United States General Accounting Office

GAO

Report to Congressional Committees

June 2001

HEALTH CENTERS AND RURAL CLINICS

Payments Likely to Be Constrained Under Medicaid's New System

GAO-01-577

Contents

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United States General Accounting Office
Washington, DC 20548

June 19, 2001

Congressional Committees

To increase the accessibility of primary and preventive health services for low-income people living in medically underserved areas, Congress made Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) eligible for Medicaid payments. FQHCs are urban or rural centers that provide comprehensive community-based primary care services to the medically underserved regardless of their ability to pay; FQHCs have two major revenue sources—Medicaid (34 percent) and federal grant funds from the Health Resources and Services Administration (23 percent). RHCs provide primary care services in rural underserved areas and may be operated either as independent clinics or as parts of larger organizations, such as hospitals. On average, RHCs receive approximately 25 percent of their revenue from Medicaid, and almost 60 percent of their revenue from Medicare and private insurance payments. Since 1989, federal law has required the Medicaid program to reimburse both FQHCs and RHCs based on their reasonable costs, that is, costs that are not excessive for a type of cost or service provided to Medicaid beneficiaries.[1] While such reimbursement can ensure that service providers are reimbursed for necessary costs, it is also regarded as inflationary because providers can increase their payments by raising their costs.

From 1997 through 2000, Congress on three occasions has modified requirements for Medicaid reimbursement for FQHCs and RHCs. These changes have generally relaxed requirements to use cost-based reimbursement, but have also aimed to ensure the financial well-being of FQHCs and RHCs. The Balanced Budget Act of 1997 (BBA) gave states the flexibility to gradually phase out Medicaid cost-based reimbursement by 2003.[2] However, BBA also required that states using capitated managed care plans in their Medicaid programs supplement managed care plan payments to FQHCs and RHCs if necessary to ensure they receive as much

[1]Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. No. 101-239, 103 Stat. 2258, 2264) established the Federally Qualified Health Centers program in Medicaid and required state Medicaid agencies to reimburse FQHCs for 100 percent of reasonable costs. Cost-based reimbursement for RHCs dates back to 1977. See P.L. No. 95-210, 91 Stat. 1485, 1488).

[2]See Section 4712 of the Balanced Budget Act of 1997 (P.L. 105-33).

as they would have under the cost-based reimbursement requirements.[3] The Balanced Budget Refinement Act of 1999 (BBRA) slowed the phase out of cost-based reimbursement requirements for FQHCs and RHCs.[4] Most recently, the Benefits Improvement and Protection Act of 2000 (BIPA) replaced the requirement for cost-based reimbursement with a new prospective payment system (PPS) that is effective for services provided beginning January 1, 2001.[5] Under the PPS, the first year's payment is set at an FQHC's or RHC's average cost per visit for 1999 and 2000. Future years' payments are adjusted annually for inflation, and when necessary, for changes in the scope of services.

BBRA also required that we evaluate the impact of changing Medicaid reimbursement to FQHCs and RHCs. Specifically, we (1) describe how states implemented the pre-BBA cost-based reimbursement requirement and the extent to which states' practices changed following the enactment of BBA and (2) assess the potential impact of the PPS enacted under BIPA on FQHCs and RHCs.

To examine these issues, we surveyed Medicaid officials in 50 states and the District of Columbia regarding their FQHC and RHC reimbursement policies. We visited eight FQHCs and nine RHCs in five states with varying reimbursement policies. (For additional detail on our survey and the FQHCs and RHCs we visited, see app. I.) We spoke with officials at the federal Health Care Financing Administration (HCFA), which oversees states' Medicaid programs and also has responsibilities for RHCs.[6] We also spoke with officials from the Health Resources and Services Administration (HRSA), which is responsible for reviewing FQHC applications and disbursing federal grant funds to FQHCs. Our work was conducted from May 2000 through May 2001 in accordance with generally accepted government auditing standards.

[3]Over one-half of the states currently have some populations enrolled in capitated managed care plans.

[4]See Section 603 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement of 1999 (P.L. 106-113).

[5]See Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554).

[6]On June 14, 2001, the Secretary of Health and Human Services announced that the name of HCFA has been changed to the Centers for Medicare & Medicaid Services (CMS).

Results in Brief

In implementing the pre-BBA cost-based reimbursement requirement, many states controlled payment rates by imposing limits on what costs were considered reasonable. These limits resulted in payments to FQHCs and RHCs below the actual costs incurred. States generally reported using three types of limits on costs to be reimbursed—setting overall caps, limiting administrative costs, or setting performance standards. Following the enactment of BBA, only a few states chose to use the authority granted in the act to reduce payments to FQHCs and RHCs. Thirty-eight states and the District of Columbia were subject to the BBA requirement to provide supplemental payments to FQHCs and RHCs where required to ensure that total reimbursement for Medicaid managed care beneficiaries was equivalent to what would be paid under the cost-based requirement. The remaining states had received approval from HCFA to waive the requirement for making supplemental payments.

BIPA established a new nationwide PPS for Medicaid reimbursement of FQHCs and RHCs that is likely to constrain future payments. Initial payments under the PPS will reflect each FQHC's or RHC's average 1999 and 2000 per-visit reasonable costs as defined by each state. In many cases, this average payment may be lower than what an FQHC or RHC received in 2000. Beginning in 2002, payments will be adjusted annually using an inflation index independent of individual FQHCs' and RHCs' costs, and increases are likely to be lower than what had been historically provided. Ultimately, an FQHC's and RHC's ability to manage under the new PPS will depend on its initial rate and its ability to keep its cost growth at or below the inflation adjustment. FQHCs or RHCs that, for example, had high per-visit costs when the rates were established, may be able to manage by increasing service volume or find other efficiencies to lower their per-visit costs. FQHCs or RHCs with low initial per-visit costs, however, may be less able to reduce their cost growth.

In commenting on a draft of this report, the Department of Health and Human Services (HHS) generally concurred that the new BIPA PPS has the potential to limit payments to FQHCs and RHCs. Furthermore, HHS also noted that the effects of the new system would vary among FQHCs and RHCs, and agreed that FQHCs and RHCs that are already operating efficiently could be penalized. HHS also requested that we provide greater emphasis in our discussion of several provisions in BIPA.

Background

FQHCs and RHCs operate under separate programs, both of which were established to increase access to care for low-income people in medically underserved areas. FQHCs are required to provide a comprehensive set of

primary care services to any individual, regardless of ability to pay. In addition, a distinguishing feature of FQHCs is that they provide enabling services that help patients gain access to health care, such as outreach, translation, and transportation. FQHCs include community health centers, migrant health centers, public housing programs, health care for the homeless, and other centers and clinics. FQHCs vary considerably based on their location, size of their uninsured and Medicaid populations, revenue mix, market competition, and managed care penetration in the surrounding area. For instance, an FQHC may be located in an urban area with a large uninsured or Medicaid population and high capitated Medicaid managed care penetration, or in a rural area, where it serves as the only source of primary health care for several communities. Currently, there are over 1,200 FQHCs operating over 3,000 delivery sites that provide services to about 11 million people each year.

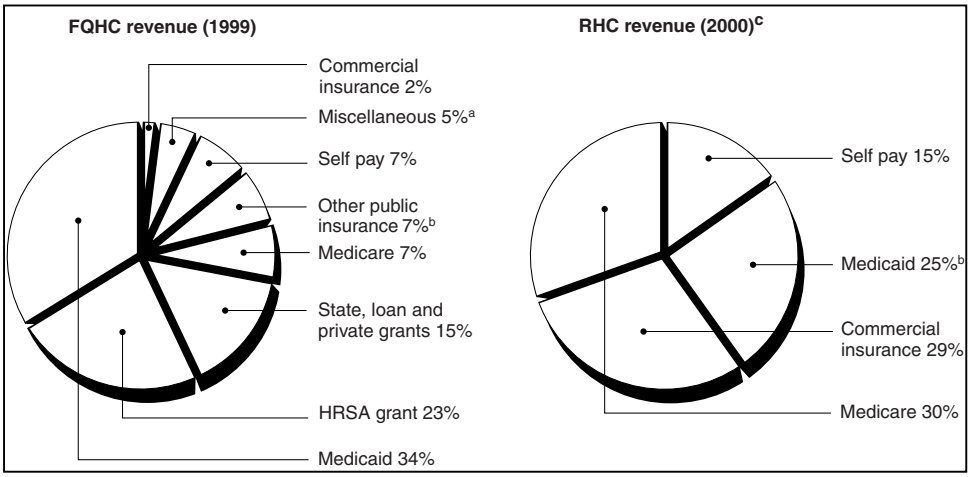
Unlike FQHCs, RHCs are not required to provide services to all individuals; however, they are required to operate in areas that are designated as underserved. RHCs can operate either independently or as parts of larger organizations, such as hospitals, skilled nursing facilities, or home health agencies. RHCs can serve as specialty clinics, focusing their services on particular populations or specialties such as pediatrics or obstetrics and gynecology. There are now approximately 3,500 RHCs.[7]

FQHCs and RHCs receive, on average, one-quarter to one-third of their revenues from Medicaid, a joint federal-state program that annually finances health care for more than 40 million low-income Americans. (See fig. 1.) FQHCs primarily rely on Medicaid reimbursement and HRSA grant funds as sources of revenue. From 1996 through 1999, Medicaid dollars per Medicaid patient increased from $348 to $383, while HRSA grant dollars per uninsured FQHC patient declined from $228 to $219.[8] FQHCs also receive revenue from state, local, and private grants; Medicare and other public insurance; and self-pay and commercial insurance. In contrast, RHCs receive a smaller proportion of revenue from Medicaid and a much higher proportion of Medicare, commercial insurance, and self-pay revenue.

[7]There are no RHCs in Connecticut, Delaware, the District of Columbia, Maryland, Massachusetts, or New Jersey.

[8]While the amount of HRSA grant dollars per uninsured has declined, aggregate funding for the grant program has increased in recent years.

Figure 1: Comparison of Revenue Sources for FQHCs and RHCs



[a]Miscellaneous revenue includes other federal grants and non-patient-related revenue.

[b]Revenue from the State Children's Health Insurance Program (SCHIP) is reported differently by FQHCs and RHCs. FQHCs report SCHIP revenue under Medicaid or the Other Public Insurance category, while RHCs report SCHIP revenue under the Medicaid category only.

[c]RHC data are from a National Rural Health Clinic Survey that was sent to a random sample of approximately one-half of the RHCs; response rate to this survey was 42 percent. Because component percentages were rounded, totals do not add to 100 percent.

Source: FQHC Data – Uniform Data System—HRSA; RHC Data – National Rural Health Clinic Survey.

Medicaid Reimbursement for FQHCs and RHCs

Prior to BBA, federal law required state Medicaid programs to pay FQHCs and RHCs on a cost-related basis. In determining payments, states required FQHCs and RHCs to submit cost reports. States reviewed these cost reports to determine which reported costs were allowable (related to providing services to Medicaid beneficiaries) and reasonable (not an excessive amount for a type of cost or service).

For purposes of reimbursing FQHCs and RHCs for services, the Medicaid statute directs states to follow the Medicare statute and regulations.[9] The Medicare regulations provide guidance on the types of allowable costs, citing activities such as compensation for physicians and other staff, supplies, administrative overhead, and other items. With regard to

[9]See Title XIX of the Social Security Act, § 1902(a)(13)(C).

reasonableness of cost, states may set limits, or in the case of RHCs, may rely on Medicare limits on the cost of providing a service.[10] These limits can include a ceiling on recognized costs per service, such as a medical visit, or a limit on a type of cost, such as administrative costs.

Since regulations require payments to be based on actual costs—which could only be reported after the close of an FQHC's or RHC's fiscal year—states generally made interim payments to FQHCs and RHCs throughout the year and subsequently adjusted these payments after actual cost reports were filed. The regulations state that these interim payments to FQHCs and RHCs are subject to reconciliation, which generally occurred after the submission of a cost report.[11] During reconciliation, the total amount of reasonable costs was determined and compared to the interim payments that the FQHCs or RHCs received, and the state Medicaid program either paid any shortfall or recouped any overage.

BBA gave states the option of phasing out cost-based reimbursement by percentage reductions in reasonable costs reimbursed—to 95 percent of an FQHC's or RHC's reasonable costs in 2000, 90 percent in 2001, 85 percent in 2002, and 70 percent in 2003—and discontinuing the cost-based reimbursement requirement after 2003. States were simultaneously required to make supplemental payments to FQHCs and RHCs that served capitated Medicaid managed care plan enrollees. Under BBA, states were required to compare the aggregate managed care plans' payments to the amount that an FQHC or RHC would receive under the cost-based reimbursement methodology. In the event that total managed care payments were less, states were expected to provide supplemental payments to FQHCs and RHCs to make up the difference.[12]

BBRA slowed the phase out of cost-based reimbursement, freezing allowed reductions at 95 percent for 2001 and 2002. It allowed states to resume reductions to 90 percent of costs in 2003, 85 percent of costs for 2004, and a complete phase out of the cost-based reimbursement

[10]In some cases, particularly with RHCs, a state's Medicaid program adopted Medicare's payment rate as permitted by statute and regulation. See Title XIX of the Social Security Act, § 1902(a)(13)(C).

[11]See 42 C.F.R. § 405.2466.

[12]To the extent that managed care plans reduced the volume of visits, an FQHC or RHC may still receive less under this arrangement than what it might have received under cost-based reimbursement, which has no constraints on patient visits.

requirement in 2005. BBRA also extended requirements for supplemental payments through 2004 for FQHCs and RHCs participating in capitated Medicaid managed care.

BIPA specified a new nationwide PPS to reimburse FQHCs and RHCs for Medicaid visits. An FQHC's or RHC's PPS rate is the average of its own 1999 and 2000 reasonable costs per visit, effective for services provided beginning January 1, 2001. For future years' payments, this amount will be adjusted annually for inflation.[13] In addition to this annual adjustment, BIPA requires that payments to FQHCs and RHCs be adjusted in the event of any increase or decrease in the scope of services furnished. States also may receive approval from HCFA to use an alternative system if they can demonstrate that the alternative payment methodology used results in rates no lower than the prospective system's minimum payment and if the FQHC or RHC agrees to its use.

Payment Rates Generally Complied With Federal Requirements, but Many States Limited Costs Reimbursed

In fulfilling prior federal requirements to use cost-based reimbursement for FQHCs and RHCs, many states controlled payment rates by imposing limits on costs considered reasonable. States generally reported using three types of spending limits—setting overall caps, limiting administrative costs, or setting performance standards—in defining reasonable costs. As a result, not all costs incurred by FQHCs, RHCs, or both were reimbursed. A few states did not reconcile costs—that is, compare the total Medicaid reimbursement with the total amount of Medicaid payments for a reporting period and settle any over- or under-payments—as required by HCFA regulation.[14]

BBA contained two major provisions regarding Medicaid reimbursement for FQHCs and RHCs: allowing states to reduce the percentage of reasonable cost reimbursed and mandating that states make supplemental payments. With regard to the first provision, most states did not choose to modify their payment practices and reduce the percentage of reasonable costs reimbursed. With regard to the second provision, 38 states and the District of Columbia were subject to the BBA requirement to provide supplemental payments to FQHCs and RHCs that were contracting with capitated Medicaid managed care plans in the event that plan payments

[13]The inflation adjuster will be the Medicare Economic Index for primary care, which represents the increase applied to physician fees in order to reflect inflation.

[14]42 C.F.R. § 405.2466.

were less than what these FQHCs and RHCs would have received under cost-based reimbursement.

Many States Already Limited Costs Reimbursed Before BBA Enactment

Many states' Medicaid programs reported imposing one or more limits in defining FQHCs' and RHCs' reasonable costs. These limits can significantly affect what FQHCs and RHCs are paid. While most states employed a retrospective system that reconciled reimbursement with actual reasonable costs, at least seven states based payments for FQHCs, RHCs, or both on a prior period's reasonable costs, and most adjusted them for inflation without a reconciliation process—a practice that is inconsistent with HCFA reconciliation regulations.

For FQHCs, states reported using three types of limits in defining reasonable costs: setting overall caps, setting performance standards, or limiting administrative costs.[15]

- Twenty-four states reported limits on how much they reimbursed for a patient's visit, sometimes by comparing FQHCs' costs across the state to establish a cap. Alabama and Florida, for example, limited reasonable costs to the 80th percentile of FQHCs' costs per visit, while Maryland limited reasonable costs by establishing an overall cap at 115 percent of the median cost per visit across FQHCs.
- Twelve states limited reasonable costs by setting performance or productivity standards. For instance, some states stipulated the number of visits per year that a full-time-equivalent physician should provide; similar guidelines were used for nurse practitioners and physician assistants. Similarly, New Jersey required a certain number of visits per hour for physicians and other medical personnel.
- Ten states reported limits on administrative costs, disallowing administrative costs exceeding 30 to 45 percent of total costs. For example, Maryland limited the amount of administrative costs reimbursed

[15]As part of our survey, we asked states to report or provide documentation regarding their reimbursement practices. States' responses, however, varied in the amount of documentation provided. Thus, our counts reflect the minimum number of states that may use these limits.

to one-third of total costs, while Wisconsin did not reimburse administrative costs in excess of 30 percent of the center's total costs.[16]

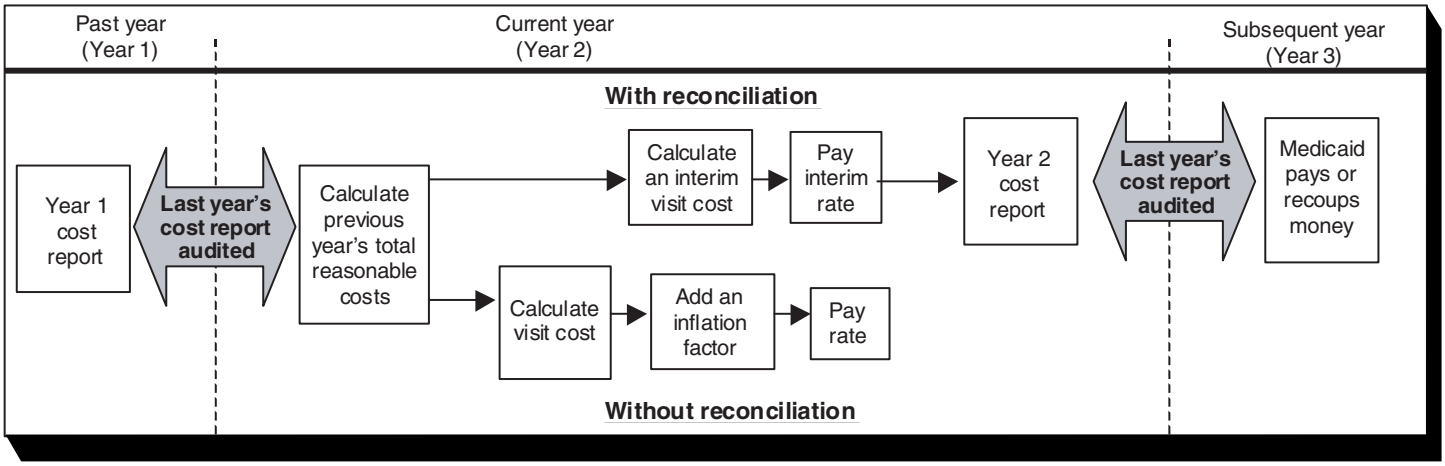
With regard to RHCs, 32 of the 45 states with RHCs reported relying on Medicare's payment methodology for determining reasonable costs. Medicare payment policies include both an overall cap and a performance or productivity standard. In 2000, the Medicare payment cap for RHCs was $61.85 per visit.

As noted above, HCFA regulations provide that Medicaid interim payments to FQHCs and RHCs are subject to reconciliation based on actual reasonable costs. Most states reimbursed FQHCs and RHCs under a retrospective system that includes interim payments based on estimated costs and a year-end reconciliation process to account for differences in reimbursement and actual reasonable costs. However, seven states (Colorado, Connecticut, Delaware, Florida, Maryland, New York, and Rhode Island) and the District of Columbia reported setting payment rates for FQHCs based on a prior year's costs with most adjusting for inflation—essentially establishing prospectively determined rates. The difference between these states' processes and states with end-of-year reconciliation is illustrated in figure 2. Four of the seven states—Delaware, Maryland, New York, and Rhode Island—were granted a waiver of the reconciliation requirement under Section 1115 of the Social Security Act.[17] However, the remaining three states—Colorado, Connecticut, and Florida—and the District of Columbia were not in compliance with the reconciliation regulation since they did not reconcile with their FQHCs and RHCs and did not obtain a waiver of this requirement.

[16]Limits on reasonable costs have been a matter of legal dispute between FQHCs and RHCs and states' Medicaid programs. For example, in a settlement agreement Florida expanded its definition of reasonable costs to include additional administrative costs. In contrast, a New Jersey official reported that a recent legal challenge to the state's definition of reasonable costs was unsuccessful.

[17]Section 1115 of the Social Security Act grants HCFA the authority to provide states with a waiver of certain Medicaid requirements to test concepts likely to assist in promoting program objectives; these waivers are intended to offer greater flexibility in the areas of utilization, benefit modification, eligibility, and reimbursement rules.

Figure 2: The Typical Reimbursement Process for FQHCs



Source: GAO analysis.

Few States Used BBA Flexibility to Reduce Payments and All Made Supplemental Payments, if Required

Most states chose not to reduce their reimbursements to FQHCs and RHCs as allowed by BBA. According to our survey, five states and the District of Columbia chose to implement the BBA reduction to 95 percent of reasonable costs for their FQHCs, RHCs, or both. Alabama, Minnesota, and Nevada reduced payments to both FQHCs and RHCs. Connecticut and the District of Columbia reduced payments to FQHCs, while Maine did so for RHCs.

As required by BBA, states with capitated managed care plans did make supplemental payments to FQHCs or RHCs or received a waiver from HCFA from this requirement. These supplemental payments were to make up the difference between the reimbursement FQHCs and RHCs received from managed care organizations and what they would have received under cost-based reimbursement. Not all states were required to make supplemental payments. Thirty-eight states and the District of Columbia were subject to this BBA requirement, while the remaining 12 states received approval from HCFA to waive supplemental payments. (See fig. 3.)

Figure 3: The Applicability of the Supplemental Payment Requirement in BBA

Source: GAO Survey, 2000.

Of the 38 states and the District of Columbia that were subject to the BBA requirement for supplemental payments, 12 states did not have capitated Medicaid managed care, so the BBA policy did not affect them. Twenty-five of the remaining 26 states and the District of Columbia made supplemental payments to FQHCs participating in Medicaid managed care, while 16 states made payments to RHCs.[18] Fewer RHCs qualified for supplemental payments because many operated in areas that did not have

[18]New Hampshire did not have any FQHCs participating in capitated Medicaid managed care.

managed care. (App. II shows states' practices with regard to supplemental payments.)

The 12 states that have received approval to waive supplemental payments are operating under Section 1115 waivers, under which HCFA can allow states to waive most federal Medicaid requirements for a demonstration project that is likely to assist in promoting program objectives. Of the 12 states with waivers, 4 states—Arizona, Hawaii, New York, and Rhode Island—made supplemental payments, but not the full amount that would be required under BBA.[19] New York, for example, provided varying percentages of the difference between reasonable costs and managed care payments, depending on when mandatory managed care enrollment began in the county where the FQHC is located. New York reimbursed FQHCs 90 percent of the difference during the first year of mandatory managed care and 50 percent in subsequent years.[20] RHCs in New York received supplemental payments only if (1) at least 50 percent of the RHC's visits were provided to Medicaid beneficiaries or (2) 60 percent of the visits were provided to Medicaid beneficiaries and indigent persons; as of April 2001, no RHCs had qualified under this provision. In Rhode Island, supplemental payments were unrelated to the costs of an FQHC or RHC; instead, the state legislature allocated funds that were distributed to FQHCs and RHCs based on a set per-member-per-month amount.

New System Likely to Constrain Future Payments

BIPA established a new nationwide PPS for Medicaid that is likely to constrain future payments. In particular, some FQHCs and RHCs may receive Medicaid payment increases that are lower than what they have received in the past. Ultimately, an FQHC's or RHC's ability to manage under the new PPS will depend on its initial payment rate, and changes it can make to keep its cost growth at or below the inflation index.

[19]Of the eight states that currently operate under 1115 waivers and do not provide supplemental payments, two of these states—Oklahoma and Delaware—previously offered such payments during the initial years of the waiver, but have discontinued this practice.

[20]New York planned to phase out supplemental payments after 2 years; however, instead of phasing out payments, the state has maintained the provision of supplemental payments at 50 percent.

All states—including those with 1115 waivers—will have to comply with the new payment system requirement established by BIPA.[21] Under this new system, an FQHC's or RHC's prospective payment rate is the average of its own 1999 and 2000 reasonable costs per visit, which will be updated for inflation in future years. These initial rates became effective for services provided beginning January 1, 2001. States may receive approval from HCFA to use an alternative system to reimburse some or all of their FQHCs and RHCs, if they can demonstrate that the alternative payment methodology would result in rates no lower than the prospective system's minimum payment and if the FQHC or RHC agrees to the alternative methodology. In addition, BIPA requires that we assess the need for adjusting the initial rate for FQHCs and RHCs.[22]

States can continue to use their prior methods of determining reasonable costs in establishing the 2001 payment rate under the PPS. Under these circumstances, the initial PPS rates would reflect average 1999 and 2000 per-visit reasonable costs rather than the actual costs incurred by the FQHC or RHC. For the FQHCs and RHCs in the states that have applied limits in determining reasonable costs, this could result in 2001 PPS rates well below their actual costs. In contrast, the 2001 PPS rate for FQHCs and RHCs in states that did not incorporate reasonable cost limits—or that have costs below their states' overall caps—will be closer to their actual costs.

Further, the 2001 PPS rate will not be updated for inflation from 1999 through 2001. This could mean that most FQHCs and RHCs would receive lower per-visit payments in 2001 than in the prior year.[23] BIPA does require the rates for 2002 be adjusted for inflation using the Medicare Economic Index for primary care services (MEI-PC). This adjustment will be the only automatic annual modification of Medicaid rates to reflect increasing costs.[24] If changes in patients' needs or other factors result in costs

[21]On January 19, 2001, HCFA issued a letter to state Medicaid directors describing the new payment system, indicating that all states, including those operating 1115 waiver programs, are subject to the new PPS outlined in BIPA.

[22]P.L. 106-554 requires that we report on our assessment by December 2004.

[23]Assuming an FQHC's or RHC's costs increase each year, PPS rates for 2001 will be less than what the FQHC or RHC received in 2000 as states are required to average 1999 and 2000 costs in determining the initial PPS payment rate.

[24]However, BIPA requires that payments to FQHCs and RHCs be adjusted in the event of any decrease or increase in the scope of services furnished.

increasing more than the index, those additional costs will not result automatically in higher Medicaid rates as they did under the prior state systems. The MEI-PC has increased less than other measures of inflation, making the Medicaid payment increases under the PPS less than what some states have used in the past. For example, four states that previously set prospective rates using a prior year's cost updated for inflation used inflation indexes that have grown faster than the MEI-PC. (See table 1.)

Table 1: Percentage Increase in BIPA Index Compared to Indexes Used by States That Paid FQHCs Prospectively, 1996 Through 1999

		States[a]			
Year	BIPA[b]	Colorado[c]	Connecticut[d]	Delaware[e]	Florida[f]
1996	**2.0**	3.8	4.4	6	6
1997	**2.0**	3.7	3.6	6	5.9
1998	**2.2**	2.8	3.9	4.5	3.4
1999	**2.3**	3.5	3.8	4.5	4.6
Cumulative growth	**8.8**	14.5	16.6	22.7[g]	21.3[g]

[a]Colorado, Connecticut, Delaware, Florida, Maryland, Rhode Island, and the District of Columbia all pay prospectively. We did not obtain annual rates of change from Arizona, Rhode Island, and the District of Columbia; New York's rates are frozen at 1992 levels, and Maryland reported using the MEI-PC as its inflationary index beginning in July 2000.

[b]BIPA uses the MEI-PC.

[c]Colorado used the Medical Care component of the Consumer Price Index (CPI) for Urban Wage Earners and Clerical Workers.

[d]Connecticut inflated the most recent cost report with a change factor derived from the Gross Domestic Product deflator.

[e]Delaware had a contract with the University of Delaware to calculate a unique inflation factor for the state. In calculating this index, the contractor reviewed other inflation indexes such as the Eggert Consensus Estimates.

[f]Florida used the CPI All Urban Inflation Index for the South Atlantic Region.

[g]States used actual prior year's reasonable cost and applied the index to determine rates for the following year. If actual reasonable costs grew faster than the index, that growth would be incorporated in subsequent years' rates. Under these circumstances, cumulative increases on average rates in these states would exceed the cumulative growth in each index.

Source: GAO analysis of state information.

The PPS created by BIPA provides stronger control over state payments to FQHCs and RHCs than the previously required cost-based systems by limiting per-visit payment increases to what appears to be a historically low measure of inflation. It also creates incentives and pressures for FQHCs and RHCs to operate efficiently. However, the pressure on individual FQHCs and RHCs to control or reduce costs, created by the

PPS, could vary considerably. If payment increases lag behind necessary cost increases, FQHCs and RHCs with low average costs may have less ability to keep future costs at or below their payment rates than higher cost centers.

FQHCs' and RHCs' ability to manage under the new PPS will depend on their initial rate and their ability to keep cost growth at or below the inflation index. For example, FQHCs and RHCs that had a low volume of visits and high per-visit costs when the rates were established may be better able to manage by increasing service volume to lower their per-visit costs. FQHCs and RHCs with low initial per-visit costs, however, may have more difficulties. To the extent that lower initial per-visit costs already reflect greater efficiency, there may be fewer options for an efficient FQHC or RHC to adapt to necessary cost increases not reflected in the inflation index. FQHCs and RHCs that face an increasingly complex mix of patients may be also disadvantaged as the PPS incorporates payment increases only related to inflation or changes in scope of service.

Because of their heightened reliance on Medicaid, FQHCs are likely to be more affected than RHCs by the new payment system. As noted earlier, grant dollars per uninsured FQHC patient have been declining, making Medicaid reimbursement even more critical to FQHC operations.

Concluding Observations

In part because of their mandate to preserve and expand necessary primary care health services, FQHCs and RHCs have received reimbursement based on their costs in an effort to ensure adequate payment. However, this approach does little to encourage efficiency. The new payment system mandated by BIPA attempts to ensure adequacy by basing payments on historical rates while promoting efficiency by limiting increases. However, the combination of reimbursement limits imposed historically by many states and the inflation adjustments in the new PPS may constrain future Medicaid payment to some FQHCs and RHCs. Finding a mechanism to strike the proper balance between payment adequacy and incentives for efficiency has been, and will likely be, a challenge.

Agency Comments

We provided HHS an opportunity to comment on a draft of this report. In its comments, HHS generally concurred that the new BIPA PPS has the potential to limit payments to FQHCs and RHCs. Although HHS stated that the BIPA payment system may result in higher payments than the staged phase out of cost-based reimbursement, as we note in the report, we found

that few states had taken action aimed at making reductions in cost-based reimbursement. HHS also agreed that the effects of the new system would vary among FQHCs and RHCs, and that FQHCs and RHCs that are already operating efficiently could be penalized.

HHS suggested that we place greater emphasis on three aspects of the BIPA PPS. In particular, HHS suggested that we include more discussion about potential adjustments to the base rate in addition to those for inflation. We have done so by including additional reference to BIPA's provision that rates should be adjusted to account for a change in the scope of service. Second, HHS suggested that we place greater emphasis on states' ability to implement an alternative payment methodology under BIPA, which may result in higher payments to FQHCs and RHCs. Our draft report already recognized that payments under the alternative methodology can be no lower than payments under the PPS, and we have not changed the report. Third, HHS requested that we emphasize that states cannot impose a stricter definition of reasonable costs in establishing 2001 payment rates than they had under the prior reimbursement system. We have no basis to question HHS' position, but because BIPA does not include explicit language to that effect, we have not modified the report.

HHS also provided technical comments, which we incorporated where appropriate. HHS' comments are provided in appendix III.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. We will also make copies available to others on request. If you or your staffs have questions about this report, please contact me or Janet Heinrich at (202) 512-7114. An additional GAO contact and the names of other staff who made key contributions to this report are listed in appendix IV.

William J. Scanlon
Director, Health Care Issues

List of Committees

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
The Honorable Arlen Specter
Ranking Minority Member
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Human Services, and Education
Committee on Appropriations
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Committee on Energy and Commerce
House of Representatives

The Honorable Ralph Regula
Chairman
The Honorable David Obey
Ranking Minority Member
Subcommittee on Labor, Health and
Human Services, and Education
Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

To describe how states implemented cost-based reimbursement and the extent to which states' practices changed as a result of BBA, we surveyed Medicaid officials in the 50 states and the District of Columbia regarding their FQHC and RHC reimbursement policies. We analyzed responses to our mail survey from all 50 states and the District of Columbia regarding

- whether states were phasing out or continuing cost-based reimbursement or had a waiver of the cost-based reimbursement requirement,
- states' reimbursement practices,
- managed care participation and supplemental payments, and
- general information on other funding sources.

Additionally, we interviewed representatives from 12 state Primary Care Associations, which are private, nonprofit membership organizations that receive grant funds from HRSA. We also analyzed national demographic, financial, and utilization information on FQHCs using HRSA's Uniform Data System (UDS) for 1996 through 1999.

We conducted site visits in five states: Michigan, New York, Ohio, Oklahoma, and Rhode Island. We selected these states because they had (1) unique reimbursement methodologies, (2) rural and/or urban populations, or (3) different levels of managed care penetration. These states also varied in their policies regarding supplemental payments, ranging from making the full payments required by BBA to having received approval to waive supplemental payments entirely. Within each state, we interviewed representatives from the Medicaid office and Medicaid managed care organizations. We also met with officials from eight FQHCs and nine RHCs.

To assess the impact of the new PPS enacted under BIPA for 2001, we examined BIPA in light of previous statutes regarding Medicaid reimbursement for FQHCs and RHCs and HCFA regulations applicable to the new statute. We examined the indexes used by four states–Connecticut, Colorado, Delaware, and Florida—from 1996 through 1999 and compared them to the annual inflation adjustments specified in BIPA.[1]

[1]Initially, we considered analyzing the financial data from the UDS, HRSA's database of information on FQHCs, to compare the annual increases in Medicaid reimbursement per encounter for FQHCs in all states from 1996 through 1999. However, after making several adjustments to the data, numerous problems and limitations still existed. As a result, we could not analyze the UDS for this purpose. Thus, we included the indexes used by these four states to demonstrate changes in reimbursement.

Our work was conducted from May 2000 through May 2001 in accordance with generally accepted government auditing standards.

Appendix II: State Practices Regarding Supplemental Payments

Table 2 shows states' practices regarding the provision of supplemental payments to FQHCs and RHCs participating in capitated Medicaid managed care. As shown below, 25 states and the District of Columbia have made supplemental payments to FQHCs as required by BBA. Additionally, four states have made payments to FQHCs that are not the full amount required under BBA since the states have 1115 waivers. RHCs have received supplemental payments as required by BBA in 16 states, while 2 states with 1115 waivers have made some level of payment to RHCs. The remaining states do not make supplemental payments to FQHCs or RHCs because there is no capitated Medicaid managed care in the state, no FQHCs or RHCs contract with Medicaid managed care organizations, or the state has an 1115 waiver and thus is not required to make supplemental payments.

Table 2: States' Provision of Supplemental Payments to FQHCs and RHCs, 2000

State	FQHC	RHC
Alabama	a	a
Alaska	a	a
Arizona	❍	b
Arkansas	a	a
California	●	●
Colorado	●	●
Connecticut	●	c
Delaware	b	b, c
District of Columbia	●	c
Florida	●	●
Georgia	a	a
Hawaii	❍	❍
Idaho	a	a
Illinois	●	d
Indiana	●	d
Iowa	●	●
Kansas	●	●
Kentucky	b	b
Louisiana	a	a
Maine	●	●
Maryland	b	b, c
Massachusetts	b	b, c
Michigan	●	●
Minnesota	●	●
Mississippi	a	a
Missouri	●	●
Montana	a	a

State	FQHC	RHC
Nebraska	●	d
Nevada	●	d
New Hampshire	d	d
New Jersey	●	c
New Mexico	●	●
New York	❍	e
North Carolina	a	a
North Dakota	●	d
Ohio	b	b, d
Oklahoma	b	b
Oregon	b	b
Pennsylvania	●	●
Rhode Island	❍	❍
South Carolina	●	●
South Dakota	a	a
Tennessee	b	b
Texas	●	●
Utah	●	d
Vermont	a	a
Virginia	●	e
Washington	●	●
West Virginia	●	●
Wisconsin	●	●
Wyoming	a	a

● The state makes supplemental payments.

❍ The state has an 1115 waiver and, while not required to make supplemental payments, the state offers payments that are less than what would be required under BBA.

[a]There is no capitated Medicaid managed care in the state and, thus, no need for supplemental payments.

[b]The state has an 1115 waiver and is not required to make supplemental payments.

[c]There are no RHCs in the state.

[d]Although capitated Medicaid managed care exists in the state, no FQHCs and/or RHCs contract with Medicaid managed care organizations.

[e]Although the state makes supplemental payments available to RHCs, no RHCs have applied for or received such payments.

Source: GAO Survey, 2000.

Appendix III: Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUN - 4 2001

Ms. Janet Heinrich
Director, Health Care--Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Heinrich:

Enclosed are the Department's comments on your draft report, "Health Centers and Rural Clinics: Payments Likely to be Constrained Under Medicaid's New System." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano

Michael F. Mangano
Acting Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

The Department of Health and Human Services Comments on the GAO Report, *Health Centers and Rural Clinics: Payments Likely to be Constrained Under Medicaid's New System* (GAO-01-577)

While the Benefits Improvement and Protection Act (BIPA) payment system has the potential to limit payments as compared to straight reimbursement based on costs, as indicated in the draft report, payments for many community health clinics (CHCs) under the BIPA can be expected to be higher than they would have been if the phase-out that was current law at the BIPA's enactment had been allowed to continue. In fact, the BIPA's payment system for Federally qualified health centers (FQHCs) and rural health clinics (RHCs) was supported enthusiastically by the National Association of Community Health Centers (NACHC), which was its principal architect. The NACHC proposed and supported this type of payment system because it is viewed as preferable to the staged phase-out of cost-based reimbursement for FQHCs and RHCs, which has existed in some form in the statute since 1997.

Throughout the report, reference is made to the Medicare Economic Index for Primary Care (MEI-PC) as the single means of updating the prospective payment system (PPS) baseline rate. However, the PPS base rate may also be adjusted (up or down) by a change in the scope of services. We suggest adding this reference.

There is very little reference to the ability of States to implement an alternative methodology. Since the use of an alternative methodology may result in higher payments to FQHCs or RHCs, we suggest that the report incorporate more than a passing reference to this option.

Similarly, while the report notes that four States have used inflators more generously than the MEI-PC, it does not mention the consistent increases in payments across all States, which would result from universal application of an inflator. The report correctly notes that while the BIPA reimbursement system creates incentives for efficient operation, a FQHC or RHC that is already operating efficiently may be penalized because it has little flexibility. We believe some caution is appropriate, but we would like to see the report make the point more strongly that the impact of the BIPA payment system will vary across States and across providers within States, and that its effects are likely to be mixed and not always negative.

The General Accounting Office (GAO) states that currently over 1,200 FQHCs operate over 3,000 delivery sites which provide services to about 11 million people each year. The Department would like GAO to distinguish between section 330, Consolidated Health Centers; FQHC look-alikes; and Title V, Urban Indian Clinics. Consolidated Health Centers include CHCs, migrant health centers, health care for the homeless, and public housing programs. In 2000, 750 section 330 grantee organizations served approximately 9.6 million users at over 3,200 sites. FQHC look-alikes--entities that do

not receive grant funding but meet the requirements of FQHCs–served 1.12 million users at 115 entities and 211 sites.

While GAO's draft report indicates that States can continue to use their prior methods of determining reasonable costs in establishing the 2001 payment rate under the PPS, the Department requests that GAO emphasize that States cannot impose a stricter definition of reasonableness. The Department's position assumes that States' prior calculations of reasonable costs were made strictly in accordance with Medicare FQHC regulations.

Regarding the report's "Concluding Observations," the use of reimbursement limits by States is included as a significant factor contributing to the potential for constrained future Medicaid payments. In a previous section, the report indicated that there were "many" States imposing such limits. The Concluding Observations section refers to "most" States as imposing such limits. Given the weight attached to the imposition of such limits, we suggest that the report include at least a footnote with the actual number of States imposing limits on reasonable costs.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

Catina Bradley, Barbara Chapman, Michelle Rosenberg, Behn Miller, Sharon Brigner, Anne Dievler, and Evan Stoll made key contributions to this report.

Related GAO Products

Health Care Access: Programs for Underserved Populations Could Be Improved (GAO/T-HEHS-00-81, Mar. 23, 2000).

Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success (GAO/HEHS-00-39, Mar. 10, 2000).

Health Care Access: Opportunities to Target Programs and Improve Accountability (GAO/T-HEHS-97-204, Sept. 11, 1997).

Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996).

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