

Testimony of

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Supporting
House Bill 7191: An Act Concerning Medicaid Rate Increases, Planning and Sustainability

Human Services Committee
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Thank you for the opportunity to provide support for House Bill 7191, An Act Concerning Medicaid Rate Increases, Planning, and Sustainability.

On behalf of the Community Health Center Association of Connecticut (CHC/ACT), and its sixteen member health centers, I want to thank the Committee for its dedication to improving the HUSKY program and the health of people in our state. Connecticut's Community Health Centers serve more than 440,000 people each year – about 1 in every 8 residents – providing medical, behavioral health, and dental care in hundreds of locations across the state. Of those patients, about 264,000 are on HUSKY, representing about 27% of the total HUSKY population.

We stand with others in strong support of this bill, particularly sections 2 and 3, which directly relate to federally-qualified health centers.

Section 2

Medicaid rates for Connecticut's community health centers were set in 2002, based on allowable costs from 2000 and 2001. Since then, they have received the minimal annual adjustment required by federal law (the Medicare Economic Index). Additionally, some health centers have received marginal, yet insufficient, rate increases through the Department of Social Services (DSS) Change in Scope process. However, that process is inconsistent, broken, and out of compliance with federal law.

Section 2 is an effort to resolve these issues.

New Subsection (b): We thank the Committee for including this rate increase language specifically for health centers.

Rates for all health care providers – including FQHCs– are woefully inadequate, which is causing serious financial harm. Some Connecticut health centers have reduced services and/or hours, and others are seriously considering doing so. This means that people across our state are

losing access to the quality healthcare they need. **The situation is now urgent, and we need your assistance.**

As you know, the Department of Social Services recently completed the second phase of its rate study. That study compared Medicaid rates paid to health centers in Connecticut to those paid by three comparison states: Maine, New Jersey, and New York and found that, on average, Connecticut's rates are 80% of those states' rates. CHC/ACT reached out to its peer associations in Massachusetts and Rhode Island to get their Medicaid rates and found that, including those two states and updating Maine's data, the discrepancy grows: CT's rates are only 75% of the average of those five states.

In addition to comparing Connecticut's rates to other states, CHC/ACT also compared CT health center rates to costs, as determined on the annual cost reports health centers file with DSS. **On average, health centers in Connecticut lose \$85 on every Medicaid medical visit and \$121 on every Medicaid dental visit – for a total loss of about \$80 million annually.**

While we recognize all Medicaid providers are underpaid, health centers are unique in that they cannot restrict the number of, or turn away, Medicaid patients. By federal law, we are required to see all people who need assistance. We do not have the option that other providers have limit the number of Medicaid patients we see. After 24 years of attempting to address this issue, Connecticut's health centers can no longer subsidize the state's Medicaid program.

Connecticut health centers provide primary medical, dental, or behavioral health care to 440,000 people annually, including 264,000 Medicaid enrollees. The state has set a goal to enhance access to primary care, and the most effective way to do so for Medicaid enrollees is to ensure the financial stability of health centers.

New Subsections (c) & (d): The Change in Scope process is dictated in federal law for health centers 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, Connecticut's process is vague and inconsistent. DSS has a long and consistent history of denying legitimate requests for these rate adjustments – and usually these denials are based on reasons that appear arbitrary. Simply put, this process is broken.

Passing this legislation would fix the rate setting/review system, bringing it into compliance with federal law, and ensuring a fair and transparent process for both DSS and the health centers seeking rate reviews.

We have taken the liberty of attaching slightly-modified language to this section at the end of our testimony.

Section 3

The federal Medicare Economic Index (MEI) serves as an antiquated but still used cost-of-living adjustment for health centers across the country. MEI is announced each September for the upcoming calendar year. Most states implement this increase in January, and some in July. *Connecticut is one of the only states that implements this increase 10 months into the calendar*

year, in October. This keeps health center rates lower than necessary for longer than necessary and leaves millions of federal dollars in Washington each year.

Changing the implementation date to January would have a one-time cost of about \$10 million (state cost of \$4-5 million).

We believe the intent of this section could be clearer, and so we respectfully have included the following substitute language for the Committee's consideration:

Sec. 3. (*Effective from passage*) As of January 1, 2024, the Commissioner of Social Services shall increase Medicaid rates of reimbursement for federally qualified health centers on January 1 of each year by the Medicare Economic Index that has been announced for that calendar year in the federal register.

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

Suggested language for Section 2 of HB 7191

§ 17b-245d. Information to be provided by federally qualified health centers. Adjustment of encounter rates.

(a) On or before February 1, 2013, and on January 1st annually thereafter, each federally qualified health center shall file with the Department of Social Services the following documents for the previous state fiscal year: (1) Medicaid cost report; (2) audited financial statements; and (3) any additional information reasonably required by the department. Any federally qualified health center that does not use the state fiscal year as its fiscal year shall have six months from the completion of such health center's fiscal year to file said documents with the department.

(b) Each federally qualified health center shall provide to the Department of Social Services a copy of its original scope of project, as approved by the federal Health Resources and Services Administration, and all subsequently approved amendments to its original scope of project. Each federally qualified health center should notify the department, in writing, of all approvals for additional amendments to its scope of project, and provide to the department a copy of such amended scope of project[, not later than thirty days after such approvals].

[(c) If there is an increase or a decrease in the scope of services furnished by a federally qualified health center, the federally qualified health center shall notify the Department of Social Services, in writing, of any such increase or decrease not later than thirty days after such increase or decrease and provide any additional information reasonably requested by the department not later than thirty days after the request.

(d) The Commissioner of Social Services may impose a civil penalty of five hundred dollars per day on any federally qualified health center that fails to provide any information required pursuant to this section not later than thirty days after the date such information is due.

(e) The department may adjust a federally qualified health center's encounter rate based upon an increase or decrease in the scope of services furnished by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), following receipt of the written notification described in subsection (c) of this section or based upon the department's review of documents filed in accordance with subsections (a) and (b) of this section.

(f) The Commissioner of Social Services shall implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.]

(c) No later than October 1, 2025, the department shall provide an alternative, updated prospective payment method for each federally qualified health center that is the same as the prospective payment system set forth in 42 U.S.C. 1396a(bb)(3), except that the base year for determining the costs of providing each of medical, dental, and behavioral healthcare services

must be equal to the allowable costs per encounter incurred in the federally qualified health center's fiscal year ending in 2024, as reflected on the Medicaid cost report submitted under this section; provided, however, that such new encounter rate shall be no less than the encounter rate currently being received from the department by the federally qualified health center.

- (i) The encounter rates calculated under this subsection shall be adjusted annually for inflation, as measured by the federally qualified health center market basket percentage published by the United States Centers for Medicare and Medicaid Services.
 - (ii) The rates also shall be adjusted for any changes in scope of services, as determined through the process set forth in this section.
 - (iii) The department shall collaborate with federally qualified health centers and their representatives when determining the updated rates, which shall be included in final rate letters delivered to each federally qualified health center no later than October 1, 2025. Each such rate letter shall constitute a decision of the Commissioner of Social Services, subject to the review prescribed by Section 17b-238(b) of the General Statutes.
- (d) The department shall adjust a federally qualified health center's encounter rate based upon a change in the scope of services furnished by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), as follows:
- (i) Federally qualified health centers may submit requests for rate adjustments based on changes in scope of services: (A) at the time of submitting the Medicaid cost report and audited financial statements required by this section; or (B) at other times, for any change(s) in scope of service.
 - (ii) The department shall decide a request for a rate adjustment based on a change in scope of services within 90 days of receipt.
 - (iii) The new rate(s) shall be made effective as of the date of the federally qualified health center's change in scope rate adjustment request.
- (e) In determining whether to adjust an FQHC's encounter rate based on a change in scope of services, the department shall consider only whether a change in scope of services, as defined by this subsection, has occurred and the costs associated with the change in scope of services. For these purposes, a change in scope of services means a change in the type, amount, intensity, or duration of services provided by the federally qualified health center that was not included in the federally qualified health center's baseline rate calculation. Examples of a change in scope of services by a federally qualified health center for which the department must adjust the encounter rate include, but are not limited to, the following:

- (i) The addition or deletion of any Medicaid-covered service eligible under the FQHC reimbursement program;
 - (ii) A change in the amount of services as a result of the expansion or reduction of an existing clinic, or the addition or discontinuance of a satellite or new site;
 - (iii) A change in operational costs that is attributable to capital expenditures, including for new service facilities or regulatory compliance, resulting in a change in the type, duration, amount, or intensity of services;
 - (iv) A change in operational costs attributable to changes in technology or medical practices at the FQHC;
 - (v) A change of costs due to recurring taxes, malpractice insurance premiums, workers' compensation premiums;
 - (vi) A change in federal or state regulatory requirements that would impact FQHC costs;
 - (vii) A HRSA-approved change in the scope of project; or
 - (viii) A change in the characteristics of the population receiving a service that affects the cost of the service.
- (f) Within 90 days of this provision's effective date, the department shall publish a standard, easily comprehensible form that a federally qualified health center may elect to use to submit a rate adjustment based on a change in scope of services.
- (h) The Department may further implement the foregoing provisions of this section only through formally promulgated regulations that comply in all respects with the Connecticut Administrative Procedures Act and do not conflict with existing state or federal law.