

# **Community Health Center, Inc.**

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## **HUMAN SERVICES COMMITTEE**

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### **Testimony on House Bill No 1364**

Good Morning, My name is Stewart Joslin and I am the Chief Financial Officer at Community Health Center, Inc., a federally qualified health center (FQHC) headquartered in Middletown Connecticut. While I am here to discuss House Bill No 1364 - let me give you a quick overview of our operation. CHC is a state-wide FQHC with sites in ten cities and 95 schools across the Connecticut and cares for patients residing in more than two thirds of the State. Seventy thousand patients consider us their health care home and last year we provided approximately 200,000 encounters to that population of which about fifty percent is covered under the Medicaid program. Medicaid reimbursement rates have taken a torturous path in the past and we would like to ensure that when the methodology for setting these rates is established that certain core tenants be observed and considered.

Before going into the methodology for setting the rates it might be helpful to consider the path that the Medicaid rate setting process has followed over the past. In 1989 Congress established the FQHC program to respond to concerns that health centers were using Federal grant funds intended to support care for the uninsured to supplement Medicare and Medicaid payments from the States. Congress at that time established a cost based reimbursement to the FQHC's for serving Medicaid patients. By doing this Congress prevented the federal grants designated to aid the uninsured from subsidizing the States financial obligation in serving their Medicaid populations.

This system stayed in place for almost ten years until the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid. While the prospective payment system continued Congress allowed the States to either establish a mutually agreeable system or they must take the average payments made to the FQHC in their FY 1999 and FY 2000 rate period. Connecticut opted for the average rate and since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic

Index. This adjustment has been a little less than three percent in each year since the system went into place. Unfortunately, medical inflation, by any measurement, has far outstripped this adjustment and the health centers find themselves in the unenviable position of having more than fifty percent of their patient base paying for a smaller and smaller proportion of their expenses.

The current language of the Bill allows for the FQHC's to petition the Commissioner once each fiscal year for an adjustment to its reimbursement rates under the Medicaid program. This annual ability to adjust its rates to keep pace with rising wages and other inflationary cost increases is critical to maintaining agencies that can continue to attract top quality providers and staff to provide services to the populations served. There would be very little additional administrative burden placed upon DSS as all of the required reporting is already being supplied to the Department in the form of an annual cost report which could be used as the basis for adjusting the FQHC's rates. These cost reports are all based upon the FQHC's annual audited financial statements which treat all costs consistent with the allowable cost standards dictated by the State. The only footnote to this rate is that we are not allowed to include any capital cost in our rate request only operational expenses/

The bill has also added language on line 74 that appears to have added a cap to the maximum payment that the FQHC's would be entitled to receive at 115% of some undefined median cost. We oppose this language but are supportive of the other language that has been added. There has never been a cap in reimbursement under BIPA and the prospective payment system or under any alternative approved payment system. A cap on Medicaid reimbursement rates will adversely affect the operations of the health center and ultimately could negatively affect the outcomes of our patients.

We would like to take this opportunity to thank the Department for the positive working relationship and commend Commissioner Starkowski and his team. The Community Health Center takes the Medicaid dollars that it receives very seriously and works diligently to invest those dollars into improved outcomes for our patients. Ensuring that Medicaid rates are set fairly and consistently at a level that will support these goals is a top priority for all who work to serve the underserved. Thank you for the opportunity to express both our concerns and thoughts on this bill.