Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

May 21, 2015 Joint Committee on Finance Paper #349

Reimbursement Rates for Federally Qualified Health Centers (Health Services -- Medical Assistance -- General)

[LFB 2015-17 Budget Summary: Page 206, #5]

CURRENT LAW

Federally qualified health centers (FQHCs), also known as community health centers, provide comprehensive health care services in medically underserved areas, or to underserved populations. These centers qualify for federal grant funding, and enhanced reimbursement under the medical assistance (MA, or "Medicaid") and Medicare programs. Table 1 provides a list of the 17 FQHCs in Wisconsin, some of which operate multiple sites.

Under the Medicaid program, states may choose to pay FQHCs through a prospective payment system (PPS), or using an alternate payment methodology that results in payments at least equal to the PPS. Federal law requires that an FQHC's PPS rate equal that center's reasonable costs during 1999 and 2000, adjusted for the following factors: (a) annual adjustments for medical cost inflation (measured by changes in the Medicare economic index); and (b) adjustments to take into account any increase or decrease in the scope of services provided by the center.

Currently, Wisconsin reimburses FQHCs for the reasonable cost of services provided. DHS provides monthly or quarterly payments based on the number of face-to-face contacts with a medical provider in an FQHC (known as "encounters"). FQHCs then submit reports to DHS of all encounters and costs. DHS audits these reports, and provides a final "cost settlement."

GOVERNOR

Transition, over three years, from the current FQHC reasonable cost reimbursement system to PPS reimbursement. Reduce funding for MA benefits by $7,245,800 (-$2,898,300 GPR and -$4,347,500 FED) in 2015-16 and $17,535,000 (-$7,014,000 GPR and -$10,521,000 FED) in 2016-17 to reflect the administration's estimate of the effect of this change.

TABLE 1

List of FQHCs in Wisconsin, and Primary Site*

Access Community Health Centers	Madison
Bridge Community Health Clinic	Wausau
Community Health Systems	Beloit
Family Health Center of Marshfield	Marshfield
Family Health/La Clinica	Wautoma
Kenosha Community Health Center	Kenosha
Lake Superior Community Health Center	Superior
Lakeshore Community Health Center	Sheboygan
Milwaukee Health Services	Milwaukee
N.E.W. Community Clinic	Green Bay
Northern Health Centers	Lakewood
NorthLakes Community Clinic	Iron River
Outreach Community Health Centers	Milwaukee
Partnership Community Health Center	Menasha
Progressive Community Health Centers	Milwaukee
Scenic Bluffs Community Health Centers	Cashton
Sixteenth Street Community Health Center	Milwaukee

*An FQHC may have multiple clinic sites.

DISCUSSION POINTS

1. FQHCs provide a range of medical, dental, and behavioral health services in medically underserved areas, or to underserved populations. According to the National Association of Community Health Centers, in 2013, 60% of patients seen by Wisconsin FQHCs qualified for Medicaid, and 23% were uninsured. DHS estimates that the MA program will spend approximately $152.1 million in 2014-15 for FQHC reimbursement, not including payments made to FQHCs by BadgerCare Plus health maintenance organizations for services provided to their members.

2. Federal law requires that state MA programs reimburse FQHCs for services they provide to MA recipients, at a minimum, at the PPS rate. The PPS rate specific to each FQHC equals the per-visit cost at an FQHC in 1999 and 2000, adjusted by an annual measure of medical cost inflation, and any changes in the scope of services that an FQHC offers. The Centers for Medicare and Medicaid Services (CMS) has indicated in guidance provided to states that scope of services means "the type, intensity, duration and/or amount of services" provided by an FQHC. This could include the addition or deletion of services, such as dental or behavioral health services, or the change in the mix of services provided.

3. States may pay FQHCs at an alternate rate, as long as that alternative is at least equal to amount an FQHC would receive under the PPS. Wisconsin currently reimburses FQHCs at 100% of their reasonable costs. This reasonable cost system was in effect in all states prior to the implementation of the PPS provisions in federal law.

4. Twenty-four states reimbursed FQHCs at PPS rates in 2014. The Governor recommends transitioning FQHC reimbursement over the next three state fiscal years to the PPS system. The administration indicates that it intends to continue the current cost reimbursement for tribal health clinics and rural health clinics.

5. The PPS system establishes a payment rate before the FQHC provides the services, compared to the current system in which the state accounts for the cost of services after they have been provided. An argument for transitioning to a prospective system such as the PPS, rather than the current retrospective system, is to achieve administrative simplification and predictability of annual costs. Also, since payments are based on an annually-adjusted flat rate, rather than actual costs incurred, the transition to the PPS may create incentives for FQHCs to find ways to operate more efficiently and contain costs.

6. FQHCs argue, however, that the current full cost reimbursement system allows for the ability to provide and expand services that, while potentially increasing FQHC costs, may result in lower total healthcare spending (for instance, increased behavioral health services that result in lower hospital emergency department use). They also indicate changes to the current cost-based reimbursement system, or reductions in rates paid to FQHCs generally, could negatively impact services available to medically underserved populations or in underserved areas, by limiting the services centers are able to provide both to Medicaid enrollees and uninsured individuals.

7. FQHCs also have raised concerns with the structure of the PPS provisions in federal law, including that the Medicare economic index is not an appropriate measure of FQHC cost inflation due to the mix of services provided and population served by FQHCs. The Government Accountability Office (GAO) also raised this concern in a 2005 report on PPS implementation.

8. Attachment 1 provides the projected funding reduction, by FQHC, that the administration used to generate the fiscal estimate for this item ($7,245,800 all funds in 2015-16, and $17,535,000 all funds in 2016-17). The administration based the cost estimate on the difference between projected current law rates and assumed PPS rates in each year of the 2015-17 biennium, applied to an assumed number of encounters with MA participants at each FQHC.

9. Subsequent to the introduction of the budget, the administration provided an updated analysis of this proposal that included all FQHCs in Wisconsin (as well as two border state FQHCs, and one Urban Indian Health Center), and updated certain assumptions of the model. Attachment 2 provides the administration's updated estimate of the fiscal effect for the 2015-17 biennium, and for the fully-implemented policy in 2017-18. This updated version assumes all funds reductions of $8,063,500 in 2015-16, $19,578,400 in 2016-17, and $33,425,800 in 2017-18.

10. The estimates shown are based on a projected rate under the current system, and a transitional PPS rate that reflects the administration's plan to implement the changes over the next three state fiscal years. One-third of the difference between the assumed current law rate and the PPS rate would be applied in 2015-16, two-thirds would be applied in 2016-17, and FQHCs would be reimbursed at the fully-implemented PPS rate in 2017-18. The annual increases in the administration's savings estimate reflect this implementation schedule.

11. The administration's estimate accounts for annual adjustments related to medical cost inflation. However, the assumed PPS rates do not adjust for changes in the scope of services offered by FQHCs. As a result, the assumed PPS rate for any FQHC that has changed its scope of services (either increased or decreased) since 2000 would not be accurately accounted for in the bill.

12. The administration indicates it will account for scope of service changes that have occurred in FQHCs when implementing this proposal, as federal law requires. DHS plans to continue to reimburse FQHCs at the current interim encounter rate while it seeks federal approval for this change under a state Medicaid plan amendment, and any it would retroactively apply any change to all payments made after July 1, 2015.

13. Both DHS and the Wisconsin Primary Health Care Association (WPHCA), an organization that represents FQHCs, indicate that it is not possible at this time to estimate appropriate scope of service adjustments for each FQHC, and developing a methodology and submit necessary information would require considerable work by the Department and the FQHCs. Consequently, it is not possible to reestimate the administration's projections to more accurately reflect the fiscal impact of this decision until the scope of service adjustment is included in the rates.

14. The length of time the state would need to develop and implement the PPS system is also not known. GAO indicated in its 2005 report that it took states an average of 15 months from the effective date of the federal law to complete implementation of the PPS, though this average length may not be instructive to the proposed transition in Wisconsin.

15. This proposal may also affect administrative costs, although the overall effect on workload is not known. The administrative work to audit FQHC cost reports would be expected to decrease, though the costs to develop a process for making scope of service changes, and to review and approve those changes on an ongoing basis, may offset those potential savings.

16. DHS indicates that it believes the estimates in the bill are reasonable, and has not recommended any changes to the fiscal effect associated with this item. However, the projected impact on FQHC reimbursement under the administration's model calls into question the feasibility of generating a similar amount of savings after implementing the PPS rates. The updated estimates shown in Attachment 2 result in average rate decreases of 8% in 2015-16, 17% in 2016-17, and 27% once the provision is fully implemented in 2017-18. NorthLakes Community Clinic's estimated percentage reductions are the largest, at 18%, 37%, and 57%, respectively.

Rate decreases of the magnitude projected under these estimates would presumably have a major impact on FQHC operations. The average projected MA funding reduction in 2017-18 shown in Attachment 2 equals $1.6 million. While some FQHCs would see relatively small total revenue reductions (either because the projected PPS and current law rates are similar, or because the center sees a relatively low number of Wisconsin Medicaid participants), other FQHCs have significant projected reductions. For instance, the administration's estimates include a projected revenue decrease of $8.2 million to Access Community Health Centers in 2017-18, an amount that would represent 30% of its total reported 2013-14 patient service and other revenue of $27.8 million.

DHS cautions against relying on the FQHC-specific projections contained in the model prior

to accounting for scope of service changes. However, it is not clear how the administration could generate the total savings associated with this item without reducing payments to FQHCs by amounts that, on average, are similar to those shown in Attachment 2.

17. A transition to the PPS system would likely constrain overall payments to FQHCs, since reimbursement would no longer be linked directly to an FQHC's full cost. However, for the reasons discussed above, the Committee should not assume that this item would result in the savings amount initially estimated by the administration.

18. The Committee could adopt the Governor's proposal as introduced (Alternative 1). However, if the proposal did not generate the estimated savings projected by the administration, and if DHS did not generate savings in other parts of the Medicaid program, this would result in a deficit in the Medicaid budget of approximately $10 million GPR ($24 million all funds) over the 2015-17 biennium.

19. If the Committee wants to allow DHS to phase in the PPS rates for paying FQHCs, but does not want to assume that the savings estimated under the bill will be realized, it could delete the fiscal changes. As current statutes are silent as to the Department's methodology for reimbursing FQHCs, DHS would be able to pursue the PPS payment system (Alternative 2).

20. If the Committee wanted to delete the Governor's recommendation, and ensure that DHS did not change the current cost-based reimbursement system, it would have to enact a statutory change to prohibit the Department from doing so (Alternative 3). This would prevent DHS from changing the current payment system, but could constrain DHS from making other possible adjustments that may improve the reimbursement system or patient care provided at FQHCs.

21. WPHCA has indicated that there may be other policy options to achieve administration simplification and other goals of the PPS. These include transitioning to PPS rates with an FQHC's most current reasonable cost as the "base" amounts, or implementing an alternate system that does not reimburse solely based on the number of patient encounters. The Committee could delete the provision, and require DHS to develop a proposal, in consultation with FQHCs, to change the FQHC reimbursement system. Under this alternative, DHS would be required to include this proposal in its agency budget request for the 2017-19 biennium (Alternative 4).

22. If the Committee agrees with the administration's position that the PPS would produce administrative and cost-saving benefits for the Medicaid program, but wanted to provide more time for the Department to fully develop the proposal and the necessary scope of service changes for PPS rates, and provide time for FQHCs to plan for any changes in reimbursement, it could delay the implementation of the proposal.

23. Under Alternative 5, DHS would be required to reimburse FQHCs under the current methodology for services provided in the 2015-17 biennium. Beginning on July 1, 2017, DHS would be required to reimburse FQHCs at rates based on the PPS for Medicaid services, with the effect phased-in over state fiscal years 2017-18, 2018-19, and 2019-20. Similar to Alternative 4, DHS would be required to consult with FQHCs while finalizing the provisions of this system.

24. Finally, the Committee could impose a one-year delay on the implementation of the PPS system to allow for additional planning and consultation with FQHCs. Under this alternative, the Committee could delete the fiscal effect associated with this item, recognizing that the actual effect will depend on the scope of service changes (Alternative 6a). Alternatively, the Committee could partially delete the funding reduction, using the DHS methodology for projecting the fiscal effect (Alternative 6b). This would restore $15,797,900 ($5,790,100 GPR and $9,320,500 FED) over the biennium, though this estimate would be subject to the same potential issues regarding scope of service adjustments as the administration's initial estimate. If the estimated savings do not occur, this could result in a deficit in the Medicaid budget.

ALTERNATIVES

1. Adopt the Governor's recommendation.

2. Delete provision.

ALT 2	Change to Bill
GPR	$9,912,300
FED	14,868,500
Total	$24,780,800

3. Delete provision. In addition, prohibit DHS from changing its FQHC reimbursement methodology from the methodology that was in effect on January 1, 2015.

ALT 3	Change to Bill
GPR	$9,912,300
FED	14,868,500
Total	$24,780,800

4. Delete provision. Instead, require DHS to develop a proposal, in consultation with FQHCs, to modify the system of reimbursement for FQHCs. Require DHS to submit this proposal as part of its agency budget request for the 2017-19 biennium.

ALT 4	Change to Bill
GPR	$9,912,300
FED	14,868,500
Total	$24,780,800

5. Delete provision. Instead, require DHS to reimburse FQHCs, for services provided prior to July 1, 2017, under the methodology in effect on January 1, 2015. Require DHS to reimburse FQHCs, for service provided on or after July 1, 2017, at a payment system based on the

Medicaid prospective payment system, with a three-year phase-in for the new rates (effective for fiscal years 2017-18, 2018-19, and 2019-20). Require DHS to consult with FQHCs as it develops this system.

ALT 5	Change to Bill
GPR	$9,912,300
FED	14,868,500
Total	$24,780,800

6. Require DHS to reimburse FQHCs, for services provided prior to July 1, 2016, under the methodology in effect on January 1, 2015. Require DHS to reimburse FQHCs for services provided on or after July 1, 2016, at a payment system based on the Medicaid prospective payment system, with a three-year phase-in for new rates (effective for fiscal years 2016-17, 2017-18, and 2018-19). Require DHS to consult with FQHCs as it develops this system. In addition, adopt one of the two fiscal changes shown below:

a. Delete the fiscal changes recommended in the bill.

ALT 6a	Change to Bill
GPR	$9,912,300
FED	14,868,500
Total	$24,780,800

b. Increase MA benefits funding by $7,245,800 ($2,898,300 GPR and $4,347,500 FED) in 2015-16, and $8,552,100 ($3,579,100 GPR and $4,973,000 FED) to reflect a one-year delay of the fiscal effect of this item under the administration's methodology.

ALT 6b	Change to Bill
GPR	$6,477,400
FED	9,230,500
Total	$15,797,900

Prepared by: Sam Austin
Attachments

ATTACHMENT 1

Original Administration Estimates of the Fiscal Effect of Proposed FQHC Reimbursement Change
(Basis for Amount in Biennial Budget Bill)

	2015-16			2016-17		
	Projected Current Law Rate	Transitional PPS Rate	Fiscal Effect	Projected Current Law Rate	Transitional PPS Rate	Fiscal Effect
Access Community Health Centers	$213.62	$184.33	-$2,049,600	$221.52	$158.93	-$4,789,900
Family Health Center of Marshfield	246.62	232.67	-1,209,700	255.75	223.81	-3,011,300
Family Health Center of Marshfield - Dental	247.34	233.15	-954,900	256.49	224.06	-2,373,700
NorthLakes Community Clinic	279.24	228.25	-962,600	289.57	181.97	-2,224,000
Kenosha Community Health Center	175.06	158.63	-759,800	181.54	145.61	-1,813,100
Partnership Community Health Center	184.69	168.05	-365,600	191.52	155.04	-874,900
Scenic Bluffs Community Health Centers	237.32	203.29	-335,500	246.10	173.55	-782,500
Northern Health Centers	225.04	191.89	-322,900	233.36	162.77	-752,200
Milwaukee Health Services	229.32	226.19	-103,700	237.81	228.08	-342,600
Community Health Systems	196.52	194.85	-49,100	203.79	197.51	-193,900
Family Health/La Clinica	164.24	154.42	-101,800	170.31	147.97	-252,100
Progressive Community Health Centers	186.90	185.92	-8,400	193.81	189.08	-42,200
Lake Superior Community Health Center	219.10	217.23	-10,300	227.20	220.20	-40,700
Outreach Community Health Centers	196.94	194.75	-11,900	204.23	196.90	-41,900
Total			-$7,245,800			-$17,535,000

ATTACHMENT 2

Revised Administration Estimates of the Fiscal Effect of Proposed FQHC Reimbursement Change

	2015-16			2016-17			2017-18		
	Projected Current Law Rate	Transitional PPS Rate	Fiscal Effect	Projected Current Law Rate	Transitional PPS Rate	Fiscal Effect	Projected Current Law Rate	Projected PPS Rate	Fiscal Effect
Access Community Health Centers	$213.62	$183.97	-$2,113,600	$221.52	$158.03	-$4,948,500	$229.72	$127.93	-$8,161,100
Family Health Center of Marshfield	246.62	232.08	-1,312,200	255.75	222.35	-3,277,000	265.21	208.32	-5,737,600
Family Health Center of Marshfield - Dental	249.60	234.07	-1,060,200	258.83	223.37	-2,632,700	268.41	208.32	-4,586,300
NorthLakes Community Clinic	275.76	225.57	-932,600	285.96	179.86	-2,157,900	296.54	128.46	-3,517,400
Kenosha Community Health Center	175.06	158.26	-768,600	181.54	144.71	-1,839,100	188.26	127.93	-3,097,400
Partnership Community Health Center	184.10	167.27	-375,100	190.92	153.87	-900,700	197.98	137.11	-1,521,900
Lakeshore Community Health Center	266.48	222.19	-378,000	276.34	182.35	-877,700	286.57	137.11	-1,435,800
Northern Health Centers	229.89	194.76	-343,000	238.40	163.55	-799,400	247.22	127.77	-1,312,400
Scenic Bluffs Community Health Centers	237.32	202.90	-338,200	246.10	172.58	-790,200	255.21	137.58	-1,300,500
Milwaukee Health Services	226.86	223.91	-101,700	235.25	225.66	-351,900	243.96	223.73	-765,200
Community Health Systems	196.52	194.30	-63,800	203.79	196.14	-232,300	211.33	194.81	-517,700
Family Health/La Clinica	168.49	156.87	-120,600	174.73	148.48	-296,300	181.19	137.11	-511,500
Bridge Community Health Clinic	196.90	196.13	-11,100	204.19	199.47	-69,900	211.74	199.67	-186,700
Gerald L. Ignace Indian Health Center	289.98	256.23	-44,500	300.71	227.70	-105,200	311.84	193.68	-175,200
Progressive Community Health Centers	186.90	185.39	-12,900	193.81	187.77	-54,300	200.98	187.14	-128,700
Outreach Community Health Centers	196.94	194.21	-14,800	204.23	195.54	-50,000	211.78	193.68	-107,300
Lake Superior Community Health Center	219.10	216.62	-13,000	227.20	218.67	-47,500	235.61	217.20	-105,900
N.E.W. Community Clinic	215.77	204.64	-21,900	223.75	197.75	-55,600	232.03	187.14	-98,700
Upper Peninsula Association of Rural Health Services	155.26	145.01	-18,600	161.01	137.75	-46,000	166.96	127.77	-79,800
Crescent Community Health Center	178.06	163.40	-19,100	184.65	152.09	-46,200	191.48	137.58	-78,700
Sixteenth Street Community Health Center	173.99	176.78	0	180.43	183.30	0	187.10	187.14	0
Total			-$8,063,500			-$19,578,400			-$33,425,800