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State Subsidies for Federally Qualified Health Centers in New Jersey: Options for Reform

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Executive Summary

Federally Qualified Health Centers provide preventive and other health services to poor and uninsured individuals throughout the United States. In addition to federal grants, FQHCs in New Jersey received more than \$10 million in state subsidies in fiscal year 2004 to support services to the uninsured. The subsidy is distributed to FQHCs based on the number of uninsured visits provided in comparison with federal volume standards that were established in the early 1990's. Specifically, payments are made to FQHCs for every uninsured visit that exceeds the volume threshold, which is different for each FQHC.

Over the past decade a number of health system changes have occurred, which make it necessary to rethink the method of providing state support to FQHCs. These changes include the introduction of new centers, reductions in federal grants and Medicaid reimbursement to existing centers, and demands for greater healthcare quality and accountability placed on all healthcare providers including FQHCs.

This report provides guidance to policymakers in New Jersey on how to reform the FQHC subsidy to address these concerns. After reviewing current FQHC reimbursement and subsidy policies, the following three reform options are analyzed:

- Option 1: Distribute subsidy dollars based on the proportion of statewide uninsured visits provided by each FQHC.
- Option 2: Distribute subsidy dollars based on uninsured burden, defined as the percentage of total visits provided to uninsured patients, in addition to total uninsured volume
- Option 3: Distribute subsidy dollars based on healthcare quality indicators and the provision of preventive services in addition to total uninsured volume.

Assuming that no new money will be allocated for FQHC subsidies, each option entails a significant amount of redistribution across FQHCs. However, sudden changes in FQHC revenue streams can be avoided by blending current and reformed payment formulas with increasing weight placed on the reformed formula over time.

It is recommended that the state gradually phase in a blended subsidy formula based on Options 1 and 2 as defined above and in the report. The use of quality and prevention indicators also holds promise for advancing state health policy goals. However, a more thorough analysis and specification of indicators is warranted before implementing this type of approach.

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Introduction

Federally Qualified Health Centers (FQHCs) provide ambulatory care to the uninsured and other vulnerable populations across the United States. In 2002, more than 11 million individuals received primary care and other ambulatory care services from 843 FQHCs nationwide (Bureau of Primary Health Care, 2002). Because their patients have limited means to pay for care, FQHCs depend heavily on government grants, private foundation grants, and distributions from indigent care subsidies. In 2002, FQHCs received 45% of their revenue from these sources. FQHCs also depend heavily on reimbursement from Medicaid, which is widely regarded as significantly less remunerative than other forms of third party payment. In 2002, Medicaid accounted for 35% of FQHC revenue (Bureau of Primary Health Care, 2002).

In the late 1990's, a growing number of FQHCs experienced serious financial difficulty due to several contemporaneous factors. These include growth in the uninsured population, tightening reimbursement under Medicaid managed care, the phase-out of federally mandated cost-based reimbursement (discussed below), and the failure of federal FQHC grants to keep pace with rising FQHC costs (McAlearney, 2002).

While these problems still remain, in 2002 the Bush Administration launched an initiative to finance the expansion and creation of new FQHCs and other health centers. The goal of the initiative is to add 1,200 new and expanded health center sites and increase the number of people served annually from about 10 million to 16 million by 2006. In 2002 and 2003, the federal Department of Health and Human Services funded nearly 220 new center sites and expanded capacity at more than 250 other sites (HRSA Press Office, 2004). In New Jersey, this initiative has led to "six new primary care sites, three medical capacity expansions, six dental expansions, one new homeless program, one expanded homeless program, and one new mental health program since 2001" (Grant-Davis, 2004).

In New Jersey, FQHCs receive additional funds from the state to support the provision of services to the uninsured. These funds are raised from a hospital revenue tax and distributed to FQHCs based on a formula that takes into account the number of

uninsured visits provided. The formula was first implemented in 1992 and is based on federal volume standards that were established in the early 1990's. As a result, the current formula is limited in its ability to recognize current FQHC performance in providing services to the uninsured. The current formula also makes it difficult to add new FQHCs to the subsidy program, because they do not have historical data to place into the formula. Moreover, because it does not account for type of services provided to the uninsured, the current formula does not contribute to the goals shared by many policymakers of providing the uninsured with greater access to preventive services.

This report provides guidance to policymakers in New Jersey on how to reform the FQHC subsidy to address these concerns. After providing a brief overview of the FQHC program, the report gives a detailed description of New Jersey's FQHC subsidy. The following section of the report provides an overview of strategies used by other states to subsidize care to the uninsured provided by FQHCs. Some of these strategies are taken into account for the creation of three payment reform options that may be considered by policymakers in New Jersey. A simulation analysis is then conducted to show how each option would affect the distribution of payments across FQHCs in NJ. The report concludes with a discussion of additional issues that must be considered to reform the FQHC payment subsidy in NJ.

Overview of the FQHC Program

FQHCs trace their origins to the Neighborhood Health Centers Program, which began as a series of demonstration projects in 1965 by the federal Office of Economic Opportunity (Hawkins and Rosenbaum, 1998). The goal of this program was to provide comprehensive primary and preventive care to low income and medically under-served residents of the United States. Federal guidelines require that the scope of services offered by these centers include pediatric/well child care, adolescent healthcare, internal medicine/adult healthcare, geriatric care, obstetrics/gynecology, and primary and preventive dental care. The centers are also required to provide enabling services such as social services, community outreach, transportation, nutrition counseling, and multilingual services to facilitate access to the medical services that are offered. In return, health centers receive federal funds for start-up costs and receive operating subsidies that allow them to function in environments where most patients have limited means to pay for care.

In 1975, Congress enacted legislation that gave more permanent status to Neighborhood Health Centers, which became known as Community Health Centers (CHCs) (Hawkins and Rosenbaum, 1998). From the mid-70s to the late-80s, CHCs experienced an unstable stream of rising and falling financial support from the federal government.

In 1989, Congress passed the Omnibus Budget Reconciliation Act (OBRA), which created the special designation of Federally Qualified Health Center (FQHC). Under OBRA, a health center must meet the following requirements to be designated as an FQHC:

- Serve a federally designated health professional shortage area, medically underserved area, or medically underserved population as determined by the federal Bureau of Primary Health Care
- Provide services to patients regardless of insurance status
- Use a sliding fee scale for uninsured patients based on their income
- Operate as a nonprofit corporation governed by a board of directors of which a majority are users of the health center

In practice, FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act – specifically, Community and Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs, and School Based Health Centers.¹ Certain Tribal Health Programs are also eligible for FQHC status. Finally, CHCs that do not receive Section 330 grants may receive FQHC “Look-Alike” status if they meet the other requirements described above.

Organizations classified as FQHCs receive a variety of benefits. These include FQHC grant funding, enhanced Medicare and Medicaid reimbursement rates, medical malpractice coverage, ability to purchase medications at reduced prices (through federal purchasing arrangements), access to the National Health Service Corps, access to the Vaccine for Children program, and eligibility for a variety of other grants. FQHC Look-Alikes do not receive federal grant money but are eligible for enhanced Medicare and Medicaid reimbursement rates and medication discounts.

Enhanced Medicaid reimbursement is perhaps the most controversial provision in the FQHC Program. OBRA 1989 mandates that all state Medicaid programs pay FQHCs 100% of “reasonable” costs of providing FQHC services that are covered under Medicaid. Before OBRA was implemented, Medicaid payment rates to CHCs were often set well

below the costs of providing services. For example, in 1989 the average CHC revenue per Medicaid patient visit was only \$40, while the corresponding cost was \$77 (Lewis-Idema, 1991). Anticipating greater spending on Medicaid services, many states viewed cost-based reimbursement as an unfunded mandate. In contrast, federal officials viewed it as a way of preserving resources intended to support services for the uninsured. Specifically, inadequate Medicaid reimbursement rates created an incentive for CHCs to use federal grant money to make up for inadequate Medicaid payments instead of expanding services to the uninsured as the grant programs intended.

Although the FQHC Program did contribute to rising federal and state Medicaid expenditures, Lewis-Idema et al. (1998) found that the cost-based reimbursement provisions of that program appears to have expanded access for both uninsured and Medicaid patients. Lewis-Idema et al. concluded further that cost-based reimbursement for FQHCs was not inherently inflationary as prior research had found to be the case for hospitals and private physicians.

Nevertheless, budget pressures at the federal level led to the gradual erosion of cost-based reimbursement for FQHCs beginning in the late 1990's. In 1997, the Balanced Budget Act (BBA) introduced major changes in federal requirements for FQHC reimbursement. First, the BBA allowed states to gradually abandon cost-based Medicaid payments by percentage reductions in reasonable costs reimbursed to FQHCs over a five year phase out period – to 95% of an FQHCs reasonable costs in 2000, 90% in 2001, 85% in 2002 and 70% in 2003. After 2003, states could discontinue cost-based reimbursement (GAO, 2001; Lewis-Idema, 1998). The BBA also established a “wrap-around” payment mechanism where states would reimburse FQHCs for the difference between their statutory payment rate and the amount they received under their Medicaid managed care contracts.

The Balanced Budget Refinement Act (BBRA) of 1999 provided temporary relief to FQHCs by slowing the pace at which cost-based reimbursement would be phased out. Specifically, states were required to pay 95% of reasonable costs in 2001 and 2002, 90% in 2003, and 85% in 2004. After 2004, states could completely phase out cost-based reimbursement. The BBRA also extended requirements for wrap around payments through 2004 for FQHCs participating in Medicaid managed care. (GAO, 2001).

Beginning in 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 provided FQHCs a more permanent form of relief from the phase-out of cost-based reimbursement (Koppen, 2001). Specifically, the BIPA provided a

permanent floor below which state payments to FQHCs could not fall. This floor is based on a blended per visit rate that reflects 100% of reasonable costs averaged over 1999 and 2000. States have some discretion as to whether the average should be weighted more towards the year with the higher or lower costs. After 2001, these Prospective Payment System (PPS) payments are updated for inflation based on the Medicare Economic Index for primary care and any change in the scope of services provided. Like all prospective systems, the Medicaid PPS will create financial difficulty for providers that experience cost growth in excess of the inflation update and will reward providers that keep costs below allowable inflation.

During the 1980's and 90's, FQHCs continued to rely heavily on federal grants to support their mission to service the uninsured. However, federal grant funding has not kept pace with the growing number of uninsured FQHC users. While federal grants increased in nominal terms, inflation-adjusted grant funding to FQHCs decreased by 30% from 1980 to 2000 (Markus, Roby, and Rosenbaum, 2002). This decrease coincided with a 22% increase in the number of FQHCs and a 54% increase in the number of uninsured users of FQHCs (Markus, Roby, and Rosenbaum, 2002).

State Support for FQHCs in New Jersey

In New Jersey, FQHCs receive an additional subsidy from the state to support the provision of services to the uninsured. The subsidy is financed by a statewide hospital tax of 0.53% levied on hospital operating revenue. Revenue from this tax is deposited into the Health Care Subsidy Fund (sometimes referred to as the "0.53 funds"), which was created by the Health Care Reform Act of 1991 and is administered by the New Jersey Department of Health and Senior Services (NJDHSS).

A portion of monies from the Fund is distributed to FQHCs (and FQHC Look-Alikes) on the basis of primary medical and dental visits provided to the uninsured (above a center-specific threshold described below). Per visit payment is set at the FQHC encounter rate established under the State's Medicaid Prospective Payment system up to a maximum of \$104. Historically, the portion of 0.53 funds allocated for this purpose has been capped at \$8 million to \$12 million since the Health Care Subsidy Fund was created. To qualify for payment, visits must satisfy a number of criteria that are verified through audits by the NJDHSS. The most important criteria are:

1. Patients must be uninsured and ineligible for government coverage or other medical assistance.

2. Patients must have income below 250% of the Federal Poverty Level.
3. Payment is given only for uninsured visits that exceed a site-specific baseline level.

The baseline visit requirement is the most controversial aspect of the subsidy program. This requirement is based on self-pay visit levels from the early 1990's. The rationale was that the State would cover only the costs of uninsured visits in excess of the pre-existing number of uninsured visits, measured on a monthly basis, prior to the implementation of the State program. If in any given month the FQHC did not achieve this established baseline, then it would not be eligible for subsidy funding from the State for that month. Limiting payment under the subsidy to uninsured visits above the baseline threshold was seen as a mechanism to avoid displacing pre-existing federal funds with new State money.

Because it was established in the early 1990's, the baseline threshold does not provide a useful measure of current FQHC performance in providing services to the uninsured. Also, for FQHCs that opened after the 0.53 subsidy was established, thresholds were often determined arbitrarily until a more systematic baseline number could be calculated. In practice, thresholds established for new centers were not routinely adjusted leading to inequities in the establishment of threshold requirements across FQHCs.

Subsidy payments to FQHCs are made on a monthly basis pending submission of manual daily patient logs and monthly reports. Under certain conditions, FQHCs may receive advanced payments. With or without advanced payment, all FQHCs are required to hold up to 10% of payments in reserve to allow for any adjustments that are deemed necessary by periodic audits.

Support for FQHCs by Other States

Several other states provide subsidies for uninsured care provided by FQHCs and other health centers. To assist policymakers in reforming the FQHC subsidy in New Jersey, the CSHP has gathered information about health center subsidies for uninsured care in five states – California (CA), Connecticut (CT), Massachusetts (MA), New York (NY), and Washington (WA). These subsidy programs vary across a number of dimensions that include source of funding, eligibility, and specific populations targeted for support.

California's Expanded Access to Primary Care Program

In CA, state subsidies are available to all licensed healthcare clinics for care provided to the low-income uninsured through the Expanded Access to Primary Care (EAPC) Program. The program is funded by annual appropriations in the state budget. Clinics receive \$71.50 per visit for primary and dental care services provided to uninsured individuals with income below 200% of the FPL.

While program payments are subject to available funds, the EAPC Program contains three features to preserve at least partially the stability of payments to clinics. First, new clinics do not receive funds from the program if the EAPC appropriation falls below its prior year level. Second, all clinics funded receive a minimum of \$25,000. Third, all continuing clinics receive at least 90% of their prior year allocation, if services to the uninsured are maintained. After these minimum requirements are met, remaining funds are distributed to clinics based on the proportion of uninsured visits they provide.

Connecticut's Community Health Service Program

In CT, subsidies for uninsured care are available to all FQHCs and Look-Alikes in the state through the Community Health Service (CHS) Program. The program is funded through annual appropriations in the state budget. Health centers submit reports to the state documenting the number self-pay visits provided on a quarterly basis. Available funds for the CHS Program are then distributed to the centers based on the percentage of total self-pay visits provided by each center. CT differs somewhat from other states in that it does not consider the income of a center's uninsured patients in determining the level of subsidy provided.

The Massachusetts Uncompensated Care Pool

In MA, all Community Health Centers (CHCs) are eligible for reimbursement from the state's Uncompensated Care Pool (UCP), which provides support for uncompensated care delivered by hospitals and health clinics. Money flows into the pool from three sources – hospital assessments, payer surcharges, and general revenues.

Hospitals and health clinics receive payments from the UCP based on the amount of free care provided.² Free care falls into one of three categories. The first is full free care, which is provided to uninsured individuals with income below 200% of the FPL.

These individuals (who account for the largest share of payments from the UCP) do not pay any portion of charges. The second category is partial free care, which is provided to uninsured individuals with income between 200% and 400% of the FPL. The UCP reimburses providers for amounts above an income-based deductible paid by these individuals. The third category is medical hardship assistance, which is provided to uninsured individuals in any income group whose medical expenses are beyond their means to pay. Qualification for medical hardship assistance involves an asset test.

Payments from the UCP to CHCs are made at a rate of \$85.47 per visit with a physician, nurse practitioner, nurse midwife, or physician assistant. Services provided by dentists are reimbursed at \$64.10 per visit and services provided by psychologists and social workers are reimbursed at \$42.74 per visit. Also, the UCP reimburses CHCs for on-site ancillary services such as laboratory and radiology at 25% of charges.

The Indigent Care Pool for Diagnostic & Treatment Centers in New York

New York State supports uninsured care provided by hospitals and different types of health centers – known collectively as Diagnostic & Treatment Centers (D&TCs) – through a set of Indigent Care Pools. There is a specific Indigent Care Pool that provides financial support to public and non-profit D&TCs (including FQHCs, Look-Alikes, and other clinics). The pools are financed by various surcharges on hospital and D&TC payment rates and on hospital inpatient revenue.

Distributions from the D&TC Indigent Care Pool are based on a series of formulas that work as follows. For every D&TC, the cost of treating the uninsured is approximated by self-pay volume times the Medicaid payment rate. From this number, “uninsured need” is calculated by subtracting self-pay collections from the estimated uninsured cost. Uninsured need is then weighted according to uninsured burden, which is defined as the percentage of patients who are uninsured. Available funds in the D&TC Indigent Care Pool are allocated to facilities based on this weighted need calculation.

An important feature of the NY subsidy has to do with the timing of the payments. Because the subsidy formula requires detailed cost and self-pay collections data, there is a two year lag between provision of uninsured care and payment from the pool. To compensate for the two year lag, supplemental funds are reserved within the pool for new D&TCs and for D&TCs that experience significant increases in uninsured volume.

Washington's Community Health Services Program

Washington supports the provision of uninsured care by community health clinics through the Community Health Services (CHS) Program. The CHS Program provides grants to public and private non-profit health clinics, which are financed through annual appropriations in the state budget. Grant funds are targeted to clinics that provide services to individuals who are uninsured and have income below 200% of the FPL. Specifically, clinics receiving funding from the CHS Program must meet the following criteria:

- Be a private, nonprofit, tax-exempt organization incorporated in Washington State or a public agency under the jurisdiction of a local or county government
- Operate as a community health clinic providing primary health care for at least 18 months prior to applying for funding
- Have established a sliding-fee schedule for adjustment of charges, based upon the individual's ability to pay
- Provide health care regardless of the individual's ability to pay
- Have established policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served.

Separate funds are appropriated annually for medical, dental, and migrant healthcare services. For the medical service appropriation, up to 10% of these funds are held in reserve to provide funding for new clinics, special projects, and emergency needs. An additional 10% may be held in reserve for administrative expenses related to the CHS Program. The remaining funds are referred to as the medical base. Forty percent of the medical base is distributed equally among health clinics. Thirty percent of the medical base is allocated to clinics based on their share of sliding scale fee users as a percentage of sliding scale fee users among all clinics receiving funds from the CHS Program. Similarly, the remaining 30% of the medical base is allocated to clinics based on their share of sliding scale fee encounters as a percentage of sliding scale fee encounters among all clinics receiving funds from the CHS Program. At the end of the year, unused funds that were held in reserve are distributed to clinics in proportion to the funds received from the medical base. The allocation formulas for dental and migrant services are similar.

Payment Reform Options for FQHCs in New Jersey

This section describes three options that may be considered to reform FQHC payment policy in New Jersey. After presenting the options, simulations are performed for the first two options. These simulations show the impact of each policy on subsidy allocations for each center. These simulations provide “static estimates” of the effect of each option. In other words, they are based on the assumption that FQHCs do not adjust their behavior in response to changes in the subsidy formula. Because FQHCs can be expected to respond to any new incentives, and because of the limitations of available data, the simulation results provided in this report should be considered illustrative of the probable impact moving to a new reimbursement structure and not a definitive forecast of the impact of the payment options. Implications of this assumption are addressed in the discussion section.

The third option is less developed than the first two due to data limitations. Therefore, Option 3 is illustrated with examples rather than formal simulation. Finally, the analysis shows how different options may be combined or phased-in gradually over time.

Although the analyses in this report are based on a fixed number of FQHCs receiving allocations from the subsidy pool, the formulas presented can be applied to new centers if needed. However, the addition of new centers will require a policy choice between making additional funds available for new centers and dividing a fixed pool of money among a growing total number of centers.

The analysis presented below also assumes that data about care to the uninsured are collected on an annual basis with subsidies paid retrospectively. In practice, data collection and payment of subsidies can occur much more frequently, as they do under the current administration of 0.53 funds. This issue is addressed further in the discussion section.

Description of Payment Options

The first payment option is similar to the one currently used in Connecticut where subsidy dollars are allocated based on the relative share of uninsured patients seen by FQHCs. This approach is also used in California’s EAPC Program to allocate funds above statutorily defined minimum payments to individual centers. Under this option, a fixed pool of FQHC subsidy dollars are allocated to centers based on relative shares of

uninsured visits. For illustrative purposes, the pool is assumed to be fixed at the subsidy level in SFY2004.

The greatest advantage of Option 1 is its simplicity. The allocation formula is straightforward, can be applied easily to new centers, and requires no new data collection. However, this option generates a clear bias in favor of larger FQHCs that provide a high volume of all visits including those that are reimbursed by third party payers. As a result, this option leaves relatively little funds to support uninsured volume provided by smaller FQHCs. Also, Option 1 does not consider the ability of FQHCs to use revenue from other sources such as third party payments to cross subsidize some of the costs of uninsured care.

Option 2 addresses the cross subsidy issue by making an allowance for uninsured burden defined as the percentage of total visits that are attributable to uninsured patients. Specifically, FQHCs with higher burden receive greater payment per uninsured visit. This provision is similar to (though not as elaborate as) the one used in New York for the allocation of its Indigent Care Pools. The rationale for this allowance is that FQHCs with a higher percentage of patients with third party coverage (i.e., those with low burden) should have more resources available to offset the costs of caring for the uninsured. Implicitly, this rationale assumes that third party payment received by FQHCs is sufficient to cover the costs of patient care with some left over to cross subsidize other patients. As described earlier in the case of Medicaid payment to FQHCs, this assumption may not match the current payment experience of many FQHCs. Nevertheless, the assumption will be retained for the purposes of payment simulation with a more critical discussion reserved for the end of the report.

The mechanics of Option 2 work as follows. A base payment of \$100 is set for every uninsured visit provided. The base payment is then modified based on each center's uninsured burden defined as the percentage of visits that are provided to uninsured individuals. Specifically, burden is calculated for each FQHC and a statewide average burden is also calculated. The center specific burden is divided by the statewide average to obtain the relative burden faced by each center. The relative burden is multiplied by the base payment rate to obtain the final per visit payment for each center. The per visit payment times the number of uninsured visits determines the total payment to each FQHC. If total payments to FQHCs exceed the total amount of funds available, then all FQHCs receive proportionate decreases, so that the sum of all payments is exactly equal to the total funds available.

A potential weakness shared by Options 1 and 2 alike is that neither provides any incentive or additional support for preventive care for the uninsured. This issue is addressed in Option 3. Specifically, the third payment option provides a fixed payment per uninsured visit with an enhanced payment for visits that include “favored services”. For illustrative purposes, favored services in this report are defined as pap smears, immunizations, HIV tests, first trimester prenatal care, newborn visits within 4 weeks of birth, and well child visits. This list of services was chosen based on conversations with state officials in New Jersey and the availability of data. Potential modifications of this list are discussed later in the report.

Under Option 3, a base payment rate of \$100 is set for each uninsured visit. This payment rate is modified using an approach similar to the one used for Option 2. The percentage of total services (i.e., encounters) falling into the favored category is calculated for each FQHC and a statewide average of this percentage is also calculated. The center specific percentage is divided by the statewide average to obtain a relative value for each center. The relative value is multiplied by the base payment rate to obtain the final per visit payment for each center. The per visit payment times the number of uninsured visits determines the total payment to each FQHC. If total payments to FQHCs exceed the total amount of funds available, then all FQHCs receive proportionate decreases, so that the sum of all payments is exactly equal to the total funds available.

Data

Payment simulations are based on data obtained from the NJDHSS related to the distribution of 0.53 funds in State Fiscal Year (SFY) 2003. These data provide information about the total number of uninsured visits and total payments received from the Healthcare Subsidy Fund. However, these data do not provide information about uninsured burden or provision of favored services, which are required for the analysis of Options 2 and 3. These variables are estimated using data from the Uniform Data System (UDS), which is collected and maintained by the federal Bureau of Primary Health Care of the Health Resources and Services Administration. The most recent year of data available to the CSHP at the time of this analysis is 2002. The payment simulations are based on 10 FQHCs that provide comprehensive primary care in NJ and for which usable data are available.

Uninsured burden is defined above as the number of uninsured visits divided by total visits. Since these numbers are not available, burden is approximated by the number

of uninsured users divided by the total number of users for each FQHC according to the 2002 UDS data.

The percentage of uninsured visits falling into the favored category is not reported in the UDS data. It is approximated by the percentage of all users receiving any of the favored services as calculated from the 2002 UDS. This number provides only a very rough proxy for the level of preventive services provided to the uninsured. Therefore, formal simulation of this option cannot be done reliably. Instead a few examples of how this option may affect different centers are presented for discussion.

Simulation Results

Table 1 shows how the 0.53 funds are currently allocated across the ten FQHCs with usable data. In SFY 2003, these funds totaled \$10,964,983. As currently written, the formula that determines the distribution of these funds favors centers with large numbers of uninsured visits combined with a relatively low threshold to meet before additional visits become eligible for subsidy payment. For example, Austin Health Center and Horizon Health Center provided similar amounts of uninsured visits in SFY 2004. However, due to its higher baseline level of visits, Austin received only 1/5 of the subsidy amount distributed to Horizon.

Conversely, Austin has a baseline visit threshold that is similar to that of South Jersey Family Medical Centers, yet South Jersey receives a subsidy amount that is 8 ½ times the amount received by Austin. The greater payment to South Jersey is obviously driven by its greater number of total uninsured visits. It is important to note, however, that South Jersey provides less than 2 ½ times as many uninsured visits as Austin.

This seemingly disproportionate subsidy payment to South Jersey relative to Austin is a direct consequence of requiring a threshold to be achieved before any payment is made for uninsured visits. When viewed in terms of volume above baseline, the number of additional visits at South Jersey (9,533) is more than ten times greater than the number of visits at Austin (822). This clearly reflects the original intent of the Health Care Reform Act of 1991, which was to expand access levels above those that existed in the early 1990's. Nevertheless, to the extent that the baseline thresholds do not represent uninsured care with other sources of support, the current subsidy creates inequities in payment for total numbers of uninsured visits.

The current formula also generates large disparities in the amount of state funds received per uninsured visit. This amount ranges from \$18.13 at Austin to \$98.46 at North Hudson Community Action Corporation Health Center.

**Table 1: Distribution of Subsidy Payments under Current Law in
State Fiscal Year 2003**

FQHC	Uninsured Visits	Baseline Visits	Subsidy Payment^a	Share of Total Subsidy	Payment per Uninsured Visit
Henry J. Austin Health Center	6,234	5,412	\$113	1%	\$18.13
CAMcare Health Corporation	18,620	4,992	\$1,417	13%	\$76.12
Eric B. Chandler Health Center	15,127	504	\$1,506	14%	\$99.53
Community Health Care	12,365	4,920	\$774	7%	\$62.62
Horizon Health Center	6,929	1,836	\$530	5%	\$76.44
Jewish Renaissance Medical Center	2,023	794	\$128	1%	\$63.18
North Hudson Community Action Corporation Health Center	32,008	1,704	\$3,152	29%	\$98.46
Paterson Community Health Center	9,839	6,504	\$347	3%	\$35.25
Plainfield Health Center	23,801	4,500	\$2,007	18%	\$84.34
Southern Jersey Family Medical Centers	14,741	5,208	\$991	9%	\$67.26

Source: New Jersey Department of Health and Senior Services administrative data

^aDollar figures are in thousands.

Table 2 shows how the distribution of 0.53 funds would differ under Option 1 where funds are allocated in proportion to total uninsured visits provided. In this and all remaining tables, the identity of each FQHC is replaced with generic identifiers – i.e., FQHC A, B, C, etc. Note that the order of FQHCs in the tables with de-identified entries does not match the order in Table 1, which contains publicly known information.

The determinant of payment under Option 1 is the percentage of total statewide uninsured visits provided by each center. The average percentage is 10% across all ten centers with a range from 1% to 23%. As intended, FQHCs with the highest percentage of uninsured visits would receive the greatest portion of the \$10,964,983 available in SFY2004 (assuming budget neutrality). A clear difference from the current allocation of 0.53 funds is that under Option 1 all FQHCs receive \$77.39 per uninsured visit beginning with the first visit provided.

Relative to the current subsidy, Option 1 would redistribute revenue significantly across FQHCs. For some centers subsidy revenue would more than double. For others, receipt of 0.53 funds would fall by approximately 20%. In a few cases, subsidy payment would change by less than 5%.

Table 2: Distribution of Subsidy Payments under Option 1 – Allocation According to Share of Uninsured Visits

FQHC	Share of Visits	Subsidy Payment ^a	Payment per Uninsured Visit
A	13%	\$1,441	\$77.39
B	23%	\$2,477	\$77.39
C	17%	\$1,842	\$77.39
D	4%	\$482	\$77.39
E	5%	\$536	\$77.39
F	1%	\$157	\$77.39
G	7%	\$761	\$77.39
H	9%	\$957	\$77.39
I	10%	\$1,141	\$77.39
J	11%	\$1,171	\$77.39

Source: New Jersey Department of Health and Senior Services administrative data

^aDollar figures are in thousands.

Table 3 shows how the distribution of 0.53 funds would differ under Option 2, which is based on uninsured burden in addition to total uninsured visits provided. On average, uninsured burden is 41% across the ten FQHCs in Table 3 with a range of 24% to 50%. However, burden is not the only determinant of payment, as an FQHC with a relatively low burden could still receive significant payments from the Healthcare Subsidy Fund under Option 2, if that FQHCs total volume of uninsured visits is high.

Unlike Option 1, Option 2 does not eliminate variation in subsidy payment per uninsured visit. However, the range of payment per visit is compressed under Option 2 relative to the current subsidy. In particular, the range in payment per visit is \$49.02 under Option 2 compared to \$81.40 under the current system.

Like Option 1, however, Option 2 would also redistribute revenue significantly across FQHCs (relative to the current subsidy). Some centers would experience a doubling of receipts from the subsidy while at least one center is expected to experience

a 40% loss. Several other centers would experience gains or losses in excess of 10% of their current allocations.

Table 3: Distribution of Subsidy Payments under Option 2 – Allocation Based on Uninsured Burden

FQHC	Uninsured Burden ^a	Subsidy Payment ^b	Payment per Uninsured Visit
A	24%	\$842	\$45.25
B	43%	\$2,595	\$81.07
C	50%	\$2,244	\$94.26
D	38%	\$447	\$71.64
E	33%	\$431	\$62.21
F	50%	\$191	\$94.26
G	46%	\$853	\$86.72
H	33%	\$769	\$62.21
I	42%	\$1,167	\$79.18
J	50%	\$1,426	\$94.26

Sources: New Jersey Department of Health and Senior Services administrative data Bureau of Primary Health Care Uniform Data System (UDS)

^aUninsured burden is defined as total uninsured encounters divided by total encounters for all payers as recorded in the UDS.

^bDollar figures are in thousands.

Option 3 involves the use of incentives to provide the preventive services listed above. Due to data limitations, it is not possible to provide a full simulation of payment distribution under this option. However, a few examples illustrate how this kind of option may affect FQHC payment.

FQHCs I and J are similar in the number of uninsured visits provided, but they differ significantly in terms of favored service percentages – 35% for FQHC-I and 80% for FQHC-J (according to 2002 UDS data). As a result, payment under Option 3 would be \$678,449 for FQHC-I and \$1,591,348 for FQHC-J. Although the total number of visits is similar, the estimated composition of these visits has a large impact on total payment. Comparison of FQHCs A and G show the opposite scenario – i.e., similarity in the favored service percentage with a large difference in total uninsured visits. FQHCs A and G both have a favored service percentage equal to 56%, but FQHC-A provides twice as many total uninsured visits. As a result, payment under Option 3 would be \$1,371,166 for FQHC-A and \$724,538 for FQHC-G.

Blended Payment Options

The State may consider blending several payment options to achieve multiple goals or to provide a gradual transition to a new payment system. Table 4 shows the distribution of payments to FQHCs under Options 1 and 2 and a blended version of these options. The blended version averages the two payments and continues to meet the requirement of budget neutrality. Some FQHCs such as FQHC-A receive greater payment under Option 1 than Option 2. Others such as FQHC-J receive greater payment under Option 2. In cases like these, a blended approach may be viewed as an acceptable compromise for FQHCs that stand to gain or lose a great deal from any particular option. The combination of Options 1 and 2 also has the appeal of addressing two policy goals simultaneously – 1) provision of incentives and support for additional uninsured visits and 2) provision of greater assistance to FQHCs in the weakest position to cross subsidize uninsured care.

Regardless of which payment reform option is chosen, any change to the current system will necessarily involve redistribution of payment from some FQHCs to others (assuming budget neutrality). The initial impact of such redistribution can be modified by blending the pre-existing subsidy with any new option to create a gradually phased-in payment change. Table 4 shows how phased-in payments might work in practice. For options 1 and 2, the phased-in payment takes the average of current and new payment. For the combination of options 1 and 2, the phased-in payment takes the average of three payment methodologies – Option 1, Option 2, and the current subsidy. In each case, phased-in payment reduces the size of any gains or losses experienced by FQHCs under any of the subsidy reform options.

Table 4: Blended and Phased-in Payment Options^a

FQHC	Option 1 ^b	Option 2 ^c	Blended Options 1 & 2 ^d	Phased-in Option 1 ^e	Phased-in Option 2 ^e	Phased-in Blended Options 1 & 2 ^f
A	\$1,441	\$842	\$1,142	\$1,429	\$1,130	\$1,234
B	\$2,477	\$2,595	\$2,536	\$2,814	\$2,873	\$2,741
C	\$1,842	\$2,244	\$2,043	\$1,925	\$2,125	\$2,031
D	\$482	\$447	\$465	\$298	\$280	\$347
E	\$536	\$431	\$484	\$533	\$480	\$499
F	\$157	\$191	\$174	\$142	\$159	\$158
G	\$761	\$853	\$807	\$554	\$600	\$654
H	\$957	\$769	\$863	\$866	\$772	\$833
I	\$1,141	\$1,167	\$1,154	\$1,066	\$1,079	\$1,100
J	\$1,171	\$1,426	\$1,298	\$1,338	\$1,466	\$1,367

Sources: New Jersey Department of Health and Senior Services administrative data Bureau of Primary Health Care Uniform Data System (UDS)

^aDollar figures are in thousands.

^bOption 1 is based on the percentage of total statewide uninsured visits provided by each FQHC

^cOption 2 is based on uninsured burden and total uninsured volume.

^dBlended Options 1 & 2 takes the average payment between the two options.

^ePhased-in Options 1 & 2 are calculated by taking the average of current subsidy payment and payment under each option.

^fPhased-in blended option is calculated by taking the average of current subsidy payment, Option 1, and Option 2.

Discussion

Incentive Effects

The payment simulations presented above provide “static estimates” of the distributional impact of various payment reform options. As such, these simulations do not account for behavioral responses to the various incentives that are contained in each option. While static estimates are useful for determining short run implications of subsidy reform, it is important to understand how FQHCs would likely respond to the incentives contained in each reform option when given sufficient time to adjust their behavior.

Option 1 provides reimbursement to FQHCs in proportion to the statewide total of uninsured visits they provide. Under this option, the incentive to provide an additional uninsured visit is similar to the incentives that exist under current law. In both cases a fixed payment per additional uninsured visit is provided. However, the level of payment

does differ between the two subsidy formulas – \$104 under the current subsidy versus \$77.39 under Option 1. This difference is the result of two factors. First, Option 1 provides reimbursement for all visits, while the current subsidy provides reimbursement only for visits that exceed the center-specific threshold (described above). Second, due to the imposed restriction of budget neutrality, the marginal payment of \$104 per visit must be reduced to cover a greater number of total visits. As a result, the incentive to provide additional uninsured visits beyond existing levels is reduced under Option 1.³

Nevertheless, the marginal payment of \$77.39 is comparable to health center payments in other states (subject to funding availability in those states). California's Expanded Access to Primary Care Program provides \$77.50 per uninsured visit for primary care or dental services. Health center payments from Massachusetts' Uncompensated Care Pool are set at \$85.47 per primary care visit and \$64.10 per dental visit.

Option 2 provides a somewhat different set of incentives, as the payment per additional uninsured visit varies across FQHCs. Under this option it is assumed that FQHCs with a high uninsured burden (i.e., percentage of total visits attributable to uninsured patients) are less able to draw on revenue from third party payers to cross-subsidize care for the uninsured. Therefore, centers with high burden are given a greater incentive to provide care to the uninsured. This creates a range in payment per uninsured visit from \$45.25 for the FQHC with the lowest uninsured burden to \$94.26 for the FQHC with the highest burden. For the same reasons that apply to Option 1, all FQHCs receive a marginal payment per uninsured visit under Option 2 that is less than the \$104 payment under the current system. Nevertheless, for most FQHCs, payment per uninsured visit would remain comparable to payments in other states.

Option 3 is the most difficult to assess due to the limited availability of data on preventive services and healthcare quality at the FQHC level. For illustrative purposes, a set of favored services intended to measure healthcare quality and preventive care were defined in this report as pap smears, immunizations, HIV tests, first trimester prenatal care, newborn visits within 4 weeks of birth, and well-child visits. The analysis shows that a great deal of subsidy redistribution can take place if payment is tied to the provision of these favored services. Given the data limitations, this report does not recommend that this particular option be implemented. However, the basic structure of Option 3 can be used as a basis for designing a subsidy that links payment to the provision of specific services.

For such a system to work properly, a number of issues would need to be addressed. First, healthcare quality indicators must be identified. As FQHCs move toward an electronic all-payer billing system, it will become easier to identify diagnoses and procedures that serve as the building blocks for quality measurement.

Second, quality indicators must be relevant and appropriate for the patients who come to each FQHC. For example, while first trimester prenatal care is an important indicator of healthcare quality for pregnant women, this measure is not useful for FQHCs that serve patients who are predominantly children or elderly. If the set of favored services is not designed carefully, some FQHCs would be placed at a disadvantage simply because their patients do not require one or more services appearing on the list.

The effect of any reform option on the provision of services to the uninsured is difficult to predict. In most cases, FQHCs would receive a lower payment for each additional uninsured visit. All else equal, this would create a disincentive to provide additional service to the uninsured. However, FQHCs would receive payment for other uninsured visits (those below their baseline level) that are currently not reimbursed by the 0.53 funds. In theory, these payments could provide additional resources to expand services for the uninsured. On balance, it is not clear whether any reform option would unambiguously increase or decrease total uninsured visits.

Implementation Issues

The simulations in this report assume that any change in the distribution of 0.53 funds must be budget neutral. This assumption is not unreasonable given the budget constraints currently faced by the state of NJ. However, budget neutrality has important implications for both the efficacy and political feasibility of each reform option. As mentioned above, any reform that removes the threshold requirement for reimbursement of uninsured visits will lead to lower payment per visit, since current dollars must be spread over a larger uninsured volume for each FQHC.

Furthermore, budget neutrality means that a reform that produces financial gains for one FQHC must necessarily produce a loss for one or more other FQHCs. This situation creates obvious constituencies for the status quo depending on which reform is under consideration. Support for a reformed subsidy formula could be strengthened, if the FQHCs that lose funds under the reformed system were held harmless for a short period of time as the new system is phased in. Of course, this would require additional state funds, albeit on a temporary basis, which may or may not be available.

Another option to ease the transition to a new subsidy system would involve the use of blended payment rates. The analysis presented above shows how reformed subsidy formulas can be phased-in by taking simple averages of payment under current and reformed formulas. Other phase-in schemes are also possible. For example, in the first year of reform, payment might be based 75% on the old formula and 25% on the new one. Over time, the new formula would receive greater relative weight leading to a fully reformed system at the end of the transition period. While this transition method would not hold FQHCs completely harmless, it has the advantage of being feasible in a budget neutral context. If policymakers wish to hold all FQHCs harmless in a move to a new reimbursement formula, they would have to increase the total amount available for the subsidies.

The analysis also showed how blending different options might also reduce the level of payment redistribution among FQHCs. This would occur if the facilities that currently do better than average under one option tend to do worse than average on another option. Although redistribution would be limited in this case, the new blended formula would still be useful if it contains a better set of incentives for the purpose of expanding and improving services to the uninsured. Over time, these incentives may lead to behavioral changes among FQHCs that eventually do redistribute the fixed amount of subsidy dollars available. The difference is that redistribution would take place by rewarding FQHCs that do well along multiple measures of desired outcomes instead of one measure at the exclusion of others.

The coordination of subsidy payment with benefits over time is an important issue that is not addressed in the payment simulations. Timely payment for uninsured visits is vital for FQHCs to maintain an adequate cash flow. However, rapid and frequent subsidy payments also increase the administrative requirements of the subsidy program, since visits and procedures must be documented more quickly and more often. As the state phases in its electronic billing system, administrative burden should be reduced (though not eliminated) over time.

The stability and predictability of subsidy funding are also important to consider. Over time the availability of funds for FQHC subsidies has fluctuated between \$8-12 million. Fluctuation in payment that is unrelated to policy variables (e.g., uninsured visits, burden) complicates long term planning and short term cash flow. Moreover, instability in funding would blunt the effect of incentives that may be built into new subsidy formulas. These problems could be addressed through dedicated funding for the FQHC

subsidy program. Short of that the state may consider an approach similar to California's EAPC Program where health centers that maintain their uninsured volume are guaranteed at least 90% of the prior year's allocation.

Measurement Issues

Much of the analysis presented above is based on databases that contain only proxy measures for several key variables. Specifically, Option 2 requires a measure of uninsured burden (i.e., uninsured visits divided by total visits), while Option 3 requires a list of services and procedures that reflect the quality of care provided to the uninsured. This report used data from the federally maintained Uniform Data System (UDS) as the source of information for total visits and quality indicators. While the UDS is useful for analytic purposes, it would not be adequate to administer a reformed subsidy program. Specifically, the UDS is collected for much different purposes, has a fairly long reporting lag, and is based on the calendar year instead of the state fiscal year.

The ratio of uninsured to total visits will become easier to measure when the state implements electronic billing. However, even if accurately measured uninsured burden, as defined here, may not really capture the ability of FQHCs to cross-subsidize the costs of treating the uninsured. The underlying assumption is that third party payments to FQHCs provide sufficient revenue to support cross-subsidization. As described earlier, however, Medicaid payment – which is the primary source of third party payment for FQHCs – is generally set at or below costs. Reimbursement for private payers is typically negotiated privately making it difficult to know the extent to which private payment enables cross-subsidization of uninsured care.

The state may consider other variables in addition to or in place of uninsured burden to measure differences among FQHCs in the ability to cover the costs of caring for the uninsured with pre-subsidy revenue streams. For example, the subsidy formula might consider measures of financial performance or the level of uncollected fees from patients as done in New York's subsidy for Diagnostic and Treatment Centers. Of course, these additional variables would add to the administrative costs of implementing the subsidy. In New York, payments to D&TCs are made with a two year lag to allow for all of the necessary information to be collected and tabulated. Although New York does reserve subsidy funds to provide immediate support to D&TCs that experience a rapid increase in their uninsured volume, these reserves add to the complexity of the program. Furthermore, added payment for poor financial performance or uncollected patient bills may create incentives that lead to inefficiency or reduction in collection efforts.

Nevertheless, additional measures of financial need may be useful for better targeting of the 0.53 funds.

The construction of quality measures will also be aided by the availability of electronic billing records. Nevertheless, it will still take considerable effort to decide what kinds of procedures should be counted in a reimbursement formula that rewards high quality healthcare. In this area, the state may build upon FQHC performance goals developed by the federal government (Health Resources and Services Administration, 2004).

Once a set of quality indicators is agreed upon, they must be placed appropriately into the subsidy formula. Given the diversity of patients seen by different FQHCs, it would be more appropriate to use rates of service provision for a defined population rather than total volume of service. For example, certain immunizations can be measured as rates per child within an appropriate age range. Similar quality and prevention indicators can be constructed for other types of patients.

After the set of rates is chosen, they need to be priced by the subsidy formula. At issue is how the different variables should be combined to determine payment. While the services that determine payment can all be measured as percentages of the target population, these percentages are likely to be non-comparable for the purpose of ranking FQHCs according to performance. Specifically, each percentage is likely to have very different statewide means and standard deviations. The result is that a percentage point change in one quality indicator may have greater significance than the same percentage point change in another quality indicator. For example, in New Jersey in 2001 47% of low-income women age 25-64 received Pap smears, while 65% of low-income women in this age range received mammograms (DeLia and Cantor, 2004).⁴ A 10 percentage point increase in the Pap smear rate (from 47% to 57%) has greater significance than the same percentage point increase in the mammogram rate (65% to 75%), since the improvement is a 21% gain for Pap smears ($10\%/47\%$) compared to a 15% gain for mammograms ($10\%/65\%$).

For this reason, the state may consider measuring performance indicators in statistically standardized form – i.e., as standard deviations from the mean. These standardized measures can then be legitimately combined by taking the average across all measures that are relevant for each FQHCs. Moreover, if it is decided that certain measures deserve greater consideration by the subsidy formula, then a weighted average of quality indicators can be taken instead of a simple average.

It is also important to consider how payments tied to quality measures should enter the formula. One option is to use a formula similar to that used for Option 3 in this report. The state could blend that formula with others similar to the way formulas were blended in the analysis of Options 1 and 2. Alternatively, the state may consider holding a separate pool of money from the Health Care Subsidy Fund in reserve to provide bonus payments to FQHCs that generate high quality scores. The administrative infrastructure for managing a separate bonus fund could build on the existing system used to withhold a portion of payments for post-audit reconciliations.

Other Technical Issues

Although the subsidy options analyzed in this report are presented as mutually exclusive programs, several options could be blended together to achieve various policy objectives. For example, removal of the visit baselines under the current subsidy is seen as a way to increase payment equity and better tie payment to performance. However, as discussed above, proving payment for visits below current baseline levels leads to lower payment per uninsured overall, thereby blunting the incentive at the margin to provide additional uninsured visits. One way to address this problem would be to introduce a new threshold that better reflects policy objectives. For example, the new baseline could be uniform across FQHCs or it might be allowed to vary based on each center's visit capacity. The underlying rationale is that all FQHCs are expected to provide a minimum level of uninsured visits without state support. The result is that payment for marginal visits can be increased, if payment is withheld for visits that fall below a reformulated baseline. This would represent a blending of Option 1 and the current subsidy. Similarly, the state may consider paying a "quality of care bonus" only to those FQHCs that perform exceptionally well on a quality measurement scale.

Finally, policymakers may want to consider exactly how chosen policy variables enter the subsidy formula. In the technical literature, this is referred to as the functional form of the payment formula. At issue is where the policy variables are placed in the formula and whether they should be entered in a linear or non-linear way. For example, the Prospective Payment System used by Medicare to pay for hospital services is based on a fairly elaborate econometric model of hospital costs (Rogowski and Newhouse, 1992; Pettengill and Vertrees, 1982). In that model, key variables such as hospital costs and teaching output are measured in logarithmic instead of direct form.

While such an effort may require more resources than the state has available, a brief consideration of the functional form may prove useful. For example, some variables

such as uninsured burden may have non-linear effects – e.g., a one percentage point increase in uninsured burden may have a greater impact on an FQHCs financial condition if burden is originally 70% compared to 20%. In this case, policymakers may want to consider a non-linear formula to connect the subsidy payment with uninsured burden.

Conclusion & Recommendations

There are several ways to reform the allocation of 0.53 funds to FQHCs in New Jersey. Each reform option would have different distributional consequences and create different incentives for the provision of care to the uninsured. Since any budget neutral reform will create gainers and losers relative to the status quo, the state may want to implement a reformed subsidy gradually with transition payments or blended formulas. The state may also consider combining various options to create the appropriate mixture of incentives to encourage desired performance of FQHCs.

We recommend phasing in a blended reimbursement approach based on Options 1 and 2 – that is, taking into account both the total uninsured volume at each center and the proportion of care at each center provided to the uninsured. An appropriate phase-in schedule should be developed to avoid sudden changes in revenue streams for individual FQHCs. If feasible, it would be desirable to hold FQHCs harmless under the change in reimbursement, but, as noted, doing so would require increasing total funds available through this program. Finally, we recommend further developing option 3, providing incentives for FQHCs to increase the volume of “favored services” such as preventive care. This report suggests that Option 3 may be attractive for advancing state policy goals, but a more complete analysis should be conducted before an informed decision about this option can be made.

Endnotes

- ¹ Before 1996, many of these organizations received federal grants under Sections 329, 330, 340, and 340A of the Public Health Service Act. In 1996, all of these grant authorities were consolidated into a revised Section 330 of the Public Health Service Act under the Consolidated Health Centers Act of 1996 (Hawkins and Rosenbaum, 1998).
- ² The UCP was originally designed for hospital uncompensated care in 1985. In 1991, CHCs became eligible for UCP funds. Nevertheless, in 2002 payments to CHCs accounted for only 4% of total UCP distributions.
- ³ In theory, Option 1 could increase the payment for additional uninsured visits for some FQHCs – particularly, those that did not meet their threshold, and therefore, received no payment at all under the current subsidy formula. In practice, however, no FQHC faced this situation.
- ⁴ Low-income is defined as income below 200% of the Federal Poverty Level.

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