

**Testimony of**  
**THE CONNECTICUT PRIMARY CARE ASSOCIATION**  
**Before**  
**The Human Services Committee**  
**regarding Raised Bills No. 1363 and 1364**  
**Presented by**  
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The Connecticut Primary Care Association has the privilege of representing twelve of the thirteen Federally Qualified Health Centers (FQHCs) in Connecticut. FQHCs provide critical access to and high quality primary care and preventive services to patients in underserved areas of our state regardless of ability to pay. To give you some idea of the scale of their work as an essential component of Connecticut's health care delivery system, it is important to note that in 2005 they cared for over 219,000 unduplicated users at nearly 90 sites across the state. This represents an increase of 65% since 2001 due to expansion of the number of centers and sites of service. Patient visit volume has increased 9% each year since 2003 to over 950,000 visits last year for medical, dental and mental health services.

FQHCs are the designated network of providers for recipients of State Administered General Assistance (SAGA) and care for 20,097 SAGA recipients which is 60 % of the total SAGA population in Connecticut of 33,471 individuals. FQHCs care for 25% of all of Connecticut's Medicaid patients. FQHCs cared for approximately 57,000 uninsured Connecticut citizens in 2006. Currently, FQHCs provide medical and dental care to over 64,250 school-aged children.

With regard to Raised Bill 1363, Connecticut's community health centers simply cannot provide routine eye care to SAGA and Medicaid patients at rates that are far below their federally mandated Prospective Payment rates. FQHC rates are based on the cost of care. At present, the health centers that offer eye care are forced to schedule visits for the most pressing needs of patients with hypertension, pre-glaucoma and other serious eye conditions and the health centers. They are unable to add more clinical hours for ophthalmology staff when the reimbursement rate suggested in Bill 1363 would be 75% below the cost of providing a medical visit for eye care. As such, the legislature's intent to restore some of the services cut from the SAGA program, specifically routine eye care are thwarted by legislation such as this which will restrict access by making it impossible for FQHCs to deploy their limited resources to services for which they cannot receive adequate reimbursement.

In a similar manner, Raised Bill 1364, would create restrictions on rate setting for FQHCs that would impair the FQHC's ability to receive fair compensation for the critical services they render to over a quarter of a million Connecticut residents. Productivity standards for physicians in FQHCs were the subject of a lawsuit brought by CPCA and eight FQHCs in 2002. (CPCA v. Wilson Coke, Case No. 3:02cv626, 2002) and recently decided in Federal Court for the District of Connecticut in favor of the plaintiff health centers. The Court in CPCA v. Wilson Coker found that the application of the productivity screen DSS sought to impose in the state Medicaid plan was unlawful because it was not based on any data or analysis of the appropriate productivity standard. The proposed Medicare standards in Raised Bill 1364 are not grounded in any analysis of the appropriate productivity standards for FQHCs and would summarily apply Medicare

standards to Medicaid patients without assessing whether those productivity screens are “reasonable or related to the cost of furnishing such services” as required by federal law.<sup>1</sup> FQHCs, as part of their mission to serve vulnerable populations, care for a high volume of HIV/AIDS patients, patients with chronic diseases and co-morbidities, and SAGA recipients. A large majority of health center patients require additional provider time to provide the full scope of services within the FQHC bundle of services. Literacy and linguistic barriers complicate a patient visit and extend the time of the visit which impacts provider productivity. FQHCs will not be able to continue to care for the hard to manage populations who rely on them if the FQHC’s ability to recoup full payment for services rendered is artificially restricted by legislation such as this. Changes to the FQHC reimbursement mechanism are properly made through changes to the State Medicaid Plan with notice, opportunity for comment and a full exploration of the reasonableness of the parameters imposed.

FQHCs have been the common thread running through many of the universal health care discussions going on now in Connecticut. They are a model with a proven track record that incorporates five important components:

- **Medical Home** that focuses on preventive medicine and management of chronic disease
- **Access** for hard-to-reach, uninsured, underinsured vulnerable populations  
With locations in communities of need as well as schools, nursing homes, homeless shelters, public housing all of which offer extended after hours coverage and many of which offer dental services using portable equipment or mobile vans
- **Quality care** that is evidenced based, JCAHO accredited and well regulated by the DHHS Bureau of Primary Health Care
- **Affordable and cost effective** care because the FQHCs can access discounted prescription drug prices but more importantly they can reduce reliance on more expensive emergency department services
- **Leveraging resources** is possible because FQHCs’ federal designation, FQHCs lowers the costs for expenses such as professional liability insurance which they receive at no cost through the Federal Torts Claims Act and enhances the opportunity to access federal dollars.

The expertise and long standing commitment of the FQHCs to serve hard to reach and underserved populations, including the uninsured as well as the working poor, has provided generations of Connecticut families with affordable, accessible, quality health care in their communities for the last 40 years. Connecticut’s community health centers implore the committee to refuse to pass any legislation that imposes unjustified restrictions of the setting of rates that by federal law are intended to compensate FQHCs for the true **COST** of caring for Connecticut’s neediest citizens.

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<sup>1</sup> Benefits Improvement and Protection Act of 2000 (“BIPA”), Pub. L. No. 106-554 (Dec. 21, 2000)