General Assembly

# Substitute Bill No. 5456

*February Session, 2024*

HB05456HS APP032024

## *AN ACT CONCERNING FEDERALLY QUALIFIED HEALTH CENTERS.*

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-245b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

**[**(a)**]** The Commissioner of Social Services shall, consistent with federal law, reimburse federally qualified health centers on an all-inclusive encounter rate per client encounter based on the prospective payment system required by 42 USC 1396a(bb). Any patient encounter with more than one health professional for the same type of service and multiple interactions with the same health professional that occur on the same day shall constitute a single encounter for purposes of reimbursement, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis and treatment. A federally qualified health center shall be reimbursed in accordance with the requirements prescribed in section 17b-262-1002 of the regulations of Connecticut state agencies.

**[**(b) A federally qualified health center may not provide nonemergency periodic dental services on different dates of service for the purpose of billing for separate encounters. Any nonemergency periodic dental service, including, but not limited to, (1) an examination,

(2) prophylaxis, and (3) radiographs, including bitewings, complete series and periapical imaging, if warranted, shall be completed in one visit. A second visit to complete any service normally included during the course of a nonemergency periodic dental visit shall not be eligible for reimbursement unless (A) medically necessary, and (B) such medical necessity is clearly documented in the patient's dental record.**]**

Sec. 2. Section 17b-245d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) On or before February 1, 2013, and on January first 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 shall 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.**]**

(b) On or before December 31, 2024, the Department of Social Services shall rebase each federally qualified health center's encounter rates based upon such center's costs during fiscal year 2023 divided by the number of patient encounters for a particular service during the same fiscal year, provided such new encounter rate shall be not less than the encounter rate received before such rates are rebased and shall not interfere with any annual inflationary rate adjustment.

(c) The Department of Social Services shall adjust a federally qualified health center's encounter rate based upon an increase or decrease in the scope of services furnished in a written notification to the department by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), following receipt of the written notification. If a federally qualified health center experiences additional direct or indirect costs as a result of an increase in such center's scope of services, it shall request a rate adjustment based upon the increase in scope of services on forms issued by the department for such purpose. Not later than thirty days after receipt of such rate adjustment request, the department shall meet with representatives of the federally qualified health center for the purpose of reviewing the center's additional direct and indirect costs relating to the increase in scope of services. If the increase in scope of services is related to amendments approved by the federal Health Resources and Services Administration to the federally qualified health

center's original scope of project, the federally qualified health center shall provide to the department a copy of such amended scope of project. Not later than thirty days after meeting with the federally qualified health center, the department shall issue a detailed rate adjustment decision relating to the increase in scope of services. In conducting such review, the department shall not consider the following factors as relevant or determinative with respect to whether the federally qualified health center incurred additional direct or indirect costs associated with the increase in scope of services: (1) The federally qualified health center's encounter rates for other service categories, including dental, behavioral health or medical services; (2) whether or not the federally qualified health center is showing a profit; (3) whether or not the federally qualified health center is in receipt of grant moneys or other third-party reimbursements; (4) whether the federally qualified health center's current encounter rates are higher or lower than encounter rates of similar federally qualified health centers; and (5) any other factor unrelated to increased costs associated with an increase in change of scope of services. A federally qualified health center may appeal the department's rate adjustment decision not later than ten days after it receives notice of the rate adjustment. Not later than ninety days after filing its rate adjustment appeal notice, the federally qualified health center shall submit its items of aggrievement to the department. Upon review and an opportunity for the department to request any clarifying or supporting information from the federally qualified health center, the department shall issue its decision, along with its rationale, not later than one hundred twenty days after the federally qualified health center's rate adjustment request. If the department's decision is delayed, any approved rate adjustment shall be retroactive to the date on which the decision should have been issued pursuant to this subsection.

(d) If there is 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 decrease and provide any additional information reasonably requested

by the department not later than thirty days after the department's request. 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 relating to a decrease in services to the extent that a discontinued service is a service for which the federally qualified health center is receiving additional reimbursement as the result of a prior rate adjustment related to an increase in scope of services.

**[**(f)**]** (e) 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 in accordance with chapter 54 as regulations, provided the commissioner **[**prints**]** posts notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the eRegulations System 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 and policies, procedures and regulations shall be in accordance with state and federal law.

Sec. 3. (NEW) (*Effective July 1, 2024*) The Commissioner of Social Services shall increase rates of Medicaid reimbursement for federally qualified health centers not later than January first annually by the most recent increase in the Medicare Economic Index. For purposes of this section, "Medicare Economic Index" means a measure of inflation for physicians with respect to their practice costs and wage levels as calculated by the Centers for Medicare and Medicaid Services.

| This act shall take effect as follows and shall amend the following sections: | | |
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| Section 1 | *July 1, 2024* | 17b-245b |
| Sec. 2 | *July 1, 2024* | 17b-245d |
| Sec. 3 | *July 1, 2024* | New section |

***HS*** *Joint Favorable Subst. C/R* APP