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Community Health Center Association of Connecticut

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Testimony of

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In opposition to
House Bill 5373: An Act Concerning Various Revisions to Human Services Statutes

Human Services Committee
March 5, 2024

Thank you for the opportunity to provide comments on House Bill 5373, An Act Concerning Various Revisions to Human Services Statutes.

On behalf of the Community Health Center Association of Connecticut (CHC/ACT), and its sixteen-member community health centers, I want to thank the Committee for its dedication to listening to Connecticut's residents about these important issues. Connecticut's community health centers serve more than 420,000 people each year, providing medical, behavioral health, and dental care in hundreds of locations across the state.

We strongly oppose Section 5 of this bill, which is designed to make it harder for Community Health Centers, also known as FQHCs, and other providers to obtain reasonable rates.

For background: as you may know, under federal law, FQHCs are reimbursed on a Prospective Payment System ("PPS") basis. This is a cost-based process protected by the federal Benefits Improvement and Protection Act (BIPA) of 2001.

Each FQHC in Connecticut has a Medicaid rate for medical visits, one for dental visits, and one for behavioral health visits. Federal law dictates that each state utilize a process, called a Change in Scope, for FQHCs to submit to their state Medicaid agency for a rate change, tied to a change in service type, duration, or intensity. Despite the clarity of federal law, CT has a long history of denying legitimate requests for these rate adjustments. To be clear, Connecticut has the right to create a process for FQHCs to submit and review these requests for Changes in Scope, based upon a process created in federal law. However, it does not have the authority to unilaterally reject Change in Scope requests based upon an arbitrary process.

In the current Change in Scope process (which does not comply with federal law):

1) Health centers apply to the state for a rate review and provide supportive documentation that represents a change in type, intensity, or duration of services. Documentation for the review process can be voluminous, sometimes approaching 1,000 pages of information, and typically requires the hiring of an attorney.
2) DSS rejects nearly all initial rate requests. Of the five rate requests that our member health centers filed in the past year, each one was rejected on the first attempt. Typically, requests are rejected immediately - and usually for arbitrary reasons which don't seem to hold from one request to another. At this point, the health center can appeal the decision for a second review by the Department. This causes further delays and the health center incurs more expenses. Unfortunately, this step is required to get them to the next part of the process.
3) If the second review is also unfavorable to the health center – and it very likely will be – health centers have the option of binding arbitration or Superior Court. Both will require an attorney, but binding arbitration is faster and less expensive for both the health centers AND for the state. Due to already-low funding, health centers do not have the financial resources and time required to bring a Superior Court case to argue for higher rates.

To provide further understanding of the true intent of this proposed legislation, as mentioned above, at least five health centers filed for a Change in Scope with DSS last year. All were denied and are now in the appeal process which DSS would like to change with this legislative proposal. This leads us to ask: Why is DSS focusing on limiting the rights of FQHCs, instead of trying to address the underlying reason why there are so many appeals? Unfortunately, it seems **the purpose of this proposal is to prevent FQHCs from being successful in seeking rate increases – or even attempting them - by making the process more expensive.**

In fact, if you examine the agency's legislative proposal to the governor, DSS references a recent binding arbitration they participated in with Fair Haven Community Health Care; Fair Haven won that case. According to their proposal, "there is the possibility of a minor fiscal savings to removal of the arbitration panel. In the recent Fair Haven matter, there was a $15,000 PSA executed for the arbitrator DSS was responsible for appointing. Potentially, there could be several appeals a year, so removing the arbitration panel could potentially have a minor, positive budgetary impact."

Notably, the Attorney General's Office recently released a Request for Proposals to spend up to $500,000 on outside attorneys to work on Medicaid and other federal issues for the Department of Social Services. In other words, **it appears that DSS, instead of creating a transparent process to work with health care providers to address known rate issues, is willing to spend scarce state resources to fight against rate increases for providers like health centers – in the most expensive way possible for the health centers – instead of granting those increases as they are required to do.**

The current binding arbitration process is a reasonable option that allows for a neutral party to render a decision. On behalf of the state's Community Health Centers, I strongly urge you to reject this proposal.

Thank you for your consideration and your hard work on behalf of our great state. Please feel free to reach out with any questions: sfrick@chcact.org or 860.667.7820.