

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

Final Report

Public Consulting Group LLC

TABLE OF CONTENTS

- EXECUTIVE SUMMARY 4**
 - Approach and Methodology 4
 - Overview 4
 - Conclusion 5
 - Recommendations 5

- INTRODUCTION 6**

- STATUTORY ANALYSIS 6**
 - FQHC and RHC General Characteristics 6
 - Reimbursement and Payment Structures 8
 - Medicare 8
 - Medicaid 9
 - Background of the Benefits Improvement and Protection Act (BIPA) 9
 - Change in Scope of Services Policy 9
 - South Dakota Regulations 10
 - Eligibility and Requirements for FQHC/RHC Providers in South Dakota 10
 - Covered Services 10
 - Required Cost Reports 11
 - Payments for Services 11
 - Change in Scope of Services 11

- SOUTH DAKOTA'S FQHC AND RHC LANDSCAPE OVERVIEW 12**
 - South Dakota’s Geographic Distribution and Access 12
 - Workforce and Capacity 13
 - FQHC and RHC Program Background 13
 - Understanding the Structure and Flexibility of the PPS Reimbursement Model 15
 - Services Outside the PPS Reimbursement Model 15
 - Overview of Medicaid Claiming 15

- PROVIDER SURVEY FINDINGS 21**
 - Respondent Information 22
 - Cost Report Data 23
 - CMS-222-17 23
 - CMS-224-14 24
 - CMS-2552-10 25
 - Direct Costs and Visits 27
 - Dental Costs 27
 - Ancillary and Support Costs 28

Administrative and Overhead Costs.....	29
Non-Reimbursable Costs.....	29
Total Visits and Allowable Costs.....	30
FQHC / RHC Challenges and Considerations.....	31
Barriers to Service Delivery.....	31
Impact on Key Services.....	32
Workforce Sustainability.....	33
Change in Scope of Services Policy.....	34
Alternative Payment Models (APMs).....	35
Opportunities for Improvement.....	35
Provider Workgroups.....	35
Summary of Workgroup Activities and Findings.....	35
ALTERNATIVE PAYMENT METHODOLOGY (APM) / VALUE-BASED PAYMENT (VBP)	
OVERVIEW.....	38
Methodologies.....	38
Value-Based Payments.....	40
Peer State Analysis.....	40
Change in Scope of Service Policies.....	48
Services Outside the PPS Model.....	48
RATE MODELS.....	49
Overview.....	50
Benchmarks.....	51
Rate Adjustments.....	52
Dental Services.....	53
Encounter Projections.....	54
SCOPE OF SERVICE AND RATE REIMBURSEMENT METHODOLOGY RECOMMENDATIONS...55	
Recommendations to Reimbursement Policies.....	56
Recommended Implementation of an Alternative Payment Methodology (APM).....	56
Strategic Considerations and Recommendations for Value-Based Payment Options for South Dakota.....	57
Change in Scope of Services Policies and Processes Recommendations.....	60
Qualifying Changes.....	60
Recommended Rate Change Formula.....	61
Data Requirements.....	62
Setting a Rate for a New FQHC or RHC.....	62
Appeals Process.....	63
FISCAL IMPACT ASSESSMENT.....	63
Strategies for Closing the Cost Gap.....	63

Using Current Rates and Applying a One-Time Percentage Increase	64
Rates Based on Service Types	64
Periodic Rebasing	64
Incorporating a Ceiling	65
Policy Implications	65
APPENDIX A. DATA AND CITATIONS	66
Peer State Research	67
Citations	84
Change in Scope of Services Policy	87

EXECUTIVE SUMMARY

Public Consulting Group LLC (PCG) in partnership with the South Dakota Department of Social Services (DSS) conducted a Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services Rate Study from March to August 2025. The purpose of the rate study was to evaluate the adequacy, equity, and sustainability of South Dakota's current reimbursement policies for FQHCs and RHCs, identify areas for improvement, and recommend alternative methodologies to align reimbursement more closely with reducing the cost gap and evolving service needs.

APPROACH AND METHODOLOGY

The rate review team completed an analysis of FQHC and RHC reimbursement rates. The analysis included:

- ▶ Reviewing historical Medicaid Management Information System (MMIS) claims, cost report data, and encounter data to assess whether the existing reimbursement rates accurately reflect cost.
- ▶ Collecting and analyzing data from publicly available sources, DSS data sources, and FQHCs and RHCs to build a comprehensive understanding of the healthcare landscape in South Dakota.
- ▶ Facilitating stakeholder engagement to ensure collaborative input and alignment with real-world perspectives and operational realities.
- ▶ Conducting a provider survey to gather current financial and operational data, including staffing models and cost structures.
- ▶ Conducting peer-state benchmarking to compare South Dakota's practices with leading models in similar rural areas and assessing reimbursement methodologies to inform recommendations for implementing Alternative Payment Methodologies (APM) and Value-Based Payment (VBP) initiatives.
- ▶ Developing recommendations to support the adoption of a cost-based APM, with a focus on enhancing reimbursement policies and procedures, particularly those related to changes in scope of services.

OVERVIEW

Below are the key sections of the final report, focusing on reimbursement adequacy, financial sustainability, and opportunities for enhancement through an APM:

- ▶ **Statutory and Regulatory Analysis:** Summarizes the federal and state legal frameworks for FQHC and RHC rate setting, cost reporting, and provider eligibility, with emphasis on transparency and accountability
- ▶ **FQHC and RHC Landscape:** Details the South Dakota healthcare landscape including geographic distribution, population demographics, service coverage and workforce capacity, highlighting barriers and disparities in access to care
- ▶ **Reimbursement Structures:** Provides a background of the Prospective Payment System (PPS) methodology under federal guidelines, outlines allowable services, and discusses payment for services included and excluded in the PPS
- ▶ **Provider Survey and Cost Report Analysis:** Integrates financial and operational data from surveyed providers, including the breakdown of cost categories, encounter data, and fiscal sustainability
- ▶ **Stakeholder Engagement:** Presents qualitative insights gathered from stakeholders into barriers, service impacts, workforce sustainability and administrative burdens in service delivery
- ▶ **Alternative Payment Methodologies:** Reviews a variety of APMs and VBP models, emphasizing data-driven approaches and leveraging state flexibility to design reimbursement models that reflect the actual cost of care delivery
- ▶ **Rate Modeling and Recommendations:** Offers cost-based APM models that incorporate statewide and regional averages, applying statistically valid methods, and includes scenario analyses to assess the fiscal impact

- ▶ **Change in Scope of Service Recommendations:** Recommends a clearer, more standardized process for scope of service rate adjustments, informed by transparent policies, thorough documentation, and stakeholder feedback

CONCLUSION

The rate study finds that current reimbursement structures in South Dakota are inadequate to sustain the accessible and comprehensive care rendered by FQHCs and RHCs. A transition to an APM focused on narrowing the cost gap, alongside streamlined administrative policies and clear scope of service adjustment processes, is recommended to ensure financial sustainability, workforce stability, and access to essential services. These recommendations are informed by robust data analysis, stakeholder engagement, and peer state comparison, positioning South Dakota to modernize its reimbursement approach in response to evolving community needs.

RECOMMENDATIONS

Based on the analysis of cost report data, MMIS data, relevant research, and federal and state guidance, PCG has provided the following recommendations:

- ▶ **Adopt an APM that is structured by statewide weighted average rates or a blended rate.**
Using an encounter weighted statewide average rate or a blended rate helps in establishing equitable and fair rates for FQHCs and RHCs. This data-driven approach would deliver greater efficiency, streamlining rate setting processes that capture actual service volumes across the state and reduce disparities between FQHCs and RHCs with similar service mixes, but differing cost structures. Overall administrative burden would be reduced, simplifying implementation, especially for new FQHCs or RHCs. The updated rates would also offer a simplified approach to elevate reimbursement for those lower-paid providers, improving access to health services. Finally, the rates would allow for predicted budget forecasting.
- ▶ **Integrate an updated change in scope of service policy.**
Implementing a revised change in scope of service policy better captures operational shifts, such as service expansions or population changes, and ensures that timely rate adjustments are aligned with actual service delivery. An updated policy that is clearly defined, including calculation methodology, data requirements, state level contact information, and a defined appeals process, provides a strong foundation for equitable rate setting practices.
- ▶ **Invest in primary care and support provider participation in value-based care models.**
Strengthen the healthcare delivery system by increasing investments in primary care and creating incentives for FQHCs and RHCs to participate in value-based care models. This approach can enhance care coordination efforts, promote preventive care, and support improved patient outcomes while containing costs. By aligning reimbursement structures with quality and outcome metrics, FQHCs and RHCs are better equipped to deliver efficient, patient-centered care that advances the goals of the state Medicaid agency.

INTRODUCTION

Under Request for Proposal (RFP) #12548, the South Dakota Department of Social Services (DSS), Division of Medical Services, commissioned a rate study to evaluate and enhance reimbursement policies and scope of services processes for FQHCs and RHCs (also known as “Provider”). These providers are uniquely positioned to forge community partnerships, improve population health outcomes, enhance care coordination and develop innovative approaches to meet the needs of the communities they service.

This final report presents the findings of the rate study designed to ensure that reimbursement methodologies are adequate, equitable, and aligned with principles of efficiency, economy, and quality of care. The study supports DSS’ commitment to maintaining sustainable access to essential health services for members across South Dakota.

The proposed rate model reflects a thorough assessment of:

- ▶ State and federal regulatory frameworks
- ▶ The current landscape of FQHC and RHC services
- ▶ Delivery models and payment streams in peer states
- ▶ Programmatic goals established by DSS

The PCG Team employed best practices and used cost report data to develop a rate model grounded in allowable Medicaid costs. This model aims to support fair and consistent reimbursement while promoting financial sustainability and service innovation among FQHCs and RHCs.

STATUTORY ANALYSIS

PCG’s team members have conducted a review of the regulations applicable to FQHC and RHC services in South Dakota.

South Dakota has enacted specific statutory provisions governing rate-setting and cost reporting for community-based health and human service providers, including FQHCs and RHCs. Codified Law 28-22 establishes a framework for a rate-setting methodology and mandates that each category of service undergoes comprehensive rate modeling and analysis at least once every five (5) years. This analysis must include a review of current cost report data, staffing and service delivery requirements, training standards, market factors, and relevant state and federal policies. The law also requires that any new service model undergo rate modeling prior to implementation.

Importantly, the statute emphasizes the regulatory role of cost reporting in informing rate adjustments. Historical cost report data is used to determine rates prospectively, ensuring that reimbursement reflects cost. The law also mandates transparency, requiring that all information gathered during the rate modeling process be treated as public record. Furthermore, DSS must report any rate variances annually to the Governor and Legislature, reinforcing accountability and oversight in the rate-setting process.

This statutory framework supports a data-driven, transparent, and collaborative approach to rate-setting, aligning with broader goals of efficiency, economy, and quality in Medicaid reimbursement policy. DSS anticipates a follow-up analysis under this framework will occur no later than 2030.

FQHC AND RHC GENERAL CHARACTERISTICS

FQHCs and RHCs share many commonalities and have been grouped together for review purposes. Both FQHCs and RHCs are:

- ▶ Subject to a PPS reimbursement floor as defined in the Benefits Improvement and Protection Act (BIPA) of 2000
- ▶ Required to render care to individuals regardless of ability to pay

- ▶ Offering a range of services which can span medical, dental and behavioral health to meet the needs of their communities
- ▶ Subject to cost reporting requirements under Medicare
- ▶ Under Medicaid, cost reporting requirements vary state by state which can depend by payment methodology being used

FQHC Federal Requirements

Per the federal Health Resources and Services Administration (HRSA), FQHCs are safety net providers that primarily provide services typically furnished in an outpatient clinic. FQHCs may include:

- ▶ Community health centers
- ▶ Migrant health centers
- ▶ Health care for the homeless health centers
- ▶ Public housing primary care centers
- ▶ Health center program “lookalikes”
- ▶ Outpatient health programs
- ▶ Facilities operated by a tribe or tribal organization or by an urban Indian organization

To be certified as an FQHC, an entity must meet one of these requirements:

- ▶ Is receiving a grant under Section 330 of the Public Health Service (PHS) Act¹ (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements
- ▶ Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a “FQHC look-alike”) based on the recommendation of HRSA
- ▶ Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally funded health center as of January 1, 1990
- ▶ Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act² as of October 1991

For certification as an FQHC, the entity must meet all these requirements:

- ▶ Provide comprehensive services and have an ongoing quality assurance program
- ▶ Meet other health and safety requirements
- ▶ Not be concurrently approved as a Rural Health Clinic
- ▶ Serve a designated medically underserved area or medically underserved population
- ▶ Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level
- ▶ Be governed by a board of directors, of whom a majority of the members receive care at the FQHC

FQHCs are paid based on the FQHC PPS for medically necessary primary health services and qualified preventive health services furnished by an FQHC practitioner. FQHC services may include but are not limited to:

- ▶ Preventive health services
- ▶ Dental services
- ▶ Prenatal care

¹ United States Government Publishing Office. May 2025. Accessed at: [Public Health Service Act](#)

² Library of Congress. May 2025. Accessed at: [Indian Health Care Improvement Act](#)

- ▶ Mental health and substance abuse services
- ▶ Medicare Part-B covered drugs prescribed by a certified FQHC practitioner

RHC Federal Requirements

Per the Centers for Medicare and Medicaid Services (CMS), the RHCs program...”provides qualifying Clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain nonphysician services.” RHCs are federally designated through CMS. RHCs must also meet coverage provisions and requirements outlined by South Dakota Legislature in Chapter 67:16:44³ of the Administrative Rules.

Per CMS, to qualify as an RHC, a clinic must:

- ▶ Be located in:
 - A non-urbanized area, as defined by the U.S. Census Bureau,
 - and in an area with one of the following current designations:
 - Medically Underserved Area (MUA)
 - Geographic or population-based Health Professional Shortage Area (HPSA), or
 - A Governor-designated and Secretary certified shortage area.
- ▶ Employ a mid-level practitioner who is available to furnish services at least 50 percent of the time the clinic is furnishing services
- ▶ Furnish routine diagnostic and laboratory services
- ▶ Establish arrangements with providers and suppliers to furnish medically-necessary services not available at the clinic

RHCs must also meet all regulations underlined in 42 CFR Parts 405⁴ and 491⁵.

Services provided in an RHC include, but are not limited to, the following:

- ▶ Primary care services
- ▶ Diagnostic and laboratory services
- ▶ Covered drugs that are furnished by RHC practitioners
- ▶ Nursing services
- ▶ Mental health and substance abuse services
- ▶ First response emergency care

REIMBURSEMENT AND PAYMENT STRUCTURES

Medicare

Under 42 CFR § 405.2462⁶, reimbursement for RHCs under Medicare are reimbursed based on a single, bundled payment per patient visit (an All-Inclusive Reimbursement Rate (AIRR)) determined by a cost report. The 2025 Medicare AIRR for RHCs is \$152 per visit.

Medicare reimbursement for FQHCs is based on a PPS, which uses a single, per diem rate established for each facility to cover all qualifying services. This rate is adjusted to account for:

- ▶ Geographic cost variations, using the Geographic Practice Cost Indices (GPCIs);
- ▶ Services provided to new patients at the facility, including all affiliated sites; and

³ South Dakota Legislative Research Council. Administrative Rules. May 2025. Accessed at: [Administrative Rules 67:16:44](#)

⁴ Code of Federal Regulations, Title 42. National Archives. May 2025. Accessed at: [42 CFR Part 405](#)

⁵ Code of Federal Regulations, Title 42. National Archives. May 2025. Accessed at: [42 CFR Part 491](#)

⁶ Code of Federal Regulations, Title 42. National Archives. May 2025. Accessed at: [eCFR :: 42 CFR Part 405 Subpart X - Payment for Rural Health Clinic and Federally Qualified Health Center Services](#)

- ▶ Services delivered during a comprehensive initial Medicare visit or a subsequent annual wellness visit.

In 2025, the Medicare Base Payment for FQHCs is \$202.65. South Dakota's geographic adjustment is 1.0 resulting in a rate equal to the base rate.

Medicare reimbursement to FQHCs and RHCs is 80% paid by Medicare and 20% coinsurance paid by the patient, although coinsurance is waived for certain preventive services.

Medicaid

In accordance with the BIPA and Section 1902(bb) of the Social Security Act⁷, FQHCs and RHCs are reimbursed for providing covered services to Medicaid-eligible individuals using the PPS methodology. The requirements for this methodology are outlined in sections 1902(bb)(2) through (4) and 1902(bb)(6) of the Social Security Act. This framework also allows for a state-specific Alternative Payment Methodology (APM), provided it is mutually agreed upon by the state and the FQHC or RHC, and ensures payment is at least equivalent to what would be received under the PPS. The PPS rate is adjusted annually to reflect:

- ▶ The percentage increase in the Medicare Economic Index (MEI); and
- ▶ Any increase or decrease in the scope of services provided by the facility during the fiscal year.

Background of the Benefits Improvement and Protection Act (BIPA)

Before 2001, federal law required state Medicaid agencies to reimburse FQHCs and RHCs based on the reasonable costs of providing services. States had flexibility in defining what constituted "reasonable costs." The BIPA changed these payment requirements. It amended Section 1902(bb) of the Social Security Act to require Medicaid programs to pay FQHCs and RHCs on a per-visit basis, using either:

- ▶ The reasonable cost of services documented during a baseline period of Fiscal Year 1999 and Fiscal Year 2000, with certain adjustments, or
- ▶ An APM, provided it meets federal requirements

Unlike traditional cost-based reimbursement, BIPA introduced a PPS. Under PPS, a provider's payment rate is established before services are delivered and is not dependent on actual costs or charges. Under this new methodology, starting after fiscal year 2000, federal law no longer requires cost reports to be submitted after the base year. Rate changes under PPS can only be adjusted based on the two factors outlined in the above section and as stated in the statute.

CHANGE IN SCOPE OF SERVICES POLICY

A change in the scope of service occurs when an FQHC or RHC has experienced a change in the type, intensity, duration or amount of a service. FQHCs and RHCs are reimbursed on a PPS which is a fixed, per-visit rate based on historical costs of providing Medicaid services. Per the Federal law, Section 1902(bb)(3) of the Social Security Act, states are required to include in their Medicaid State Plan adjustments to the PPS rate to allow for inflation and to consider any increase or decrease in the scope of services provided by the facility. The Medicaid statute does not define the term "increase or decrease in the scope of services" and does not prescribe a specific process states must use to adjust rates.

In 2001, CMS issued further guidance to state that a change in the scope of services occurs if the center has added or has dropped any service that meets the definition of FQHC/RHC services and is included as a covered Medicaid service under the Medicaid state plan.

⁷ Social Security Act. State Plans for Medical Assistance. May 2025: Accessed at: [Section 1902\(bb\) of the Social Security Act](#)

States have flexibility in how they implement the Medicaid statute's change in scope requirement. An effective change in scope rate adjustment process has two basic features: 1) a definition of a qualifying event for a change in scope; and (2) a description of the methodology used to compute the change in rate.

SOUTH DAKOTA REGULATIONS

Eligibility and Requirements for FQHC/RHC Providers in South Dakota

DSS requires that FQHCs and RHCs (also known as "Provider") must be enrolled with Medicare and recognized as such to participate in South Dakota Medicaid. This requirement does not apply to stand-alone FQHC dental clinics. In order for providers to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid.

As of June 2024, the following individual provider types are eligible to generate a FQHC/RHC PPS encounter:

- ▶ Dentist;
- ▶ Nurse practitioner;
- ▶ Physician;
- ▶ Nurse midwife;
- ▶ Physician assistant;
- ▶ Psychologist;
- ▶ CSW-PIP;
- ▶ CSW-PIP Candidate;
- ▶ LPC-MH;
- ▶ LPC working toward MH designation;
- ▶ Clinical Nurse Specialist – Mental Health;
- ▶ Licensed marriage and family therapists;
- ▶ Other qualified healthcare providers when administering a vaccine at a standalone visit;
- ▶ Substance Use Disorder Agencies accredited by the Division of Behavioral Health; and
- ▶ Visiting nursing services may be provided by a registered nurse or a licensed practical nurse.

Registered nurses and licensed practical nurses are not eligible to enroll with South Dakota Medicaid. Dietitians, nutritionists, applied behavior analysts, speech language pathologists, occupational therapists, and physical therapists are not eligible to enroll as a servicing provider of an FQHC/RHC.

Most FQHC/RHC services are covered on a per visit basis. A visit is defined as a face-to-face or telehealth encounter between a FQHC or RHC patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, mental health provider listed in § 67:16:41:03⁸, dentist, or an accredited substance use disorder provider.

Covered Services

In the South Dakota Medicaid State Plan, Section 3.1⁹ outlines covered services, including "each item or service listed in section 1905(a)(1) through (5) and (21) of the Act". These regulations define FQHC and

⁸ South Dakota Legislative Research Council. Administrative Rules. May 2025. Accessed at: [Administrative Rules 67:16:41:03](#)

⁹ South Dakota Department of Social Services. Medicaid State Plan. May 2025. Accessed at: [Section 3.1 Amount, Duration, and Scope of Services](#)

RHC services as those required under federal legislation. Providers must also meet the following South Dakota Medicaid coverage requirements for all services according to the General Coverage Principles¹⁰:

- ▶ The provider must be properly enrolled;
- ▶ Services must be medically necessary;
- ▶ The recipient must be eligible; and
- ▶ If applicable, the service must be prior authorized.

Most services provided by FQHCs/RHCs are covered on a per visit basis. A “visit” is defined as a face-to-face encounter between a FQHC or RHC patient and an eligible provider that can generate a PPS encounter based on the South Dakota Medicaid Billing and Policy Manual for FQHC and RHC Services¹¹. Services must also be provided under the medical direction of a physician.

Required Cost Reports

Required cost reports are included in the South Dakota Administrative Rule 67:16:44:05¹². A provider must submit a completed copy of the provider’s cost report to DSS, Office of Provider Reimbursement and Audits, showing the actual costs incurred during the reporting period and the total number of visits for the services furnished as required in chapter 29 of the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report Form CMS-222-92. The provider must submit the required cost report to the department within five months after the provider's fiscal year ends.

Payments for Services

South Dakota follows the federal law of Section 702 of the BIPA of 2000 when determining how it pays FQHCs and RHCs. Per the South Dakota Medicaid State Plan Amendment¹³, FQHC and RHC services are reimbursed using a PPS effective January 1, 2001. Payment is set prospectively using the FQHC’s/RHC’s reasonable costs of providing Medicaid covered services during Fiscal Years (FYs) 1999 and 2000, adjusted for any increase and decrease in the scope of services during FY 2001. The baseline per visit rate was determined for each FQHC/RHC by:

- ▶ Calculating a per visit rate for FQHC/RHC based on FY 1999 and FY 2000 cost reports,
- ▶ Adding the two rates together, and
- ▶ Dividing the sum by two.

For new FQHCs/RHCs (after FY 2000), the initial payment is based on the statewide average per-visit rate, updated annually using the MEI. After submitting two full years of Medicaid cost reports, a prospective rate is calculated using the same method described above. Beginning October 1, 2001, and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the MEI for primary care services and adjusted for any increase or decrease in the scope of services furnished by the FQHC/RHC.

Change in Scope of Services

In the South Dakota Medicaid State Plan Section 4.19-B¹⁴, a change in the 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

¹⁰ South Dakota Department of Social Services. Medicaid General Information. May 2025. Accessed at: [General Coverage Principles](#)

¹¹ South Dakota Department of Social Services. Provider Manuals. May 2025. Accessed at: [South Dakota Medicaid Billing and Policy Manual for FQHC and RHC Services](#)

¹² South Dakota Legislative Research Council. Administrative Rules. May 2025. Accessed at: [Administrative Rules 67:16:44:05](#)

¹³ South Dakota Department of Social Services. Medicaid State Plan. May 2025. Accessed at: [South Dakota Medicaid State Plan Attachment 4.19-B](#)

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 FQHC/RHC services as provided in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act¹⁴; and
- ▶ The service is covered by South Dakota Medicaid.

A change in scope of services is limited to a review of the costs for the specific service and will not result in an evaluation of the costs for other FQHC/RHCs services.

SOUTH DAKOTA'S FQHC AND RHC LANDSCAPE OVERVIEW

To inform this rate study, PCG performed a comprehensive review of South Dakota's healthcare infrastructure, focusing on the operational, demographic, and financial characteristics of FQHCs and RHCs across the state. Additionally, PCG analyzed factors such as clinic locations, population characteristics, service offerings, and the integration of FQHCs and RHCs within the broader healthcare systems. These insights have guided the evaluation of the current FQHC and RHC rate study by assessing the effectiveness of the existing reimbursement model and identifying opportunities to improve reimbursement rates for FQHC and RHC providers.

SOUTH DAKOTA'S GEOGRAPHIC DISTRIBUTION AND ACCESS

South Dakota spans over 75,000 square miles in the upper Midwest and is a designated frontier state by the Affordable Care Act. This means that at least 50% of the counties are frontier counties, in which areas are described as rural and are geographically isolated from population centers and services. Of the sixty-six (66) total counties in the state, thirty (30) are defined as rural and thirty-four (34) counties are defined as frontier counties. According to the Office of Management and Budget, over half of individuals in South Dakota live in a county that has been classified as a rural, non-metro county. There are also nine (9) federally recognized American Indian tribes within the state borders. Over two-thirds of the state is classified as a HPSA reflecting the persistent difficulty in ensuring equitable access to care across rural and tribal communities.

To better understand the populations served by South Dakota's FQHCs and RHCs, PCG examined demographic and statistical data. South Dakota's population is growing at a faster rate than the national average with over 50% of individuals living in rural areas. FQHCs and RHCs collectively serve a significant portion of the state's population, including a high percentage of individuals who are uninsured or living below 200% of the federal poverty level. The state houses a diverse landscape with an estimated 909,824 population with an average population density of 11.7 people per square mile in 2025 according to HRSA. According to the United States Census Bureau, the state's population by race and Hispanic origin include 84.2% white, 2.6% black, 8.5% American Indian and Alaska Native, 1.8% Asian, 0.1% Native Hawaiian and Other Pacific Islander, 2.8% two or more races, and 5.1% Hispanic or Latino.

According to the National Association of Community Health Centers, 28.3% of the patients utilizing FQHC and RHC services are adolescents, and 25.9% identify as members of an ethnic or racial minority group. Additionally, there is a growing number of patients with complex needs, including multiple chronic conditions and co-occurring behavioral health concerns. This underscores the importance of providing holistic, integrated services within these facilities. Beyond age, race, and geographic isolation, payer mix is another critical demographic factor, as it reflects the economic realities of the populations served.

¹⁴ Social Security Act. Definitions. May 2025. Accessed at: [Social Security Act Section 1905\(a\)\(2\)\(B\) and 1905\(a\)\(2\)\(C\)](#)

Approximately 11% of South Dakota's population lives below the federal poverty level. Approximately 8% of residents are uninsured, while 15% are enrolled in Medicaid and 19% receive Medicare benefits. This highlights the significant reliance on public coverage programs and the essential role of FQHCs and RHCs in delivering comprehensive care. The diverse populations served by FQHCs and RHCs place unique demands on these clinics, requiring them to stay up to date on relevant policies, covered services, eligible providers, and other factors that influence their service delivery models.

According to the South Dakota Mortality Report, chronic conditions such as heart disease, cancer, and Alzheimer's disease remain the leading causes of death in the state. These conditions typically require ongoing, coordinated care, and services that are often managed by FQHCs and RHCs in rural communities. Furthermore, data from the Area Health Resources Files (AHRF) provided by HRSA supports the observation that healthcare utilization is higher in regions with more consistent access to care, such as the South-Central Plains, reinforcing the importance of equitable care site distribution.

WORKFORCE AND CAPACITY

As the state's frontier landscape presents unique challenges for service delivery, these communities often face challenges in maintaining a healthcare workforce. According to the Department of Health's 2024 South Dakota Health Care Workforce Trends report, South Dakota's healthcare workforce has expanded significantly in the past decade. Despite the growth in workforce overall, PCG understands that many FQHCs and RHCs service MUAs and HPSAs where recruitment and retention may be a significant challenge and cost driver.

This shortage is further shaped by the geographic and demographic realities of South Dakota's frontier designation. While the healthcare workforce has grown overall, the distribution remains uneven, with many providers concentrated in urban centers, leaving rural clinics and critical access hospitals struggling to fill essential roles. Rural or frontier-designated counties often experience higher rates of chronic illness, limited access to care, and cultural barriers, all of which intensify the demand for a well-distributed and culturally competent healthcare workforce.

The Community HealthCare Association of the Dakotas (CHAD) released its 2024 Economic Impact Report in July 2025, highlighting the significant role FQHCs play in South Dakota's economy and workforce:

- ▶ \$236 million in total annual economic impact statewide
- ▶ 126,663 individuals served across over 120 delivery sites
- ▶ 1,509 full-time jobs supported, with an additional 571 jobs generated in other sectors

Health centers act as economic anchors in rural communities, helping retain local businesses and attract new employers by ensuring access to affordable, high-quality care.

These findings demonstrate the dual role of health centers as economic engines that sustain community viability. In smaller towns, access to local care reduces the need for long-distance travel, supports workforce stability, and enhances the ability to recruit and retain employers.

South Dakota's health centers are mission-driven organizations that provide comprehensive primary and preventive care regardless of a patient's ability to pay. This model helps reduce overall healthcare costs by preventing high-cost services such as emergency room visits and avoidable hospitalizations. According to CHAD's report, Medicaid patients receiving care at health centers contribute to 24% annual cost savings for the healthcare system, illustrating the value of investing in community-based care.

FQHC AND RHC PROGRAM BACKGROUND

South Dakota maintains a network of FQHCs and RHCs that serve as critical access points, strategically located in underserved and low-income rural areas across the state. These facilities provide essential

access to affordable, high-quality healthcare. The populations served by FQHCs and RHCs in South Dakota include:

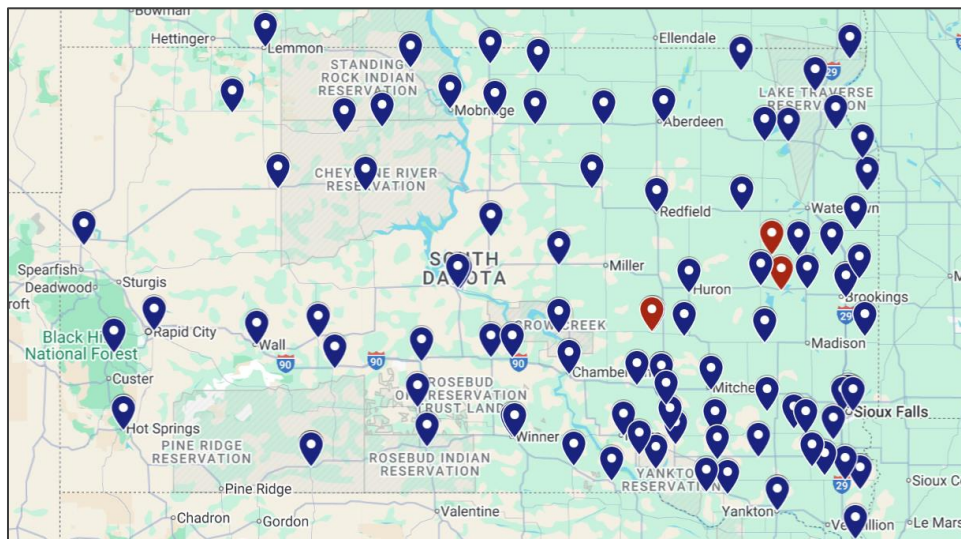
- ▶ Rural and frontier areas
- ▶ Veterans
- ▶ Limited English proficiency
- ▶ Uninsured
- ▶ Medicare and Medicaid
- ▶ Low-income

FQHCs and RHCs in South Dakota collectively served over 124,000 patients across multiple service delivery sites, based on the most recent HRSA program awardee data from 2023. According to the Medicare cost reports in 2024, these four (4) HRSA program awardee organizations delivered a total of 293,811 encounters, including 248,967 medical encounters, 9,787 mental health encounters, and 35,057 dental encounters, reflecting the essential role these health centers play in providing comprehensive care throughout the state, particularly in rural and underserved communities. FQHCs and RHCs in South Dakota are primarily concentrated in the central and southeastern regions of the state, with additional facilities located in the northeastern and western areas. An analysis of care site density across South Dakota's rural and frontier regions reveals significant variation in access to FQHCs and RHCs.

For example, Horizon Health Care Inc. operates a wide network of service sites across the state, including locations in Aberdeen, Alcester, Plankinton, Bison, De Smet, Elk Point, Faith, Eagle Butte, Fort Thompson, Howard, Isabel, Huron, Wessington Springs, Martin, White River, Mission, Woonsocket, and Yankton. These sites span both medical and dental services and reflect a strong presence in central and western South Dakota.

Rural Health Care, Inc. also maintains multiple clinics in Mitchell, Chamberlain, Highmore, Murdo, Kennebec, Fort Pierre, Onida, Presho, and Brookings, serving a broad area of rural communities. Additional providers such as Falls Community Health in Sioux Falls, Complete Health in Rapid City, and South Dakota Urban Indian Health in Pierre and Sioux Falls further contribute to urban and tribal health access.

Figure 1 below represents the spread of FQHCs and RHCs in the state of South Dakota based on DSS data.



Note: The markers in red indicate a clinic that has been permanently closed.

FIGURE 1

Understanding the Structure and Flexibility of the PPS Reimbursement Model

The PPS model is designed to promote financial stability and support comprehensive care delivery by bundling a range of services into a single, predictable payment. This approach simplifies billing for core medical and behavioral health services but also requires strict adherence to encounter definitions and provider eligibility criteria. While the PPS model offers advantages in terms of administrative efficiency and sustainability, it also demands robust internal systems to ensure compliance with federal requirements. States have the flexibility to control a variety of factors that impact PPS rates including defining which services are included in an encounter, establishing limits and types of encounters an FQHC/RHC can bill per member per day, limiting the number of reimbursable encounters in a year, and requiring prior authorization for encounters that exceed the number allowed.

Overall, this reimbursement structure allows FQHCs and RHCs to offer a wide array of services while maintaining financial viability. However, it also introduces complexity in billing and compliance, requiring clear operational protocols and ongoing training. PPS rates for FQHCs and RHCs can become outdated over time, as annual inflation adjustments often fall behind rising operating costs and service expansion efforts. While these rules are embedded in federal law and require significant policy change to keep up to pace with costs, more states have begun to look at APMs, increasing flexibility in delivering integrated and value-based care.

Services Outside the PPS Reimbursement Model

In addition to the traditional PPS services provided by FQHCs and RHCs, PCG also identified a separate category of services for non-PPS services in South Dakota. These non-PPS services include diagnostic procedures such as imaging and laboratory work, technical components of services, durable medical equipment, prosthetic devices, certain dental services, practitioner services at another facility provided to a Medicaid recipient including inpatient and outpatient hospital and ambulatory surgical centers, remote patient monitoring, transportation services and hospital services. These services must be billed separately using a different group NPI, and each servicing provider must be individually enrolled with South Dakota Medicaid. Reimbursement for non-PPS services follows the traditional Medicaid Fee-For-Service (FFS) model.

OVERVIEW OF MEDICAID CLAIMING

PCG conducted a review of the South Dakota MMIS claims provided of FQHCs and RHCs from Calendar Year (CY) 2021 through 2024. Based on this review, the primary services billed by FQHCs and RHCs are summarized in *Table 1* below, averaged yearly.

Services	Average Billed Units Per Year	Average Billed Amount Per Year
Physician Services	117,239	\$14,201,164.07
Children’s Health Insurance Program	10,861	\$1,331,731.70
Non-Medicaid Children’s Health Insurance Program	3,181	\$380,634.99
EPSDT Services	979	\$240,647.62

TABLE 1

In addition to the services listed above, two (2) units of outpatient hospital services were billed in CY2022, totaling \$983.00.

Additionally, upon review of the dental claims data, there were three (3) FQHCs billing for dental services. In total, there were 44,271 unique dental encounters provided from CY21-CY24. *Table 2* below presents a breakdown of the total unique encounters by the FQHCs from CY21-CY24.

Provider	Total Unique Dental Encounters from CY21-CY24
FQHC 1	7,556
FQHC 2	20,629
FQHC 3	16,086

TABLE 2

This suggests that physician services are among the most frequently utilized in FQHCs and RHCs across the state. As there are only three (3) providers billing for dental services, this trend highlights an opportunity to evaluate dental services within the current reimbursement structure to better support FQHC and RHC providers.

Table 3 presents the ten (10) most frequently billed codes by average annual paid amount (excluding dental FFS codes) from CY21-CY24. The average annual paid amounts include both FFS and encounter payments. This highlights the utilization of primary medical care, pediatric services, behavioral health services, and immunization services across FQHCs and RHCs in South Dakota.

Procedure Code	Description	Service Category	Average Yearly Paid Amount (CY21-CY24)
99213	Office o/p est low 20 min	Primary Medical	\$5,986,609.24
99214	Office o/p est mod 30 min	Primary Medical	\$1,944,843.28
99212	Office o/p est sf 10 min	Primary Medical	\$444,453.03
99392	Prev visit est age 1-4	Pediatric Services	\$398,527.31
99391	Per pm reeval est pat infant	Pediatric Services	\$368,990.35
99394	Prev visit est age 12-17	Pediatric Services	\$334,920.07
99393	Prev visit est age 5-11	Pediatric Services	\$326,354.56
99203	Office o/p new low 30 min	Primary Medical	\$172,249.70
90832	Psytx w pt 30 minutes	Behavioral Health Services	\$162,673.63
90471	Immunization admin	Immunization Services	\$151,616.91

TABLE 3

The PCG team also reviewed PPS FFS codes from CY21-CY24 for medical only which includes fifteen (15) Healthcare Common Procedure Coding System (HCPCS) codes. From CY21-CY24, a total of 2,108 units were billed, resulting in a total paid amount of \$329,979.00. *Table 4* presents the PPS FFS procedure codes including average yearly billed units and average yearly paid amounts.

Procedure Code	Description	Average Yearly Billed Units (CY21-CY24)	Average Yearly Paid Amount (CY21-CY24)
0500F	Initial prenatal care visit	7	\$20.85
99188	App topical fluoride varnish	267	\$2,289.90
G9151	Prenatal Care Enhanced Payment	2	\$103.13
G9152	Postpartum Visit Enhanced Payment	2	\$38.44
J7296	Kyleena, 19.5 mg	1	\$346.56
J7297	Liletta, 52 mg	5	\$4.44
J7298	Mirena, 52 mg	16	\$5,098.58
J7300	Contraceptive IUD, Copper	7	\$497.94
J7301	Skyla, 13.5 mg	2	\$437.06
J7307	Etonogestrel implant system	72	\$18,847.77
Q3014	Telehealth Site Fee	138	\$2,063.40
S0280	Person-centered Care Plan	9	\$220.94
S0281	Transitional Care Plan	2	\$19.69

TABLE 4

In reviewing the dental claims data from CY21-CY24, the three (3) FQHC providers billing dental along with their average yearly unique encounters and average yearly approved amounts are displayed in *Table 5*. The average yearly approved amounts includes both FFS and encounter payments.

Provider	Average Yearly Encounters (CY21-CY24)	Average Yearly Approved Amount (CY21-CY24)
FQHC 1	1,889	\$237,862.70
FQHC 2	5,157	\$845,644.89
FQHC 3	4,022	\$844,833.11

TABLE 5

Table 6 presents the top ten (10) approved billed dental procedure codes from CY21-CY24. Overall, the data indicates that the majority of dental services rendered were diagnostic and preventive in nature.

Dental Procedure Code	Description	Approved Amount (CY21-CY24)
D2392	Composite 2 Surface	\$717,647.17
D2391	Composite 1 Surface	\$569,593.91

Dental Procedure Code	Description	Approved Amount (CY21-CY24)
D7140	Tooth Extract	\$564,568.09
D1110	Prophylaxis - Adult	\$504,332.65
D5110	Complete U. Denture	\$385,616.41
D0150	Comp Oral Eval	\$360,495.07
D0120	Periodic Oral Eval	\$344,250.13
D0210	Full Mouth X Rays	\$326,889.77
D1351	Sealant Application	\$294,543.52
D1120	Prophylaxis - Child	\$289,498.55

TABLE 6

Table 7 below displays the top five (5) dental procedure codes (including both encounter-based and FFS payments), along with approved amounts for each FQHC, from CY21-CY24.

FQHC 1		
Dental Procedure Code	Description	Approved Amount (CY21-CY24)
D2392	Composite 2 Surface	\$97,992.33
D1110	Prophylaxis - Adult	\$93,092.21
D2391	Composite 1 Surface	\$82,037.75
D0210	Full Mouth X Rays	\$71,092.88
D0150	Comp Oral Eval	\$69,457.45
FQHC 2		
Dental Procedure Code	Description	Approved Amount (CY21-CY24)
D2392	Composite 2 Surface	\$305,323.90
D2391	Composite 1 Surface	\$262,348.90
D1110	Prophylaxis - Adult	\$216,916.41
D7140	Tooth Extract	\$205,196.58
D5110	Complete U. Denture	\$199,439.97
FQHC 3		
Dental Procedure Code	Description	Approved Amount (CY21-CY24)
D2392	Composite 2 Surface	\$314,331.00
D7140	Tooth Extract	\$309,420.90
D2391	Composite 1 Surface	\$225,207.30

D1110	Prophylaxis - Adult	\$194,324.00
D5110	Complete U. Denture	\$186,176.40

TABLE 7

In South Dakota, FQHCs are reimbursed on an FFS basis rather than the encounter rate for prosthodontic procedures (codes D5000–D5899) and orthodontic procedures (codes D8000–D8999). From CY21-CY24, a total of \$985,299.65 was billed for dental FFS procedures. *Table 8* below presents the top ten (10) dental FFS procedure codes billed by the three (3) FQHCs from CY21-CY24, along with their approved amounts.

Dental Procedure Code	Description	Approved Amount (CY21-24)
D5110	Complete Denture - Maxillary	\$386,506.75
D5120	Complete Denture - Mandibular	\$267,040.08
D5214	Mandibular Partial Denture - Cast Metal Framework	\$108,960.12
D5899	Removable Prosthodontic Procedure, By Report	\$78,439.65
D5213	Maxillary Partial Denture - Cast Metal Framework	\$51,793.90
D5820	Interim Partial Denture (Maxillary)	\$20,843.64
D5130	Immediate Denture - Maxillary	\$14,609.47
D5226	Mandibular Partial Denture - Flexible Base	\$10,099.15
D5212	Mandibular Partial Denture - Resin Based	\$8,012.32
D5225	Maxillary Partial Denture - Flexible Base	\$6,012.68

TABLE 8

Table 9 illustrates average unique encounters and approved payments across the three (3) FQHC providers billing for dental services. As the amounts listed in the table reflect both encounter-based and dental FFS payments, moving toward a dental APM that continues to carve out higher cost dental services, such as dentures and certain orthodontic services, are a more viable approach. These services exhibit high variability in cost and complexity, making them difficult to standardize within an APM. Additionally, because some of these services are less common than routine primary care and preventive services, paying them FFS ensures that providers are appropriately reimbursed, without distorting the statewide weighted average rate.

Dental Encounter Metrics	
Metric	Average
Average Unique Visits	43,992
Average Approved Payments (\$)	2,587,116

Note: These metrics include both encounter-based and dental FFS amounts.

TABLE 9

PCG also analyzed the largest ten (10) providers, based on unique NPIs, along with their average yearly paid amounts from CY21-CY24 in *Table 10* below:

Provider	Average Yearly Paid Amount (CY21-24)
Provider 1	\$1,416,016.16
Provider 2	\$1,102,721.67
Provider 3	\$1,076,842.29
Provider 4	\$628,423.28
Provider 5	\$551,412.34
Provider 6	\$464,316.36
Provider 7	\$441,245.17
Provider 8	\$409,640.55
Provider 9	\$406,434.57
Provider 10	\$392,747.31

TABLE 10

South Dakota Medicaid includes three (3) distinct care management programs for its recipients:

- ▶ Health Home
- ▶ Primary Care Case Management (PCCM)
- ▶ BabyReady

Effective July 1, 2023, FQHCs and RHCs started receiving PCCM fees. Prior to this date, these fees were included in the encounter payment. According to the care management data provided by DSS, *Table 11* presents the average yearly paid amounts for each managed care program from CY21-CY24. This reflects a small proportion of Medicaid payments to providers, as the average annual payments for each managed care program are relatively low.

Claim Type	Care Management Program	Average Yearly Paid Amount (CY21-CY24)
14	Primary Care Case Management*	\$2,729.55
16	Health Home	\$50,506.64
18	BabyReady*	\$229.08

**Note: PCCM fees were added for FQHC/RHC PCCMs effective July 1, 2023. The BabyReady Program was implemented on April 1, 2024, so these amounts will not reflect the current or future payment levels.*

TABLE 11

An analysis of care management payments from CY21 to CY24 shows that one-hundred nine (109) unique providers billed for managed care services, with the top five (5) providers listed in *Table 12*.

Provider	Average Yearly Paid Amount (CY21-24)
Provider 1	\$1,713.39
Provider 2	\$1,681.12
Provider 3	\$1,637.94
Provider 4	\$1,588.35
Provider 5	\$1,580.85

TABLE 12

Overall, from CY21-CY24, a total of 1,129 unique procedure codes were billed on the medical side, including both encounter-based and FFS codes, resulting in \$46.4 million in total payments. Medical FFS procedure codes accounted for \$329,979.00 of total costs from CY21-CY24. According to South Dakota Medicaid’s Procedure Code Lookup Tool, 94.2% of the total codes were allowable for facility reimbursement, with only sixty-five (65) classified as non-allowable. Separately, dental services accounted for 44,271 unique encounters and \$7.7 million in approved payments, including both encounter-based and FFS codes. Dental FFS procedure codes accounted for \$985,299.65 of the total dental costs from CY21-CY24. A total of \$213,861.05 was billed for care management, representing approximately 1% of all claims.

PROVIDER SURVEY FINDINGS

PCG, in partnership with DSS, conducted a provider survey in May through July of 2025 to assess the current reimbursement and policy landscape for FQHCs and RHCs in the state. The survey aimed to collect detailed data on services, staffing, and cost structures to inform the rate modeling process. The survey was distributed to FQHC and RHC providers across South Dakota beginning on May 14, 2025, and closed on July 11, 2025. It included both required and optional sections to capture a wide range of financial and operational data. The survey was structured into the following key sections:

- ▶ Respondent and Facility Information
- ▶ Cost Report Information
- ▶ Challenges and Considerations Specific to FQHCs and RHCs

South Dakota’s FQHCs and RHCs face significant financial and operational challenges that threaten their ability to deliver comprehensive care, especially in rural and underserved areas. The key takeaways from the providers who completed the survey are as follows:

- ▶ Most providers report that current Medicaid reimbursement rates do not cover the full cost of care, particularly behavioral health, dental, and substance abuse services.
- ▶ Administrative burdens consume valuable resources and reduce efficiency. These include:
 - Complex billing and reporting requirements, especially navigating Medicaid guidance and reconciling claims.

- Time-consuming documentation requirements tied to billing, audits, and compliance.
 - Burden of maintaining compliance with audits, financial reporting, and quality benchmarks.
 - Paper-based secondary claims filing, which adds inefficiency to billing workflows.
 - Medicaid audit and recoupment practices, requiring extensive research into third-party coverage.
 - Inconsistent and unclear guidance from Medicaid, leading to delays and uncertainty.
 - Lack of clarity in rate setting and change in scope processes, complicating financial planning and service delivery.
- ▶ Workforce sustainability is at risk due to low reimbursement, inability to offer competitive wages, and difficulty recruiting in rural areas.
 - ▶ Providers expressed a lack of clarity and consistency in the change in scope of services process.
 - ▶ Some providers have closed clinics or discontinued services due to financial infeasibility.

The survey provided valuable insights into the delivery of FQHC and RHC services in South Dakota, highlighting both strengths and areas for improvement. While a solid data foundation exists, gaps in reimbursement rates and policy alignment necessitate further refinement. PCG incorporated national benchmarks and supplemented these key takeaways with additional research to support and inform both the change in scope of services process and the rate model components.

RESPONDENT INFORMATION

The provider survey collected contact details and organizational information, including billing practices, location, and identifiers such as Tax Identification Number (TIN) and NPI. It also asked whether the facility bills for non-prospective payment services and allowed providers to report specific services provided by each service delivery site.

A total of eleven (11) provider organizations submitted responses, representing a diverse range of roles including Chief Financial Officers (CFOs), Chief Executive Officers (CEOs), Controllers, Clinic Managers, and Public Health Directors. In addition, PCG received cost reports from eight (8) providers who did not complete the survey. These nineteen (19) provider organizations accounted for approximately 86.1% of approved claim amounts, based on MMIS data from CY21-CY24. Of the eleven (11) respondents who completed the survey in full, each provided detailed information about their facilities, including multiple clinic sites operating under shared administrative structures.

- ▶ Five (5) organizations indicated they bill for non-prospective payment services.
- ▶ Six (6) organizations reported they do not bill for such services.

Several respondents operate multiple clinic sites across South Dakota. *Table 13* provides a breakdown of the nineteen (19) cost reports received, distinguishing between FQHCs and RHCs:

Facility Type (FQHC / RHC)	Cost Report Start and End Date
FQHC 1	01/01/2024 – 12/31/2024
FQHC 2	01/01/2024 – 12/31/2024
FQHC 3	01/01/2024 – 12/31/2024
FQHC 4	01/01/2024 – 12/31/2024
FQHC 5	10/01/2023 – 09/30/2024

Facility Type (FQHC / RHC)	Cost Report Start and End Date
FQHC 6	10/01/2023 – 09/30/2024
RHC 1	07/01/2023 – 06/30/2024
RHC 2	07/01/2023 – 06/30/2024
RHC 3	07/01/2023 – 06/30/2024
RHC 4	07/01/2023 – 06/30/2024
RHC 5	01/01/2023 – 12/31/2023
RHC 6	01/01/2024 – 12/31/2024
RHC 7	07/01/2023 – 06/30/2024
RHC 8	01/01/2024 – 12/31/2024
RHC 9	01/01/2024 – 12/31/2024
RHC 10	07/01/2023 – 06/30/2024
RHC 11	10/01/2023 – 09/30/2024
RHC 12	01/01/2024 – 12/31/2024
RHC 13	01/01/2024 – 12/31/2024

TABLE 13

Clinics are located in both rural and urban settings, including cities like Rapid City and Sioux Falls and smaller towns such as Howard, Tripp, Revillo, and Waubay. This geographical diversity highlights the importance of flexible reimbursement models that account for regional cost variations and access challenges.

COST REPORT DATA

All respondents submitted their most recently completed Medicare cost reports, which included both independent and provider-based clinics. These cost reports served as the primary source of financial and operational data for the development of the recommended rate model. The Medicare cost reports provided standardized information on allowable costs, Full-Time Equivalents (FTEs), and total visits, which were used to assess the financial sustainability of FQHC and RHC operations across South Dakota.

PCG received the Medicare cost reports, and there were three (3) different types identified:

- ▶ CMS-222-17: Independent RHC Cost Report
- ▶ CMS-224-14: Independent FQHC Cost Report
- ▶ CMS-2552-10: Hospital and Hospital Health Care Complex Cost Report for provider-based FQHCs and RHCs

Due to the varying types of cost reports, PCG cross-walked each report type to ensure data consistency. The following tables outline this crosswalk for the different categories of costs, FTEs, and visits per each different cost report.

CMS-222-17

Cost Category	PCG Survey Field	CMS-222-17 Worksheet	Line Number(s)	Column(s)
Direct Cost	Salary	Worksheet A	14	Salaries (1)
	Fringe Benefits	Worksheet A	14	Other (2)

Cost Category	PCG Survey Field	CMS-222-17 Worksheet	Line Number(s)	Column(s)
	Contract Cost	Worksheet A	17	Total (3)
	Reclassifications and Adjustments	Worksheet A	14, 17	Reclassifications (4) and Adjustments (6)
	Direct Service Non-Personnel	Worksheet A	38	Total (3)
	Direct Service Non-Personnel Reclassifications and Adjustments	Worksheet A	38	Reclassifications (4) and Adjustments (6)
	Number of FTE	Worksheet B Parts I & II	1 - 9.11	Number of FTE Personnel (1)
	Total Visits	Worksheet S-3	7	Total All Patients (5)
Ancillary and Support Cost	Cost	Worksheet A	79, 81	Total (3)
	Reclassifications and Adjustments	Worksheet A	79, 81	Reclassifications (4) and Adjustments (6)
Administrative and Overhead Cost	Cost	Worksheet A	59, 73	Total (3)
	Reclassifications and Adjustments	Worksheet A	59, 73	Reclassifications (4) and Adjustments (6)
Non-Reimbursable Cost	Cost	Worksheet A	90	Total (3)
	Reclassifications and Adjustments	Worksheet A	90	Reclassifications (4) and Adjustments (6)

TABLE 14

Two (2) providers submitted the CMS-222-17 cost report.

CMS-224-14

Cost Category	PCG Survey Field	CMS-224-14 Worksheet	Line Number(s)	Columns(s)
Direct Cost	Salary	Worksheet A	23, 25-36	Salaries (1)
	Fringe Benefits	Worksheet A	23, 25-36	Other (2)
	Contract Cost	Worksheet A	24	Total (3)

Cost Category	PCG Survey Field	CMS-224-14 Worksheet	Line Number(s)	Columns(s)
	Reclassifications and Adjustments	Worksheet A	23, 24, 25-36	Reclassifications (4) and Adjustments (6)
	Direct Service Non-Personnel	Worksheet A	10, 11, 48, 49, 49.10, 49.11, 50	Total (3)
	Direct Service Non-Personnel Reclassifications and Adjustments	Worksheet A	10, 11, 48, 49, 49.10, 49.11, 50	Reclassifications (4) and Adjustments (6)
	Number of FTE	Worksheet S-3 Part III	16-29	Total (3)
	Total Visits	Worksheet B Parts I & II	1-10	Total Medical & Mental Health Visits by Practitioner (2)
Ancillary and Support Cost	Cost	Worksheet A	7, 12.02, 12.03, 66, 67	Total (3)
	Reclassifications and Adjustments	Worksheet A	7, 12.02, 12.03, 66, 67	Reclassifications (4) and Adjustments (6)
Administrative and Overhead Cost	Cost	Worksheet A	1-6, 12, 12.01-12.06	Total (3)
	Reclassifications and Adjustments	Worksheet A	1-6, 12, 12.01-12.06	Reclassifications (4) and Adjustments (6)
Non-Reimbursable Cost	Cost	Worksheet A	9, 12.01, 12.05, 12.06, 12.07, 12.08, 60-62, 68, 69, 77, 79.01, 79.02	Total (3)
	Reclassifications and Adjustments	Worksheet A	9, 12.01, 12.05, 12.06, 12.07, 12.08, 60-62, 68, 69, 77, 79.01, 79.02	Reclassifications (4) and Adjustments (6)

TABLE 15

Six (6) providers submitted the CMS-224-14 cost report.

CMS-2552-10

Cost Category	PCG Survey Field	CMS-2552-10 Worksheet	Line Number(s)	Columns(s)
Direct Cost	Salary	Worksheet M-1	10	Compensation (1)

Cost Category	PCG Survey Field	CMS-2552-10 Worksheet	Line Number(s)	Columns(s)
	Fringe Benefits	Worksheet M-1	10	Other Costs (2)
	Contract Cost	Worksheet A	14	Total (3)
	Reclassifications and Adjustments	Worksheet A	10, 14	Reclassifications (4) and Adjustments (6)
	Direct Service Non-Personnel	Worksheet A	15, 19, 21	Total (3)
		Worksheet M-4	4	Pneumococcal Vaccines (1), Influenza Vaccines (2), COVID-19 Vaccines (2.01), Monoclonal Antibody Products (2.02)
	Direct Service Non-Personnel Reclassifications and Adjustments	Worksheet A	15, 19, 21	Reclassifications (4) and Adjustments (6)
	Number of FTE	Worksheet M-2	8	Number of FTE Personnel (1)
	Total Visits	Worksheet M-2	8	Total Visits (2)
Ancillary and Support Cost	Cost	Worksheet B Part I	88-89	Nursing Administration (13), Pharmacy (15), Medical Records & Library (16), and Social Service (17)
		Worksheet M-1	25.01	Total (3)
Administrative and Overhead Cost	Cost	Worksheet M-1	31	Total (3)
		Worksheet B Part I	88-89	Administrative & General (5), Bldg & Fixt (1), Mvble Equip (2), Employee Benefits Department (4), Cashiering/Accounts Receivable (5.02), Maintenance & Repairs (6), Operation of Plant (7), Laundry and & Linen Service (8), Housekeeping (9), Central Service & Supply (14)

Cost Category	PCG Survey Field	CMS-2552-10 Worksheet	Line Number(s)	Columns(s)
	Reclassifications and Adjustments	Worksheet M-1	31	Reclassifications (4) and Adjustments (6)
Non-Reimbursable Cost	Cost	Worksheet M-1	28	Total (3)
		Worksheet B Part I	88-89	Cafeteria (11)
	Reclassifications and Adjustments	Worksheet M-1	28	Reclassifications (4) and Adjustments (6)

TABLE 16

Eleven (11) providers submitted the CMS-2552-10 cost report.

Direct Costs and Visits

The cost reports included visits and FTEs as the primary units of service volume and staffing. Providers reported total direct costs associated with each clinical provider type using the following Medicare cost report worksheets:

- ▶ Salaries and wages
- ▶ Fringe benefits
- ▶ Contracted personnel costs
- ▶ Medical supplies and other direct non-personnel costs
- ▶ Non-reimbursable costs
- ▶ Reclassifications and adjustments
- ▶ FTE staffing levels
- ▶ Total patient visits (encounters)

Direct costs—comprising salaries, fringe benefits, contracted personnel, and non-personnel clinical expenses— totaled approximately \$72.2 million across all nineteen (19) reporting organizations. On average, each organization incurred about \$3.8 million in direct costs, including dental costs. Despite these common cost drivers, there was considerable variation in staffing models and cost intensity across organizations.

The table below presents the total direct spending across FQHCs and RHCs, along with the percentage of direct spending relative to total annual spending for each facility type.

	Total Direct Spending	Percentage of Direct Spending Relative to Total Annual Spending
FQHCs	\$52,249,298	40.8%
RHCs	\$19,983,478	57.9%

TABLE 17

Dental Costs

This section reflects the costs associated with dental services. These services are a critical component of comprehensive patient care and are typically reported separately from consolidated Medicare cost reports, as Medicare does not cover most routine dental services. Providers reported dental-specific expenditures such as:

- ▶ Salaries and Wages
- ▶ Fringe Benefits
- ▶ Contracted Personnel Costs
- ▶ Medical Supplies and Other Direct Non-Personnel Costs
- ▶ Non-Reimbursable Costs
- ▶ Reclassifications and Adjustments
- ▶ FTE Staffing Levels
- ▶ Total Patient Visits (Encounters)

Dental services accounted for a total of \$9,717,244.75 across three (3) reporting organizations, representing approximately 7.6% of total spending. On average, each organization that provided dental services reported about \$3.2 million in dental-related expenditures in CY24. These services are a vital component of integrated care delivery, especially among FQHCs that offer comprehensive services including medical, behavioral health, and pharmacy. While some providers reported minimal dental costs, others allocated substantial resources to dental operations, reflecting their commitment to improving oral health outcomes and addressing broader patient needs. *Table 18* displays the total dental spending and percentage of dental spending relative to total annual spending for FQHCs.

	Total Dental Spending	Percentage of Dental Spending Relative to Total Annual Spending
FQHCs	\$9,717,244.75	7.6%

TABLE 18

Ancillary and Support Costs

This section captured the costs associated with supportive services that assist in patient care but are not the primary reason for a visit. These services are essential to the overall delivery of care and are typically reported in aggregate within the Medicare cost reports.

Based on the submitted cost reports, ancillary and support costs were primarily captured under:

- ▶ Drugs Charged to Patients
- ▶ Interpreter
- ▶ Patient Education Materials
- ▶ Medical Records & Library
- ▶ Nursing Administration
- ▶ Social Service
- ▶ Telehealth

Ancillary and support services accounted for a total of \$1,119,053.00 across all reporting organizations, representing approximately 1.4% of total spending. On average, each organization reported about \$58,897.53 in ancillary and support expenditures. These services play a critical role in supporting integrated care delivery, particularly among larger FQHCs that offer a broader range of services such as behavioral health, dental, pharmacy, and care coordination. While some providers reported minimal ancillary costs, others allocated substantial resources to these areas, reflecting their expanded role in managing complex patient needs and improving health outcomes.

Table 19 below presents the total ancillary and support spending across FQHCs and RHCs, along with the percentage of ancillary and support spending relative to total annual spending for each facility type.

	Total Ancillary and Support Spending	Percentage of Ancillary and Support Spending Relative to Total Annual Spending
FQHCs	\$858,152.00	0.7%
RHCs	\$260,901.00	0.8%

TABLE 19

Administrative and Overhead Costs

Providers reported total costs for administrative and operational functions that support the delivery of clinical services. These costs reflect the infrastructure required to maintain compliance, manage operations, and ensure continuity of care.

Based on the submitted Medicare cost reports, administrative and overhead costs were captured as the following total facility overhead costs:

- ▶ Accounting, administrative professional fees and general services, billing, clerical, and human resources
- ▶ Continuing education, dues, memberships, recruitment, and retention
- ▶ Information technology, legal, communications, and security
- ▶ Facility-related expenses such as utilities, housekeeping/laundry, janitorial, insurance, lease/rent, depreciation, and equipment

Administrative and overhead expenses totaled \$60.1 million across all reporting providers, accounting for approximately 37% of total spending. On average, each provider reported \$3.16 million in administrative and overhead expenditures. These costs reflect the operational demands of managing multi-site clinics, maintaining compliance, overseeing billing and reporting systems, and supporting non-clinical staff. These findings suggest that administrative overhead is a major component of the overall cost structure. Given the high percentage of administrative and overhead expenses relative to total annual spending reported by providers, PCG incorporated a consideration of an Administrative Overhead cap (Admin OH cap) into the rate model.

Table 20 below presents the total administrative and overhead spending across FQHCs and RHCs, along with the percentage of administrative and overhead spending relative to total annual spending for each facility type.

	Total Administrative and Overhead Spending	Percentage of Administrative and Overhead Spending Relative to Total Annual Spending
FQHCs	\$46,909,298.00	37%
RHCs	\$13,149,046.00	38%

TABLE 20

Non-Reimbursable Costs

Facilities also reported costs that are not reimbursed a per-visit rate or are non-reimbursable by Medicare. These costs represent services and activities that, while essential to community health and operations, fall outside the scope of PPS-based reimbursable care for FQHCs/RHCs. Some of these items are paid through FFS under South Dakota Medicaid and were excluded from the total allowable cost calculation. Examples include:

- ▶ Ambulance services
- ▶ Diagnostic and screening lab tests
- ▶ Durable medical equipment
- ▶ Lab and radiology supplies
- ▶ Prosthetic devices
- ▶ Radiology

Non-reimbursable costs across all reporting providers totaled \$19.61 million, representing approximately 12% of total spending. On average, each provider reported \$1.03 million in non-reimbursable expenditures. These expenses highlight the broader role that FQHCs and RHCs play in addressing social determinants of health and supporting underserved populations. A subset of these costs related to services not covered by traditional reimbursement models may be absorbed by the organization, placing additional strain on financial sustainability, particularly for smaller or rural clinics with limited resources.

Table 21 presents the total non-reimbursable spending across FQHCs and RHCs, along with the percentage of non-reimbursable spending relative to total annual spending for each facility type.

	Total Non-Reimbursable Spending	Percentage of Non-Reimbursable Spending Relative to Total Annual Spending
FQHCs	\$18,479,557.00	14%
RHCs	\$1,126,047.00	3%

TABLE 21

Total Visits and Allowable Costs

The cost report data received included varying time periods, with providers reporting costs from 2023 to 2024. For consistency within the data, PCG adjusted the total allowable cost to reflect the January 2024 to December 2024 time period. The cost report data showed significant variation in cost per visit, ranging from \$170.74 to \$1,030.44, reflecting differences in facility size, staffing models, service intensity, and patient populations. Despite this variation, the overarching trend appeared that many providers are operating at a financial deficit, with reimbursement levels falling short of the actual costs required to deliver care.

Table 22 presents the total reported visits, allowable costs, and the calculated cost per visit for each provider, including medical, behavioral health, and dental services.

Facility Type	Total Visits/Encounters	Total Allowable Cost	Cost Per Encounter
FQHC 1	77,398	\$16,745,702.00	\$216.36
FQHC 2	21,866	\$9,920,289.00	\$453.69
FQHC 3	24,989	\$10,550,802.00	\$422.22
FQHC 4	94,505	\$31,787,829.75	\$336.36
FQHC 5	152,451	\$34,161,813.95	\$224.08
FQHC 6	6,714	\$6,918,367.64	\$1,030.44

Facility Type	Total Visits/Encounters	Total Allowable Cost	Cost Per Encounter
RHC 1	5,593	\$1,969,397.84	\$352.12
RHC 2	940	\$386,252.84	\$410.91
RHC 3	776	\$283,233.23	\$364.99
RHC 4	20,354	\$4,479,362.28	\$220.07
RHC 5	4,111	\$1,179,853.69	\$287.00
RHC 6	14,926	\$4,006,731.00	\$268.44
RHC 7	3,632	\$1,027,317.22	\$282.85
RHC 8	11,454	\$3,495,020.00	\$305.14
RHC 9	6,615	\$2,185,306.00	\$330.36
RHC 10	14,339	\$4,018,223.63	\$280.23
RHC 11	19,148	\$7,395,916.76	\$386.25
RHC 12	8,748	\$2,622,761.00	\$298.58
RHC 13	3,821	\$652,384.00	\$170.74

TABLE 22

Upon reviewing the cost report data, there was only one (1) provider that was identified as an outlier due to its significantly higher cost per visit compared to most other providers. This deviation was primarily attributed to the following factors:

- ▶ Higher direct, administrative and overhead costs
- ▶ Lower non-allowable costs reported, further impacting the total allowable costs
- ▶ A lower volume of reported visits relative to direct service costs (6,714 total), which increased the cost per visit, contributing to the higher rate observed

FQHC / RHC CHALLENGES AND CONSIDERATIONS

This section summarizes insights gathered from the optional qualitative portion of the survey, which explored barriers to reimbursement rates and limitations, change in scope of service policy, workforce sustainability, administrative burdens, and opportunities for improvement. A strong majority of respondents (82%) chose to complete this section, offering valuable perspectives on challenges faced by FQHCs and RHCs in South Dakota.

Barriers to Service Delivery

Respondents identified a wide range of systemic and operational barriers affecting their respective facilities. The most frequently cited are displayed in *Figure 2* below:

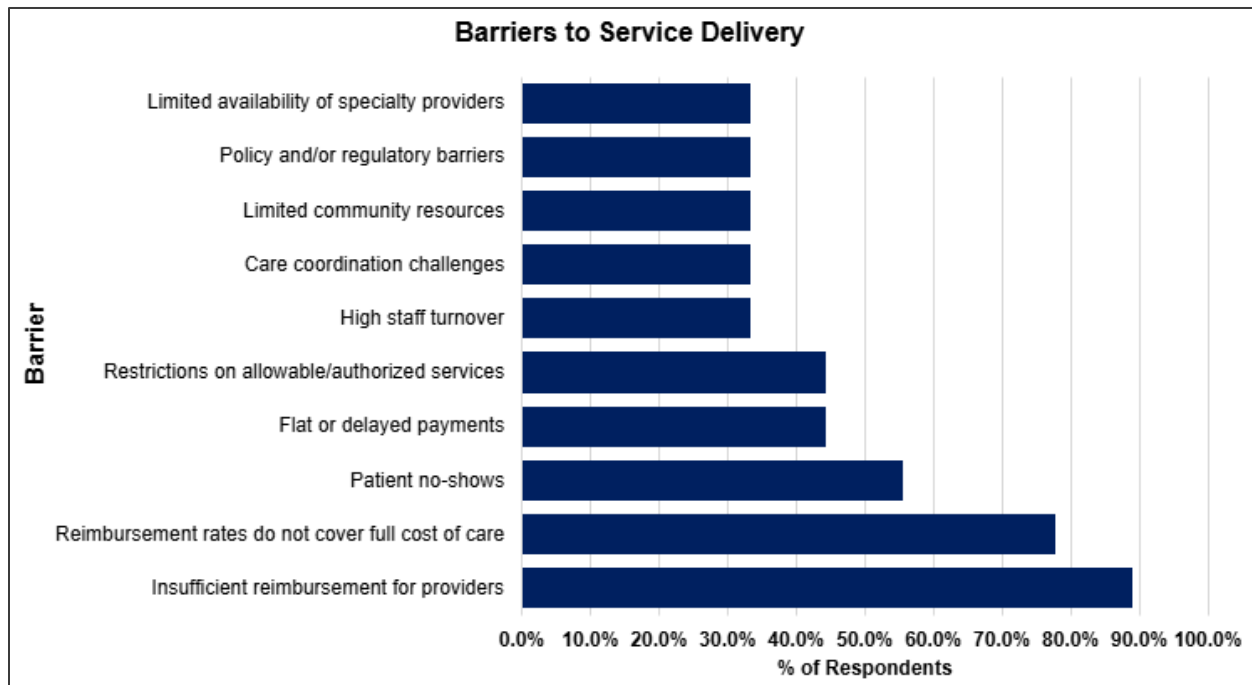


FIGURE 2

Of the options provided in the dropdown of the survey question, providers indicated that the most common barriers included:

- ▶ Insufficient reimbursement for providers (88.9%)
- ▶ Reimbursement rates do not cover full cost of care (77.8%)
- ▶ Patient no-shows (55.6%)
- ▶ Flat or delayed payments (44.4%)
- ▶ Restrictions on the structure of allowable/authorized services (44.4%)
- ▶ High staff turnover (33.3%)
- ▶ Care coordination challenges (33.3%)
- ▶ Limited community resources (33.3%)
- ▶ Policy and/or regulatory barriers (33.3%)
- ▶ Limited availability of specialty providers (33.3%)

These barriers are particularly acute in rural and underserved areas, where access to care is already limited. The findings related to barriers to service delivery are consistent with national trends, where rural health providers frequently cite reimbursement and workforce shortages as top challenges. However, the high rate of concern around service restrictions and administrative complexity may indicate unique pressures within South Dakota’s healthcare landscape.

Impact on Key Services

Many providers reported that current reimbursement rates have led them to reduce or eliminate critical services. The services that received the greatest impact are displayed in *Figure 3*:

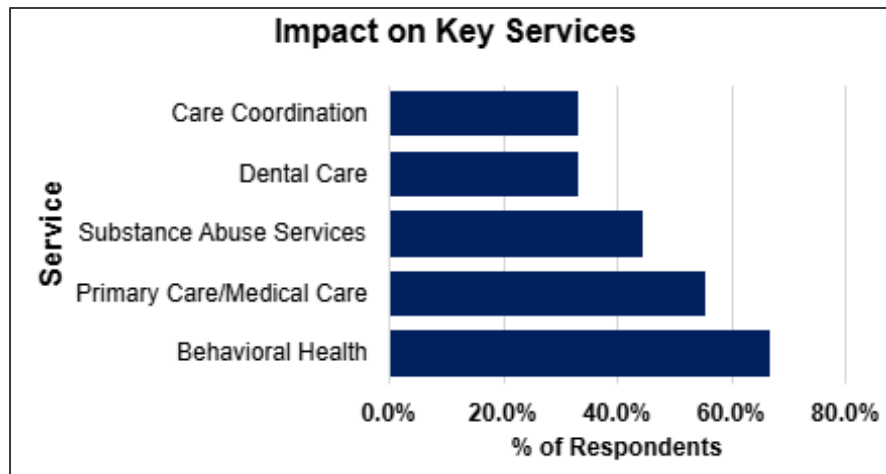


FIGURE 3

The services most affected were:

- ▶ Behavioral Health (66.7%)
- ▶ Primary Care/Medical Care (55.6%)
- ▶ Substance Abuse Services (44.4%)
- ▶ Dental Care (33.3%)
- ▶ Care Coordination (33.3%)

Some organizations have already closed clinics or discontinued services due to financial infeasibility, with one provider noting the closure of a school-based clinic serving predominantly Medicaid patients.

Workforce Sustainability

Reimbursement rates were widely cited as a major factor affecting the ability to recruit and retain qualified staff. Many providers emphasized that current rates did not adequately cover the true cost of care delivery, making it difficult to offer competitive salaries and benefits. Some providers noted that their facilities were competing against larger health care systems and private practices, which often offer higher salaries and comprehensive benefits. In addition to the challenges of recruiting and retaining qualified staff, many providers also reported high costs associated with hiring and onboarding, as well as job positions remaining open longer than usual. The disparity between reimbursement rates and the growing workforce demands has significantly affected providers, leading to higher turnover rates, increased burnout, and reduced access to care for patients. The most affected roles include behavioral health providers, dentists, medical providers, and front-line support staff. *Figure 4* below displays the specific challenges that providers face in maintaining a stable and sustainable workforce.

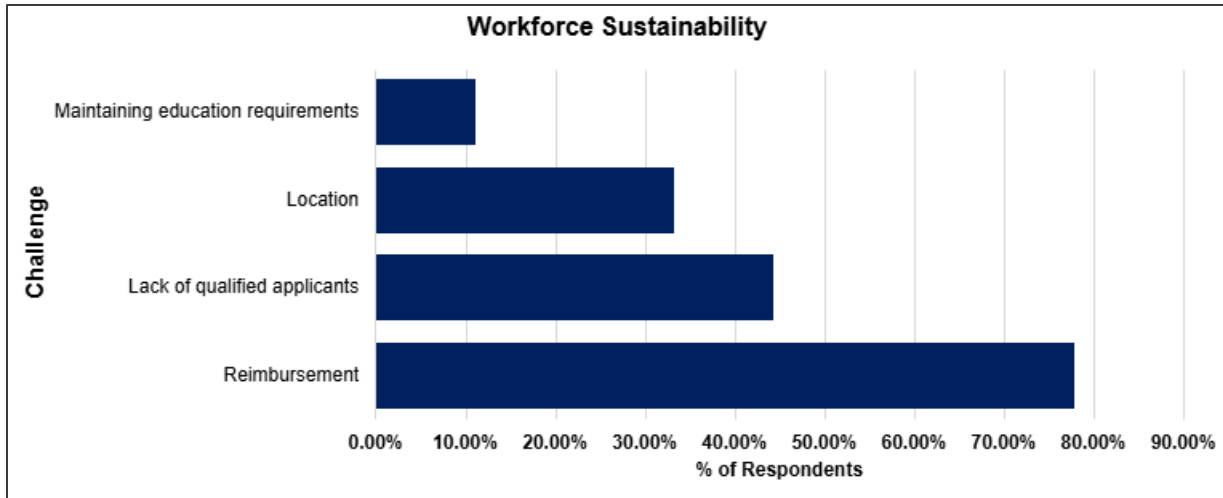


FIGURE 4

Specific challenges included:

- ▶ Reimbursement (77.8%)
- ▶ Lack of qualified applicants (44.4%)
- ▶ Location (33.3%)
- ▶ Maintaining education requirements (11.1%)

Change in Scope of Services Policy

Respondents expressed a need for modification in the existing process for requesting a change in scope of services, citing both procedural complexity and a change in the way the change in scope is calculated over the years. Providers emphasized the need for clearer definitions and standardized requirements related to rate adjustments, particularly as they expand or modify services to meet evolving needs. *Figure 5* below illustrates the key concerns providers face in requesting a change in scope of services within the current policy.

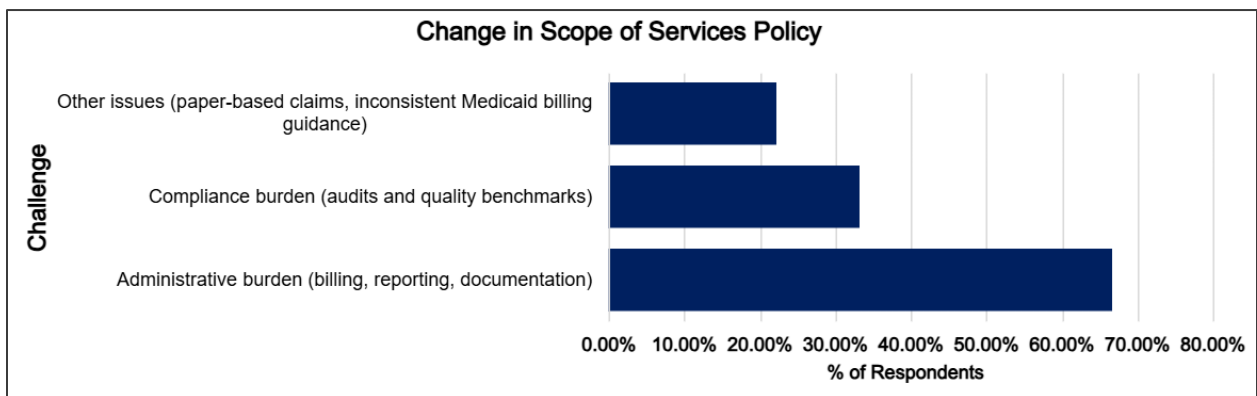


FIGURE 5

Key concerns included:

- ▶ Administrative burden related to billing, reporting, and documentation requirements (66.7%)
- ▶ Burden of maintaining compliance with audits and quality benchmarks (33.3%)

- ▶ Other issues such as paper-based claims and inconsistent Medicaid billing guidance (22.2%)

Alternative Payment Models (APMs)

PCG received limited feedback regarding participation in APMs or care transformation initiatives. It was indicated that one (1) provider participated in an APM under the Medicare Shared Savings Program. This model was generally viewed as more sustainable and better aligned with quality care goals, though implementation challenges remain.

Opportunities for Improvement

Respondents strongly supported reforms to rate-setting and reporting processes. Recommendations included:

- ▶ Aligning Medicaid rates with Medicare cost reports
- ▶ Establishing a transparent and consistent rate-setting framework, including streamlined documentation and reporting requirements to reduce administrative burden and improve efficiency
- ▶ Investing in primary care to reduce downstream healthcare costs
- ▶ Clarifying definitions and expectations for scope of service changes

Providers emphasized that improving reimbursement and reducing administrative complexity are essential to sustaining access to care in rural and underserved communities.

PROVIDER WORKGROUPS

PCG collaborated with DSS to facilitate a stakeholder engagement session. A core component of this engagement was the formation of a diverse and representative stakeholder workgroup. Recruitment was informed by provider survey responses and included a broad group of FQHCs, RHCs, and advocacy organizations such as the CHAD and the South Dakota Association of Healthcare Organizations (SDAHO). The participants represented a diverse range of provider types, services offered, client populations served, payer mix, and organizational size. The primary goal of the workgroup was to collect insights from individuals working within these facilities and to supplement findings from the provider survey. The workgroup discussions included targeted questions designed to elicit feedback on current reimbursement rates and policies, as well as stakeholder recommendations for potential APMs. PCG also identified specific questions to further explore key themes that emerged from the provider survey analysis.

Summary of Workgroup Activities and Findings

The primary objectives of the stakeholder workgroup session were to provide participants with an overview of the comprehensive rate study for FQHC and RHC services in South Dakota, encourage and facilitate provider engagement in the rate study process, and identify key challenges and opportunities for improvement related to reimbursement rates and policies. The discussion yielded valuable insights into current operational and policy barriers that impact care delivery and financial sustainability across the safety-net provider landscape. Ultimately, current reimbursement rates have had a substantial impact on provider sustainability, constraining budgets, limiting access to care in rural and frontier regions, stifling innovation, and creating major challenges in recruiting and retaining qualified providers. Outlined below are the critical insights and recurring themes identified during the workgroup session, which informed the development of the recommendations throughout the project.

Reimbursement Rates

Participants voiced strong concern that current reimbursement rates do not align with the actual cost of

delivering care, particularly in high-cost service areas. Providers emphasized that Medicaid reimbursement typically covers a fraction of the true per-visit cost, leaving a substantial financial gap that threatens the sustainability of service delivery. This imbalance places significant strain on providers' ability to cover essential labor, facility, and operational expenses.

Many have noted that, despite ongoing increases in costs, including rising wages, supply expenses, and infrastructure demands, MEI increases have not kept pace. As a result, safety net providers, who serve a disproportionately high number of Medicaid and uninsured patients, are increasingly forced to make difficult decisions about how to maintain access to care for the most vulnerable populations. Some have been compelled to reduce service offerings, limit patient volume, or delay planned expansions and investments. Without targeted reimbursement reform, participants warned that continued underfunding could erode the capacity of FQHCs and RHCs to deliver comprehensive, high-quality care in their communities.

Staffing and Workforce Challenges

Financial challenges driven by current reimbursement rates have been further exacerbated by persistent workforce and staffing shortages, particularly in rural and frontier areas. Providers in these regions reported significant difficulties in recruiting and retaining qualified staff due to a combination of factors, including limited housing availability, geographic isolation, low patient volume, and uncompetitive compensation. These challenges are not exclusive to remote areas. Urban providers, such as those in Rapid City, also face intense competition from higher-paying employers, including urgent care centers, hospitals, and larger health systems.

As a result, providers across the state are being pushed to offer higher salaries, enhanced benefit packages, and sign-on incentives in an effort to attract and retain essential staff. However, these measures are often financially unsustainable in the context of current reimbursement rates. Many organizations noted that despite escalating compensation demands, they are unable to make long-term investments in workforce stabilization due to budget constraints. This situation has led to increased strain on existing staff, service delivery interruptions, and in some cases, reduced service availability. The combination of limited funding and workforce instability continues to undermine providers' ability to meet community needs and invest in future program growth.

Services Provided

Providers reported that current reimbursement rates are inadequate across nearly all service types, with particularly acute challenges in caring for individuals with chronic health conditions. As safety net providers, FQHCs and RHCs are seeing a growing number of patients requiring chronic care, which is often more time and resource intensive. Services such as chronic care management, pharmacy support, and case management or social work were identified as critical components of care delivery in these settings. However, without sufficient reimbursement, providers struggle to sustain these services at the scale and intensity required to meet patient needs.

Some providers indicated that they have had to limit or eliminate specific services from their care offerings due to ongoing financial constraints or difficulties in recruiting qualified staff to deliver those services. In response to these gaps, some clinics have turned to telehealth as a strategy to expand access to care and reduce delivery costs. Telehealth has been used, particularly by FQHCs, to support behavioral health and specialty services where in-person access is limited. However, adoption across the broader FQHC and RHC landscape has been inconsistent.

Telehealth utilization varied significantly between providers. While some FQHCs have successfully integrated virtual care into their service models, RHCs have been slower to adopt the approach. Providers cited multiple barriers to broader adoption, including lack of clarity in the current reimbursement policy, limitations in broadband or digital infrastructure, and challenges engaging patients effectively in virtual formats. As a result, while telehealth holds promise as a means to address service delivery gaps, its current role remains limited by both systemic and operational factors.

Operational Challenges

FQHCs and RHCs continue to face operational challenges that limit their ability to deliver planned services. In many cases, services must be paused, scaled back, or delayed due to inadequate reimbursement rates and persistent workforce shortages. These barriers are especially pronounced for high-need services such as behavioral health, where demand continues to rise but provider capacity and financial viability remain constrained. This cycle reinforces further gaps in access and care delivery, limiting the ability of clinics to meet community needs and to be appropriately reimbursed for the services they do provide.

One of the compounding factors exacerbating these challenges is the consistently high rate of patient no-shows, particularly for behavioral health appointments in remote or rural areas. These missed visits not only interrupt continuity of care but also contribute to operational inefficiencies and rising unreimbursed costs for providers, particularly for outreach and transportation efforts that are often necessary to support patient engagement in care.

To help address these issues, many clinics have adopted patient-centered strategies such as offering flexible scheduling, providing transportation assistance, and increasing patient communication through reminders and outreach. While these interventions have had some success in improving attendance, they are not reimbursed through existing payment structures. As a result, the financial burden falls solely on the clinics, adding another layer of strain for providers already working with limited resources. Without additional funding or policy changes to support these efforts, providers are left with limited tools to address access gaps and improve care continuity for their patients.

Additionally, RHCs affiliated with larger health systems, such as hospitals, have traditionally relied on financial support from their parent organizations to sustain essential services and cover gaps in reimbursement. However, these funding streams are increasingly being scrutinized or reduced as hospitals face their own financial constraints and changing payment models. As a result, FQHCs and RHCs are actively seeking alternative strategies to ensure patients receive the care they need.

Change in Scope of Services Policy

Providers expressed considerable frustration regarding the clarity of the state's change in scope of services policy. Many reported a lack of clear, publicly accessible guidance outlining the rate-setting methodology, documentation requirements, and criteria for approval. Additionally, there is widespread uncertainty about who to contact at the state level for clarification or support when navigating the process. This lack of transparency and structured communication has made it difficult for organizations to plan, budget, or make informed decisions about expanding or adjusting their service offerings.

There is strong interest across the provider community in establishing a more transparent, user-friendly process that includes standardized guidance, a clear timeline, and designated points of contact at the state level. Providers emphasized the importance of regular and inclusive rate reviews tied to meaningful changes in service delivery, along with clearer definitions of when a change in scope applies. Without these improvements, organizations fear that rates will continue to lag behind actual costs, limiting innovation and long-term sustainability.

Alternative Payment Methodologies (APMs)

Providers participating in the stakeholder session expressed interest in moving toward APMs to address cost coverage and to VBP strategies after cost coverage concerns are addressed. Many acknowledged the potential benefits of models that reward quality, improve outcomes, and incentivize more coordinated care. However, stakeholders also emphasized that cost-based reimbursement remains a critical component of financial sustainability and is needed to stabilize the current care delivery landscape. Providers noted that, without an immediate increase in reimbursement rates, particularly for core services, it will be difficult to maintain existing service levels, let alone transition to new, performance-based models.

Stakeholders underscored the importance of developing a future-facing payment framework that builds on the current system while incrementally supporting the adoption of APMs. This includes preserving cost-based reimbursement where needed, while gradually introducing payment strategies that reflect value, quality, and outcomes. However, providers were clear that any such evolution must be grounded in the realities they are currently facing, such as rising costs of living, housing instability, post-COVID 19 funding shifts, and ongoing policy changes that have left many organizations in a vulnerable state.

There was strong consensus that before providers can meet performance metrics under a value-based system, the foundational challenges must be addressed. This includes increasing reimbursement rates to close the cost gap, ensuring workforce stability and retention, and reducing administrative burdens that hinder care delivery. Providers emphasized that they are not opposed to APMs; rather, they are asking for a thoughtful, phased approach that first prioritizes stabilization of the existing system. Only then can FQHCs and RHCs realistically participate in and benefit from alternative models designed to improve outcomes and accountability.

ALTERNATIVE PAYMENT METHODOLOGY (APM) / VALUE-BASED PAYMENT (VBP) OVERVIEW

Current regulations require states to reimburse services provided at FQHCs or RHCs using the PPS, which is a facility-specific fixed per-visit rate based on the reasonable costs of delivering services during a designated base period. Each FQHC and RHC has its own unique PPS rate. Since the PPS methodology is prospective, and the rate is not based on current costs or reconciled with cost reports, federal law does not require a cost report to be used to calculate the cost after the base year.

As another option to increase flexibility, Congress allowed states to design and implement an APM. Under federal Medicaid law of Section 1902(bb) of the Social Security Act, this allows states to implement APMs if the following conditions are met:

1. The total APM reimbursement is not less than what the FQHC or RHC would receive under the PPS methodology,
2. Each FQHC and RHC receiving APM-based reimbursement agrees to the APM, and
3. The APM is documented in the state's approved Medicaid State Plan.

If the total payments under the APM are less than what would have been paid under the PPS rate, the state must pay the difference to the FQHC or RHC.

APMs offer a new approach to Medicaid reimbursement, focusing on enhancing care quality, increasing provider accountability, and managing costs more effectively. Among these, value-based payment models have gained significant attention for their ability to prioritize patient satisfaction and overall health improvements while also reducing expenses.

METHODOLOGIES

States differ in their use of the PPS and APMs. Many have adopted a variety of APMs to reimburse FQHCs and RHCs for services provided to Medicaid patients. Some states also implement multiple APMs within their Medicaid programs, applying different models across the state, within a single health center for various services, or based on the type of provider (e.g., primary care, behavioral health, or dental providers). The most commonly used Medicaid APMs generally fall into five (5) main categories:

- ▶ **Full FQHC/RHC PPS via Managed Care:**
FQHCs are paid using the established FQHC PPS methodology, however, the full rate is paid via the Medicaid Managed Care Organization (MCO).
- ▶ **Reasonable Cost Per-Visits Bundled Payment:**

Health centers are reimbursed their reasonable costs associated with providing Medicaid covered services. This generally requires ongoing cost-report collection to ensure APM-based per-visit costs remain current.

► **Rebased Per-Visit Bundled Payment:**

The State periodically rebases health centers’ payment rates under the FQHC APM model to reflect changes in the scope of services provided and the associated costs of delivering those services.

► **Per Member Per Month Bundled Payment:**

Some FQHC APMs replace the traditional per-visit payment model with a capitated Per Member Per Month (PMPM) system. This transition enables health centers to adopt a more flexible, team-based approach to care, strengthening their role as medical homes and enhancing their ability to meet patients’ needs.

► **Bundled Payment with Quality Indicators:**

This model is still evolving, and the emerging APMs, whether per-visit or capitated PMPM, offer incentives tied to specific quality indicators, while ensuring that total payments remain at least equivalent to what health centers would have received under the traditional PPS methodology.

Overall, APMs in Medicaid reimbursement aim to transform healthcare delivery by emphasizing efficiency, quality, and sustainability. States have the flexibility of designing an APM to ensure FQHCs and RHCs are appropriately reimbursed for the services they provide. Among these flexibilities, the most common APMs implemented across states are medical APMs. However, some states have developed multiple APMs tailored to specific service types—for example, a separate dental APM. Below are some examples of varying APM models seen through other states.

State	APM Type	Included Services	Carved Out Services	Dental Services
California	Per Member Per Month (PMPM)	Primary care, mental health services, specialty care, podiatry, chiropractic and acupuncture, vaccines and related supplies	Community health workers, community support services, dental services	Excluded from the APM; included in the PPS rate
North Carolina	One primary provider-specific APM	Primary care services, well child, and dental visits	Diagnostic laboratory services, physician hospital services, pharmacy, and incentive payments	Included in the APM
North Dakota	Two APMs; one for medical and other services (i.e. Medicaid covered services other than dental) and 2) APM for dental	Primary care and other Medicaid-covered services (non-dental)	Dental, vision, pharmacy, and non-emergency medical transportation	Included in a separate dental APM from the medical APM

TABLE 23

There is growing evidence that implementing APMs and VBP models within Medicaid programs can generate potential cost savings across the broader healthcare system by reducing high-cost care utilization and improving care coordination¹⁵. For example, in the state of Maryland, FQHCs can participate in a value-based APM called the FQHC Primary Care Collaborative (FPCC) in partnership with the Maryland Community Health System. This model uses shared, measurable healthcare outcomes to establish an advanced care delivery framework tailored to the FQHCs' needs and provides prospective payments based on each FQHCs' patient populations and historical costs. A three (3) year assessment of the program revealed lower overall spending, with a 35% reduction in emergency department visits and an 11% reduction in hospitalizations for Medicaid beneficiaries across the seven (7) participating FQHCs¹⁶. Overall, these models help Medicaid programs optimize costs while ensuring that beneficiaries receive high-quality care.

VALUE-BASED PAYMENTS

VBP is a reimbursement model designed to focus on the quality and outcomes of care delivered versus the volume of services provided. VBP structures are often implemented through APMs. However, there is no universal approach to Value-Based Payments (VBPs)—different models provide unique opportunities and challenges. Successful implementation requires collaboration among all stakeholders within the healthcare system, and securing provider engagement is essential to ensuring sustainable and effective integration.

In the following section, PCG evaluates a range of VBPs and APMs, identifying a range of methodologies that can support DSS' goal of evaluating potential updated rate reimbursement methodologies for their FQHCs and RHCs. PCG also outlines APMs used by several other states. Informed by prior experience in healthcare quality metric development, payment model design, and data analysis, this assessment of reimbursement methodologies for FQHCs and RHCs is intended to support evidence-based decision-making throughout the rate study process.

PEER STATE ANALYSIS

To contextualize the landscape of FQHC and RHC VBP and APM programs, this section presents a comparative analysis with eight (8) peer states currently operating such programs: Colorado, Iowa, Minnesota, Nebraska, Oregon, Washington, New Hampshire and Montana. These eight (8) states represent prominent and well-documented examples of established or emerging VBP/APM initiatives specifically targeting FQHCs and RHCs. In addition, several of these states such as Montana, Nebraska, and New Hampshire, have high percentages of the population residing in rural areas similar to South Dakota. They offer a valuable opportunity for comparative insight, particularly for peer states with similar rural landscapes and healthcare delivery challenges to South Dakota. This section analyzes the structure, implementation strategies, and outcomes of these programs to identify transferable lessons and potential pathways for South Dakota. By understanding how these states have aligned payment reform with rural and community-based care delivery, this analysis aims to support the development of sustainable, value-driven models tailored to South Dakota's healthcare landscape.

¹⁵ Center for Health Care Strategies. How Health Centers Can Improve Patient Care Through Value-Based Payment Models. August 2025. Accessed at: [How Health Centers Can Improve Patient Care Through Value-Based Payment Models](#)

¹⁶ National Library of Medicine. Implementing Value-Based Primary Care Delivery in Federally Qualified Health Centers. August 2025. Accessed at: [Implementing Value-Based Primary Care Delivery in Federally Qualified Health Centers - PubMed](#)

COLORADO

Program Overview

Colorado's Alternative Payment Model 1 (APM 1) launched in 2017 as a value-based payment initiative for FQHCs under the state's Accountable Care Collaborative (ACC). The program is administered by the Department of Health Care Policy and Financing (HCPF) and aims to shift Medicaid primary care reimbursement to value-based care rather than volume-based. APM 1 replaces encounter-based payments with a performance-adjusted payment model, rewarding clinics for quality and access improvements. All FQHCs are automatically enrolled, while RHCs are not included in the program. The model supports care transformation by offering predictable funding and incentivizing better outcomes. As of 2025, all FQHCs are enrolled automatically in APM 1. In 2022, Colorado launched APM 2, a payment model designed to incentivize improved health outcomes and care coordination. It combines a Per Member Per Month (PMPM) payment structure with traditional FFS. APM 2 builds upon the foundation of APM 1, with a focus on primary care and a chronic condition shared savings incentive. This PMPM payment model provides facilities with predictable, steady funding while providers have the flexibility to deliver care through enhanced care coordination efforts.

Cost Report Requirements

All FQHCs must submit annual cost reports to HCPF to calculate their rates for the upcoming fiscal year based on the prior fiscal year. The Payment Methodology Agreement Form is submitted alongside the Cost Report Forms for clinics to confirm they are opting into APM 1 for that particular year. The comprehensive cost report will include all Medicaid-allowable costs ranging from clinical services to administrative expenses that pertain to servicing Medicaid patients. FQHCs will refer to cost principles outlined in the Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. Unallowable costs include offsite services, departments that do not service Medicaid patients, and costs that are reimbursed outside of the FQHC encounter rates. All clinics are expected to maintain accurate documentation to support all reported costs to verify the costs reported each year.

Payment Mechanisms

Under APM 1, FQHCs receive prospective payments that are adjusted annually based on performance across a set of quality measures. Clinics must serve at least five hundred (500) attributed Medicaid members to be included, though smaller practices may petition to participate. Payments are not encounter-based but instead reflect a PMPM structure that incorporates both attainment and improvement on selected metrics. Clinics that exceed benchmarks are rewarded with additional incentive payments on top of their calculated rate. The model is designed to align with broader state reforms and support long-term investment in primary care. Reconciliation processes are also in place to ensure clinics' rates do not fall below the PPS rates even after their quality benchmarking calculations. Under APM 2, participating practices receive PMPM payments while continuing to submit claims data to support rate-setting processes. Eligibility for APM 2 is based on prior participation in APM 1, along with additional criteria that must be met.

Quality Measures

The 2025 APM 1 measure set includes a mix of clinical quality, preventive care, and behavioral health indicators. Clinics are evaluated on both adult and pediatric measures and can select from a wide array of measures, some of which are mandatory and others of which are optional. The menu-based approach allows flexibility on behalf of the provider.

All participating clinics must report on three core measures impacting their patient populations. They must report on three of the following:

- ▶ CMS 122 – Diabetes: HbA1c Poor Control

- ▶ CMS 165 – Controlling High Blood Pressure
- ▶ CMS 1516 – Child and Adolescent Well Visits
- ▶ CMS 117 – Childhood Immunization Status
- ▶ CMS 2 – Depression Screening and Follow-Up
- ▶ CMS 1392 – Well Visits in the First 30 Months of Life

The remaining optional measures are found on a menu of over twenty (20) measure options.

Program Impact

APM 1 has helped stabilize FQHC finances by providing predictable, performance-based payments and reducing reliance on encounter volume. Clinics report increased flexibility to invest in team-based care, behavioral health integration, and chronic disease management. The program has also supported alignment with other state initiatives, including the transition to Accountable Care Collaborative (ACC) Phase 3.0. While RHCs are not currently included in APM 1, the state is continuing to explore broader value-based payment strategies across provider types.

IOWA

Program Overview

Iowa introduced APM options under State Plan Amendment (SPA) IA-15-0024, published in 2016 but launched in 2015, to reimburse FQHCs and RHCs on a FFS basis. Each provider can opt into the APM program. The effort was a part of Iowa's broader Medicaid Modernization initiative to transition nearly all Medicaid enrollees to managed care plans.

Cost Report Requirements

All clinics must submit annual cost reports to IA (Department of Health and Human Services) HHS to calculate their rates for the upcoming fiscal year based on the prior fiscal year. Cost reports are utilized to calculate PPS rates and thus integrate into APM methodologies. The comprehensive cost report will include all Medicaid-allowable costs ranging from clinical services to administrative expenses that pertain to servicing Medicaid patients. FQHCs and RHCs will refer to cost principles outlined in the Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. All clinics are expected to maintain accurate documentation to support all reported costs to verify the costs reported each year.

Payment Mechanisms

MCOs or other Iowa Medicaid payers can reimburse both FQHCs and RHCs. Quarterly analyses comparing these payments to the PPS rate are conducted. If total payments are less than the PPS rate, a wraparound supplemental payment is issued to bridge the gap. This ensures compliance with federal requirements that APMs reimburse at least the PPS amount. While the SPA was focused on and part of a broader initiative to transition Medicaid beneficiaries to managed care plans as opposed to FFS-based plans, beneficiaries can still be seen at APM participating clinics. However, the clinic and the payer must have a formal payment agreement in place. Clinics would still receive, at a minimum, the PPS-level reimbursement regardless of the patient's enrollee status as this floor payment is guaranteed to the clinic's provided that payment agreements are in place.

Quality Measures

VBP programs are required to be implemented by MCOs that contract with Iowa Medicaid for a certain portion of their enrollment population and some do choose to implement quality measure components in such programs. Whether or not MCOs implement such measures for the FQHCs and RHCs they contract with is up to them and varies by organization. Quality measures are much less common in FFS

arrangements unless agreed upon between the provider and Iowa Medicaid as these patients typically utilize a PPS methodology.

Program Impact

Specific health outcome data and cost statistics from the APM initiative in FQHCs and RHCs are not publicly available. However, the APM implementation with discretion to the individual MCOs contracted with Iowa Medicaid allows for a unique model customized to fit the state's MCO-dominant Medicaid landscape.

MINNESOTA

Program Overview

Minnesota began offering their latest APM iteration, APM IV, in 2021 after retiring their three (3) previous models in 2020. All CMS-certified FQHCs and RHCs can continue to choose between enrolling under the PPS rate methodology or APM IV. The initiative for a FQHC and RHC-focused APM was lobbied in the legislature in 2015 by the Minnesota Department of Human Services (DHS), Minnesota Association of Community Health Clinics (MNACHC), and FQHC providers to find an alternative rate-setting methodology that better reflects the current health care cost trends. The original iterations APM I – APM III were created in Minnesota following BIPA's passage in 2000 and were thus based off outdated costs and applied historical restrictions established by Medicare that could reduce the per encounter payment rate. The operational challenges providers faced in these outdated APM systems were the impetus for establishing a modern APM. While the current number of enrollees to APM IV is not publicly available information, APM IV has continued to be offered to all eligible clinics in 2025.

Cost Report Requirements

All clinics must submit annual cost reports to DHS to calculate their rates for the upcoming fiscal year based on the prior fiscal year and support inflation-related adjustments. Cost reports are utilized to calculate baseline rates and thus integrate into APM methodologies. The comprehensive cost report will include all Medicaid-allowable costs ranging from clinical services to administrative expenses that pertain to servicing Medicaid patients. FQHCs and RHCs will refer to state-specific cost reporting principles to determine reasonable costs. All clinics are expected to maintain accurate documentation to support all reported costs to verify the costs reported each year.

Payment Mechanisms

APM IV calculates clinic rates using 100% of the average costs reported on each FQHC's or RHC's cost reports from fiscal years 2017 and 2018 and then adjusts these rates by the latest FQHC Market Basket Index less a productivity adjustment. Adjustments are also made when clinics make significant changes in the scope of services provided at the clinic between rebasing years when they have resulted in a medical, dental, or both medical and dental rate change greater or less than 2.5%. The rate is rebased every two years and inflated by the most recent Market Basket Index data every year. DHS requires that the APM IV rate must not be less than the PPS rate; if it is calculated to be lower, their PPS rate will apply instead to ensure providers do not take on risk.

Quality Measures

Quality measures established under the Statewide Quality Reporting and Measurement System (SQRMS) pertaining to various healthcare quality components and provider groups do not directly tie into the APM IV rates for FQHCs and RHCs. Clinics receive payments on costs independent of their performance on quality measure performance, although participation is expected in SQRMS for quality improvement and tracking purposes.

Program Impact

DHS has not published detailed evaluations or reports assessing the outcomes of APM IV since implementation. However, the transition was intended to provide sustainable and equitable payment structures across clinics compared to the retired APM models and PPS methodology. This model was designed to offer care flexibility and financial stability for providers.

NEBRASKA

Program Overview

Nebraska implemented an APM for FQHCs and RHCs through State Plan Amendment (SPA) NE-16-0001, effective in 2016. This APM offers providers an alternative to the PPS and is a voluntary methodology that providers must opt into. The APM is designed to ensure that total reimbursement is at least equal to what would be received under the PPS but can also exceed it.

Cost Report Requirements

All clinics must submit annual cost reports to the Nebraska Department of Health and Human Services (DHHS) to calculate their rates for the upcoming fiscal year based on the prior fiscal year. Cost reports are utilized to calculate PPS rates and thus integrate into APM methodologies. The comprehensive cost report will include all Medicaid-allowable costs ranging from clinical services to administrative expenses that pertain to servicing Medicaid patients. FQHCs and RHCs will refer to cost principles outlined in the Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. All clinics are expected to maintain accurate documentation to support and verify the costs they report each year.

Payment Mechanisms

The APM base rate is determined by calculating the total allowable costs from the FQHC's cost reports, applying the MEI for inflation adjustments, and averaging costs over multiple years to establish a blended rate. FQHCs and RHCs contracting with MCEs (a broader term including MCOs that Nebraska utilizes) may receive payments under the APM. These payments are subject to quarterly analyses to ensure compliance with federal requirements that the reimbursements at least be above the PPS-equivalency rate. If the total payments from the MCE and any supplemental payments are less than the APM rate (since these are equal or higher than the PPS-equivalent rate), the state issues a wraparound payment to cover the difference. Notably, Nebraska's SPA details dental services' inclusion in the APM and wraparound payment process whereas most other states focus on traditional medical care with separate carve outs for dental services.

Quality Measures

Nebraska's Medicaid managed care program, Heritage Health, requires MCEs to implement VBP programs, which may include quality measures as a part of this program in their contracts with individual FQHCs and RHCs. These initiatives aim to improve health outcomes among Medicaid enrollees. Whether or not MCEs implement such measures for the FQHCs and RHCs they contract with is up to them and varies by organization.

Program Impact

Specific health outcome data and cost statistics from the APM initiative in FQHCs and RHCs are not publicly available. However, the APM implementation with discretion to the individual MCEs contracted with Heritage Health (Nebraska's integrated Medicaid managed care program launched in 2017) allows for a unique model customized to fit the state's MCE-dominant Medicaid landscape.

OREGON

Program Overview

Oregon's APM was among the first of its kind to launch in 2013. The initiative was launched by the Oregon Health Authority (OHA) as a component of their VBP Compact, a collaborative agreement among public and private health care stakeholders aiming to shift 70% of health care payments to advanced value-based models by 2025. FQHCs and, to a smaller extent, RHCs were brought into this broader initiative in collaboration with the Oregon Primary Care Association in order to align payment and transform care for optimal health and health equity outcomes. Beginning with a pilot group of three (3) clinics in 2013, the program has expanded to include more than twenty (20) FQHCs and two (2) RHCs.

Cost Report Requirements

All clinics must submit Cost Statements (DMAP 3027) to OHA for rate determination and adjustments for their PMPM capitated payment system to reconcile and adjust rates. The cost statement must exclude costs for services reimbursed outside the PPS, such as pharmacy, durable medical equipment, and targeted case management costs. FQHCs and RHCs will refer to cost principles outlined in the Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. They are also expected to maintain comprehensive records, including trial balances, audited financial statements, and depreciation schedules, for at least five (5) years. All clinics are expected to maintain accurate documentation to support all reported costs to verify the costs reported each year.

Payment Mechanisms

The program is voluntary for all eligible clinics to replace FFS reimbursement models. Instead, base encounter payments are substantiated with supplemental up-front capitated PMPM wrap payments. These rates are initially set based on historical PPS revenue and utilization data to ensure the participating clinics do not receive less supplemental funds than they would without participating in the program. The OHA conducts an annual reconciliation process to compare the total PMPM payments received by each clinic to the amount they would have received under the PPS model. The OHA makes up the difference if they fall short of the PPS-estimated revenue to ensure no clinic is financially disadvantaged by participating in the APM program.

Quality Measures

A portion of these payments are tied to the clinic's performance on a defined set of quality measures. If clinics underperform for four (4) consecutive quarters, they may enter a Performance Improvement Plan period that eventually result in a rate reduction. The focus on meeting metric benchmarks or improvement targets enables clinics to focus on long-term health outcomes rather than short-term service volume. APCM is an advanced iteration of the APM that integrates health innovations by aligning its quality measurement framework with the broader Coordinated Care Organization (CCO) Quality Incentive Program (overseen by OHA). All participating FQHCs and RHCs are expected to track and report on a set of standardized quality measures, which are selected annually by the Metrics and Scoring Committee to incentivize improvements in care. Clinics participating in the APM are expected to use these metrics to guide care transformation efforts and demonstrate value under the capitated payment model.

OHA tracks five (5) metrics quarterly for APM-enrolled FQHCs aligned with the CCO incentive measures:

1. Diabetes Poor Control
2. Depression Screening
3. Colorectal Cancer Screening
4. Weight Assessment and Counseling in Children and Adolescents
5. Hypertension

Care STEPS (Care and Service That Engage Patients) is also an initiative that requires quarterly reporting on behalf of the clinics to document accessibility under four (4) categories:

1. New Visit Types
2. Education, Wellness, and Health Promotion
3. Coordination and Integration
4. Reducing Barriers to Health

Program Impact

The program has been a resounding success for participating centers, who report a shift in focus on patients rather than visits due to the reimbursement model. Centers are better equipped to tailor their care to patients and to provide specialized services and utilize care innovations. For beneficiaries, the program promotes community-wide health improvements by shifting the focus for clinics to their patient's health goals rather than their patient encounter rates.

NEW HAMPSHIRE

Program Overview

New Hampshire's APM framework was formalized under State Plan Amendment (SPA) NH-20-0018 and outlined in the New Hampshire Medicaid Provider Manual for FQHCs, FQHC Look-Alikes (FQHC-LALs), and RHCs. The program allows providers to deliver services within their HRSA-approved scope, including encounter services, incidental services, and other ambulatory services. The model supports flexibility in service delivery while maintaining compliance with Medicaid coverage under Sections 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act.

Cost Report Requirements

New Hampshire required annual cost reports until FY 2011, after which they were no longer necessary. APM rates are trended forward using the FY 2011 cost-settled rates and the MEI. A one-time cost report collection and rebase capped APM rates at 94.1% of Medicare. Providers must maintain documentation supporting any changes in scope of services, including incremental cost breakdowns and visit data.

Payment Mechanisms

New Hampshire uses a dual payment methodology:

- ▶ A fixed encounter rate for medical and behavioral health services
- ▶ Fee schedules for other ambulatory services, aligned with New Hampshire Medicaid's standard rates

The encounter rate is calculated using PPS principles from BIPA 2000, based on average cost per visit from FYs 1999 and 2000, trended forward using the MEI. Since October 8, 2012, providers receive the greater of the PPS or APM rate, with annual MEI adjustments and scope of service updates. Effective January 1, 2020, encounter rates were increased by 3.1%.

Quality Measures

New Hampshire's APM does not mandate a standardized set of quality measures across all providers. However, providers participating in the APM may be subject to performance tracking depending on their agreements with New Hampshire Medicaid. Quality measurement is not embedded in the FFS structure but may be included in provider-specific arrangements or scope of service reviews.

Program Impact

New Hampshire's APM model offers a flexible reimbursement structure that allows providers to choose between PPS and APM rates, ensuring financial stability while supporting service expansion. The dual payment approach enables clinics to maintain core services under a predictable encounter rate while accessing FFS reimbursement for additional ambulatory care. Although outcome data is limited, the model's built-in protections, such as the PPS floor and MEI-based trending, help sustain provider participation and support long-term planning. The ability to request scope of service changes annually also allows clinics to adapt to evolving community needs and staffing realities.

MONTANA

Program Overview

Montana's APM framework was implemented under State Plan Amendment (SPA) MT-19-0007 and is detailed in the Montana FQHC/RHC Provider Manual (2025). The program allows FQHCs and RHCs to deliver services within their approved scope, including physician services, behavioral health, dental, visiting nurse, and clinical pharmacist practitioner services. Preventive primary care services are also covered, excluding eyeglasses and hearing aids. The APM was introduced to ensure reimbursement rates more accurately reflect the cost of current services provided.

Cost Report Requirements

Montana requires FQHCs and RHCs to submit cost reports for the previous two (2) years to calculate APM rates. These reports are used to derive a per-visit rate based on actual costs. Once a provider has submitted two (2) complete fiscal years of Medicare cost reports, a baseline PPS rate is established. Cost reports are also used to support change(s) in scope of service requests, which may result in rate adjustments.

Payment Mechanisms

Montana uses a dual methodology:

- ▶ PPS: Providers receive an interim PPS rate upon enrollment, which is later replaced by a baseline PPS rate.
- ▶ APM: Effective July 1, 2019, providers may opt into the APM, which uses current cost data to set per-visit rates. APM rates are:
 - Adjusted annually by the MEI; and
 - Modified to reflect any change in scope of services.

The APM rate must be equal to or greater than the existing PPS rate. Interim PPS rates for new or acquired clinics are based on either regional averages or projected allowable costs and visits.

Quality Measures

Montana's APM does not mandate a standardized set of quality measures across all providers. However, providers are expected to maintain compliance with Medicaid program requirements and may be subject to performance tracking through audits or scope of service reviews. Quality measurement is not embedded in the reimbursement structure but may be included in provider-specific agreements.

Program Impact

Montana's APM model provides flexibility for FQHCs and RHCs to align reimbursement with actual service costs. By allowing providers to opt into a cost-based APM, the state ensures financial sustainability while supporting service expansion. The PPS floor protects clinics from revenue loss, and annual MEI adjustments help maintain rate relevance. The ability to submit prospective or retrospective scope of service changes further supports adaptability. While outcome data is limited, the model's structure promotes tailored care delivery and financial stability for rural providers.

Change in Scope of Service Policies

Change in scope of services policies are critical to ensuring that PPS reimbursement rates for FQHCs and RHCs remain aligned with the actual services provided. South Dakota currently defines a change in scope of services as adding a new service into the current per diem service base or removing a service that is in the existing service base. However, the policy explicitly excludes changes in cost, staffing, or patient volume alone as qualifying events. While this aligns with federal guidance, peer states offer more structured and defined approaches that South Dakota may consider adopting to enhance clarity and provider engagement.

For example, New Hampshire defines a change in scope of services as a change resulting from the addition or loss of a licensed provider who delivers services not previously offered at the clinic. The state requires providers to submit detailed documentation, including the effective date of the change, Medicaid and total visit counts, incremental cost changes by category, and a per-visit rate adjustment calculation. Requests must be submitted by March 31 for implementation on July 1, creating a predictable annual cycle.

Minnesota uses a threshold-based approach, requiring that any change in scope of services result in a rate change of at least $\pm 2.5\%$ to qualify for adjustment. Providers must complete a standardized form (DHS-4561) and submit historical and projected cost data, encounter volumes, and audited financial statements. The state also conducts a “look-back” after one (1) year to reconcile projected and actual costs, with retroactive rate adjustments applied accordingly.

Montana, Oregon, and Washington allow both prospective and retrospective changes in scope of services submissions, depending on when the change occurred and when documentation is received. Oregon’s policy includes a detailed methodology for calculating rate adjustments based on Medicare cost principles, and the state uses a standardized worksheet to ensure consistency across providers. A retrospective change in scope of service occurs when a change took place in the past and the FQHC or RHC is seeking to adjust its rate based on that change. FQHCs and RHCs may request a retrospective change in scope of service rate adjustment through a single application or separately from a prospective change in scope of service. In such cases, states define a specific time period to determine how far back a triggering event may be considered to support the adjustment. For example, Washington allows retrospective changes using twelve (12) months of actual cost data, effective retroactively to the date the application was submitted¹⁷. In addition, Montana allows FQHCs and RHCs to submit a retrospective change in scope of service request if the resulting cost impact meets or exceeds a 2.5% threshold in the PPS rate. Once approved, the adjusted rate becomes effective at the start of the clinic’s next fiscal year following the scope change.

These examples suggest several opportunities for South Dakota to refine its change in scope of services policy. First, establishing a minimum threshold for rate impact (e.g. $\pm 5\%$) could help prioritize significant changes while reducing administrative burden. Second, implementing a standardized change in scope of services request form, documentation requirements, and state level contact would improve consistency and clarify requirements. Third, adopting a fixed annual submission window, as seen in New Hampshire, would streamline the review process and provide clarity for providers. Fourth, adopting a standardized appeal process to a change in scope decision. Finally, clarifying the parameters around potential retrospective adjustments is also suggested in the updated scope change policy.

Services Outside the PPS Model

South Dakota currently excludes a range of services from the PPS model, including diagnostic tests, laboratory services, Durable Medical Equipment (DME), and certain behavioral health and telehealth

¹⁷ Washington State Legislature. Federally qualified health centers—change in scope of service rate adjustment. August 2025. Accessed at: [WAC 182-548-1500](https://leg.wa.gov/CodeView.aspx?code=WAC%2F182-548-1500):

services. These services are reimbursed separately through FFS. This carve-out approach is consistent with many other states, which also exclude specific services from the PPS due to federal billing limitations or state-specific policy decisions.

States like North Dakota, Montana, and New Hampshire also carve out services such as dental, pharmacy, transportation, and vision care. These services are typically reimbursed through FFS or managed care, rather than being bundled into the PPS encounter rate. In Nebraska and Iowa, laboratory and radiology services, DME, and certain behavioral health services are carved out and billed separately, often requiring different claim forms or provider identifiers. This mirrors South Dakota's use of separate NPIs and billing pathways for non-PPS services.

Where peer states diverge from South Dakota is in their use of APMs to better integrate carved-out services into their reimbursement frameworks. States like Colorado and Montana use hybrid models that combine FFS billing with wraparound payments or cost-based adjustments to ensure providers receive total reimbursement equal to or greater than PPS. Oregon and California have PMPM models for primary care, while continuing to reimburse carved-out services, such as dental and behavioral health, under the PPS. These models include reconciliation processes and scope of service adjustments, offering providers more financial predictability and flexibility.

In summary, South Dakota's approach to carved-out services is consistent with national norms. APMs provide the state the flexibility in exploring methods that incorporate wraparound payments or PMPM models which could help South Dakota better support its providers, especially in rural and underserved areas, while maintaining alignment with federal PPS requirements.

In terms of encounter definitions, most peer states define a billable encounter as a face-to-face or synchronous telehealth visit between a Medicaid member and a qualified provider. Eligible providers typically include physicians, nurse practitioners, physician assistants, licensed clinical social workers, psychologists, and dentists. States such as North Dakota and South Dakota, limit reimbursement to one medical, one dental, and one behavioral health encounter per day, unless a separate illness or condition justifies additional visits.

Other states have adopted more flexible approaches. For example, Iowa allows multiple distinct encounters per day if properly documented and medically necessary, such as separate medical and behavioral health visits. Oregon and California include telehealth encounters in their definitions, with Oregon explicitly allowing synchronous audiovisual visits and California requiring detailed documentation of the medical reason, diagnosis, and provider credentials. Washington also permits telehealth encounters and allows more than one encounter per day if the patient experiences a separate illness or condition.

To enhance its reimbursement model, PCG has provided recommendations in the following sections that aim to increase flexibility in service delivery while simplifying reimbursement through a proposed APM. This model would cover primary care, behavioral health, and other Medicaid-covered services, with a separate dental statewide weighted average APM. Additionally, expanding the list of eligible providers and clarifying encounter definitions could support integrated care delivery and improve access to services. For example, stakeholders have raised the inclusion of other provider types, such as addiction counselors, as part of substance use disorder services. Finally, developing a comprehensive list of carved-out services and their reimbursement mechanisms would improve transparency and support provider compliance.

RATE MODELS

The proposed rate model considered the current landscape of FQHC and RHC services and delivery models in South Dakota, with a specific focus on developing an appropriate APM to update the existing reimbursement processes and policies. PCG's approach was informed by best practices, financial data

from submitted Medicare cost reports, MMIS data, and programmatic objectives established by the South Dakota DSS team. Provider-specific cost report data was used to calculate a rate model based on relevant Medicare cost centers for FQHC and RHC services and allowable South Dakota Medicaid costs.

The PCG team developed a multi-pronged reimbursement methodology for an APM, which included the following steps:

- ▶ Collecting cost report data from FQHC and RHC providers across the state
- ▶ Reviewing costs for reasonableness and calculating total allowable costs and cost per encounter
- ▶ Adjusting for inflation and geographic factors
- ▶ Analyzing MMIS data
- ▶ Modeling cost-based rates using both statewide averages, encounter-weighted statewide averages, and blended rates
- ▶ Providing a fiscal impact analysis for the projected rates

OVERVIEW

PCG researched various payment methods, along with peer states' methodologies to determine the most effective approaches for designing an APM for FQHCs and RHCs in the state of South Dakota. Below is an overview of each rate type, including the methodology for development. Each approach has advantages and challenges; however, due to the limited number of provider Medicare cost reports received, a combination of these models and different phases of implementation may be necessary to ensure accurate and appropriate rates for different FQHC and RHC providers.

- ▶ **Provider-Specific Cost-Based Rate** is a fixed rate designed to cover expenses or reimburse for services rendered. It is commonly used when cost report data is available for all providers, allowing providers to receive a rate based on their individual service delivery costs. While this approach is generally more favorable to providers, since it reflects the true cost of care, it can also create additional administrative burdens for those providers who do not complete and submit cost reports. It also places added responsibility on the state agency to regularly review and validate these reports. Lastly, it provides no value-based component, which rewards care efficiency and quality.
- ▶ **Statewide Average Rate** refers to a payment model based on the average total allowable cost per encounter, as reported in cost report submissions for the applicable provider type (FQHC or RHC). It is commonly used when individual provider cost report data is not available. This approach is generally more favorable for state Medicaid agencies, as it simplifies administration, promotes equity, and supports predictable budget forecasting. It also helps reduce rate volatility that can result from outdated cost structures or sudden drops in encounter rates at the individual provider level. Additionally, for providers with lower PPS rates, this option can help raise their reimbursement to a more favorable level. However, providers with higher encounter rates may find this approach less favorable, as they could experience payment reductions if the statewide average is below their cost-based rate.
- ▶ **Encounter Weighted Statewide Average Rate** refers to a payment model calculated by dividing the total allowable costs, summed across all providers submitting cost reports, by the total number of encounters for those providers, based on the applicable provider type (FQHC or RHC). This rate is intended to cover expenses or compensate for services rendered and is commonly used when individual provider cost report data is unavailable. This rate offers a fair approach by weighting each provider's encounter rate according to the number of encounters delivered, reflecting actual system-level utilization patterns across the state. Weighting prevents the average from being skewed by outlier providers with unusually high or low rates but few encounters. Since high-volume FQHCs and RHCs tend to operate more efficiently, encounter weighting incorporates that efficiency into the average. This can be especially

beneficial for facilities with lower PPS rates but high volumes, as it promotes rate stabilization. Additionally, encounter weighting helps avoid inflating the statewide rate due to outliers from very small or high-cost providers.

- ▶ **Blended Statewide Average Rate** refers to a payment model based on the average total cost per encounter across both FQHCs and RHCs. It is commonly used when individual provider cost report data is unavailable. This approach can be used for streamlining payment mechanisms, as it establishes a single rate for all FQHCs and RHCs combined, simplifying both the claiming process and rate updates. A blended rate can help elevate reimbursement for lower-paid providers, particularly in rural and underserved areas, thereby improving access to health services. Additionally, a uniform rate allows both providers and state Medicaid agencies to plan budgets more reliably. Although this method may be more unfavorable for those providers who have a higher cost per encounter than the majority, this may not be representative of the sample and can ignore differences in patient mix, geographic cost variations within the state, and size and scale of facilities.
- ▶ **Blended Encounter Weighted Statewide Average Rate** refers to a payment model calculated by dividing the total allowable costs, summed across all providers submitting cost reports, by the total number of encounters for those providers, and then averaging across both FQHC and RHC provider types. This results in a single per-encounter rate for all FQHCs and RHCs, with each provider's rate weighted by the number of encounters they deliver. This model is commonly used when individual provider cost report data is unavailable. It reflects the actual distribution of service volume across the system and ensures fairness. Since high-volume FQHCs and RHCs tend to operate more efficiently, encounter weighting incorporates that efficiency into the average. It also helps stabilize rates and prevents the statewide average from being skewed by outlier providers with very high or low costs but few encounters. Similar to the blended statewide average rate, the blended encounter weighted statewide average rate may not be representative of geographical cost differences.

Benchmarks

To evaluate the reasonableness of the rate modeling, the PCG Team reviewed these main benchmarks for FQHCs and RHCs. These benchmarks provided context for understanding how the modeled rates compare to actual provider costs, prevailing reimbursement structures, and payment levels in comparable markets, ensuring that the proposed rates are both equitable and consistent with federal and state policy objectives.

Cost-Based Benchmark

The PCG Team used the most recent cost report data for FQHCs and RHCs, adjusting total allowable costs based on a consistent time period: January 2024 to December 2024. To align with federal guidelines and South Dakota Medicaid's allowable cost categories and reimbursement structures, PCG developed crosswalks between the three (3) types of Medicare cost reports to determine applicable cost categories for FQHCs and RHCs. Using the cost-based method not only validated the modeled rates against actual provider costs but also helped identify outliers in the data. These outliers were addressed using additional adjustment factors, such as applying an administrative and overhead floor/cap. These adjustments ensured that reimbursement rates remained fair and consistent across providers.

Medicare-Based Rates

Using Medicare-based rates serves as a nationally recognized benchmark in rate setting practices. These rates are set using a consistent federal methodology, which provides a stable and recognized baseline for comparison of FQHC and RHC rates. The Medicare-based rates are designed to reflect reasonable costs of delivering services to Medicare patients, incorporating several factors for adjustment such as geographic adjustments and service intensity. While not identical to Medicaid populations or cost, they still represent a cost-informed rate, and many state Medicaid agencies use these Medicare rates as a

comparison when setting reimbursement rates. The Medicare base rates were reviewed for the current Medicare PPS and RHC All Inclusive Rate (AIR). For FQHCs, the CY25 base rate is \$202.65. Additional adjustment factors may apply for new patient visits, Initial Preventative Physical Examinations (IPPEs), and annual wellness visits. For CY25, the South Dakota Geographic Adjustment Factor (GAF) is 1.000 which means there is no geographic adjustment applied to the base PPS rate for FQHCs.

For independent and provider-based RHCs in hospitals with 50 or more beds, the CY25 payment limit per visit is \$152.00.

South Dakota Medicaid Management Information System (MMIS) Data

Using South Dakota MMIS data as a benchmark offers a practical approach for verifying Medicaid encounters, assessing service type trends, and analyzing differences between FFS and encounter-based payments. This analysis was used exclusively to determine the Medicaid portion of total encounter counts, specifically for medical, behavioral health, and dental services, for each calendar year. To support this effort, the PCG team utilized current MMIS data to evaluate medical and dental FFS procedure codes from CY21–CY24. This information provided historical payment tracking, which informed the recommended APM approach. Additionally, the MMIS data was utilized to account for managed care supplemental payments received by FQHCs and RHCs, helping to determine the overall fiscal impact. Because federal law requires APMs to meet or exceed the PPS, MMIS encounter data is an important resource for reconciling actual encounter counts against PPS payments and can support compliance efforts.

Rate Adjustments

Administrative and Overhead Cost

To assess total allowable costs for FQHCs and RHCs, an Administrative and Overhead (Admin OH) cap was applied due to the presence of outlier providers with significantly higher administrative and overhead costs compared to the statewide average. Applying such administrative caps and floors is a common practice in Medicaid rate setting and is used across many states to promote consistency, fiscal responsibility, and equitable reimbursement among FQHC and RHC providers. This is especially prevalent with outlier providers with significantly lower or higher administrative and overhead costs.

As there was larger spread between administrative costs for FQHCs, an Admin OH cap was calculated on a per-encounter basis by dividing the total administrative and overhead costs for all FQHCs by their respective total encounters. This produced a per-encounter administrative cost benchmark for each provider, helping to align the reporting of total allowable costs across all providers in the state.

To ensure rate equity and prevent outliers from significantly skewing statewide encounter weighted average rates and blended weights, providers with unusually high administrative costs were capped using the average per-encounter administrative cost plus one (1) standard deviation. In total, one (1) provider was capped using this methodology.

In addition to the Admin OH cap, an Admin OH floor can also be established to account for significantly low outlier providers in the data. This methodology, similar to the development of the Admin OH cap, involves calculating the average administrative and overhead costs and subtracting one (1) standard deviation to set a minimum threshold. Any provider with costs below this threshold can be adjusted upward to meet the Admin OH floor. Since no providers had a significantly low encounter rate, the Admin OH floor was not applied in the analysis. However, it remains a viable option for the state to consider if additional data becomes available.

As a result, one (1) provider was affected by the Admin OH cap adjustment, as its cost per encounter was significantly higher at \$1,030.44 prior to the cap being applied. *Table 24* below shows the cost per encounter affected by the application of the Admin OH cap.

	Cost Per Encounter Without Admin OH Cap	Cost Per Encounter With Admin OH Cap
Provider 1	\$1,030.44	\$736.85

TABLE 24

The models also included scenarios both with and without the application of an Admin OH cap for the following rate types:

- ▶ Statewide Average Rate
- ▶ Weighted Statewide Average Rate
- ▶ Blended Rate

Dental Services

Dental benefits vary widely across states, particularly in the areas of preventive and restorative care. Under federal guidelines, there are no minimum requirements for adult dental coverage under Medicaid, giving states flexibility to determine which dental services to offer and how to reimburse them. As a result, Medicaid programs differ in the scope of dental services they cover for adults, as well as in how they define and reimburse those services.

In South Dakota's current reimbursement methodology for FQHCs and RHCs, dental services are paid under the provider's PPS rate with some exclusion for high-cost items such as dentures paying at FFS. However, certain dental services can still be reimbursed on an FFS basis under an APM. This remains prevalent because dental services are often carved out of managed care contracts and due to system and billing limitations.

The rate models developed included dental services both within the overall APM framework, in its own dental APM, and as FFS payments outside of it. For dental services reimbursed on an FFS basis, providers can bill Medicaid directly for eligible services using South Dakota's dental fee schedule, based on their actual costs. While it is common for some states to include dental services in their APMs, others, such as California and North Carolina, opt to keep dental outside the APM framework. These decisions often vary based on dental utilization patterns across states and fiscal budget constraints.

In South Dakota, three (3) providers billed dental services according to MMIS data. As noted in the Medicare cost reports and discussed during the stakeholder provider workgroup, dental utilization was significant, totaling over \$9 million in dental costs accounting for approximately 10% of total allowable expenses. During the stakeholder provider workgroup, providers shared detailed insights into dental services, noting that procedures took longer to complete, which contributed to increased costs. A review of Medicaid MMIS data also revealed that dental services were a prominent source of high expenditures for providers. Including dental services in the APM rate model, using an encounter weighted statewide average rate or blended rate, provides the state with a more equitable way to align each provider's dental encounter rate based on the total number of dental encounters delivered. This approach reflects actual system-level utilization patterns statewide. The weighting method helps prevent outliers and incorporates efficiency for high volume FQHCs, promoting greater rate stabilization. In addition, given the low number of dental providers in the state, having certain dental services paid FFS such as prosthodontics and orthodontics, helps prevent overpayments to non-participating providers, improves payment accuracy based on the approved fee schedule, and enhances fiscal clarity for budget forecasting and cost projections. Utilizing an APM that reimburses providers for dental costs entirely under an FFS model is also a possibility, depending on provider interest.

Encounter Projections

In addition to developing and comparing multiple reimbursement methodologies, the PCG team evaluated the financial effect on South Dakota's 2027 fiscal year (July 2026 through June 2027). FQHC and RHC services are heavily utilized by Medicaid beneficiaries and uninsured populations. Thus, to determine the anticipated 2027 encounter levels, the state's Medicaid and uninsured populations were projected to the 2027 fiscal year. A regression line using these historical population statistics (Medicaid and uninsured) and encounter data was then determined to establish an appropriate encounter count projection. An r-squared analysis was used to balance the populations to determine the appropriate regression line, with the 2027 population projections then used to determine the estimated encounters for fiscal year 2027.

South Dakota State Population

To get an appropriate picture of the projected 2027 Medicaid and uninsured populations, the total South Dakota population was reviewed for any changes out to fiscal year 2027. Using projected population data provided by Aterio, *Table 25* below shows the population projection numbers used in the analysis¹⁸:

Population	CY24	CY25	CY26	CY27
South Dakota	907,176	921,530	929,040	937,836

TABLE 25

This data shows that South Dakota is expecting an average 1.1% increase in its overall population each year through 2027.

Medicaid Enrollment

In early 2025, South Dakota DSS provided estimates of projected Medicaid enrollment in their presentation to the Joint Committee on Appropriations¹⁹. On page 25 of this presentation, DSS showed anticipated monthly traditional Medicaid enrollment out to July 2026. These enrollment projections are informed by the impact of the following effects:

- ▶ The termination of the Public Health Emergency (PHE) effective in March 2023, which caused a steep decline in enrollment back to pre-PHE levels.
- ▶ The start of Medicaid expansion effective in July 2023, which showed a steady increase in enrollment through December 2024, before a period of leveling and modest increases.
- ▶ A decline in enrollment in the first half of 2025 due to the launch of ex-parte determinations before an enrollment uptick through fiscal year 2026. Enrollment at the end of the projection period appears to be stabilizing going into fiscal year 2027.
- ▶ The DSS presentation separately showed the enrollment projections for the Medicaid expansion population on page 32. This population is expected to level off through 2025 and provide modest growth into 2026.

What these projections do not take into account is the effect of the One Big Beautiful Bill Act (HR 1) signed into law on July 4, 2025. It is expected that HR 1 will result in a decrease in Medicaid enrollment as work requirements and more frequent eligibility assessments take effect beginning in 2027. This analysis also pulled the most recent Medicaid enrollment data from the South Dakota Legislature to adjust the projected FY25 results to actual²⁰.

The projected Medicaid enrollment for state fiscal year 2027 was then estimated from the following three (3) factors:

¹⁸ Aterio. July 2025. Accessed at: [South Dakota population forecast for 2025 and 2030 - Aterio](#)

¹⁹ South Dakota Department of Social Services. July 2025. Accessed at: [FY25 Budget Presentation](#)

²⁰ South Dakota Legislature. July 2025. Accessed at: [Medical Services | South Dakota Legislature](#)

- ▶ The projected fiscal year 2026 from the DSS presentation was adjusted for the fiscal year 2025 true-up.
- ▶ Fiscal year 2027 results were projected from the new projected 2026 results. Since the Medicaid enrollment numbers appeared to be leveling in the DSS presentation, and no other impact forces were identified, the Medicaid enrollment as a percent of total population was assumed to remain constant.
- ▶ The impact from HR 1 legislation was reflected. Referencing expected losses from HR 1 as determined by the Kaiser Family Foundation (KFF)²¹, South Dakota Medicaid is expected to lose 8,400 beneficiaries to uninsured. Since the Medicaid changes don't go into effect until 2027, PCG assumed that only 10% of that loss will impact the state's 2027 fiscal year.

Uninsured

The second component in projecting the FQHC and RHC encounter data to fiscal year 2027 is the anticipated uninsured population. Historical uninsured counts were pulled from KFF custom state reports for South Dakota²². This data was available for calendar years 2021 through 2023. With the PHE keeping enrollment in Medicaid in 2021 and 2022, the uninsurance rate in South Dakota dropped until the PHE ended and uninsured rates returned to historical levels. With the uninsured rate at 8.6% of total South Dakota population in 2023, that percentage was assumed to stay in place through fiscal year 2027 prior to reflecting the effects of HR 1.

As mentioned in the Medicaid Enrollment section above, a portion of the projected Medicaid losses to uninsured was assumed to impact fiscal year 2027. The other market expected to lose enrollment to uninsured was the Affordable Care Act (ACA) population. The KFF study expects that 3,100 ACA members will lose coverage due to the provisions of HR 1. Since these losses are expected to start in 2026, the fiscal impact modeling assumes that 50% of those losses will impact the fiscal year 2027 coverage period.

Final Encounter Projection

Since the Medicaid and uninsured populations are the heaviest utilizers of FQHC and RHC services, these two population levels were blended together to determine an appropriate independent variable for a projection of the encounter dependent variable. Using an r-squared analysis, it was determined that 45-55 blend of these populations (Medicaid to uninsured) produced the highest r-squared result over the four-year historical period (calendar years 2021 through 2024). The 2024 encounter result was 0.781 encounters per this blended population. This factor was carried out to 2027 producing an ultimate encounter estimate of 87,568 medical encounters for FQHC and RHC services.

The total of 87,568 medical encounters for fiscal year 2027 were allocated to individual providers based on their encounter volumes in calendar year 2024. As this analysis was performed solely on medical services, dental services for fiscal year 2027 were similarly incremented based upon the increase anticipated in medical services from 2024 to 2027.

SCOPE OF SERVICE AND RATE REIMBURSEMENT METHODOLOGY RECOMMENDATIONS

The PCG team collaborated with South Dakota DSS to evaluate potential reimbursement strategies that align with the state's goals. The following sections outline potential options to proceed with an APM.

²¹ KFF. July 2025. Accessed at: [How Will the 2025 Reconciliation Bill Affect the Uninsured Rate in Each State? Allocating CBO's Estimates of Coverage Loss | KFF](#)

²² KFF. July 2025. Accessed at: [Custom State Reports | KFF](#)

RECOMMENDATIONS TO REIMBURSEMENT POLICIES

In implementing an APM for FQHCs and RHCs as an alternative to the existing PPS rates, PCG recommends using the following statutory requirements and language in the current reimbursement policy. These requirements adhere to federal regulations and include:

- ▶ The APM must be agreed upon by the State and by each individual FQHC or RHC to which the State wishes to apply the methodology;
- ▶ The APM must result in a payment to the FQHC or RHC that is at least equal to the amount to which it is entitled under the PPS; and
- ▶ The APM should be described in the approved State Plan Amendment (SPA)

RECOMMENDED IMPLEMENTATION OF AN ALTERNATIVE PAYMENT METHODOLOGY (APM)

In accordance with the research and available provider cost report data, PCG recommends moving towards an APM that reduces the cost gap implemented in the near future. This approach can be implemented through various options, such as using encounter-weighted statewide average rates or blended encounter-weighted statewide average rates. Both options provide a solid framework in achieving 100% aggregate cost coverage for FQHCs and RHCs. Within the APM model, dental services would be structured as a separate dental APM, in addition to the APM for medical services. In addition to applying this methodology, outlier exclusion criteria can be developed to address atypical cost data using statistically sound approaches such as the Admin OH cap to account for significantly higher administrative costs which is seen commonly in Medicaid rate setting practices. Using encounter weighted state average rates or a blended encounter weighted statewide average rate are valuable approaches for streamlining administration and reducing the burden on providers, many of whom are operating under significant financial strain and prioritizing efforts to maintain operational continuity. Unlike provider-specific rates, which require ongoing cost report submissions, audits, and individualized calculations for each facility, the encounter-weighted statewide average along with blended rate, simplifies the process and reduces administrative burdens. The encounter weighted statewide average rate uses actual encounter volumes from both FQHCs and RHCs in the state, in which reflect the true cost of care delivery. These methods also promote equity by ensuring similar payments for similar services across providers. It helps prevent outliers, such as cases where one provider is reimbursed significantly more than another for delivering the same service, and ensures that high-volume providers, which typically have more representative data, appropriately influence the rate, thereby avoiding skewed results. Additionally, it encourages efficiency. Under provider-specific rates, a clinic with higher staffing costs and lower productivity may receive a higher base rate without any incentive to improve which may be more difficult to transition into value-based payment models. In contrast, a statewide benchmark motivates providers to operate more efficiently, knowing their reimbursement is tied to system-wide performance rather than individual cost structures.

In addition, using blended rates streamlines administration by applying a uniform formula, eliminating complex provider-specific calculations, and reducing the need for extensive audits of individual cost reports. When comparing the encounter weighted statewide average rate for FQHC and RHCs, the calculated rate for RHCs was higher at \$292.27 compared to \$285.00 for FQHCs. Although FQHC rates are typically expected to be higher than RHC rates, the cost reports provided were more representative for FQHCs than for RHCs. The lack of a representative sample for RHCs contributed to this variance. Additionally, lower encounter volumes across many RHCs drove up their statewide weighted average rate. When using a blended rate, the waiting period to establish a new rate for a new provider is eliminated, allowing them to begin with the encounter-weighted statewide or blended rate immediately. This creates a more stable and level playing field, helping to curb unnecessary cost inflation.

Table 26 below represents a comparison between the encounter weighted statewide average rate for FQHCs and RHCs, along with the blended encounter weighted statewide average rate. Using a blended rate is a reasonable approach because the encounter weighted statewide average rates for FQHCs and

RHCs are very similar. Since there is minimal variation between the two averages, applying a blended rate simplifies the methodology without creating significant payment discrepancies across provider types. Because these rates are also calculated from allowable Medicaid costs and encounters from the Medicare cost reports, setting the APM using one of these methods, ensures 100% of allowable costs are built into the encounter rate at the state level. These rates are contingent on available funding and are supported only up to the appropriate amounts implemented at the state level.

	Encounter Weighted Statewide Average Rate	Blended Encounter Weighted Statewide Average Rate
FQHC	\$285.00	\$288.63
RHC	\$292.27	\$288.63

TABLE 26

Moving towards an APM that incorporates actual service utilization across both FQHCs and RHCs, promotes equity and transparency by supporting financial stability and minimizing payment limitations seen with the different rate models presented. Both providers and the state benefit from improved forecasting and budgeting, as rates are based on historical encounter volumes and aggregated statewide costs, resulting in a more predictable budget outlook. While using statewide weighted averages for FQHC and RHC rate setting is less commonly seen, since most states rely on provider-specific costs derived from individual cost reports, each state has flexibility to tailor its methodology to meet its unique needs. As long as the approach is logical, data-driven, and actuarially sound, states can adopt alternative models, such as encounter weighted statewide averages or blended rates, to align with policy goals and budget considerations. This flexibility allows states to balance accuracy, administrative efficiency, and fairness while maintaining compliance with federal requirements.

Due to not collecting FQHC and RHC provider cost reports from all providers during the rate study, PCG recommends the state collect cost reports after the initial implementation of an APM to stay in compliance with regulatory policies. Since not all FQHC and RHC providers currently submit Medicare cost reports, as indicated by the CMS database and the DSS team, this recommendation also presents an opportunity for South Dakota to align with administrative rules requiring regular cost report submissions to the state. Collecting cost reports would also allow for the development of a distinct, state-specific cost report that aligns with South Dakota Medicaid regulations and coverage. The Medicare cost report contains cost centers that have been evaluated as either inclusive of total allowable costs, such as administrative cost centers allocated to provider-based RHCs, or as non-allowable under South Dakota Medicaid rules. This presents an opportunity for the state to design a cost report template tailored to the state’s specific needs.

Strategic Considerations and Recommendations for Value-Based Payment Options for South Dakota

South Dakota has a spectrum of Value-Based Payment (VBP) options available, ranging from low-risk pay-for-reporting models to high-risk total cost of care arrangements. The CMS defines four (4) Health Care Payment Learning & Action (LAN) categories of Alternative Payment Models (APMs) in *Table 27*:

Category	Risk Level	Model Type	Key Features
Category 2C	Low	Pay-for-performance	FFS-based with quality bonuses
Category 3A	Moderate	Shared savings (upside only)	Providers share savings if costs are below benchmark
Category 3B	Moderate-High	Shared savings + downside risk	Providers share savings and are liable for losses

Category	Risk Level	Model Type	Key Features
Category 4	High	Population-based payment	Providers receive prospective payments for total cost of care

TABLE 27

All APMs will require baseline data and quality indicators to evaluate performance and determine payment adjustments. Even the lowest-risk models must be built on a foundation of reliable data and clearly defined metrics.

Given South Dakota’s emphasis on budget neutrality, a Category 3 or Category 4 model may offer the best fit. These models allow the state to control spending while incentivizing quality and efficiency. Category 3B and Category 4 also introduce financial risk for providers. FQHCs and RHCs may be hesitant to participate in Category 4 models, which place the greatest financial responsibility on clinics. These arrangements require robust data infrastructure and provider readiness, both of which may be limited in rural settings. Additionally, the Department may not have the appetite or capacity to collect and manage the data needed to support such models.

Category 3B models offer a more balanced approach. Providers who meet quality and cost benchmarks can earn shared savings, while those who fall short may face financial penalties. To achieve budget neutrality, South Dakota must select performance measures that create meaningful differentiation. There must be both “winners” and “losers” in terms of payment outcomes. If all providers meet their targets, there is no financial surplus to distribute. For clinics designated as critical access, any downside risk may be especially concerning, as it could further strain already limited budgets. South Dakota will also be limited in the state’s ability to implement a model with downside risk due to the PPS floor. Any VBP model must still ensure total reimbursement to each provider does not fall below PPS-based reimbursement.

State Examples

There are a variety of vehicles available to states for implementing VBP models, including State Directed Payments (through managed care) and 1115 waivers. PCG did not include 1115 waiver options which take the longest to approve and require the greatest administrative oversight which South Dakota indicated may be challenging at current staffing levels.

Several states have implemented VBP arrangements that offer valuable insights for South Dakota. For instance, **California’s** FQHC APM pays clinics a PMPM rate equivalent to their PPS reimbursement, with annual adjustments for inflation, scope changes, and member mix. Clinics retain the surplus amount resulting from practice transformation, which would be the difference between what a clinic would have earned under the traditional PPS model and what it receives under the APM PMPM rate, assuming the clinic reduces its volume of PPS eligible encounters while maintaining access and quality. If a clinic delivers care more efficiently (e.g., through telehealth, care coordination, or non-billable team members) and reduces traditional visits, it still receives the full PMPM payment. Participation is voluntary and contingent on readiness. The model includes stop-loss protection, flexible service definitions (e.g., telehealth, care coordination), and robust reconciliation to ensure clinics are made whole if PMPM payments fall short. While the model is not fully capitated across all services and populations (which would be Category 4B), its structure and goals, especially the emphasis on transformation and whole-person care, place it in Category 4A.

Hawaii offers two (2) additional examples tailored to FQHCs and RHCs:

- ▶ **Shared Savings Model (AlohaCare):** FQHCs/Community Health Centers (CHCs) were paid based on the PPS for specific services and contracted rates for others. The upside risk was introduced via a risk pool payment, contingent on maintaining a positive medical loss ratio after accounting for incurred but not reported (IBNR) claims.

- ▶ **Pay-for-Quality Program – Hawaii Medical Service Association (HMSA):** Since 2011, HMSA has engaged FQHCs and RHCs in PCMH and pay-for-quality programs. In 2019, HMSA evolved its model to better align with the care delivery realities of these providers, incorporating metrics tied to state priorities and social determinants of health.

These examples show how states can tailor VBP models to accommodate the unique needs of safety-net providers while still driving quality improvement.

Recommendations for a Phased VBP Approach

Given the absence of earmarked funds for VBP implementation, **PCG recommends a phased approach** that allows South Dakota to build provider readiness and data infrastructure over time:

Start with Category 2A (Upside-Only Pay-for-Reporting):

- Providers begin reporting on selected quality measures.
- No financial penalties are imposed, but performance data is collected to establish baselines.
- This phase builds familiarity with VBP mechanics and helps identify feasible metrics.

Progress to Category 3B (Upside/Downside Shared Savings):

- Introduce financial incentives and penalties based on performance.
- Measures must be selected to ensure budget neutrality. Some providers will earn bonuses, others may face reductions.
- This phase requires more robust data systems and provider engagement.

Eventually Consider Category 4 (Total Cost of Care):

- Reserved for providers with advanced infrastructure and readiness.
- May not be suitable for all FQHCs/RHCs due to risk exposure and data demands.

Measure Selection and Data Strategy

To support a phased VBP approach, South Dakota must identify a core set of quality measures that are both meaningful and feasible for FQHCs and RHCs. In addition to existing resources like the Primary Care Provider (PCP) Scorecard, Health Home Outcome Measures, and MMIS claims-based Adult and Child Core Sets, the Certified Community Behavioral Health Clinic (CCBHC) measure set from CMS offers a standardized, nationally recognized framework that could be highly applicable in rural and behavioral health settings.

The CCBHC measures include:

- Screening and follow-up for depression
- Follow-up after emergency department visits for mental illness or substance use
- Engagement in outpatient treatment
- Access to preventive services

These measures are particularly relevant for South Dakota's target populations and can be used to align incentives with improved care coordination, behavioral health integration, and chronic disease management. Importantly, they are already validated and widely used, which reduces the burden of measure development and supports comparability across providers.

Implementation Planning and Funding Strategy

Given the lack of earmarked funds for VBP at this time, South Dakota may consider including FQHCs and RHCs within their application for **Rural Health Transformation Program (RHTP)** funding. These funds can be used to:

- Launch the initial APM focused on cost gap reduction

- Support provider transformation activities (e.g., data infrastructure, care coordination)
- Fund incentive payments during the early phases of VBP

PCG recommends that South Dakota structure its implementation timeline to align with the availability of RHTP funds. The goal should be to advance from a **Category 2A pay-for-reporting model** to a **Category 3B shared savings model with upside/downside risk** by the time RHTP funds are exhausted. This progression will allow the state to build capacity, test the model, and transition to a sustainable payment structure that rewards value over volume.

CHANGE IN SCOPE OF SERVICES POLICIES AND PROCESSES RECOMMENDATIONS

States are required to have a scope change process in place that allows for PPS rates to be adjusted in response to modifications in the type, intensity, duration, or amount of services delivered. To ensure fair and accurate PPS rate adjustments, states must establish a robust process for identifying and evaluating changes in the scope of services.

To ensure accurate and equitable reimbursement for FQHCs and RHCs, PCG recommends adopting a standardized methodology for evaluating the fiscal impact of approved changes in scope of services. This approach supports compliance with federal and state guidelines, promotes fiscal accountability, and ensures that reimbursement reflects the true cost of delivering health care services.

The change in scope adjustments will only be applied to the PPS encounter rates and will not be applied to the proposed APM rates. As discussed with South Dakota DSS, the state Medicaid agency is anticipating reviewing costs and rates every three (3) to five (5) years, rather than rebasing rates on an annual basis.

The proposed methodology uses actual cost and encounter data to determine whether an adjustment to the PPS rate is warranted. It provides a transparent, data-driven framework for assessing both the addition and removal of services, as well as changes in service intensity, duration, and volume.

Qualifying Changes

PCG recommends including the definition of a change in the scope of services under the current change in scope of services policy. To support compliance with federal guidelines, it is further recommended that criteria for changes in type, intensity, duration, and/or amount of services be explicitly referenced. Below are common examples of qualifying changes that states have incorporated into their policies for evaluating scope-of-service adjustment requests.

- ▶ The addition or deletion of a Medicaid-covered service
- ▶ Changes in service intensity or duration
- ▶ Changes in service delivery location
- ▶ Changes in service delivery methods
- ▶ Changes in provider mix
- ▶ Changes in type of patients served
- ▶ Changes in technology or medical practices utilized
- ▶ Regulatory or compliance mandates

In addition, states have the flexibility to establish a threshold for determining whether a change in the scope of services warrants a PPS rate adjustment. If the cost impact of the change, expressed as a percentage difference in the rate per encounter, does not meet or exceed the established threshold, the change is not considered significant enough to trigger a rate adjustment. Other states such as Colorado, Minnesota, and North Carolina have adopted specific thresholds:

- ▶ Colorado requires a minimum 3% difference from the current PPS rate for a change in scope of services to qualify.

- ▶ Minnesota uses a ±2.5% threshold, meaning both increases and decreases of 2.5% or more in the PPS rate due to scope changes can trigger an adjustment.
- ▶ North Carolina requires a minimum 1% increase or decrease in the PPS rate for a change in scope of services to qualify for a rate adjustment.

It is also recommended that, for a change in scope of services to qualify for a PPS rate adjustment, the change must have been in effect for a specified period of time. Additionally, states may place limits on how frequently such requests can be submitted to ensure administrative efficiency and consistency.

Many states cite examples of scope of service change requests that do not qualify for PPS rate adjustments, including:

- ▶ Changes in the cost of supplies or existing services;
- ▶ Changes in encounter volume;
- ▶ Change in patient type and/or volume without a corresponding change in the services provided;
- ▶ Changes in office hours or location;
- ▶ Changes in equipment or supplies not directly related to a change in the scope of service;
- ▶ Expansion or remodel of locations;
- ▶ The addition of a new site, removal of an existing site that offers the same Medicaid-covered services;
- ▶ The addition or removal of administrative staff;
- ▶ The addition or removal of staff members to or from an existing service;
- ▶ Changes in staff costs;
- ▶ A change in ownership;
- ▶ Addition or deletion of services that are carved out of the encounter rate

State Medicaid agencies should ensure that any determination of a change in the scope of services includes a clearly defined date or time period for when the new rate will take effect.

Recommended Rate Change Formula

The recommendation of using the overall change method described below accounts for both the addition and removal of the specific services impacting the PPS rate. This common method establishes a baseline by calculating the cost per visit prior to the change in scope of services, then compares it to the cost per visit after the change. The difference between the two represents the incremental cost attributable to the change in scope. However, it is possible that other factors unrelated to the scope change (such as organizational efficiency increases) may also affect the overall scope change impact captured by the calculations.

This methodology captures not only the addition or removal of services, but also changes in intensity, duration, and amount, recognizing that the incremental cost associated with a change in scope may be either positive or negative. PCG recommends including language in a potential Medicaid State Plan Amendment that confines scope changes to impacts that reach a minimum threshold, for both positive and negative adjustments (e.g. only processing scope change adjustments with a positive adjustment of 5% or more, and negative adjustments of 5% or more).

Rate Change Formula:

$$\text{Cost per encounter before the change in scope of service} = \frac{\text{Total inflation adjusted allowable costs before the change in scope of service}}{\text{Total encounters before the change in scope of service}}$$

$$\text{Cost per encounter after the change in scope of service} = \frac{\text{Total allowable costs after the change in scope of service}}{\text{Total encounters after the change in scope of service}}$$

Incremental change due to the change in scope of service (positive or negative) = (Cost per encounter after the change in scope of service) - (Cost per encounter before the change in scope of service)

Current baseline PPS rate + Incremental change due to the change in scope of service = New baseline rate

Data Requirements

To apply for a change in scope of services, an FQHC or RHC should notify South Dakota DSS at the time there is a change in their scope of services. Notification must be provided within a designated time period of the date of the addition or deletion of the service and providers must submit required documentation to South Dakota DSS in writing. In using the overall change methodology in calculating the cost per visit prior to the change in scope of services and after the change in scope of services, the necessary data elements would include:

- ▶ Current PPS rate;
- ▶ Cost report data;
 - Data from the most recent 12-month reporting period prior to the change;
 - Data from a 12-month reporting period after the change has been implemented;
- ▶ Encounter data

During the stakeholder workgroup session, key themes emerged regarding the change in scope of services policy. Participants noted that the current policy lacks structured guidance and clear information on the requirements for submitting a change in scope of services request. PCG recommends that FQHCs and RHCs include the following information in their application when requesting a change in scope of services:

- ▶ A narrative description of each change in scope of service
 - Some states have a dedicated change in scope request form seeking a PPS rate adjustment such as California, Colorado, and North Carolina
- ▶ The date on which the change in scope of service is scheduled to occur
- ▶ The cost report for the most recent 12-month reporting period prior to the change
- ▶ The cost report from a 12-month reporting period after the change has been implemented
- ▶ Historical and budgeting information showing the provider's expenses before and after the change in scope of services
- ▶ The projected increase or decrease in the number of encounters due to the change

Setting a Rate for a New FQHC or RHC

Per CMS guidance, for FQHCs and RHCs that do not have a 1999 or 2000 rate, the PPS rate can be set using an appropriate average. To establish an appropriate PPS rate for a new FQHC or RHC without historical cost or encounter data, the state can compare the submitted adjusted costs and rates and use the encounter weighted statewide average rate or blended encounter weighted statewide average rate, against the total set of providers located in the new provider's geographic region that provide same or similar services. The FQHC's or RHC's finalized PPS base rate will be computed after cost reports reflecting the cost before and after the new service are available. Once the new PPS base rate has been established, it will be updated annually based on the MEI. It will be the responsibility of the FQHCs and RHCs to inform and supply the Department with necessary documentation regarding changes to types of service, cost reports and any other documentation.

Using either rate approach ensures new providers are reimbursed at levels consistent with existing FQHCs and RHCs across the state, reflecting the average cost of delivering comparable services. Using either the encounter weighted statewide average rate or blended encounter weighted statewide average rate promotes consistency and predictability and simplifies the process for new providers. Using these methods align the rate more closely with actual service utilization patterns, ensuring the payment level is

both reasonable and sustainable while maintaining consistency with established rate setting practices in the state.

Appeals Process

It is important that state policies related to rate adjustments include clear procedural guidelines and provide access to an administrative appeal process. For FQHCs or RHCs that disagree with a state Medicaid agency's determination of a change in the scope of services, PCG recommends that the state incorporate language in their current policies to ensure the standard Medicaid provider appeals process is available.

FISCAL IMPACT ASSESSMENT

This section presents the estimated fiscal impact of implementing a potential APM for FQHCs and RHCs in the state of South Dakota. Building on the rate modeling described in the previous sections, this analysis compares projected Medicaid expenditures under the proposed APM with current PPS reimbursement levels. The objective is to quantify potential changes in provider payments and overall program costs, based on projected encounter rates, anticipated utilization patterns, and agreed-upon policy parameters from South Dakota DSS. The results are intended to inform decision-making of the expected budgetary implications and to highlight considerations for implementation planning.

The fiscal impact analysis in the interactive Excel tool compares the total number of medical and dental encounters in CY24, based on MMIS data, multiplied by the projected FY27 rate, with the same CY24 encounter volume multiplied by the current CY25 PPS rate. This comparison estimates the total net encounter-based payouts for both FQHCs and RHCs. Additionally, CY24 dental encounter payouts were projected using the encounter weighted statewide average rate for dental services when structured into a separate APM. In the fiscal impact assessment, medical and dental FFS payments from CY24 were incorporated into the adjusted total allowable costs. To isolate the Medicaid-only costs, the percentage of Medicaid-only encounters were applied, accounting for services that continue to be paid FFS under the current South Dakota Medicaid structure. Although care management payments represented a small percentage in CY24, the fiscal impact analysis broke out these amounts, with the FY26 Federal Medical Assistance Percentage (FMAP) applied appropriately.

Current South Dakota Medicaid reimbursement provides an estimated 60% aggregate cost coverage for FQHC and RHC providers. Based on the encounter weighted statewide average rate, the overall net fiscal impact when applying the proposed rate to CY24 encounter data is \$11,923,570.08. The funds needed to provide an estimated 100% aggregate cost coverage would be \$5,841,356.98 after the FMAP. To ensure the long-term sustainability of FQHC and RHC providers, it is important to prioritize strategies in order to implement and sustain a proposed APM.

In addition, the PCG team has provided the following recommendations and options for proceeding with an APM, based on the scenarios outlined below. These pathways reflect flexibility in state policy, allowing it to stay aligned with fiscal budgeting within a fixed funding amount allocated by South Dakota Medicaid.

STRATEGIES FOR CLOSING THE COST GAP

As the state is exploring different options to better meet the true costs of delivering care, there are options that the State could consider which would target incremental adjustments to bring FQHC and RHC reimbursement rates closer to their actual costs over time. Recognizing the cost gap in aligning to provider-specific rates, the approaches described below may be implemented individually or in combination, across multiple phases. This gradual strategy can help narrow the gap between current reimbursement levels and the documented cost of delivering care, while maintaining budget predictability and incentivizing efficient operations.

Using Current Rates and Applying a One-Time Percentage Increase

One-time percentage increases do occur in Medicaid rate setting practices, but act as a short-term goal in addressing the cost gap as opposed to an ongoing methodology. When there are budget shortfalls or additional funding allocated, this method allows for an approved percentage increase for all providers in a certain category. Some states have provided a percentage increase to address financial and operational challenges associated with current approaches. In State Fiscal Year (SFY) 2022-2023, the state of North Carolina applied a 13% rate enhancement to FQHC costs due to an additional, one-time appropriations under Session Law 2022-74²³. This reimbursement rate is adjusted annually to account for inflation. Most states commonly use annual inflation adjustments such as the MEI or Consumer Price Index (CPI) as required under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) for the PPS methodology. Though this method is not a common long-term strategy for states, this could be an option to bridge the cost gap and get rates closer to costs while a new APM is being developed.

Rates Based on Service Types

Another alternative to using a single encounter rate includes defining service categories based on different cost structures. Common service types include:

- ▶ Medical / Primary Care
- ▶ Behavioral Health
- ▶ Dental
- ▶ Other (e.g. substance use disorder, care coordination)

Setting reimbursement rates based on service type can help better align payments with actual care delivery. Rather than applying a single, blended rate across all encounters, this approach acknowledges that medical, behavioral health, dental, and other health services have distinct cost structures and encounter volumes. By allocating costs and establishing rates by service category, states can reduce cross-subsidization between services, ensuring that higher-cost areas, such as medical or dental, are adequately funded. The state can begin with the PPS rate and apply a percentage-based adjustment according to service type. This would include an adjustment factor applied to the PPS rate to more accurately reflect cost differences across service categories, such as primary care, dental, and behavioral health. Each service category would have an average cost per visit, and cost ratios could be established to calculate the adjustment percentages applied to the base PPS rate. While this method is less commonly used across states, states do have the flexibility to incorporate this into an APM.

Periodic Rebasing

Periodic rebasing occurs in FQHC/RHC rate setting for states that rebase their PPS rates to reflect true costs rather than inflating the prior base rate from 2000 forward. This method can be more common in states with high-cost volatility where policy makers want to avoid the large cost gap from actual cost coverage. States who do not rebase often have outdated PPS base rates and typically only rely on inflation adjustments such as the MEI or CPI. This method is more commonly seen in states than applying a one-time percentage increase. For example, the state of Colorado rebases its FQHC rates annually to ensure costs reflect the true cost of service delivery²⁴. In general, proper documentation of this process is essential for fiscal integrity and to ensure that payment rates are based on accurate information.

²³ North Carolina General Assembly. August 2025. Accessed at: [Microsoft Word - SL 2022-74 Section 9D.8.\(c\) FQHC Reimbursement \(Final\)](#)

²⁴ Colorado Department of Health Care Policy & Financing. August 2025. Accessed at: [Microsoft Word - 2024 FQHC Cost Report Instructions - FINAL.docx](#)

Incorporating a Ceiling

A ceiling or a rate cap can set an upper limit on the reimbursement rate an FQHC or RHC can receive per encounter basis. Federal guidance allows states flexibility, provided that both PPS and APM requirements are met. The main objectives of a rate ceiling or cap can prevent increased payments that significantly exceed actual costs and reduce budgetary instability for state Medicaid agencies. States can implement a ceiling in the following methods:

- ▶ Percentile-based
- ▶ Percentage above the benchmark
- ▶ Specific dollar cap

Though this method is uncommon among states, the state of Alabama governs a reimbursement ceiling for FQHCs which is intended to control costs and ensure consistency across providers. This ceiling is set at the 80th percentile, meaning a provider's costs must fall below the ceiling rate to qualify for reimbursement²⁵. A ceiling can prevent extreme outliers and limit the financial impacts of unusually high-cost providers while still providing adequate funding for most providers. Additionally, by capping excessive total allowable costs, states can ensure fair and equitable reimbursement for providers with moderate costs, preventing them from subsidizing outlier providers. If a ceiling is used, there should be careful consideration of rebasing the ceiling to ensure the ceiling reflects changing costs. In addition, it is important that states ensure the ceilings do not violate CMS regulations, particularly for wraparound payments or change in scope of service adjustments.

POLICY IMPLICATIONS

Most strategies that align FQHC and RHC reimbursement more closely with actual costs can be implemented within CMS guidelines, provided they meet the APM requirement in that total payments must be at least equal to the PPS amount and agreed upon by participating FQHCs and RHCs. Approaches such as service type specific rates, periodic rebasing, service-specific rate adjustments, and the use of ceilings or floors all consider a provider's actual cost of delivering services, as reported in cost reports. While less common, strategies like applying a one-time percentage increase or capping total allowable costs at a percentage can also be considered. Incorporating one or a combination of these methods can help balance fiscal sustainability with fair, cost-reflective reimbursement. It is important that these strategies are carefully designed to comply with federal requirements. The State should ensure that rate-setting methodologies are transparent, data-driven, and developed in collaboration with stakeholders. Additionally, maintaining flexibility to phase in changes gradually will help manage budget impacts and support program stability.

Stakeholder engagement is a critical component of implementing and sustaining an APM. It is important there is close collaboration among FQHC and RHC providers, state agencies, and other key players to ensure that the APM reflects operational readiness, community needs, and evidence-based practices. Equally important is aligning the APM framework with current policy priorities. In addition, stakeholders have an important opportunity to inform policymakers with data-driven insights that demonstrate an APM's impact on access, quality of care, and cost-effectiveness. This collaborative approach can help shape policy priorities and support efforts to secure sustainable and, when appropriate, enhanced funding to ensure the long-term viability of the APM model. By maintaining transparent communication and aligning the recommended APM model with broader state and federal priorities, stakeholders can position the APM as a strategic investment within the larger healthcare landscape.

²⁵ Alabama Medicaid. August 2025. Accessed at: [Microsoft Word - CPT56.doc](#)

APPENDIX A. DATA AND CITATIONS

Appendix A provides a summary of the information used in the development of this report, specifically a table outlining peer states' research on FQHC and RHCs services, reimbursement methodologies, and encounter definitions.

Additionally, the change in scope of service policy has also been attached.

PEER STATE RESEARCH

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
Colorado	<ul style="list-style-type: none"> APM 1 is a value-based payment model that shifts Medicaid primary care payments from volume-based (Fee-For-Service) to value-based, rewarding providers for quality and access <ul style="list-style-type: none"> Federally Qualified Health Centers (FQHCs) are reimbursed a cost-based encounter rate for medical, dental, and specialty behavioral health visits with qualified providers APM 2: Per Member Per Month (PMPM) Payment Model along with Fee-For-Service (FFS) and 	<ul style="list-style-type: none"> Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a 	<ul style="list-style-type: none"> Services provided in an inpatient hospital setting, The Prenatal Plus Program, The Nurse Home Visitor Program Long-Acting Reversible Contraception (LARC) devices Provision of complete dentures and partial dentures Dental services provided in an outpatient hospital setting Vivitrol COVID-19 vaccine administration Monoclonal antibody therapy treatment of COVID-19 COVID-19 antiviral medication Pharmaceuticals dispensed to patients through an FQHC operated pharmacy 	<ul style="list-style-type: none"> Dental services are carved out of the APM 2 model and continue to be billed to DentaQuest which administers Colorado's dental benefits 	<ul style="list-style-type: none"> An encounter is defined as a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication between a center client and physician, dentist, dental hygienist, dental therapist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the FQHC qualified service Multiple services provided on the same day can be counted as separate encounters if they are distinct, for example, a physical health encounter, a

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>chronic condition shared saving incentive implemented for primary care</p>	<p>licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.</p> <ul style="list-style-type: none"> • Part-time or intermittent visiting nurse care. • Medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures. • Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more 			<p>dental encounter, and a specialty behavioral health encounter occurring on the same day and at the same location count as 3 separate encounters</p>

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
		<p>providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.</p>			
<p>Iowa</p>	<ul style="list-style-type: none"> • APM established • FQHCs are reimbursed for services to Medicaid members based on 100% of the costs that are reasonable and related to the cost of providing services determined by the IME FQHC Cost Report form 	<ul style="list-style-type: none"> • Primary care • Behavioral health • Vision services • Family planning services • Enabling services 	<ul style="list-style-type: none"> • Elective, non-medically necessary procedures such as abortion, hysterectomies, sterilizations • Chiropractic services • Dental services for adults 	<ul style="list-style-type: none"> • Not covered under the PPS • Dental services are reimbursed through a separate Medicaid dental program called the Dental 	<ul style="list-style-type: none"> • Face-to-face interaction between a member and the center health professional • Only one encounter per patient per day may be billed, even if multiple services or professionals are involved

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<ul style="list-style-type: none"> ○ Until the center submits a cost report, Medicaid will make interim payments to the center based on budgeted or projected average cost per visit, and will be subject to reconciliation after a cost report has been received • FQHCs in the state that provide services under a managed care organization contract participate in the Managed Care Wraparound Payment system where the Department will supplement the payment from the managed care 		<ul style="list-style-type: none"> • Durable Medical Equipment (DME) and supplies • Family planning services 	Wellness Plan through managed care	

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>organization to provide reasonable cost reimbursement as specified by Medicare cost reimbursement principles</p> <ul style="list-style-type: none"> • Services are reimbursed at the greater of the Prospective Payment System (PPS) or cost 				
Minnesota	<ul style="list-style-type: none"> • APM IV <ul style="list-style-type: none"> ○ Rate is developed using 100% of the average costs of the FQHC and RHC during Fiscal Year end 2017 and 2018, inflated by the market basket to 2021 	<ul style="list-style-type: none"> • Dental services • Drugs and biologicals • FQHC or RHC professional services inpatient visits • FQHC or RHC surgical services • RN or LPN part-time or intermittent nursing care • Mental health • Obstetrical or perinatal • Pharmaceuticals • Services and supplies incidental to FQHC or RHC professional services 	<ul style="list-style-type: none"> • Dentures, partials, and root canals • Managed care organization enrollees' dental services • Pharmacy • Maternity and surgical services • Hospital services • Mental health targeted case management 	<ul style="list-style-type: none"> • Under APM IV, dental services are included in the overall APM 	<ul style="list-style-type: none"> • The state covers one medical and one dental encounter per day • A medical encounter and a dental encounter can occur on the same day • Dental encounter: services provided during a dental visit by a dentist, dental therapist or advanced dental therapist • Medical encounter: services provided during a medical visit, including professional services, obstetrical and perinatal care, clinic visits, FQHC or

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
		<ul style="list-style-type: none"> • SUD services • Vaccines • Other ambulatory services covered under the Minnesota State Plan • Diagnostic and lab services 			<p>RHC professional services provided to FQHC or RHC patients if covering inpatient hospital visits, FQHC or RHC professional services provided to FQHC or RHC patients if surgical services are directly provided by the center or clinic, mental health visits provided in compliance with mental health guidelines</p>
Nebraska	<ul style="list-style-type: none"> • FQHCs may elect to participate in an APM (one for medical and one for dental) <ul style="list-style-type: none"> ○ The base rate is calculated using specific line items from the Medicare cost report and trended forward to the 2014 period using 	<ul style="list-style-type: none"> • Primary care • Behavioral health services • Dental • Chronic disease management • Immunizations • Mental health and Substance Use Disorder (SUD) services 	<ul style="list-style-type: none"> • Medical transplants • Abortions • Non-FQHC services are paid according to the Nebraska Medicaid Practitioners Fee Schedule 	<ul style="list-style-type: none"> • The state has a separate dental APM which uses dental expenditure -s and visits for FQHCS using the 2016 and 2017 Uniform Data System (UDS) 	<ul style="list-style-type: none"> • A face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>the Medicare Economic Index (MEI). FQHCs receive 100% of their rate under the APM</p> <ul style="list-style-type: none"> ○ A blended average cost per visit is then calculated using three years of base data for each FQHC, with weighted averages of 10% for YE2012, 25% for YE2013, and 65% for YE2014. These percentages are determined to give apparent outliers lower weighting 			<p>submissions for each Nebraska FQHC that will operate under the APM for FQHC Dental visits</p>	<p>multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment</p>

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>and are adjusted accordingly.</p> <ul style="list-style-type: none"> ○ The resulting YE2014 blended rate is projected to CY2016 using a three-year average MEI trend of 0.8% per year ○ The APM base rate is updated annually based on the FQHC Market Basket • The state periodically rebases the FQHC rates using the FQHC most recent available cost reports and other relevant data and rebasing is only done for clinics reimbursed under the APM 				

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
Oregon	<ul style="list-style-type: none"> • Oregon’s APM program provides participating Health Centers with prospective Per Member Per Month (PMPM) payments <ul style="list-style-type: none"> ○ The Advanced Payment and Care Model (APCM) involves participation in learning communities that goes beyond the scope of the APM to align payment with an efficient, effective and emerging care model that lowers overall costs 	<ul style="list-style-type: none"> • Primary • Behavioral health • Dental 	<ul style="list-style-type: none"> • Mental Health/additions services • Prenatal/OB services • Maternity Case Management Services • Durable Medical Equipment (DME) • Home health services • Home Enteral/Parenteral and IV services • Hospital dentistry and certain dental services • Physical and occupational therapy • Private duty nursing • Speech and hearing services • Certain pharmaceutical, medical-surgical, vision, and hospital services 	<ul style="list-style-type: none"> • Dental services not included in the APM and will continue to pay at the PPS rate 	<ul style="list-style-type: none"> • A face-to-face interaction with the patient (including a traditional office visit, home visit, group visit, virtual, or Telemedicine Visit) that includes, at minimum, a medical history, problem list review, and medication and allergy review or any other medical encounter as defined in OAR 410-147-0120 that constitutes a carved-in APCM service. In the case of a virtual or Telemedicine Visit, the visit must be a “synchronous (live two-way interactive) video transmission resulting in real time communication.”
Washington	<ul style="list-style-type: none"> • APM established based on calculated costs on cost reports • The FQHC must select a rate 	<ul style="list-style-type: none"> • Physician services • Dental services • Nurse practitioner or physician assistant services 	<ul style="list-style-type: none"> • Blood draws • Laboratory tests • X-Rays • Pharmacy 	<ul style="list-style-type: none"> • Dental included in the APM encounter rate 	<ul style="list-style-type: none"> • A face-to-face visit between a client and a qualified FQHC provider (e.g. a physician, physician

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>structure that is one of the following:</p> <ul style="list-style-type: none"> ○ An all-inclusive rate ○ A separate rate for each of the five cost-centers ○ A grandfathered rate structure consistent with the rate structure used for the PPS rate development 	<ul style="list-style-type: none"> • Mental health services • Visiting nurse services • Nurse-midwife services • Preventive primary services • Naturopathic physician services • Maternity support services • Substance use disorder and mental health services • Screening, Brief, Intervention, and Referral to Treatment (SBIRT) services • Surgical procedures 			<p>assistant, or advanced registered nurse practitioner) who exercises independent judgement when providing services that qualify for an encounter rate</p>
California	<ul style="list-style-type: none"> • The state established an APM using base year managed care utilization data, under which each participating FQHC receives monthly payments equal to their total projected PPS amount. These payments are made as a Per Member Per 	<ul style="list-style-type: none"> • Primary care • Non-specialty mental health services • Specialty care in PPS (cardio, ophthalmology, dermatology) – For FQHCs that have included specialty services in their PPS rate, those 	<ul style="list-style-type: none"> • Enhanced Care Management (ECM) and associated Community Health Workers • Community Supports • Specialty mental health 	<ul style="list-style-type: none"> • Dental services not included in the APM • Vaccines and select supplies, to the extent they are not included in the Managed 	<ul style="list-style-type: none"> • A face-to-face or telehealth encounter between an FQHC patient and any of the following: <ul style="list-style-type: none"> ○ A physician, physician assistant, nurse practitioner, certified

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>Month (PMPM) rate for all members assigned to each Managed Care Plan with which the FQHC has a contract</p>	<p>services would also be part of the APM</p> <ul style="list-style-type: none"> • Podiatry • Chiropractic to the extent it is in the Managed Care Organization (MCO) contract • Acupuncture • Vaccine/select supplies to the extent included in the MCO contract and PPS 		<p>Care Plan (MCP) contract or covered under the PPS, are excluded from the APM</p>	<ul style="list-style-type: none"> ○ nurse-midwife (CNM), ○ Clinical psychologist, licensed clinical social worker, visiting nurse, or marriage and family therapist. Physician includes a physician and surgeon, osteopath, podiatrist, dentist, optometrist, chiropractor. ○ A dental hygienist oral dental hygienist in alternative practice. ○ A comprehensive perinatal practitioner, and any other provider identified in the State

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
					Plan's definition of an FQHC or RHC visit
Kansas	<ul style="list-style-type: none"> Under the PPS, the State pays an interim per-visit rate to each FQHC and RHC based on the provider's most recent Medicare cost report or the average rate of similar providers if no report is available At the end of the fiscal year, the provider submits a Medicaid cost report to determine the final allowable cost per visit. A retroactive cost settlement is performed to reconcile interim payments with actual allowable costs APM established 	<ul style="list-style-type: none"> Primary care Mental health Dental Preventive services Family planning Newborn home visit Nursing for KBH-EPSDT only Obstetrical care Sexually transmitted diseases 	<ul style="list-style-type: none"> Services furnished by auxiliary health care staff who are not employed by the clinic or center Services provided by auxiliary health care employees at the facility without direct supervision of a clinic or center practitioner Services furnished by auxiliary health care employees away from the clinic/center facility when the employee goes to the site alone, without a clinic/center practitioner Technical components of radiology and EKG Clinical diagnostic laboratory services including the six 	<ul style="list-style-type: none"> Dental included in the APM 	<ul style="list-style-type: none"> RHCs: a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, optometrist, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), nurse-midwife, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. FQHCs: a face-to-face encounter between a center patient and a center health care professional including a physician, optometrist, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), nurse-midwife, dentist,

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
			<p>required lab tests for RHC certification</p> <ul style="list-style-type: none"> • Health care services performed by outside entities, including those owned by the center's owner(s) or staff • Drugs and biologicals which can be self-administered, such as oral prescription drugs or insulin injections • Long-Acting Reversible Contraceptives (LARCs) • Hospital services • Optometry • Ambulance • Durable Medical Equipment (DME) • Occupational therapy • Physical therapy 		<p>dental hygienist with an "Extended Care Permit" per the Kansas Dental Practice Act, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse</p>
New Hampshire	<ul style="list-style-type: none"> • APM established for primary and behavioral health services calculated using the providers' 	<ul style="list-style-type: none"> • Physician services (to include physician assistants under the supervision and 	<ul style="list-style-type: none"> • Inpatient and outpatient hospital services • Radiology services • Pharmacy services 	<ul style="list-style-type: none"> • Dental not included under the APM 	<ul style="list-style-type: none"> • An encounter is comprised of all recipient visits with more than one health care practitioner or

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>fiscal year 2011 cost-settled rates as the baseline for all subsequent years' encounter rates trending forward using the Medicare Economic Index (MEI)</p> <ul style="list-style-type: none"> ○ Cost reports are no longer needed after the fiscal year ending 2011 • The state did a one-time cost report collection and rebase of the APM and capped it at a set percentage of Medicare (94.1%) • Effective January 1, 2020, the encounter rate was increased by 3.1% 	<p>direction of a physician in accordance with NH RSA 328-D:1, nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses;</p> <ul style="list-style-type: none"> • Services and supplies furnished as "incident to" professional services furnished by a physician (to include a physician assistant under the supervision and direction of the physician), nurse practitioner or certified nurse midwife; and, for visiting nurse care, related medical supplies, other than drugs and biologicals 	<ul style="list-style-type: none"> • Vision services (other than routine screenings) • Dental services • Podiatry services • Hearing services (other than routine screenings) • Non-routine laboratory services • Family planning devices such as implants and IUD's • Occupational, speech, and physical therapy services • Substance Use Disorder (SUD) Treatment and Recovery Support Services • Medical transportation services • Vaccine administration for adults and children if not part of or incidental to an encounter • Actual vaccine for adults age 19 and 		<p>multiple visits with the same health care practitioner which take place on the same day and at a single location, for the same diagnosis or treatment. A recipient may have one medical and one behavioral encounter on the same day</p>

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
			<p>over regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately</p> <ul style="list-style-type: none"> Behavioral health/psychotherapy services 		
Montana	<ul style="list-style-type: none"> APM established and is calculated based on current cost reports for the previous two years The APM is adjusted by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for that calendar year; and adjusted to take into account any change in the scope of services furnished by the clinic during that fiscal year 	<ul style="list-style-type: none"> Physician Services Nurse practitioner, nurse specialist, certified nurse midwife, or physician's assistant services Clinical psychologist, clinical social worker, licensed professional counselor, licensed addiction counselor, licensed marriage & family therapist, or in-training mental health professional services Dental services Visiting nurse services 	<ul style="list-style-type: none"> Promising Pregnancy Care Group Education Long-Acting Reversible Contraceptives (LARCs) Certified Behavioral Health Peer Support Services Telehealth originating site fee 	<ul style="list-style-type: none"> Dental included in the APM 	<ul style="list-style-type: none"> A face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC health professional for the purpose of providing RHC or FQHC services. Reimbursement is available for one encounter per day per eligible member unless it is necessary for the member The provider must be: <ul style="list-style-type: none"> Physician Nurse practitioner Physician Assistant (PA) Certified Nurse Midwife (CNM)

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
		<ul style="list-style-type: none"> • Clinical Pharmacist Practitioner services • Preventive primary services does not include eyeglasses or hearing aids, but does include: <ul style="list-style-type: none"> ○ Perinatal care for high-risk members ○ Tuberculosis testing for high-risk members ○ Risk assessment and initial counseling regarding risks ○ Preventive Dental 			<ul style="list-style-type: none"> ○ Licensed Clinical Psychologist (LCP) ○ Licensed Clinical Social Worker (LCSW) ○ Licensed Professional Counselor (LCPC) ○ Licensed Marriage and Family Therapist (LMFT) ○ Licensed Addiction Counselor (LAC) ○ Clinical Pharmacist Practitioner; and ○ In-training mental health professional
North Dakota	<ul style="list-style-type: none"> • There are two APM rates that are established: <ul style="list-style-type: none"> ○ One rate for medical and other services (i.e. Medicaid covered services) 	<ul style="list-style-type: none"> • Medical services • Dental services • Behavior health services • Vaccine administration 	<ul style="list-style-type: none"> • Vision services • Pharmacy services • Transportation services 	<ul style="list-style-type: none"> • Dental has its own APM 	<ul style="list-style-type: none"> • A face-to-face visit or synchronous telehealth visit during which a qualifying encounter service is rendered • A medical encounter can only be claimed for services rendered face-to-face by one of

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>other than dental)</p> <ul style="list-style-type: none"> ○ One rate for dental services • These are fixed rates and are not subject to adjustment or reconciliation • The APM rate shall be equal to an amount (calculated on a per visit basis that is: <ul style="list-style-type: none"> ○ For provider-based (hospital-owned) RHCs, an APM rate shall be established on 100% of the RHC's billed charges, exclusive of lab charges, for the RHC's fiscal year 2000 plus the fee schedule 				<p>the following practitioners:</p> <ul style="list-style-type: none"> ○ Physician ○ Physician Assistant ○ Nurse Practitioner ○ Certified Nurse-Midwife ○ Visiting Nurse ○ Licensed Registered Dietician ○ Podiatrist ○ Optometrist • A behavioral health encounter can only be claimed for services rendered face-to-face by a qualified behavioral health professional, which includes: <ul style="list-style-type: none"> ○ Licensed Clinical Social Worker ○ Licensed Professional Counselor ○ Licensed Marriage and Family Therapist

State	Alternative Payment Methodology (APM) Participation	Covered Services	Carved-Out Services from the APM / Prospective Payment System (PPS)	Dental	Encounter Definition
	<p>amount for laboratory services divided by the number of visits</p> <ul style="list-style-type: none"> ○ For freestanding RHCs, the rate will be \$61.85 ● The calculation of the APM rate and any subsequent adjustments to that rate shall be on the basis of reasonable costs of the RHC as provided under 42 CFR part 413 without the application of provider screens and caps or limitations on costs or cost categories ● The APM rate shall be increased by 3% effective July 1, 2024 				<ul style="list-style-type: none"> ○ Licensed Psychologist ○ Nurse Practitioner ○ Licensed Addiction Counselor ● Dental encounters are reimbursed at an all-inclusive rate. The dental encounter includes covered services and supplies. Eligible providers include: <ul style="list-style-type: none"> ○ Dentist

CITATIONS

1. Colorado Department of Health Care Policy and Financing. (2022). Federally Qualified Health Center – Alternative Payment Methodology 2 Billing Guidance. Retrieved from <https://hcpf.colorado.gov/sites/hcpf/files/Federally%20Qualified%20Health%20Center%20-%20Alternative%20Payment%20Methodology%20%20Billing%20Guidance.pdf>

2. Colorado Secretary of State. (n.d.). 10 CCR 2505-10 8.700. Retrieved from <https://sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=11543&fileName=10%20CCR%202505-10%208.700>
3. Iowa Department of Health and Human Services. (2014). Federally Qualified Health Centers Billing Guidance. Retrieved from <https://hhs.iowa.gov/media/4321/download?inline>
4. Minnesota Department of Human Services. (2015). Alternative Payment Methodology IV. Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_155131#AltPayMetAPMIV
5. Nebraska Department of Health and Human Services. (2024). NE 24-0013. Retrieved from <https://sps2019test-dhhs.ne.gov/Documents/NE%2024-0013.pdf>
6. Nebraska Department of Health and Human Services. (2024). 471-000-76 Nebraska Medicaid Billing Instructions for Federally Qualified Health Center Services. Retrieved from <https://dhhs.ne.gov/Documents/471-000-76.pdf>
7. Oregon Health Authority. (n.d.). APM FAQs. Retrieved from <https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf>
8. Oregon Health Authority. (2015). FQHC-RHC Provider Guide. Retrieved from <https://www.oregon.gov/oha/HSD/OHP/Tools/FQHC-RHC-Provider-Guide.pdf>
9. Washington State Health Care Authority. (2012). Federally Qualified Health Centers Billing Guide (July–August 2012). Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/fqhc_bi070112-083112.pdf
10. Washington State Health Care Authority. (2024). Federally Qualified Health Centers Billing Guide (April 2024). Retrieved from <https://www.hca.wa.gov/assets/billers-and-providers/FQHC-bg-20240401.pdf>
11. California Department of Health Care Services. (2025). FQHC Alternative Payment Methodology. Retrieved from https://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx
12. California Department of Health Care Services. (2022). FQHC APM September 2022 Overview. Retrieved from <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-September-2022-Overview.pdf>
13. California Department of Health Care Services. (2024). FQHC APM Program Guide. Retrieved from <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-Program-Guide.pdf>
14. Kansas Medicaid. (2022). KS 22-0002 Approval Package. Retrieved from <https://www.medicaid.gov/medicaid/spa/downloads/KS-22-0002.pdf>
15. Kansas Secretary of State. (2025). Kansas Administrative Regulations 129-5-118a. Retrieved from https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=129-5-118a

16. Kansas Medical Assistance Program. (2023). RHC/FQHC Provider Manual. Retrieved from https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/RHC_FQHC_23060_22161.pdf
17. New Hampshire Department of Health and Human Services. (2018). NH Medicaid FQHC Provider Manual (2018). Retrieved from <https://nhmmis.nh.gov/portals/wps/wcm/connect/f608718b-001f-48b9-9593-998f2f8fd94d/NH+Medicaid+rebranded+detailed+FQHC+Provider+Manual+2-1-18.pdf?MOD=AJPERES&CVID=m9FW0xC>
18. New Hampshire Medicaid. (n.d.). NH-20-0018 State Plan Amendment. Retrieved from [NH-20-0018_1.pdf](#)
19. Montana Medicaid. (2021). FQHC/RHC Manual (2021). Retrieved from <https://medicaidprovider.mt.gov/manuals/FQHCRHCmanual11302021.pdf>
20. Montana Secretary of State. (2025). Administrative Rules of Montana – Visits and Encounters. Retrieved from <https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/579745e3-7e6e-4dfc-9a77-313d77baa8d4>
21. Montana Secretary of State. (2025). Administrative Rules of Montana – Definitions. Retrieved from <https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/66f995f8-5ddd-45b2-b4ae-52fe132a4a81>
22. Montana Medicaid. (2025). FQHC and RHC Provider Manual (Effective 2025). Retrieved from <https://medicaidprovider.mt.gov/docs/manuals/RHCFQHC/FederallyQualifiedHealthCenterandRuralHealthClinicProviderManualEffective02042025.pdf>
23. North Dakota Medicaid. (2021). ND-21-0018 State Plan Amendment. Retrieved from <https://www.medicaid.gov/medicaid/spa/downloads/ND-21-0018.pdf>
24. North Dakota Department of Health and Human Services. (2024). Federally Qualified Health Centers Policy Manual. Retrieved from <https://www.hhs.nd.gov/sites/www/files/documents/medicaid-policies/federally-qualified-health-centers-FQHC.pdf>

CHANGE IN SCOPE OF SERVICES POLICY

Annually on January 1 FQHC/RHCs PPS rates are adjusted to factor in the Medicare Economic Index (MEI). PPS rates may also be adjusted through a change in scope of services, which is a process established by federal regulations that can result in an incremental change to a provider's PPS encounter rate. Incremental changes may be either positive or negative.

Change in scope adjustments are only applied to PPS encounter rates and are not applied to Alternative Payment Methodology (APM) rates. APM rates will be reviewed in accordance with SDCL Ch. 28-22, which at minimum requires a comprehensive rate review at least once every five years. Providers with an (APM) should still notify South Dakota Medicaid of changes in scope and submit the associated application as South Dakota Medicaid is required to ensure the APM is higher than the PPS rate. In the event the PPS rate exceeds the APM rate, the provider will be paid the additional amount owed to them and the provider will be transitioned back to reimbursement via the PPS rate.

Qualifying Changes

A change in the 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 scope of services occurs if:

- The addition of a new service not incorporated in the provider's PPS rate or deletion of a service incorporated in the provider's PPS rate. South Dakota Medicaid considers the addition or deletion of a specific ambulatory Medicaid benefit covered in [Supplement to Attachment 3.1-A](#) as triggering a change in scope. For example, if a provider previously did not have dental services included in their per diem and began to offer dental services, this could qualify for a change in scope.

A change in scope is also considered to have occurred if one or more of the following type, intensity, duration, and/or amount changes occurs and the change(s) are associated with change in cost of +/- 5% in the rate per encounter over the year prior to implementation:

- The addition or removal of specialty providers (Ex. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the provider; or
- A transition from mid-level providers (Ex. nurse practitioners) to physicians or vice versa with a corresponding change in the services provided by the provider;
- Changes in service due to adding or removing clinical equipment utilized by the provider that results in more or less resource-intensive visits;
- Changes in types of patients served that require more intensive and frequent care. For example, serving an increased number of homeless individuals with high healthcare needs.

Failure to notify DSS of removal of a service from an existing service base may result in recoupment of payment. The State may initiate a change in scope review if it has reason to believe a service included in a provider's encounter rate is no longer being provided.

Changes that Do Not Qualify

The following changes are not considered a change in scope:

- An increase or decrease in the cost of supplies or existing services;
- Normal and expected cost increases;
- An increase or decrease in the number of encounters without a change in services provided;
- Changes in office hours or location;
- Changes in equipment or supplies not directly related to a change in the scope of service;

- Expansion, remodel or other capital expenditures of locations;
- The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services as other locations;
- The addition or removal of administrative staff;
- The addition or removal of staff members to or from an existing service;
- Changes in salaries and benefits;
- A change in ownership; and
- Addition or deletion of services that are carved out of the encounter rate.

Initial Notification of a Change in Scope

FQHCs/RHCs are responsible for notifying DSS’s Office of Provider Reimbursements and Audits at the time there is a change in their scope of services. Notification must be provided within 9 months of the date of the addition or deletion of the service. For example, if a provider added dental services effective January 1 notification must be provided to the department within by the end of September that year. Change in scope requests that South Dakota Medicaid is not timely notified of will not be considered.

To notify the Office of Provider Reimbursements and Audit please send an email to DSSFinancePRA@state.sd.us detailing the changes.

Application for Change in Scope Request

The provider must supply the following application materials to the department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The application may be filed if initial reporting requirements were met, the change in scope has existed a full six months, and the provider can provide the following application materials:

- Completed Change in Scope Request form, including a brief narrative description of the change in scope of services including how services were provided both before and after the change and an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC or RHC.
- Historical and budgeted information showing the provider’s expenses before and after the change in scope of services including the applicable Medicare cost report prior to the change and after the change.
- The projected increase or decrease in the number of encounters due to the change.

Only one change in scope of service adjustment will be calculated per year. However, more than one change in scope in scope of services may be included in a single application.

Calculation of a Change in Scope

A change in scope of services is limited to a review of the costs for the specific service added or removed from the existing service base or other qualifying changes. It will not result in an evaluation of the costs for other FQHC/RHCs services or a rate rebase.

The change in scope will utilize cost reports and other information provided to identify the cost associated with the change. The identified cost associated with the change in scope cost will be added on or subtracted from the base rate. The added or subtracted cost will be applied to all of the provider’s sites.

$$\text{Cost per encounter before the change in scope of service} = \frac{\text{Total inflation adjusted allowable costs before the change in scope of service}}{\text{Total encounters before the change in scope of service}}$$

$$\text{Cost per encounter after the change in scope of service} = \frac{\text{Total allowable costs after the change in scope of service}}{\text{Total encounters after the change in scope of service}}$$

Incremental change due to the change in scope of service (positive or negative) = (Cost per encounter after the change in scope of service) - (Cost per encounter before the change in scope of service)

Current baseline PPS rate + Incremental change due to the change in scope of service = New baseline rate

Interim Rate

For an FQHC or RHC that qualifies for a scope change, the Department will compare the new services and rates to other FQHCs or RHCs located in the same geographic region that offer same/similar services to set the interim rate for the change in services. The FQHC's or RHC's finalized PPS base rate will be computed after cost reports reflecting the cost before and after the new service are available. Once the new PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). It is the responsibility of the FQHCs and RHCs to inform and supply the Department with necessary documentation regarding changes to types of service, cost reports and any other documentation.

Effective Date of the Rate

Upon the department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the change in scope request and the associated applications materials. If the change in scope request is not adjudicated by this date, the rate will be retroactively set to this date and claims will be reprocessed at the new encounter rate.

Appeals Process

Providers have the right to appeal a change in scope decision by requesting a Fair Hearing. Corporations must be represented by an attorney. A request for an appeal must be made to the Office of Administrative Hearings within 30 days of the decision date from South Dakota Medicaid. Your request must contain information specific to your disagreement with South Dakota Medicaid's scope change decision. Please address these appeals to:

Office of Administrative Hearings
 700 Governors Drive
 Pierre SD 57501-6851

Medicare Cost Center		/01/2023 - 06/30/20/01/2023 - 06/30/20/01/2023 - 06/30/20/01/2023 - 06/30/20/01/2023 - 12/31/20/01/2024 - 12/31/20					
		RHC Facility 1	RHC Facility 2	RHC Facility 3	RHC Facility 4	RHC Facility 5	RHC Facility 6
Worksheet A	Primary Medical						
Line 1	Physician	\$ 365,686.00	\$ -	\$ 41,699.00	\$ 571,559.00	\$ 137,442.00	\$ 1,067,132.00
Line 2	Physician Assistant	\$ 10,587.00	\$ 150,078.00	\$ -	\$ -	\$ -	\$ 235,856.00
Line 15	Physician Services Under Agreement	\$ 146,088.00	\$ -	\$ -	\$ -	\$ -	\$ -
Line 16	Physician Supervision Under Agreement	\$ -	\$ 10,500.00	\$ 10,500.00	\$ -	\$ -	\$ -
Line 3	Nurse Practitioner	\$ 249,006.00	\$ -	\$ 109,717.00	\$ 477,321.00	\$ 158,301.00	\$ 185,089.00
Line 5	Registered Nurse	\$ -	\$ 85,737.00	\$ -	\$ -	\$ -	\$ -
Line 9	Laboratory Technician	\$ -	\$ 2,941.00	\$ -	\$ -	\$ -	\$ -
Line 6	Licensed Practical Nurse	\$ -	\$ -	\$ 45,186.00	\$ 23,281.00	\$ -	\$ -
	Visiting Nurse	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Other Nurse	\$ 239,287.00	\$ -	\$ -	\$ 506,484.00	\$ -	\$ -
Line 4	Certified Nurse Midwife	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Primary Medical Staff - Subtotal	\$ 1,010,654.00	\$ 249,256.00	\$ 210,043.00	\$ 1,578,645.00	\$ 295,743.00	\$ 1,488,077.00
	Behavioral Health						
Line 7	Clinical Psychologist	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 8	Clinical Social Worker	\$ -	\$ -	\$ -	\$ 56,837.00	\$ -	\$ -
Line 8.10	Marriage and Family Therapist	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 8.11	Mental Health Counselor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Behavioral Health Staff - Subtotal	\$ -	\$ -	\$ -	\$ 56,837.00	\$ -	\$ -
	Other						
Line 10	Other Health Care Staff Costs	\$ 22,359.00	\$ 5,225.00	\$ 3,381.00	\$ 836,397.00	\$ 203,231.00	\$ 883,140.00
	Other Costs Under Agreement	\$ -	\$ -	\$ -	\$ -	\$ 4,526.00	\$ -
	Other Health Staff - Subtotal	\$ 22,359.00	\$ 5,225.00	\$ 3,381.00	\$ 836,397.00	\$ 207,757.00	\$ 883,140.00
	All Facility Health Care Staff Expenses - Subtotal	\$ 1,033,013.00	\$ 254,481.00	\$ 213,424.00	\$ 2,471,879.00	\$ 503,500.00	\$ 2,371,217.00
Worksheet S-3							
Line 2	Total Medical Encounters	5,593	940	776	19,539	4,111	14,926
Line 3	Total Mental Health Encounters	0	0	0	815	0	0
	Total Encounters - Subtotal	5,593	940	776	20,354	4,111	14,926
Worksheet A							
Line 25	Medical Supplies	\$ 76,592.00	\$ 3,254.00	\$ 3,062.00	\$ 32,803.00	\$ 123,039.00	\$ 231,064.00
Line 26	Transportation (Health Care Staff)	\$ -	\$ 884.00	\$ 395.00	\$ -	\$ -	\$ -
Line 27	Depreciation-Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Professional Liability Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 28	Malpractice Premiums	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 38	Other Health Care Costs	\$ 3,945.00	\$ -	\$ -	\$ -	\$ -	\$ 12,510.00
Line 29	Allowable GME Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 30	Pneumococcal Vaccines & Med Supplies	\$ 10,922.00	\$ 5,118.00	\$ 1,545.00	\$ 98,561.00	\$ 2,584.00	\$ 2,110.00
Line 31	Influenza Vaccines & Med Supplies	\$ 6,146.00	\$ 6,110.00	\$ 1,690.00	\$ 52,929.00	\$ 25,625.00	\$ 32,275.00
Line 31.10	COVID-19 Vaccines & Med Supplies	\$ -	\$ -	\$ -	\$ 53,040.00	\$ -	\$ 87,831.00
Line 31.11	Monoclonal Antibody Products	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Direct Service Non-Personnel - Subtotal	\$ 97,605.00	\$ 15,366.00	\$ 6,692.00	\$ 237,333.00	\$ 151,248.00	\$ 365,790.00
Worksheet A-8							
Line 8	Drugs Charged to Patients	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Interpreter	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Patient Education Materials	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A-8-1 Line 68	Medical Records & Library	\$ 5,380.00	\$ -	\$ -	\$ 18,006.00	\$ -	\$ 31,359.00
	Nursing Administration	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Social Service	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A Line 79	Telehealth	\$ 37.00	\$ 51.00	\$ 23.00	\$ 892.00	\$ -	\$ -
	Ancillary and Support Expense - Subtotal	\$ 5,417.00	\$ 51.00	\$ 23.00	\$ 18,898.00	\$ -	\$ 31,359.00
Worksheet A							
Line 64	Accounting	\$ -	\$ 52,065.00	\$ 33,554.00	\$ -	\$ -	\$ -
	Admin Professional Fees	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Administrative Costs/Administrative & General Services	\$ 332,153.00	\$ -	\$ -	\$ 412,972.00	\$ 186,220.00	\$ 689,722.00
	Board Meeting Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A-8-1 Line 25	Central Service & Supply	\$ 1,532.00	\$ -	\$ -	\$ 9,339.00	\$ 19,518.00	\$ -
	Continuing Education	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A Line 44	Depreciation-Buildings and Fixtures/Cap Rel Costs-Bldg & Fix	\$ 70,990.00	\$ -	\$ -	\$ -	\$ 46,456.00	\$ 84,448.00
Line 45	Depreciation-Moveable Equipment/Cap Rel Costs-Mvble Equip	\$ 34,052.00	\$ 1,440.00	\$ 758.00	\$ -	\$ 20,362.00	\$ 126,432.00
Line 61	Depreciation-Office Equipment	\$ -	\$ 3,566.00	\$ 483.00	\$ -	\$ -	\$ -
	Dues and Memberships	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Facility Costs	\$ 140,912.00	\$ -	\$ -	\$ 160,407.00	\$ 19,238.00	\$ 29,347.00
Line 67	Fringe Benefits and Payroll Taxes/Employee Benefits	\$ 76,572.00	\$ 10,034.00	\$ 7,840.00	\$ 726,828.00	\$ 85,075.00	\$ 61,110.00
Line 46	Housekeeping and Maintenance/Janitorial	\$ 40,915.00	\$ 2,078.00	\$ 1,475.00	\$ 35,186.00	\$ 32,853.00	\$ 85,007.00
Line 65	Insurance	\$ -	\$ 2,571.00	\$ -	\$ -	\$ -	\$ -
Line 42	Interest on Mortgage or Loans	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 48	Laundry	\$ 2,587.00	\$ 251.00	\$ 59.00	\$ 1,654.00	\$ -	\$ -
Line 63	Legal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 68	Miscellaneous/Other General Services	\$ -	\$ 2,108.00	\$ 1,528.00	\$ 243,884.00	\$ -	\$ -
	Non-capitalized Equipment/Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 60	Office Salaries	\$ -	\$ 17,117.00	\$ 7,022.00	\$ -	\$ -	\$ -
Line 62	Office Supplies	\$ -	\$ 775.00	\$ 938.00	\$ -	\$ -	\$ -
	Plant Operation & Maintenance	\$ 100,203.00	\$ -	\$ -	\$ 84,908.00	\$ 76,789.00	\$ 162,299.00
Line 47	Property Tax	\$ -	\$ 2,041.00	\$ -	\$ -	\$ -	\$ -
	Recruitment and Retention	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 40	Rent	\$ -	\$ 10,800.00	\$ 4,284.00	\$ -	\$ -	\$ -
Line 66	Telephone	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 43	Utilities	\$ -	\$ 4,949.00	\$ 343.00	\$ -	\$ -	\$ -
	Administrative Overhead Expense - Subtotal	\$ 799,916.00	\$ 109,795.00	\$ 58,284.00	\$ 1,675,178.00	\$ 486,511.00	\$ 1,238,365.00
Line 80	Ambulance Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Cafeteria	\$ -	\$ -	\$ -	\$ 10,928.00	\$ 10,858.00	\$ -
	Chronic Care Management	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Client Transportation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Community Health Worker	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Diagnostic & Screening Lab Tests	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Durable Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Fundraising	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Hospital ER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Inpatient Hospital Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Lab and Radiology Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Marketing	\$ -	\$ 7,976.00	\$ 2,455.00	\$ -	\$ -	\$ -
	Medicare Excluded Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Nonallowable GME costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Optometry	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Other nonreimbursable costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Pediatric Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 75	Pharmacy/Retail Pharmacy	\$ 43,407.00	\$ 61,938.00	\$ 3,454.00	\$ -	\$ 33,222.00	\$ -
	Prosthetic Devices	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Radiology-Diagnostic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Specialty Care/After Hours	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	WIC Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Non-Reimbursable Expense - Subtotal	\$ 43,407.00	\$ 69,914.00	\$ 5,909.00	\$ 10,928.00	\$ 44,080.00	\$ -
	Total Allowable Cost	\$ 1,935,951.00	\$ 379,693.00	\$ 278,423.00	\$ 4,403,288.00	\$ 1,141,259.00	\$ 4,006,731.00
	Cost Allocation Cap						
	Admin Cap Per Encounter	\$ 143.02	\$ 116.80	\$ 85.36	\$ 85.36	\$ 118.34	\$ 85.36
	Capped Administrative Overhead	\$ 799,916.00	\$ 109,795.00	\$ 66,239.22	\$ 1,737,413.77	\$ 486,511.00	\$ 1,274,080.67
	Total Allowable Cost With Admin Cap	\$ 1,935,951.00	\$ 379,693.00	\$ 286,378.22	\$ 4,465,523.77	\$ 1,141,259.00	\$ 4,042,446.67

Medicare Cost Center		07/01/2023 - 06/30/2024	01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	07/01/2023 - 06/30/2024	10/01/2023 - 09/30/2024	01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024
Primary Medical		RHC Facility 7	RHC Facility 8	RHC Facility 9	RHC Facility 10	RHC Facility 11	RHC Facility 12	RHC Facility 13
Worksheet A	Physician	\$ 90,402.00	\$ 1,164,913.00	\$ 316,595.00	\$ 667,450.00	\$ 1,756,000.00	\$ 162,402.00	\$ 1,416.00
Line 1	Physician Assistant	\$ 252,751.00	\$ -	\$ 181,066.00	\$ 249,808.00	\$ 256,315.00	\$ 282,064.00	\$ 96,096.00
Line 2	Physician Services Under Agreement	\$ -	\$ -	\$ -	\$ (20,750.00)	\$ -	\$ 16,713.00	\$ 88,808.00
Line 15	Physician Supervision Under Agreement	\$ -	\$ -	\$ -	\$ 10,500.00	\$ -	\$ -	\$ -
Line 16	Nurse Practitioner	\$ -	\$ 570,770.00	\$ 198,338.00	\$ 223,850.00	\$ 670,468.00	\$ -	\$ -
Line 3	Registered Nurse	\$ -	\$ -	\$ -	\$ -	\$ 70,000.00	\$ -	\$ -
Line 5	Laboratory Technician	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 9	Licensed Practical Nurse	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 6	Visiting Nurse	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Other Nurse	\$ 76,103.00	\$ 522,000.00	\$ -	\$ 613,623.00	\$ -	\$ 397,180.00	\$ -
Line 4	Certified Nurse Midwife	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Primary Medical Staff - Subtotal	\$ 419,256.00	\$ 2,257,683.00	\$ 695,999.00	\$ 1,744,481.00	\$ 2,752,783.00	\$ 858,359.00	\$ 186,320.00
	Behavioral Health							
Line 7	Clinical Psychologist	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 8	Clinical Social Worker	\$ -	\$ -	\$ 16,282.00	\$ -	\$ 56,264.00	\$ -	\$ -
Line 8.10	Marriage and Family Therapist	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 8.11	Mental Health Counselor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Behavioral Health Staff - Subtotal	\$ -	\$ -	\$ 16,282.00	\$ -	\$ 56,264.00	\$ -	\$ -
	Other							
Line 10	Other Health Care Staff Costs	\$ -	\$ -	\$ 261,549.00	\$ 123,280.00	\$ 1,426,977.00	\$ -	\$ 27,378.00
	Other Costs Under Agreement	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Other Health Staff - Subtotal	\$ -	\$ -	\$ 261,549.00	\$ 123,280.00	\$ 1,426,977.00	\$ -	\$ 27,378.00
	All Facility Health Care Staff Expenses - Subtotal	\$ 419,256.00	\$ 2,257,683.00	\$ 973,830.00	\$ 1,867,761.00	\$ 4,236,024.00	\$ 858,359.00	\$ 213,698.00
Worksheet S-3	Total Medical Encounters	3,632	11,154	6,494	14,339	18,632	8,784	3,821
Line 2	Total Mental Health Encounters	0	300	121	0	516	0	0
Line 3	Total Encounters - Subtotal	3,632	11,454	6,615	14,339	19,148	8,784	3,821
Worksheet A	Medical Supplies	\$ 3,758.00	\$ -	\$ 25,494.00	\$ 43,761.00	\$ 50,249.00	\$ 218,227.00	\$ 37,725.00
Line 25	Transportation (Health Care Staff)	\$ -	\$ -	\$ -	\$ 4,781.00	\$ -	\$ -	\$ -
Line 26	Depreciation-Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 27	Professional Liability Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,412.00
Line 28	Malpractice Premiums	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 29	Other Health Care Costs	\$ 129,649.00	\$ 213,803.00	\$ 76,911.00	\$ 2,246.00	\$ -	\$ -	\$ 13,099.00
Line 38	Allowable GME Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 30	Pneumococcal Vaccines & Med Supplies	\$ 22,610.00	\$ 5,651.00	\$ 7,482.00	\$ 64,307.00	\$ 108,560.00	\$ 25,212.00	\$ 4,920.00
Line 31	Influenza Vaccines & Med Supplies	\$ 17,226.00	\$ 4,830.00	\$ 17,265.00	\$ 26,934.00	\$ 69,900.00	\$ 31,053.00	\$ 2,850.00
Line 31.10	COVID-19 Vaccines & Med Supplies	\$ 16,608.00	\$ 19,989.00	\$ 11,165.00	\$ 24,894.00	\$ 58,370.00	\$ 65,750.00	\$ 5,628.00
Line 31.11	Monoclonal Antibody Products	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Direct Service Non-Personnel - Subtotal	\$ 189,851.00	\$ 244,273.00	\$ 138,317.00	\$ 166,923.00	\$ 287,079.00	\$ 340,242.00	\$ 68,634.00
Worksheet A-8	Drugs Charged to Patients	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 8	Interpreter	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Patient Education Materials	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A-8-1 Line 68	Medical Records & Library	\$ -	\$ 78,026.00	\$ -	\$ 17,518.00	\$ 53,906.00	\$ 10,622.00	\$ 9,317.00
	Nursing Administration	\$ -	\$ -	\$ -	\$ 13,120.00	\$ -	\$ -	\$ -
	Social Service	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A Line 79	Telehealth	\$ -	\$ -	\$ 22,258.00	\$ 386.00	\$ -	\$ -	\$ -
	Ancillary and Support Expense - Subtotal	\$ -	\$ 78,026.00	\$ 22,258.00	\$ 31,024.00	\$ 53,906.00	\$ 10,622.00	\$ 9,317.00
Worksheet A	Accounting	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 64	Admin Professional Fees	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Administrative Costs/Administrative & General Services	\$ 171,468.00	\$ 458,557.00	\$ 409,543.00	\$ 1,005,336.00	\$ 1,152,263.00	\$ 794,876.00	\$ 127,413.00
Worksheet A-8-1 Line 25	Board Meeting Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Central Service & Supply	\$ -	\$ -	\$ 25,269.00	\$ 50,712.00	\$ -	\$ -	\$ -
	Continuing Education	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Worksheet A Line 44	Depreciation-Buildings and Fixtures/Cap Rel Costs-Bldg & Fix	\$ 76,554.00	\$ 104,843.00	\$ 109,084.00	\$ 252,270.00	\$ -	\$ 70,946.00	\$ 31,772.00
Line 45	Depreciation-Moveable Equipment/Cap Rel Costs-Mble Equip	\$ 1,943.00	\$ 343.00	\$ 84,450.00	\$ 26,758.00	\$ 146,827.00	\$ 24,149.00	\$ 9,616.00
Line 41	Depreciation-Office Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Dues and Memberships	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Facility Costs	\$ 8,758.00	\$ 28,178.00	\$ 1,340.00	\$ 226,607.00	\$ 151,493.00	\$ 28,803.00	\$ -
Line 67	Fringe Benefits and Payroll Taxes/Employee Benefits	\$ 70,508.00	\$ 10,279.00	\$ 273,440.00	\$ 140,090.00	\$ 893,985.00	\$ 302,946.00	\$ 70,710.00
Line 46	Housekeeping and Maintenance/Janitorial	\$ 16,278.00	\$ 67,092.00	\$ 51,911.00	\$ 24,893.00	\$ 109,747.00	\$ -	\$ 14,867.00
Line 65	Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 42	Interest on Mortgage or Loans	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 48	Laundry	\$ 3,363.00	\$ 276.00	\$ 475.00	\$ 3,605.00	\$ 5,266.00	\$ 684.00	\$ 109.00
Line 63	Legal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 68	Miscellaneous/Other General Services	\$ -	\$ 198,019.00	\$ -	\$ -	\$ -	\$ 70,833.00	\$ 32,435.00
	Non-capitalized Equipment/Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 60	Office Salaries	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 62	Office Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Plant Operation & Maintenance	\$ 51,891.00	\$ 49,451.00	\$ 95,389.00	\$ 154,002.00	\$ 296,168.00	\$ 120,301.00	\$ 73,813.00
Line 47	Property Tax	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Recruitment and Retention	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 40	Rent	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 66	Telephone	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 43	Utilities	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Administrative Overhead Expense - Subtotal	\$ 400,763.00	\$ 915,038.00	\$ 1,050,901.00	\$ 1,884,273.00	\$ 2,755,749.00	\$ 1,413,538.00	\$ 360,735.00
	Ambulance Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 80	Cafeteria	\$ -	\$ 23,042.00	\$ 41,407.00	\$ -	\$ 70,839.00	\$ -	\$ -
	Chronic Care Management	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Client Transportation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Community Health Worker	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Diagnostic & Screening Lab Tests	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Durable Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Fundraising	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Hospital ER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Inpatient Hospital Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Lab and Radiology Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Marketing	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Medicare Excluded Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Nonallowable GME costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Optometry	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Other nonreimbursable costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Pediatric Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Line 75	Pharmacy/Retail Pharmacy	\$ -	\$ -	\$ -	\$ 816,521.00	\$ -	\$ -	\$ -
	Prosthetic Devices	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Radiology-Diagnostic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Specialty Care/After Hours	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	WIC Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Non-Reimbursable Expense - Subtotal	\$ -	\$ 23,042.00	\$ 41,407.00	\$ 816,521.00	\$ 70,839.00	\$ -	\$ -
	Total Allowable Cost	\$ 1,009,870.00	\$ 3,495,020.00	\$ 2,185,306.00	\$ 3,949,981.00	\$ 7,332,758.00	\$ 2,622,761.00	\$ 652,384.00
	Cost Allocation Cap							
	Admin Cap Per Encounter	\$ 110.34	\$ 85.36	\$ 144.33	\$ 131.41	\$ 143.92	\$ 144.33	\$ 94.41
	Capped Administrative Overhead	\$ 400,763.00	\$ 977,711.38	\$ 954,755.40	\$ 1,884,273.00	\$ 2,755,749.00	\$ 1,267,811.25	\$ 360,735.00
	Total Allowable Cost With Admin Cap	\$ 1,009,870.00	\$ 3,557,693.38	\$ 2,089,160.40	\$ 3,949,981.00	\$ 7,332,758.00	\$ 2,477,034.25	\$ 652,384.00

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

	01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	10/01/2023 - 09/30/2024	10/01/2023 - 09/30/2024
	FQHC Facility 1	FQHC Facility 2	FQHC Facility 3	FQHC Facility 4	FQHC Facility 5	FQHC Facility 6
Medicare Cost Center						
Worksheet A	Primary Medical					
Line 23	Physician	\$ - \$ 444,847.00	\$ 168,335.00	\$ 1,476,006.00	\$ - \$ -	\$ -
Line 25	Physician Assistant	\$ - \$ 154,415.00	\$ 177,230.00	\$ 1,909,680.00	\$ 289,904.00	\$ -
Line 24	Physician Services Under Agreement	\$ 9,380,623.00	\$ -	\$ 452,788.00	\$ 124,946.00	\$ 14,200,328.00
Line 26	Physician Supervision Under Agreement	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Nurse Practitioner	\$ - \$ 1,066,430.00	\$ 573,907.00	\$ 3,939,521.00	\$ 294,688.00	\$ 568,528.00
	Registered Nurse	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Licensed Practical Nurse	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Other Nurse	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 29	Certified Nurse Midwife	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 323	Laboratory Technician	\$ - \$ -	\$ 308,154.00	\$ -	\$ 89,182.00	\$ 155,939.00
	Primary Medical Staff - Subtotal	\$ 9,380,623.00	\$ 1,665,492.00	\$ 1,880,414.00	\$ 7,450,153.00	\$ 14,874,102.00
	Behavioral Health					
Line 30	Clinical Psychologist	\$ - \$ 216.00	\$ -	\$ 3,350.00	\$ -	\$ -
Line 31	Clinical Social Worker	\$ - \$ 97,150.00	\$ -	\$ 281,063.00	\$ -	\$ 172,591.00
Line 31.10	Marriage and Family Therapist	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 31.11	Mental Health Counselor	\$ - \$ -	\$ 131,198.00	\$ -	\$ -	\$ -
	Behavioral Health Staff - Subtotal	\$ - \$ 97,366.00	\$ 131,198.00	\$ 284,413.00	\$ -	\$ 172,591.00
	Other					
Line 36	Other Health Care Staff Costs	\$ - \$ 2,662,222.00	\$ 2,515,100.00	\$ 3,781,052.00	\$ 756,561.00	\$ 1,592,098.00
	Other Costs Under Agreement	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Other Health Staff - Allowable Medical Cost	\$ - \$ 2,662,222.00	\$ 2,515,100.00	\$ 3,781,052.00	\$ -	\$ -
	Other Health Staff - Allowable Dental Cost	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Other Health Staff - Subtotal	\$ - \$ 2,662,222.00	\$ 2,515,100.00	\$ 3,781,052.00	\$ 756,561.00	\$ 1,592,098.00
	All Facility Health Care Staff Expenses - Subtotal	\$ 9,380,623.00	\$ 4,425,080.00	\$ 4,326,712.00	\$ 11,515,618.00	\$ 15,630,663.00
Line 60	Total Dental Expenses	\$ - \$ 1,614,125	\$ - \$ 2,442,671	\$ - \$ 5,537,919	\$ -	\$ -
	Total Dental Expenses - Overhead cost	\$ - \$ 1,038,782	\$ - \$ 1,001,715	\$ - \$ 2,769,718	\$ -	\$ -
	Dental - Subtotal (including overhead)	\$ - \$ 2,652,907.34	\$ - \$ 3,451,386.94	\$ - \$ 8,307,636.91	\$ -	\$ -
Worksheet S3						
Line 2	Total Medical Encounters	72,420	15,185	16,377	68,620	148,785
Line 4	Total Mental Health Encounters	4,978	172	1,371	4,578	3,666
	Total Dental Encounters	0	6,509	7,241	21,307	0
	Total Encounters - Subtotal	77,398	21,866	24,989	94,505	162,451
Worksheet A						
Line 10	Medical Supplies	\$ 484.00	\$ 224,297.00	\$ 226,223.00	\$ 696,982.00	\$ 242,255.00
Line 11	Transportation (Health Care Staff)	\$ - \$ -	\$ -	\$ 22,429.00	\$ 54,444.00	\$ 201,310.00
	Depreciation-Medical Equipment	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Professional Liability Insurance	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Malpractice Premiums	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Other Health Care Costs	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Allowable GME Costs	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 48	Pneumococcal Vaccines & Med Supplies	\$ 195,567.00	\$ 112,009.00	\$ 49,208.00	\$ 121,077.00	\$ 640,253.00
Line 49	Influenza Vaccines & Med Supplies	\$ 140,302.00	\$ 43,103.00	\$ 24,096.00	\$ 143,616.00	\$ 407,807.00
Line 49.10	COVID-19 Vaccines & Med Supplies	\$ 69,182.00	\$ -	\$ 11,582.00	\$ 71,045.00	\$ 325,836.00
Line 49.11	Monoclonal Antibody Products	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Direct Service Non-Personnel - Subtotal	\$ 405,535.00	\$ 379,409.00	\$ 333,538.00	\$ 1,087,184.00	\$ 1,616,151.00
Line 67	Drugs Charged to Patients	\$ - \$ -	\$ -	\$ 27,112.00	\$ -	\$ -
Line 12.02	Interpreter	\$ - \$ -	\$ -	\$ 261,740.00	\$ -	\$ -
Line 12.03	Patient Education Materials	\$ - \$ -	\$ -	\$ 5,043.00	\$ -	\$ -
Line 7	Medical Records & Library	\$ - \$ -	\$ -	\$ 82,440.00	\$ 220,111.00	\$ 104,831.00
	Nursing Administration	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Social Service	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 66	Telehealth	\$ - \$ 5,712.00	\$ -	\$ 151,163.00	\$ -	\$ -
	Ancillary and Support Expense - Subtotal	\$ - \$ 5,712.00	\$ 376,335.00	\$ 371,274.00	\$ -	\$ 104,831.00
Line 4	Accounting	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Admin Professional Fees	\$ - \$ -	\$ -	\$ 146,792.00	\$ -	\$ -
	Administrative Costs/Administrative & General Services	\$ 4,459,337.00	\$ 2,582,624.00	\$ 2,901,775.00	\$ 6,672,087.00	\$ 12,431,622.00
	Board Meeting Expense	\$ - \$ -	\$ -	\$ -	\$ 10,254.00	\$ -
	Central Service & Supply	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Continuing Education	\$ - \$ -	\$ -	\$ 31,297.00	\$ -	\$ -
Line 1	Depreciation-Buildings and Fixtures/Cap Rel Costs-Bldg & Fix	\$ - \$ 148,983.00	\$ 150,552.00	\$ 486,822.00	\$ 62,957.00	\$ 273,702.00
Line 2	Depreciation-Movable Equipment/Cap Rel Costs-Mobile Equip	\$ 7,407.00	\$ 624,958.00	\$ 67,342.00	\$ 1,572,413.00	\$ 144,777.00
	Depreciation-Office Equipment	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Dues and Memberships	\$ - \$ -	\$ -	\$ 36,586.00	\$ -	\$ -
	Facility Costs	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Fringe Benefits and Payroll Taxes/Employee Benefits	\$ - \$ -	\$ -	\$ 1,819,508.00	\$ -	\$ 1,037,767.00
Line 6	Housekeeping and Maintenance/Janitorial	\$ 14,981.00	\$ -	\$ 64,230.00	\$ 232,350.00	\$ 76,729.00
	Insurance	\$ - \$ -	\$ -	\$ 36,983.00	\$ -	\$ 56,427.00
	Interest on Mortgage or Loans	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Laundry	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Legal	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Miscellaneous/Other General Services	\$ 2,390,790.00	\$ -	\$ -	\$ -	\$ 3,646,586.00
	Non-capitalized Equipment/Maintenance	\$ - \$ -	\$ 102,128.00	\$ -	\$ -	\$ -
	Office Salaries	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Office Supplies	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 5	Plant Operation & Maintenance	\$ 87,029.00	\$ 133,067.00	\$ 170,934.00	\$ 1,160,509.00	\$ 260,598.00
	Property Tax	\$ - \$ -	\$ -	\$ -	\$ -	\$ 214,788.00
	Recruitment and Retention	\$ - \$ -	\$ -	\$ 79,197.00	\$ -	\$ -
	Rent	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Telephone	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Utilities	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Admin. Overhead- Allowable Medical Cost	\$ 6,959,544.00	\$ 2,450,849.66	\$ 2,455,246.06	\$ 9,515,080.09	\$ 16,623,269.00
	Admin. Overhead- Allowable Dental Cost	\$ - \$ 1,038,782.34	\$ 1,001,714.94	\$ 2,769,717.91	\$ -	\$ -
	Administrative Overhead Expense - Subtotal	\$ 6,959,544.00	\$ 3,489,632.00	\$ 3,456,961.00	\$ 12,284,798.00	\$ 16,623,269.00
Line 65	Ambulance Services	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Cafeteria	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
Line 68	Chronic Care Management	\$ - \$ -	\$ -	\$ 304,357.00	\$ -	\$ -
Line 12.01	Client Transportation	\$ - \$ -	\$ 35,773.00	\$ -	\$ -	\$ -
	Community Health Worker	\$ - \$ 156,996.00	\$ -	\$ -	\$ -	\$ -
Line 61	Diagnostic & Screening Lab Tests	\$ - \$ 831.00	\$ -	\$ 1,045,715.00	\$ 28,339.00	\$ -
Line 64	Durable Medical Equipment	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Fundraising	\$ - \$ -	\$ -	\$ 5,157.00	\$ -	\$ -
Line 79.02	Grants	\$ - \$ -	\$ 90,828.00	\$ -	\$ -	\$ -
Line 79.01	Inpatient Hospital Services	\$ - \$ -	\$ 345,600.00	\$ -	\$ -	\$ -
	Lab and Radiology Supplies	\$ - \$ -	\$ 308,154.00	\$ -	\$ -	\$ -
	Marketing	\$ - \$ -	\$ -	\$ 457,797.00	\$ -	\$ -
Line 60	Medicare Excluded Services	\$ - \$ 1,620,456.00	\$ 2,449,671.00	\$ 5,537,919.00	\$ -	\$ -
Line 78	Nonallowable GME costs	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Optomety	\$ - \$ -	\$ 64,369.00	\$ -	\$ -	\$ -
	Other nonreimbursable costs	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Pediatric Program	\$ - \$ 670,740.00	\$ -	\$ -	\$ -	\$ -
Line 9	Pharmacy/Retail Pharmacy	\$ 699,883.00	\$ 2,550,678.00	\$ 374,229.00	\$ -	\$ 1,442,878.00
Line 63	Prosthetic Devices	\$ - \$ -	\$ -	\$ -	\$ 9,307,636.91	\$ 61,960.00
Line 62	Radiology-Diagnostic	\$ - \$ 95,245.00	\$ 125,062.00	\$ 228,147.00	\$ -	\$ -
Line 12.05	Specialty Care/After Hours	\$ - \$ -	\$ 8,086.00	\$ -	\$ -	\$ -
	WIC Program	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
	Non-Reimbursable Expense - Subtotal	\$ 699,883.00	\$ 5,094,946.00	\$ 3,801,772.00	\$ 7,579,092.00	\$ 1,471,217.00
	Total Allowable Cost - Medical	\$ 16,745,702.00	\$ 7,261,050.66	\$ 7,491,831.06	\$ 22,489,136.09	\$ 33,870,083.00
	Total Allowable Cost - Dental	\$ -	\$ 2,652,907.34	\$ 3,451,386.94	\$ 8,307,636.91	\$ -
	Total Allowable Cost	\$ 16,745,702.00	\$ 9,913,958.00	\$ 10,943,217.00	\$ 30,796,773.00	\$ 33,870,083.00
Administrative and Overhead Allocations						
	Allocation Percentage - Medical		70.23%	71.02%	77.45%	
	Allocation Percentage - Dental		29.77%	28.98%	22.55%	
	Administrative Overhead Expense	\$ 6,959,544.00	\$ 3,489,632.00	\$ 3,456,961.00	\$ 12,284,798.00	\$ 16,623,269.00
	Administrative Overhead Allocated to Medical	\$ 6,959,544.00	\$ 2,450,849.66	\$ 2,455,246.06	\$ 9,515,080.09	\$ 16,623,269.00
	Administrative Overhead Allocated to Dental	\$ -	\$ 1,038,782.34	\$ 1,001,714.94	\$ 2,769,717.91	\$ -
Cost Allocation Cap						
	Admin Cap Per Encounter - Medical	\$ 89.92	\$ 159.59	\$ 138.34	\$ 129.99	\$ 109.04
	Admin Cap Per Encounter - Dental	\$ -	\$ 149.67	\$ 138.34	\$ 129.99	\$ 296.71
	Capped Administrative Overhead - Medical	\$ 6,959,544.00	\$ 2,450,849.66	\$ 2,455,246.06	\$ 9,515,080.09	\$ 16,623,269.00
	Capped Administrative Overhead - Dental	\$ -	\$ 974,218.83	\$ 1,001,714.94	\$ 2,769,717.91	\$ -
	Total Allowable Cost With Admin Cap - Medical	\$ 16,745,702.00	\$ 7,261,050.66	\$ 7,491,831.06	\$ 22,489,136.09	\$ 33,870,083.00
	Total Allowable Cost With Admin Cap - Dental	\$ -	\$ 2,598,343.93	\$ 2,451,358.94	\$ 8,307,636.91	\$ 4,893,961.68
	Total Allowable Cost With Admin Cap - Total	\$ 16,745,702.00	\$ 9,859,394.49	\$ 10,943,217.00	\$ 30,796,773.00	\$ 33,870,083.00

Medicaid Only and Adjusted for Fee-For-Service (Dental)

FQHC - Cost Based Adjusted for Administrative and Overhead (Admin OH) Cap

Provider Name	Total Allowable Cost - Dental	Total Dental Encounters	Total Dental Medicaid Encounters	Percentage of Medicaid Only Encounters	Adjusted Total Allowable Cost - Dental Only	Total Dental Medicaid Only Cost	Dental Cost Paid at FFS	Dental Medicaid Costs - Allowable in Per Diem	Cost Per Diem	Weighted Average	Weighted Average Amount
Dental Facility 1	\$2,652,907.34	6,509	2,344	36.01%	\$2,588,343.83	\$932,106.00	\$-	\$932,106.00	\$397.66	23.11%	\$91.91
Dental Facility 2	\$3,451,385.94	7,241	3,446	47.59%	\$3,451,385.94	\$1,642,518.43	\$130,456.67	\$1,512,061.76	\$438.79	33.98%	\$149.09
Dental Facility 3	\$8,307,636.91	21,307	4,352	20.43%	\$8,307,636.91	\$1,696,852.48	\$182,018.41	\$1,514,834.07	\$348.08	42.91%	\$149.36
	\$14,411,930.19	35,057	10,142		\$14,347,366.68	\$4,271,476.91	\$312,475.08	\$3,959,001.83	\$394.84	100.00%	\$390.36

Medicaid Only and Adjusted for Fee-For-Service (Medical) and Care Management

FQHC - Cost Based Adjusted for Administrative and Overhead (Admin OH) Cap

Provider Name	Total Allowable Cost - Medical	Total Encounters - Excludes Dental	Total Medicaid Encounters	Percentage of Medicaid Only Encounters	Adjusted Total Allowable Cost - Excludes Dental	Total Medicaid Only Cost	Medical Cost Paid at FFS	Care Management Payments	Medicaid Costs - FFS and Care Management Amounts	Cost Per Diem	Weighted Average	Weighted Average Amount
Facility 1	\$16,745,702.00	77,398	14	0.02%	\$16,745,702.00	\$3,029.02	\$-	\$-	\$3,029.02	\$216.36	0.03%	\$0.06
Facility 2	\$7,261,050.66	15,357	9,143	59.54%	\$7,261,050.66	\$4,322,965.82	\$1,566.44	\$2,177.00	\$4,319,222.38	\$472.41	19.18%	\$90.61
Facility 3	\$7,491,831.06	17,748	6,032	33.99%	\$7,491,831.06	\$2,546,243.24	\$-	\$2,714.36	\$2,543,528.88	\$421.67	12.65%	\$53.36
Facility 4	\$22,489,136.09	73,198	18,672	25.51%	\$22,489,136.09	\$5,736,729.82	\$1,725.49	\$25,784.09	\$5,709,220.24	\$305.76	39.17%	\$119.77
Facility 5	\$33,870,083.00	152,451	12,906	8.47%	\$33,870,083.00	\$2,867,329.77	\$37,002.00	\$7,848.97	\$2,822,478.80	\$218.70	27.08%	\$59.21
Facility 6	\$6,859,287.00	6,714	900	13.40%	\$4,893,961.68	\$656,027.03	\$-	\$3,342.80	\$652,684.23	\$725.20	1.89%	\$13.69
	\$94,717,089.81	342,866	47,667		\$92,751,764.49	\$16,132,324.70	\$40,293.93	\$41,867.22	\$2,153,052.92	\$393.35	100%	\$336.71

Final Rates

The Department developed reimbursement rates using a standardized rate-setting methodology based on allowable cost data, utilization, and applicable policy adjustments. This methodology produced modeled rates intended to reflect the full cost of service delivery.

The modeled rates are as follows:

- Medical: \$336.71
- Dental: \$390.36

Admin Costs

Administrative and overhead costs are not treated as standalone service-specific expenses but are instead recognized as shared costs across the entire facility. These costs include, but are not limited to, executive leadership, billing and finance functions, human resources, facility operations, and other general administrative activities necessary to support service delivery.

To appropriately reflect the role of these costs in rate development, administrative expenses are allocated proportionally across all program services. This allocation is based on each service's share of total facility costs, ensuring that administrative overhead is distributed in a manner consistent with overall resource utilization.

As a result, the administrative cost component embedded within each rate represents a proportionate share of total facility-wide administrative expenses, rather than a direct attribution to any single service line. This approach aligns with standard cost reporting practices and ensures that rates reflect the full cost of operating a provider, including necessary support functions.