Data Note

September 2022

What are Talevski's Implications for Community Health Centers and Their Patients? Estimating the Impact of Losing Federally Enforceable Medicaid FQHC Payment Rights

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Executive Summary

During its upcoming term, the United States Supreme Court is expected to hear arguments in ***Health and Hospital Corporation of Marion County v Talevski***, which could determine whether beneficiaries and health care providers will be able to seek the aid of the courts when official state actions threaten federal Medicaid rights. Among the providers that would be affected are community health centers, which have special payment protections under Medicaid's "Federally Qualified Health Center (FQHC)" federal payment guarantee. Should health centers lose the ability to enforce FQHC rights, they would risk serious financial losses in those states that fail to honor FQHC payment rules, and these mounting revenue losses would significantly affect patient care. Using FQHC Medicaid payment data from the 2021 federal Uniform Data System, we estimate that nationwide, the potential lost revenue in one year alone could be between $643 million and $4.1 billion. Losses of this magnitude would translate into:

- Between 500,000 and 3.2 million fewer patients served.
- Between 4,500 and 29,000 fewer staff members.
- Between 2 million and 13 million fewer patient visits.

Our estimates are conservative since they are based on a single-year snapshot and thus do not account for ongoing financial losses over multiple years. Nor do they take into account total funding losses health centers could experience if their Medicaid-insured patients lose coverage as a result of an inability to enforce their entitlement to benefits. Surveys of **Primary Care Associations** (PCAs) and community health centers confirm that past state Medicaid failures to comply with health centers' full FQHC payment rights have had a serious impact on health centers' operational capacity, including their staffing and provision of services.

Federal Medicaid Law Establishes Payment Rights for Community Health Centers

During its upcoming term, the United States Supreme Court is expected to hear arguments in ***Health and Hospital Corporation of Marion County v Talevski***. The *Talevski* case concerns a question of seminal national health policy importance: whether beneficiaries and health care providers can enforce their federal Medicaid rights in cases in which state policies and practices threaten these rights.

A legal entitlement to public benefits depends on the ability to enforce a right against unlawful government interference–in the case of Medicaid, unlawful state action. Medicaid is a federal-state partnership. Although the Centers for Medicare and Medicaid Services (CMS) has federal enforcement authority, its powers are limited. Most importantly, unlike the federal courts, CMS lacks the ability to rapidly intervene and, through injunctive relief, avert injury before it occurs. CMS can attempt to persuade state officials to follow the law, but ultimately, the federal agency's only real power is to withhold federal Medicaid funding. This is a punishment no one wants to impose because of its widespread effects on a state's entire Medicaid population and its health care system. Federal courts, by contrast, have the power to fashion pinpointed, specific remedies focused on a particular legal violation and structured to stop a specific harm without disturbing the rest of a state's Medicaid program.

Nearly 82 million beneficiaries depend on Medicaid. Federal Medicaid law not only entitles states to federal financial support but also guarantees key individual rights, including the right to apply for assistance, the right to prompt enrollment if determined eligible, and the right to comprehensive coverage for necessary medical care. Certain health care providers also have rights. Among these providers are community health centers, whose services are a basic Medicaid benefit and who have a special right to payment in accordance with a **"Federally Qualified Health Center" (FQHC) payment formula**. The FQHC coverage and payment right, added to Medicaid in 1989 and modified in 2000, assures that health centers will be paid at a rate that reflects the reasonable cost of serving Medicaid patients. Congress added these guarantees in order to promote the stability of community health centers and to ensure that health centers can dedicate their limited federal grant support to costs related to treating uninsured patients and furnishing care that may be excluded from coverage, such as adult dental care.

In 2021, the most recent year for which nationwide government data from the Uniform Data System (UDS) on health center patients, services, staffing, and revenue are available, the federal health center appropriation under Section 330 of the **Public Health Service Act** represented only 13 percent of total health center revenue (excluding special time-limited $2.2 billion in **supplemental COVID-19 grant funding reported in 2021**), even as health centers cared for 6.1 million uninsured patients that year.

The FQHC payment provisions in federal law establish a "prospective payment system" (PPS) that provides health centers with annual, predictable Medicaid revenue approximating the cost of care. Under PPS, states are required to pay health centers for the covered services they furnish and must set an annual payment rate reflecting the reasonable costs each health center incurs in furnishing care. As the scope of care expands (for example, if a health center adds dental care for children), then the PPS formula must be updated. Furthermore, annual rates must be adjusted to account for inflation cost growth.

Some states pay health centers at their full PPS rate for each visit. In many states, however, health centers receive their FQHC payments in two parts: an interim payment, followed by a supplemental payment that reflects the balance owed under the health center's rate for the year in question. For example, if a particular health center's annual PPS rate is $150 per visit, the state (or its managed care contractor in states that **administer Medicaid through managed care** systems) may make a $100 interim payment per visit, followed by a final, reconciled $50 per visit times the number of covered visits throughout the year.

There have been times when states have refused to comply with the PPS requirements by failing to update rates, set rates that reflect the scope of services furnished, or make the reconciled, supplemental payments. These failures can result in serious underpayment. At times, health centers have sued to enforce their payment rights in order to avert the major financial losses that in turn can lead to reduced services and staffing. Like beneficiaries, health centers have based their suits on Section 1983, which permits plaintiffs to seek the aid of the courts when state officials threaten rights guaranteed by law. In virtually every FQHC payment case brought to date, the courts have recognized that the FQHC statute creates legally enforceable rights of the type that can be protected under Section 1983.[1] The ability to bring a Section 1983 action does not guarantee that a case will be won on its merits. But the fact that PPS payment is recognized as a legally enforceable right means that health centers, and the medically underserved rural and urban communities that depend on health centers, can seek the help of the federal courts when they believe that states have wrongfully withheld funds owed, thereby implicating their ability to serve their patients.

[1] See, *Rio Grande Community Health Center, Inc. v. Rullan*, 397 F.3d 56 (1st Cir. 2005); *New Jersey Primary Care Association, Inc. v. New Jersey Department of Human Servs.*, 722 F.3d 527 (3rd Cir. 2013); *Three Lower Counties Community Health Services*, 498 F.3d 292 (4th Cir. 2007); *Legacy Community Health Services, Inc. v. Smith*, 881 F.3d 358, 371 n.13, 372, 373 (5th Cir. 2018), cert. denied, 139 S. Ct. 211 (2018); *California Association of Rural Health Clinics v. Douglas*, 738 F.3d 1007 (9th Cir. 2013); *Community Health Care Association of New York, et al. v. Shah*, 770 F.3d 129 (2nd Cir. 2014); *Arizona Alliance for Community Health Centers v. Arizona Health Care Cost Containment System*, No. 21-16262, 2022 WL 4005328 (9th Cir. 2022)

Should the Court in *Talevski* end Medicaid as a legally enforceable right by refusing to permit Section 1983 Medicaid lawsuits, health centers would be deeply affected in three distinct ways. First, some 82 million people would lose their legally enforceable right to Medicaid, a shift that would deeply affect health centers since Medicaid insures nearly half of all health center patients (48 percent of health center patients were covered by Medicaid in 2021). Ending Medicaid as an enforceable right would make patients vulnerable to unlawful denial or termination of Medicaid eligibility, leaving them uninsured and health centers without a source of payment. Second, a state could unlawfully refuse to pay for federally-required services, meaning that patients would be uncovered for necessary medical care; for example, a state could refuse to pay for the full range of prescription drugs required by law. Third, a state could refuse to comply with the FQHC PPS payment guarantee, and health centers would be left without federal legal recourse.

Below, we estimate the nationwide revenue impact of failure to comply with the FQHC PPS guarantee that interim payment rates will be reconciled against the amount owed under the FQHC formula.

Estimating the Potential Impact on Health Centers of Losing the Ability to Enforce Medicaid PPS Payment Rights

Our analysis consisted of two components. In the first component, we calculated the potential revenue losses if states failed to make the reconciled payments owed in 2021. These reconciled Medicaid payments are reported in the Uniform Data System (UDS), a special government reporting system covering all health centers.[2] These reconciled amounts reflect payments owed for both the current year (CY)[3] and the previous year(s) (PY).[4] The share of total revenue from these reconciled amounts were then applied as a loss percentage in order to calculate the total number of patients, total full-time equivalent (FTE) staff members, and total visits (including both clinic and virtual visits) that would have been affected during 2021, based on patients, visits, and staffing reported in the 2021 UDS. The higher estimates were based on the loss of both CY and PY payments, while the lower estimates were based on the loss of PY payments only. Based on these revenue losses, we estimated the annual number of patients that health centers would no longer be able to serve, the staff members health centers would no longer be able to employ, and the number of visits that health centers would no longer be able to provide, at the national level and for the 50 states, the District of Columbia, and Puerto Rico.

The second component presents findings from national surveys of state and regional Primary Care Associations (PCAs) and community health centers that were conducted by the National Association of Community Health Centers (NACHC) in August 2022. The purpose of the surveys was to understand the potential operational impact of delayed or lost revenue.

Findings

Reconciled payments account for one in four Medicaid dollars received by health centers, and in some states, more than half of health centers' Medicaid revenue. **Table 1** provides insight into the amount of health center Medicaid revenue over one year that could potentially be at risk were community health centers to lose their enforceable right to secure payment in full, as required under Medicaid's FQHC provisions. This table presents total 2021 health center Medicaid revenue from reconciled payments. In 2021, health centers nationally reported $4.1 billion ($3.5 billion from CY payments and $643 million in PY payments) in revenue from reconciled payments, which accounted for 26 percent of the $15.6 billion in Medicaid revenue collected that year. In seven states (AL, AK, DE, KS, NH, SD, WY) health centers are not required to undergo a reconciliation process; that is, their states make a single PPS payment in

[2] These payments are defined in the UDS manual (p. 143): "Reconciliations are lump sum retroactive adjustments based on the filing of a cost report. Wraparound payments are additional amounts for each visit to bring payment up to FQHC level."
[3] UDS manual (p. 143): "for services provided during the current calendar year."
[4] UDS manual (p. 143): "for services provided during previous calendar years."
[5] As noted in the UDS manual (p. 143): "States that pay the FQHC rate rather than a market rate will typically not make wraparound reconciliation payments."

full rather than paying an interim rate to be followed by reconciliation against the approved rate.[5]

In the remaining states, as well as the District of Columbia and Puerto Rico, health centers reported Medicaid revenue received through reconciled payments as a supplement to their interim payment rate or through wraparound payments.[6] In some of these states, as Table 1 shows, the amount of revenue withheld until the reconciliation phase can be considerable. For example, the **2021 Oklahoma** Medicaid reconciliation amount was $2,102; in contrast, a total of $1.7 billion in reconciliation payments was paid to **California's health centers** that year. Reconciled payments accounted for as much as 60 percent of total 2021 health center Medicaid revenue in Indiana and over half of Medicaid revenue (54 percent) in New Jersey. Reconciled payments accounted for 40-49 percent of health center Medicaid revenue in five states (MO, TN, VA, WA, WI).

Health centers in many states face long payment delays, with hundreds of millions of dollars owed in delayed payments. The UDS data also show health centers had to wait more than a year to reconcile $642.8 million to cover underpayments for services provided in previous years. Although late reconciled payments accounted for only three percent of California health center Medicaid revenue in 2021, because health centers in California serve such a high proportion of Medicaid patients in the state, the delayed revenue accounted for **$158 million in Medicaid payments**. Virginia health centers reported late reconciliation payments of **$18.9 million**—19 percent of their 2021 Medicaid revenue. The loss of health centers' ability to file suit in court to correct States' unreasonable delays in reconciling payments or refusal to make such payments altogether would have profound effects on health center access and capacity.

Patient care capacity and health center staffing hinge heavily on the reconciled payment guarantee. The amount of Medicaid revenue flowing through the reconciliation phase has enormous implications for patient care and health center staffing. **Table 1** translates potential reconciled revenue losses into patient, staffing (in terms of full-time equivalent [FTE] staff members) and visit capacity. We present our estimates according to a range, with higher estimates based on the loss of reconciled/wraparound payments for both current-year (CY) and previous year(s) (PY) payments, and lower estimates based on the loss of PY payments only. For health centers nationally, the maximum or higher estimate is based upon an 11 percent loss of total revenue in 2021, while the minimum or lower range is based upon a loss of two percent of total revenue in 2021. Estimates for the 50 states, the District of Columbia, and Puerto Rico are based on the loss of total revenue from reconciled payments ranging from 0 percent to 31 percent. In the case of failure to reconcile 2021 Medicaid revenue against the approved PPS rate:

- Patient capacity nationally would decrease by an estimated 500,000 to 3.2 million patients.
- Health center staff would decrease by 4,500 to 29,000 FTE staff members.
- Patient visits would drop by between 2 million and 13 million visits.

The greatest impact would be experienced by health centers and their communities in California, Washington, New York, Florida, New Jersey, and Indiana, with potential statewide losses of patient capacity ranging from approximately 20,300 to nearly 1.09 million patients, losses of staffing capacity ranging from 198 to approximately 10,600 FTE staff members, and losses of visit capacity ranging from nearly 80,000 to more than 5.4 million visits in one year. No losses are estimated for the seven states (Alabama, Alaska, Delaware, Kansas, New Hampshire, South Dakota, and Wyoming) that did not report any Medicaid reconciled or wraparound payments in 2021.

If anything, these estimates seriously understate the effects of losing the ability to enforce full PPS payment rights. Our estimates represent a single-year snapshot. The loss of enforcement rights would, of course, carry long-term financial consequences that would permanently reduce health center capacity unless Congress restored enforcement powers or dramatically increased appropriations to offset Medicaid revenue losses. Furthermore, these estimates do

[6] These payments are defined in the **UDS manual** (p. 143): "Reconciliations are lump sum retroactive adjustments based on the filing of a cost report. Wraparound payments are additional amounts for each visit to bring payment up to FQHC level."

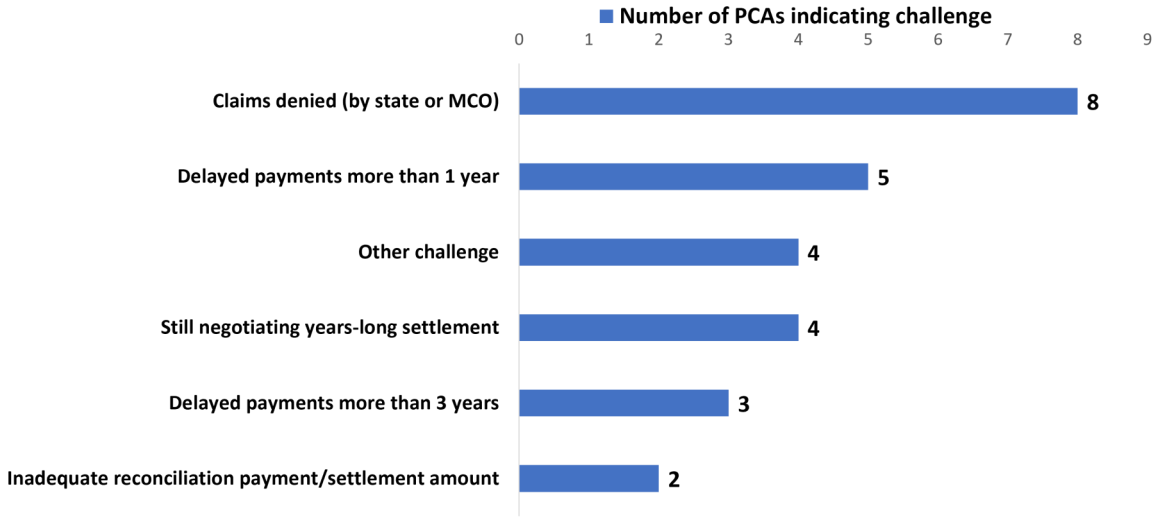
not take into account the potential impact of the Court's decision on Medicaid beneficiaries themselves. If beneficiaries were to lose their enforceable right to coverage, PPS payments, no matter how generous, would have no bearing on health centers because their patients would have lost Medicaid entirely and therefore, visits previously insured through Medicaid would become uninsured visits. Health centers would similarly need massive appropriations increases from Congress to offset these losses.

Primary Care Associations report that health centers facing PPS payment issues experienced major patient care and staffing challenges. A recent survey of state or regional Primary Care Associations (PCAs) conducted by NACHC and focusing on health care and staffing challenges associated with PPS payment issues sheds additional light on the types of problems health centers could face if they lose their right to payment at the FQHC PPS rate. A total of 16 state or regional primary care associations representing 16 states responded to the survey, representing 403 health centers (29 percent of community health centers nationally) and 9.5 million patients (32 percent of patients served in 2021). The health centers represented by these associations collected $5 billion in Medicaid revenue, of which 28 percent was from reconciled payments.

Of the 16 responding PCAs, 11 indicated that their member health centers experienced challenges over the previous five years in reconciling their interim Medicaid FQHC payment against the PPS rate amount owed for the year in question. These 11 PCAs represented 289 community health centers serving seven million patients in 2021, and their health centers accounted for $4.1 billion in Medicaid revenue, of which 33 percent was from reconciled payments.

Figure 1 shows that half (8) of the responding PCAs reported that in the previous five years, health centers had experienced claim denials either by the state or by one or more managed care organizations (MCOs). Five PCAs reported payment delays of more than a year, and three of those five associations reported that payment delays exceeded three years. Four PCAs each indicated that they were still negotiating long overdue settlements and reported other problems.

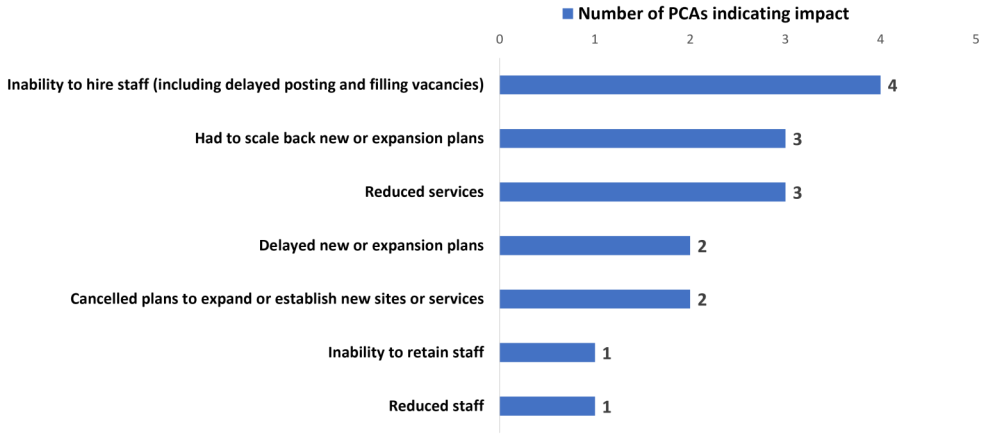
Figure 1. Reconciled Medicaid Payment Challenges Over the Past Five Years, as Reported by Primary Care Associations



Notes: Of 16 responding PCAs, 11 indicated that their member health centers experienced challenges over the past five years in reconciling their interim Medicaid FQHC payments against the amount owed for the year in question under the PPS rate. Respondents were able to select more than one challenge. Source: NACHC Survey of Primary Care Associations, 2022.

Five PCAs out of the 16 responding reported that states' failure to reconcile payment against amounts owed created significant operational challenges for member health centers (**Figure 2**), including cancelled development of new sites or services, delayed or scaled-back expansion plans, reduced services or staff, inability to hire new staff, and problems retaining existing staff.

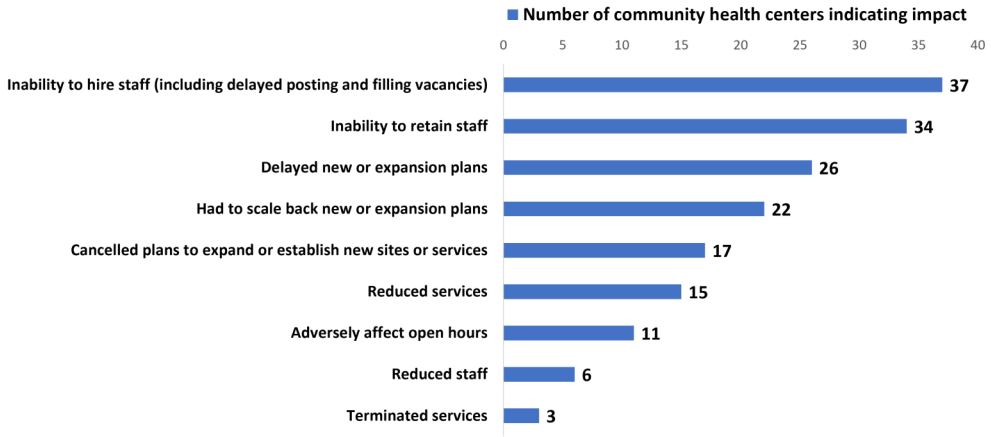
Figure 2. Impact of Reconciled Payment Challenges on Health Center Capacity, Operations, and Planning, as Reported by 16 Primary Care Associations



Notes: Of 16 PCAs, 5 were able to identify various impacts on health centers' capacity, operations, and planning. Respondents were able to select more than one impact. Source: NACHC Survey of Primary Care Associations, 2022.

A concurrent survey of health centers also reveals the types of care and staffing problems that arise when expected revenue payments decline. A total of 148 health centers across 41 states and Puerto Rico responded to the survey. **Figure 3** shows the range of effects reported. In all, 81 (55 percent) health centers reported at least one type of problem when payments fell below their anticipated FQHC PPS rate. Thirty-seven (25 percent) health centers reported inability to hire staff and 34 (23 percent) health centers reported inability to retain staff. Seventeen (11 percent) reported cancelled, 26 (18 percent) delayed, and 22 (15 percent) health centers scaled back plans to add or expand their sites or services. Although these findings are not necessarily representative of health center payment issues nationally, they suggest the types of problems that arise when payments fall significantly short of amounts owed.

Figure 3. Community Health Centers Reporting Impact of Reconciled Payment Challenges on Health Center Capacity, Operations, and Planning Impact



Note: Of 148 health center respondents, 81 identified various impacts. Respondents were able to select more than one impact. Source: NACHC Survey of Community Health Centers, 2022.

Conclusion

Medicaid has enabled community health centers to grow into the nation's most important source of comprehensive primary care. The benefits from Medicaid result from the fact that millions of health center patients have an enforceable right to coverage, and health centers themselves have the right to payments that cover the reasonable cost of the care they furnish to their Medicaid patients. Without adequate Medicaid financing, health centers would be virtually entirely dependent on federal appropriations, which fall dramatically short of costs associated with caring for 30 million patients.

Medicaid's guarantee of coverage and payment is fundamental to its success in funding health care for the nation's most vulnerable populations. Equally fundamental to Medicaid's success is the ability of providers and beneficiaries to protect these guarantees when they are threatened.

This analysis sheds light on the implications of removing enforcement rights and leaving the Medicaid population and the health care providers on which they depend without the means to shield these rights against unlawful governmental actions. In the end, this assessment of the potential impact of *Talevski* likely understates its potential consequences owing to the challenges inherent in estimating the full meaning and effects of withdrawing anything as profound as the basic legal protections that Medicaid affords the poor and that undergird their ability to secure access to health care.

Table 1: Estimated loss of patient, staffing, and visit capacity at community health centers if Medicaid current-year (CY) and previous-year(s) (PY) reconciliation or wraparound payments are not paid

State	2021 Total Medicaid reconciled/ wraparound Payments (CY and PY)	Share of 2021 Medicaid revenue from CY and PY Medicaid wrap payments	Share of 2021 Medicaid revenue from PY Medicaid wrap payments	Total revenue lost if CY and PY wrap payments not paid	Total revenue lost if PY wrap payments not paid	Lost patient capacity (CY and PY)	Lost FTE staffing capacity (CY and PY)	Lost visit capacity (CY and PY)	Lost patient capacity (PY only)	Lost FTE staffing capacity (PY only)	Lost visit capacity (PY only)
Total U.S.	**$4,122,549,451**	**26%**	**4%**	**11%**	**2%**	**-3,204,078**	**-28,841**	**-13,181,179**	**-499,604**	**-4,497**	**-2,055,310**
Alabama	$0	0%	0%	0%	0%	0	0	0	0	0	0
Alaska	$0	0%	0%	0%	0%	0	0	0	0	0	0
Arizona	$38,339,124	7%	3%	4%	2%	-31,635	-312	-132,175	-12,412	-122	-51,858
Arkansas	$14,627,223	22%	17%	5%	4%	-15,205	-120	-56,378	-11,891	-94	-44,091
California	$1,726,624,108	38%	3%	21%	2%	-1,086,083	-10,566	-5,414,738	-99,178	-965	-494,457
Colorado	$2,951,557	1%	1%	0.4%	0.2%	-2,449	-23	-10,414	-1,375	-13	-5,845
Connecticut	$897,335	0.3%	0%	0.1%	0%	-601	-7	-3,281	0	0	0
Delaware	$0	0%	0%	0%	0%	0	0	0	0	0	0
District of Columbia	$4,241,780	3%	2%	1.1%	0.9%	-2,160	-25	-10,126	-1,754	-21	-8,224
Florida	$178,987,429	36%	8%	11%	2%	-180,735	-1,286	-654,243	-37,966	-270	-137,433
Georgia	$131,327	0.2%	0.1%	0.023%	0.015%	-151	-1	-489	-102	-1	-330
Hawaii	$3,903,305	3%	3%	1%	1%	-2,239	-30	-10,407	-1,923	-26	-8,936
Idaho	$544,885	1%	1%	0.2%	0.2%	-313	-3	-1,335	-313	-3	-1,335
Illinois	$12,613,754	2%	1%	1%	0.4%	-12,559	-88	-45,553	-6,241	-44	-22,638
Indiana	$172,059,574	60%	11%	31%	6%	-173,184	-1,398	-644,735	-31,561	-255	-117,495

State	2021 Total Medicaid reconciled/ wraparound Payments (CY and PY)	Share of 2021 Medicaid revenue from CY and PY Medicaid wrap payments	Share of 2021 Medicaid revenue from PY Medicaid wrap payments	Total revenue lost if CY and PY wrap payments not paid	Total revenue lost if PY wrap payments not paid	Lost patient capacity (CY and PY)	Lost FTE staffing capacity (CY and PY)	Lost visit capacity (CY and PY)	Lost patient capacity (PY only)	Lost FTE staffing capacity (PY only)	Lost visit capacity (PY only)
Iowa	$10,751,227	10%	5%	4%	2%	-10,324	-85	-36,571	-5,263	-44	-18,642
Kansas	$0	0%	0%	0%	0%	0	0	0	0	0	0
Kentucky	$83,647,085	34%	4%	14%	2%	-83,946	-620	-335,047	-10,352	-76	-41,318
Louisiana	$82,221	0.05%	0.05%	0.02%	0.02%	-70	-1	-277	-70	-1	-275
Maine	$481,913	1%	1%	0.2%	0.2%	-359	-4	-1,603	-353	-4	-1,576
Maryland	$1,947,650	1%	1%	0.4%	0.4%	-1,296	-12	-5,486	-1,291	-12	-5,467
Massachusetts	$2,079,704	1%	0.1%	0.1%	0.03%	-1,127	-14	-5,544	-206	-3	-1,012
Michigan	$89,324,226	32%	6%	11%	2%	-74,557	-704	-283,899	-14,710	-139	-56,013
Minnesota	$993,657	1%	0.1%	0.4%	0.03%	-648	-7	-2,466	-41	0	-157
Mississippi	$75,042	0.3%	0.1%	0.03%	0.01%	-85	-1	-279	-35	0	-116
Missouri	$112,131,892	41%	11%	16%	4%	-96,282	-875	-366,492	-26,901	-245	-102,398
Montana	$227,576	0.3%	0.01%	0.1%	0.003%	-131	-2	-498	-4	0	-15
Nebraska	$122,905	0.4%	0.001%	0.1%	0.0002%	-109	-1	-363	0	0	-1
Nevada	$13,359,102	32%	2%	9%	1%	-9,768	-97	-34,880	-657	-7	-2,347
New Hampshire	$0	0%	0%	0%	0%	0	0	0	0	0	0
New Jersey	$107,479,960	54%	15%	22%	6%	-125,604	-742	-446,296	-33,695	-199	-119,724
New Mexico	$704,414	1%	1%	0.2%	0.2%	-595	-6	-3,011	-553	-6	-2,795
New York	$439,397,206	31%	5%	14%	2%	-306,457	-2,717	-1,368,186	-47,121	-418	-210,372

State	2021 Total Medicaid reconciled/ wraparound Payments (CY and PY)	Share of 2021 Medicaid revenue from CY and PY Medicaid wrap payments	Share of 2021 Medicaid revenue from PY Medicaid wrap payments	Total revenue lost if CY and PY wrap payments not paid	Total revenue lost if PY wrap payments not paid	Lost patient capacity (CY and PY)	Lost FTE staffing capacity (CY and PY)	Lost visit capacity (CY and PY)	Lost patient capacity (PY only)	Lost FTE staffing capacity (PY only)	Lost visit capacity (PY only)
North Carolina	$11,877,293	11%	9%	2%	2%	-12,402	-88	-38,005	-10,892	-77	-33,377
North Dakota	$1,045,976	11%	2%	2%	0.4%	-765	-7	-2,702	-131	-1	-463
Ohio	$89,235,322	26%	6%	10%	2%	-83,315	-703	-346,028	-18,362	-155	-76,264
Oklahoma	$2,102	0.002%	0%	0.001%	0%	-2	0	-7	0	0	0
Oregon	$183,754,542	37%	12%	21%	7%	-77,466	-1,179	-350,886	-25,730	-392	-116,547
Pennsylvania	$21,524,154	5%	5%	2%	2%	-19,226	-150	-69,764	-18,377	-143	-66,686
Rhode Island	$54,752,610	38%	6%	19%	3%	-36,712	-391	-172,895	-5,915	-63	-27,856
South Carolina	$3,312,950	3%	1%	1%	0.2%	-2,260	-23	-9,571	-1,036	-10	-4,390
South Dakota	$0	0%	0%	0%	0%	0	0	0	0	0	0
Tennessee	$30,984,312	40%	10%	8%	2%	-35,894	-270	-132,249	-8,854	-67	-32,622
Texas	$117,622	0.03%	0.01%	0.01%	0.002%	-107	-1	-386	-30	0	-110
Utah	$1,992,900	4%	2%	1%	0.5%	-1,658	-15	-5,539	-781	-7	-2,609
Vermont	$1,346,163	3%	1%	1%	0.3%	-1,135	-10	-4,495	-610	-5	-2,415
Virginia	$47,715,233	49%	19%	12%	5%	-44,101	-418	-160,990	-17,454	-165	-63,716
Washington	$510,793,917	47%	3%	28%	2%	-330,466	-3,237	-1,302,998	-20,257	-198	-79,873
West Virginia	$1,502,056	1%	0.4%	0.3%	0.1%	-1,451	-11	-5,587	-535	-4	-2,059
Wisconsin	$65,894,165	44%	7%	19%	3%	-51,408	-497	-209,589	-8,074	-78	-32,917
Wyoming	$0	0%	0%	0%	0%	0	0	0	0	0	0

State	2021 Total Medicaid reconciled/ wraparound Payments (CY and PY)	Share of 2021 Medicaid revenue from CY and PY Medicaid wrap payments	Share of 2021 Medicaid revenue from PY Medicaid wrap payments	Total revenue lost if CY and PY wrap payments not paid	Total revenue lost if PY wrap payments not paid	Lost patient capacity (CY and PY)	Lost FTE staffing capacity (CY and PY)	Lost visit capacity (CY and PY)	Lost patient capacity (PY only)	Lost FTE staffing capacity (PY only)	Lost visit capacity (PY only)
Puerto Rico	$76,195,481	31%	6%	16%	3%	-65,492	-720	-278,068	-13,311	-146	-56,516

Source: GWU analysis of 2021 UDS data, Health Resources and Services Administration