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## **OLR Bill Analysis**

### **sHB 5285**

#### ***AN ACT ADJUSTING COMMUNITY HEALTH CENTER RATES FOR CAPITAL INVESTMENTS.***

#### **SUMMARY:**

This bill permits the Department of Social Services (DSS) commissioner, beginning with the 2013 rate year (October 1 through September 30) and annually thereafter, to add to a community health center's Medicaid rate a capital cost rate adjustment associated with major capital projects (i.e., those costing more than \$2 million). The adjustment is equivalent to the center's actual or projected year-to-year increase in total allowable depreciation and interest expenses associated with the projects divided by the projected number of service visits. The commissioner can revise these adjustments retroactively based on actual allowable depreciation and interest expenses or actual service visit volume for the rate period.

The bill requires the commissioner to establish separate adjustments for each Medicaid service a center provides (e.g., dental, behavioral health).

The bill prohibits DSS from granting an adjustment for any depreciation or interest expense that the U. S. Department of Health and Human Services or another federal or state government agency with health services-related capital expenditure approval authority disapproves.

The bill authorizes the commissioner to allow actual debt service instead of depreciation and interest if the debt service amounts are deemed reasonable considering the interest rate and other loan terms.

The bill requires the commissioner to implement policies and procedures to carry out its provisions while in the process of adopting them in regulation. He must publish notice of intent to adopt the

regulations in the *Connecticut Law Journal* no later than 20 days after implementing them. The policies and procedures are in effect until the final regulations are effective.

EFFECTIVE DATE: October 1, 2012

## **RATE ADJUSTMENTS FOR CAPITAL INVESTMENTS**

### ***Definition of Capital Costs***

The bill defines “capital costs” as expenditures for land or building purchases, fixed assets, movable equipment, capitalized financing fees, and capitalized construction period interest.

## **BACKGROUND**

### ***Community Health Centers Definition***

The law defines a community health center as a public or nonprofit medical care facility that:

1. is not part of a hospital and is organized and operated to provide comprehensive primary care services;
2. is located in an area that has a demonstrated need for services based on geographic, demographic, and economic factors;
3. serves low-income, uninsured, minority, and elderly people;
4. makes its services available to anyone, regardless of their ability to pay;
5. uses a sliding fee scale based on income;
6. provides, on an ongoing basis, primary health services by physicians and where appropriate, midlevel practitioners, diagnostic lab and x-ray services, preventive health services, and patient care case management;
7. provides for needed pharmacy services either on-site or through a firm arrangement;
8. has at least half of its full-time equivalent primary care providers

- employed as full-time staff members;
9. maintains an ongoing quality assurance program;
  10. participates in Medicaid and Medicare;
  11. has a governing board of nine to 25 members, the majority of whom are active center users and of the nonuser members, no more than half may derive more than 10% of their annual income from the health care industry; and
  12. provides primary care services at least 32 hours per week and has arrangements for professional coverage during the hours it is closed (CGS § 19a-490a).

***Rate Setting in Federally Qualified Health Centers (FQHC) and Medical Clinics***

FQHC reimbursement is based on medical, dental, and mental health federally approved prospective rates. Included in these center-specific rates is reimbursement for a center's historical interest and depreciation average costs reported in the base 1999 and 2000 Medicaid cost reports. The base rates established using this methodology were effective January 1, 2001, and are inflated annually by the Medicare Economic Index every October 1. Under this federally prescribed and approved prospective rate setting system (42 USC § 1396a(bb)(3)), an FQHC can apply to DSS for a "scope of service" review and possible associated rate adjustments. For example, if a center wishes to add a service it previously has not offered and needs to purchase equipment, it can ask DSS for one of these reviews. DSS has granted numerous scope-of-service rate increases for capital and operational improvements and expansions.

DSS separately sets rates for clinics that are not FQHCs. These rates are the same for every clinic and cover particular services provided. They do not take into account the clinic's capital expenses.

**COMMITTEE ACTION**

Human Services Committee

Joint Favorable Substitute

Yea 16 Nay 0 (03/22/2012)