processes
- Exploring **alternative payment model** options
- Identifying **areas for improvement and providing detailed recommendations** to achieve **better health outcomes and reduce healthcare costs**



Purpose of Presentation

The background is a solid blue color with several decorative elements. On the left side, there are several overlapping rounded rectangles and squares in various shades of blue, some with white outlines. On the right side, there are also overlapping rounded rectangles and squares, some with white outlines, creating a modern, geometric aesthetic.

Purpose of Presentation

PCG and SD DSS hope to **closely collaborate with FQHC and RHC providers** throughout the project timeline to ensure the proposed rates and policy changes align with clinics' needs and expectations and create better health outcomes for all.

This presentation is intended to encourage **provider participation in this process** by highlighting the project's goals, engaging in ongoing discussion with key stakeholders, and identifying areas for improvement in the FQHC and RHC space pertaining to current rates and policy.



Inform providers on the overall project and its key phases



Review the provider survey distributed in May 2025



Allow a space for discussion of key areas for improvement and overall feedback

Implementation of any adopted recommendations will be contingent on state and federal approval, state rule-making, and the state's budget process.

The background is a solid blue color with several decorative elements: various shades of blue squares and rounded rectangles, some with white outlines and some with solid fills, scattered across the page.

Rate Reform & Policy Review Process

Rate Reform & Policy Review Process

This project has been outlined into 5 distinct phases:

1. Data Collection:

- PCG received relevant data from DSS, retrieved publicly available data sources, and distributed a provider survey

2. Research & Planning

- Additional research was conducted to prepare a cost analysis on current rate policy and evaluate alternative models utilized in peer states' programs

3. Stakeholder Engagement

- A stakeholder workgroup meeting was organized to incorporate provider feedback on areas of improvement and the current landscape for FQHCs and RHCs across the State

4. Rate Model Development & Fiscal Analysis

- Rate models will be developed following a comprehensive review of the data gathered, evaluated, and incorporated following stakeholder and state feedback
- A fiscal impact analysis will be conducted to ensure health outcomes are improved while keeping health costs efficient

5. Create Final Report

- PCG will develop a final report documenting the potential rate and policy recommendations in August 2025





Data Collection:
Gather data from DSS, provider surveys and publicly available data sources



Research and Planning: Perform research and cost analysis on the current model and alternative models



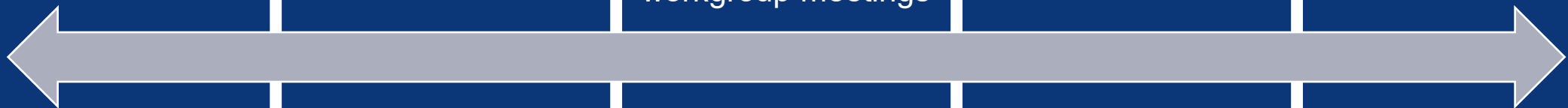
Stakeholder Engagement:
Facilitate ongoing stakeholder engagement including stakeholder workgroup meetings



Rate Model Development:
Develop rate models and a fiscal impact calculation



Reporting: Develop a final report documenting financial and policy recommendations



Provider Survey

The background is a solid blue color with various geometric shapes scattered across it. These shapes include solid blue squares and rounded rectangles of different sizes and shades of blue, as well as white-outlined squares and rounded rectangles. The shapes are arranged in a way that creates a sense of depth and movement, with some appearing to overlap others.

Provider Survey

A provider survey was administered to providers in May 2025 to collect detailed data on the following:

- Organizational Information
- Range of services provided
- Cost report participation status
- Direct costs and hours for clinical and ancillary staff
- Overhead and administrative costs
- Non-reimbursable services' costs
- Barriers to healthcare services across the FQHC and RHC landscape
- The impact of reimbursement opportunities and Alternative Payment Model (APM) or care transformation initiatives

10 providers responded between May 14, 2025, and June 13, 2025.



Provider Survey Takeaways

- 52 total unique FQHC and RHC site locations were identified within the survey responses
- Common barriers in delivering healthcare services in an FQHC/RHC:
 - Insufficient reimbursement for providers
 - Reimbursement rates do not cover full cost of care
 - Patient no-shows
- Common challenges related to reimbursement rates:
 - Reimbursement rates fall significantly below actual cost of care, particularly in rural and underserved areas
 - Medicare Economic Index (MEI) / Prospective Payment System (PPS) adjustments have not kept pace with inflation, rising staffing costs, or service delivery demands



Provider Survey Takeaways – Continued

- Top 3 services considered critical but not adequately reimbursed:
 - Behavioral health
 - Dental care
 - Substance abuse treatment
- Common barriers in the change of scope of services process:
 - Lack of clarity and consistency in scope change guidance and definitions across Medicaid staff and over time
 - Unclear or inadequate rate adjustment methodology following scope changes, leaving organizations unable to plan financially
 - Cumbersome documentation and regulatory requirements, including time-consuming audits and slow feedback or approval processes



The background is a solid blue color with various geometric shapes scattered across it. These shapes include solid blue squares and rounded rectangles of different sizes and shades of blue, as well as white-outlined squares and rounded rectangles. The shapes are arranged in a way that suggests a network or a flow of information, with some shapes overlapping others.

Questions for Discussion

Questions for Discussion



Questions?

- The chat function is available for questions and feedback
- Please use the raise hand feature if you would like to speak
- Microphone and Video is enabled for participant questions



Additional Feedback

- Submit questions and/or feedback to our project email sdfqrhc@pcgus.com following the presentation
- All comments will be reviewed and incorporated as appropriate

Questions for Discussion

1. What are the reimbursement insufficiencies for providers that make it difficult to provide care on a day-to-day basis? Is this related to individual providers or facilities as providers?
2. How do current reimbursement rates (Medicare & Medicaid) in South Dakota impact your ability to deliver comprehensive quality care, especially in rural or underserved areas?
3. What services are not reimbursed at rates that cover the full cost of care, and can any examples be provided?
4. Have reimbursement levels influenced your capacity to accept new patients, provide certain services or develop new programs (e.g., behavioral health, dental, care coordination)?



Questions for Discussion

5. How do no shows impact your business and what percentage of no shows do you see each day, week or month? What strategies are used to assist with no shows?
6. Has telehealth improved patient care delivery and no shows? How can changes to current telehealth payment/services best improve your clinic's ability to delivery key services?
7. What staffing cost or positions are challenging to maintain due to current area wages and/or difficult to fill positions? How is this impacting your business and ability to deliver services?



Rate Reform & Policy Review Process

Service Categorizations

As a part of the research and planning phase, PCG has analyzed claims data provided by DSS to categorize services into overarching groups. The following **6 core categories** have been identified from the claims data:

- Primary Care
- Behavioral Health
- Dental Care
- Laboratory and Diagnostic
- Pediatric Services
- Women's Health

8. Do these core service categories sufficiently cover the range of services your clinic provides? Could any categories be added or renamed?

Questions for Discussion

Change in Scope of Services

A change in scope of services is defined as adding a new service into the current per diem service base or removing a service that is in the existing service base.

- A change in the cost of a service is not considered a change in the scope of services
- A change in the scope of services occurs if:
 - The FQHC/RHC has made a material change in services through the addition or deletion of any service that meets the definition of an FQHC/RHC; and
 - The service is covered by South Dakota Medicaid

9. How could the policy related to the scope of service change process be updated to provide clear guidance for organizations?

10. How can the rate adjustment methodology be improved following a scope change?



Reimbursement Methodologies Overview

➤ Current Reimbursement Model: Prospective Payment System (PPS)

- A standard reimbursement methodology where FQHCs and RHCs are paid a **fixed, per-visit rate** for Medicaid-covered services, rather than billed for each individual service

➤ Alternative Payment Methodology (APM)

- A reimbursement methodology that replaces or supplements the standard PPS methodology by ensuring rates **at least meet or even exceed PPS rates**
- APMs **pay for outcomes rather than visits** through per-member-per-month (PMPM), bundled, or hybrid model payments. This can promote healthcare innovation, simplify billing processes, and enhance financial predictability

➤ Value-Based Purchasing (VBP)

- A reimbursement methodology that focuses on quality and efficiency by rewarding providers with **enhanced rates for meeting predetermined healthcare outcome and cost benchmarks**



Questions for Discussion

11. Are there any particular reimbursement models (e.g., fee-for-service, value-based care) that you think would be more effective for your clinic? How to you think it would benefit or harm your organization?
12. What specific changes to reimbursement policies would most benefit your clinic and why?



Contact Information & Next Steps

Contact Information

Thank you for participating in today's workgroup session!

Your insights are critical in helping us gain a deeper understanding of current reimbursement methodologies and inform our recommendations to DSS.

Please reach out to us for further feedback and questions at the following contact:



Reach out to our project inbox: sdfqrhc@pcgus.com



PUBLIC[™]
CONSULTING GROUP

Solutions that Matter