# House of Representatives

General Assembly

**File No. 445**

*February Session, 2026*

Substitute House Bill No. 5561

*House of Representatives, April 7, 2026*

The Committee on Human Services reported through REP. GILCHREST of the 18th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## *AN ACT CONCERNING MEDICAID RATE INCREASES FOR CERTAIN PROVIDERS.*

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

Section 1. (*Effective July 1, 2026*) (a) As used in this section, (1) "cognitive impairment" means a deficiency in (A) short-term memory or long-term memory, (B) orientation as to person, place and time, or (C) deductive or abstract reasoning; and (2) "clinician" means a physician, physician assistant, advanced practice registered nurse, clinical nurse specialist or certified nurse-midwife licensed to practice in the state.

(b) The Commissioner of Social Services shall amend the Medicaid state plan to incorporate the Medicare billing code reimbursement criteria for a cognitive assessment and care planning ordered by a clinician for a patient age sixty-four or younger who is enrolled in the Medicaid program and shows signs of cognitive impairment.

Sec. 2. Subsection (a) of section 17b-282c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1,*

*2026*):

(a) All nonemergency dental services provided under the Department of Social Services' dental programs, as described in section 17b-282b, shall be subject to prior authorization. Nonemergency services that are exempt from the prior authorization process shall include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and reasonable dental practices. Payment for nonemergency dental services shall not exceed one thousand dollars per calendar year for an individual adult, provided prevention services such as oral exams and dental cleanings and services determined to be medically necessary, as defined in section 17b-259b, including dentures, shall not be subject to such payment cap. Dental benefit limitations shall apply to each client regardless of the number of providers serving the client. The commissioner may recoup payments for services that are determined not to be for an emergency condition or otherwise in excess of what is medically necessary. The commissioner shall periodically, but not less than quarterly, review payments for emergency dental services and basic restoration procedures for appropriateness of payment. For the purposes of this section, "emergency condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate dental attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, cause serious impairment to body functions or cause serious dysfunction of any body organ or part.

Sec. 3. Subsection (a) of section 17b-282d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The Commissioner of Social Services shall modify the extent of nonemergency adult dental services provided under the Medicaid program. Such modifications shall include, but are not limited to,

providing one periodic dental exam, one dental cleaning, periodontal therapy and one set of bitewing x-rays each year for a healthy adult. For purposes of this section, "healthy adult" means a person twenty-one years of age or older for whom there is no evidence indicating that dental disease is an aggravating factor for the person's overall health condition.

Sec. 4. Subsection (c) of section 17b-28 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) On and after October 31, 2017, the council shall be composed of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services, public health and appropriations and the budgets of state agencies, or their designees;

(2) Five appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly, one of whom shall be a community provider of adult Medicaid health services, one of whom shall be a recipient of Medicaid benefits for the aged, blind and disabled or an advocate for such a recipient, one of whom shall be a representative of the state's federally qualified health clinics and one of whom shall be a member of the Connecticut Hospital Association;

(3) Five appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly, one of whom shall be a representative of the home health care industry, one of whom shall be a primary care medical home provider, one of whom shall be an advocate for Department of Children and Families foster families and one of whom shall be a representative of the business community with experience in cost efficiency management;

(4) Three appointed by the majority leader of the House of Representatives, one of whom shall be an advocate for persons with

substance abuse disabilities, one of whom shall be a Medicaid dental provider and one of whom shall be a representative of the for-profit nursing home industry;

(5) Three appointed by the majority leader of the Senate, one of whom shall be a representative of school-based health centers, one of whom shall be a recipient of benefits under the HUSKY Health program and one of whom shall be a physician who serves Medicaid clients;

(6) Three appointed by the minority leader of the House of Representatives, one of whom shall be an advocate for persons with disabilities, one of whom shall be a dually eligible Medicaid-Medicare beneficiary or an advocate for such a beneficiary and one of whom shall be a representative of the not-for-profit nursing home industry;

(7) Three appointed by the minority leader of the Senate, one of whom shall be a low-income adult recipient of Medicaid benefits or an advocate for such a recipient, one of whom shall be a representative of hospitals and one of whom shall be a representative of the business community with experience in cost efficiency management;

(8) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

(9) A member of the Commission on Women, Children, Seniors, Equity and Opportunity, designated by the executive director of said commission;

(10) A representative of the Long-Term Care Advisory Council;

(11) The Commissioners of Social Services, Children and Families, Public Health, Developmental Services, Aging and Disability Services and Mental Health and Addiction Services, or their designees, who shall be ex-officio nonvoting members;

(12) The Comptroller, or the Comptroller's designee, who shall be an ex-officio nonvoting member;

(13) The Secretary of the Office of Policy and Management, or the secretary's designee, who shall be an ex-officio nonvoting member; **[**and**]**

(14) One representative of an administrative services organization which contracts with the Department of Social Services in the administration of the Medicaid program, who shall be a nonvoting member; and

(15) Two representatives of the Connecticut Dental Health Partnership, appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to human services.

Sec. 5. (NEW) (*Effective July 1, 2026*) As used in this section, "safety net pediatric dental clinic" means a nonprofit, public or community-based provider that offers dental care to children from low-income or uninsured families, regardless of ability to pay. The Commissioner of Social Services shall amend the Medicaid state plan to increase Medicaid rates of reimbursement for services provided by a safety net pediatric dental clinic to not less than the rates for such services provided by a federally qualified health center. Within available appropriations, the commissioner may establish a supplemental payment pool to reimburse a safety net pediatric dental clinic for uncompensated care.

Sec. 6. (*Effective from passage*) As used in this section, "biomarker testing" has the same meaning as provided in section 17b-278m of the general statutes. Not later than October 1, 2026, the Commissioner of Social Services shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committee of the General Assembly having cognizance of matters relating to human services on (1) prior authorization requirements for Medicaid coverage of biomarker testing, including, but not limited to, any impact such requirements have on access to biomarker testing by Medicaid beneficiaries, and (2) the number of Medicaid beneficiaries who have had biomarker testing approved for Medicaid coverage in the fiscal year ending June 30, 2026.

Sec. 7. (*Effective July 1, 2026*) The Commissioner of Social Services shall adjust rates of reimbursement under the Medicaid program so that an optometrist licensed pursuant to chapter 380 of the general statutes receives the same rate as an ophthalmologist licensed pursuant to chapter 370 of the general statutes for performing the same medical service or procedure. The commissioner shall seek federal approval to amend the Medicaid state plan, if necessary, to adjust the rate of reimbursement in accordance with this section.

Sec. 8. (*Effective July 1, 2026*) The Commissioner of Social Services, within available appropriations, shall amend the Medicaid state plan to increase rates of reimbursement for services provided by a doula certified pursuant to chapter 377a of the general statutes, a psychologist licensed pursuant to chapter 383 of the general statutes, an acupuncturist licensed pursuant to chapter 384c of the general statutes and an emergency room physician licensed pursuant to chapter 370 of the general statutes.

Sec. 9. Section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. On and after January 1, 2024, the commissioner shall increase the

fee schedule for complex care nursing services provided to individuals over the age of eighteen such that the rate of reimbursement is equal to the rate for such services provided to individuals age eighteen and under. There shall be no differential in fees paid for such services based on the age of the patient. On and after July 1, 2026, until June 30, 2031, the commissioner, within available appropriations, shall annually increase the fee schedule for all home health services by ten per cent. The commissioner **[**may**]** shall increase any fee payable to a home health care agency or home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) safety escort services for nurses making home visits; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is posted on the eRegulations System not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months. For purposes of this subsection, "complex care nursing services" means intensive, specialized nursing services provided to a patient with complex care needs who requires skilled nursing care at home.

(b) The Department of Social Services shall monitor the rates charged by home health care agencies and home health aide agencies. Such agencies shall file annual cost reports and service charge information

with the department.

(c) The home health services fee schedule shall include a fee for the administration of medication, which shall apply when the purpose of a nurse's visit is limited to the administration of medication. Administration of medication may include, but is not limited to, blood pressure checks, glucometer readings, pulse rate checks and similar indicators of health status. The fee for medication administration shall include administration of medications while the nurse is present, the pre-pouring of additional doses that the client will self-administer at a later time and the teaching of self-administration. The department shall not pay for medication administration in addition to any other nursing service at the same visit. The department may establish prior authorization requirements for this service. Before implementing such change, the Commissioner of Social Services shall consult with the chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services. The commissioner shall monitor Medicaid home health care savings achieved through the implementation of nurse delegation of medication administration pursuant to section 19a-492e. If, by January 1, 2016, the commissioner determines that the rate of savings is not adequate to meet the annualized savings assumed in the budget for the biennium ending June 30, 2017, the department may reduce rates for medication administration as necessary to achieve the savings assumed in the budget. Prior to any rate reduction, the department shall report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services provider specific cost and utilization trend data for those patients receiving medication administration. Should the department determine it necessary to reduce medication administration rates under this section, it shall examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for those providers, as determined by the commissioner, who have established successful nurse delegation programs.

(d) The home health services fee schedule established pursuant to

subsection (c) of this section shall include rates for psychiatric nurse visits. There shall be no reduction in rates for subsequent visits by the same nurse to the same address to provide behavioral health services.

(e) The Department of Social Services, when processing or auditing claims for reimbursement submitted by home health care agencies and home health aide agencies shall, in accordance with the provisions of chapter 15, accept electronic records and records bearing the electronic signature of a licensed physician or licensed practitioner of a healthcare profession that has been submitted to the home health care agency or home health aide agency.

(f) If the electronic record or signature that has been transmitted to a home health care agency or home health aide agency is illegible or the department is unable to determine the validity of such electronic record or signature, the department shall review additional evidence of the accuracy or validity of the record or signature, including, but not limited to, (1) the original of the record or signature, or (2) a written statement, made under penalty of false statement, from (A) the licensed physician or licensed practitioner of a health care profession who signed such record, or (B) if such licensed physician or licensed practitioner of a health care profession is unavailable, the medical director of the agency verifying the accuracy or validity of such record or signature, and the department shall make a determination whether the electronic record or signature is valid.

(g) The Department of Social Services, when auditing claims submitted by home health care agencies and home health aide agencies, shall consider any signature from a licensed physician or licensed practitioner of a health care profession that may be required on a plan of care for home health services, to have been provided in timely fashion if (1) the document bearing such signature was signed prior to the time when such agency seeks reimbursement from the department for services provided, and (2) verbal or telephone orders from the licensed physician or licensed practitioner of a health care profession were received prior to the commencement of services covered by the plan of

care and such orders were subsequently documented. Nothing in this subsection shall be construed as limiting the powers of the Commissioner of Public Health to enforce the provisions of sections 19-13-D73 and 19-13-D74 of the regulations of Connecticut state agencies and 42 CFR 484.18(c).

(h) Any order for home health care services covered by the Department of Social Services may be issued by any licensed practitioner authorized to issue such an order pursuant to section 19a-496a. Any Department of Social Services regulation, policy or procedure that applies to a physician who orders such home health care services, including related provisions such as review and approval of care plans for home health care services, shall apply to any licensed practitioner authorized to order such home health care services pursuant to section 19a-496a.

(i) For purposes of this section, "licensed practitioner of a healthcare profession" has the same meaning as "licensed practitioner" in section 21a-244a.

Sec. 10. Section 17b-343 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of Social Services shall establish annually the maximum allowable rate to be paid by agencies for homemaker services, chore person services, companion services, respite care, meals on wheels, adult day care services, case management and assessment services, transportation, mental health counseling and elderly foster care. The Commissioner of Social Services shall prescribe uniform forms on which agencies providing such services shall report their costs for such services. Such rates shall be determined on the basis of a reasonable payment for necessary services rendered. The maximum allowable rates established by the Commissioner of Social Services for the Connecticut home-care program for the elderly established under section 17b-342 shall constitute the rates required under this section until revised in accordance with this section. The Commissioner of Social Services shall establish a fee schedule, to be effective on and after July 1, 1994, for

homemaker services, chore person services, companion services, respite care, meals on wheels, adult day care services, case management and assessment services, transportation, mental health counseling and elderly foster care. The commissioner may annually increase the fee schedule based on an increase in the cost of services. The commissioner shall increase the fee schedule effective July 1, 2000, by not less than five per cent, for adult day care services. The commissioner shall increase the fee schedule effective July 1, 2011, by four dollars per person, per day for adult day care services. For each of the fiscal years ending June 30, 2027, and June 30, 2028, the commissioner, within available appropriations, shall increase the fee schedule for homemaker-companion services by thirteen per cent. For each of the fiscal years ending June 30, 2029, June 30, 2030, and June 30, 2031, the commissioner, within available appropriations, shall increase such fee schedule by ten per cent. The commissioner shall increase the fee schedule effective July 1, 2019, for meals on wheels by ten per cent over the fee schedule for meals on wheels for the previous fiscal year. Effective July 1, 2020, and annually thereafter, the commissioner may increase the fee schedule for meals on wheels providers serving participants in the Connecticut home-care program for the elderly by, at a minimum, the cost-of-living adjustment as measured by the consumer price index. Effective July 1, 2026, the commissioner, within available appropriations, shall increase the fee schedule for meals on wheels providers by four and nine-tenths per cent. The commissioner may increase any fee payable to a meals on wheels provider upon the application of such provider evidencing extraordinary costs related to delivery of meals on wheels in sparsely populated rural regions of the state. Nothing contained in this section shall authorize a payment by the state to any agency for such services in excess of the amount charged by such agency for such services to the general public.

Sec. 11. (*Effective July 1, 2026*) Within available appropriations, the Commissioner of Social Services shall increase the Medicaid reimbursement rate for Gaylord Specialty Care by two hundred six dollars per patient per day to achieve rate parity for long-term acute care hospitals in the state.

Sec. 12. (NEW) (*Effective July 1, 2026*) (a) As used in this section, "nonopioid drug" means a nonopioid prescription drug approved by the United States Food and Drug Administration for the treatment or management of pain.

(b) The Department of Social Services shall not disadvantage or discourage a nonopioid drug with respect to coverage in the Medicaid program relative to any opioid drug for the treatment or management of pain. For purposes of this section, disadvantaging or discouragement of a nonopioid drug includes, but is not limited to (1) imposing more restrictive coverage criteria on any such nonopioid drug than the least restrictive coverage criteria imposed on an opioid drug, or (2) establishing more restrictive or more extensive utilization management requirements, including, but not limited to, more restrictive or more extensive prior authorization or step therapy requirements for such nonopioid drug than the least restrictive or least extensive utilization management requirements applicable to any opioid drug.

Sec. 13. (NEW) (*Effective July 1, 2026*) (a) As used in this section, (1) "prescribing practitioner" means a physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse or nurse-midwife enrolled as a Medicaid provider who is licensed by the state and authorized to prescribe opioid drugs within the scope of such person's practice, and (2) "opioid drug" has the same meaning as provided in section 20-14o of the general statutes.

(b) The Commissioner of Social Services may require a prescribing practitioner, as a condition for the receipt of Medicaid reimbursement for prescribing an opioid drug to a Medicaid recipient, to complete training in effective pain management, including, but not limited to: (1) Appropriate, available nonopioid alternatives for the treatment of pain, and (2) the advantages and disadvantages of the use of nonopioid treatment alternatives, considering a patient's risk of substance misuse.

(c) A prescribing practitioner who prescribes an opioid drug for the treatment of a Medicaid beneficiary's pain shall consider the feasibility of nonopioid treatment options, including, but not limited to,

chiropractic treatment, spinal cord stimulation, massage therapy, acupuncture and physical therapy.

(d) The commissioner may adopt regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of this section.

Sec. 14. (*Effective July 1, 2026*) The Commissioner of Social Services, within available appropriations, shall amend the Medicaid state plan to increase the rate of Medicaid reimbursement for providers of family planning services. For purposes of this section, "family planning services" includes, but is not limited to, contraceptives, medical exams and laboratory tests.

Sec. 15. Section 17b-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for individuals with intellectual disabilities, shall be determined annually by the Commissioner of Social Services, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. Any facility with real property other than land placed in service prior to July 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding July 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request by such facility, allow actual debt service, comprised of principal and interest, on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are reasonable in

relation to the useful life and the base value of the property. In the case of facilities financed through the Connecticut Housing Finance Authority, the commissioner shall allow actual debt service, comprised of principal, interest and a reasonable repair and replacement reserve on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are determined by the commissioner at the time the loan is entered into to be reasonable in relation to the useful life and base value of the property. The commissioner may allow fees associated with mortgage refinancing provided such refinancing will result in state reimbursement savings, after comparing costs over the terms of the existing proposed loans. For the fiscal year ending June 30, 1992, the inflation factor used to determine rates shall be one-half of the gross national product percentage increase for the period between the midpoint of the cost year through the midpoint of the rate year. For fiscal year ending June 30, 1993, the inflation factor used to determine rates shall be two-thirds of the gross national product percentage increase from the midpoint of the cost year to the midpoint of the rate year. For the fiscal years ending June 30, 1996, and June 30, 1997, no inflation factor shall be applied in determining rates. The Commissioner of Social Services shall prescribe uniform forms on which such facilities shall report their costs. Such rates shall be determined on the basis of a reasonable payment for necessary services. Any increase in grants, gifts, fund-raising or endowment income used for the payment of operating costs by a private facility in the fiscal year ending June 30, 1992, shall be excluded by the commissioner from the income of the facility in determining the rates to be paid to the facility for the fiscal year ending June 30, 1993, provided any operating costs funded by such increase shall not obligate the state to increase expenditures in subsequent fiscal years. Nothing contained in this section shall authorize a payment by the state to any such facility in excess of the charges made by the facility for comparable services to the general public. The service component of the rates to be paid by the state to private facilities and facilities operated by regional education

service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for individuals with intellectual disabilities, shall be determined annually by the Commissioner of Developmental Services in accordance with section 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2008, except any facility that would have been issued a lower rate effective July 1, 2008, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2009, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (A) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2011, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2012, and (B) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. Any facility that has a significant decrease in land and building costs shall

receive a reduced rate to reflect such decrease in land and building costs. The rate paid to a facility may be increased if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2014, or June 30, 2015, only to the extent such increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2015, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2016, or June 30, 2017, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2018, and June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2017, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2017, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2018, or June 30, 2019, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2019, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2020, or June 30, 2021, to the extent such rate increases are within available appropriations. For the fiscal

years ending June 30, 2022, and June 30, 2023, rates shall be based upon rates in effect for the fiscal year ending June 30, 2021, inflated by the gross domestic product deflator applicable to each rate year, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years ending September 30, 2020, and September 30, 2021, that are not otherwise included in rates issued, or if a rate adjustment for a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2022, or June 30, 2023. For the fiscal year ending June 30, 2024, rates shall not exceed those in effect for the fiscal year ending June 30, 2023, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2023, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2024, to the extent such rate increases are within available appropriations. For the fiscal year ending June 30, 2027, and each fiscal year thereafter, the Commissioner of Social Services, within available appropriations, shall increase rates by the most recent increase in the consumer price index for all urban consumers and base such rates on the most recent cost report filed by a facility.

(b) Notwithstanding the provisions of subsection (a) of this section, state rates of payment for the fiscal years ending June 30, 2018, June 30, 2019, June 30, 2020, and June 30, 2021, for residential care homes and community living arrangements that receive the flat rate for residential services under section 17-311-54 of the regulations of Connecticut state agencies shall be set in accordance with section 298 of public act 19-117. For the fiscal years ending June 30, 2022, and June 30, 2023, such rates shall be based upon rates in effect for the fiscal year ending June 30, 2021, inflated by the gross domestic product deflator applicable to each rate year. For the fiscal year ending June 30, 2027, and each fiscal year

thereafter, the Commissioner of Social Services, within available appropriations, shall increase such rates by the most recent increase in the consumer price index for all urban consumers and base such rates on the most recent cost report filed by a facility.

(c) For the fiscal year ending June 30, 2024, and each subsequent fiscal year, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years that are not otherwise included in rates issued.

(d) The Commissioner of Social Services and the Commissioner of Developmental Services shall adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section.

Sec. 16. Section 4-220 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) As used in this section, (1) "private provider organization" and "purchase of service contract" each have the same meanings as provided in section 4-70b; (2) "health and human services" means services provided under contract with a state agency that directly support the health, safety and welfare of residents, including, but not limited to, those residents who may have conditions that include, but are not limited to, behavioral health disorders, intellectual disabilities, developmental disabilities, physical disabilities and autism spectrum disorder; (3) "attempt to recover or otherwise offset" means efforts to recoup savings at the end of each fiscal year; and (4) "state agency" means the Departments of Developmental Services, Mental Health and Addiction Services, Social Services and Children and Families.

(b) Subject to the provisions of **[**subsection (c)**]** subsections (c) and (d) of this section, each state agency that contracts with a nonprofit private provider organization for health and human services shall allow such nonprofit organization that otherwise meets contractual requirements, including, but not limited to, its contractual obligations regarding services provided and clients served, to retain any savings from a

purchase of service contract at the end of each fiscal year. No state agency shall attempt to recover or otherwise offset funds retained by such nonprofit organization from the contracted cost for services.

(c) Any nonprofit private provider organization allowed to retain savings under this section shall submit an application to the contracting state agency on how savings are planned to be reinvested and report to the contracting state agency on how savings will be reinvested to strengthen quality, invest in deferred maintenance and make asset improvements. The commissioner of each state agency shall prescribe the form and manner of such application form and the frequency of such reports. The commissioner of each state agency shall review an application submitted pursuant to this subsection and respond to a nonprofit private provider organization not later than ninety days after receiving such application from such provider organization. Retained funds may only be used for the purposes of strengthening quality, investing in deferred maintenance and making asset improvements. The commissioner of each state agency shall approve, disapprove or modify any application for funds in accordance with the allowable uses in this subsection. Nonprofit private provider organizations providing health and human services shall be permitted to expend retained funds on programs that are funded by the same state agency except as provided in subsection (d) of this section.

(d) Notwithstanding the provisions of subsection (c) of this section, the Secretary of the Office of Policy and Management shall authorize a nonprofit private provider organization that provides services for the Departments of Social Services and Developmental Services to reinvest savings retained pursuant to a contract with the Department of Developmental Services into services provided by such organization pursuant to a contract with the Department of Social Services.

**[**(d)**]** (e) Notwithstanding any provisions to the contrary in this section, a state agency shall not allow a nonprofit private provider organization to retain surplus funds from the contracted cost of services under a contract funded in whole, or in part, with federal funds when

allowing such organization to retain such funds would jeopardize federal funding or reimbursement for such contract or when such allowance is prohibited by federal law or regulations.

**[**(e)**]** (f) The Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management and the Commissioners of Children and Families, Mental Health and Addiction Services and Developmental Services, may undertake a study of the contracting and billing practices of such nonprofit private provider organizations to ensure compliance with all Medicaid waivers and Medicaid state plan amendments. Any study started under this subsection shall be completed not later than December 31, 2024.

**[**(f)**]** (g) Notwithstanding the provisions of subsections (a) to **[**(e)**]** (f), inclusive, of this section, the Commissioner of Developmental Services, in consultation with the Secretary of the Office of Policy and Management, may extend the provisions of this section to other private provider organizations with which the Department of Developmental Services contracts, provided they meet all of the requirements set forth in this section, including, but not limited to, meeting all terms and conditions of their contracts for services with the Department of Developmental Services.

Sec. 17. (*Effective from passage*) (a) The Commissioner of Social Services, in collaboration with the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, shall study (1) the percentage of services under programs administered by each commissioner that are provided by nonprofit organizations, (2) rates of state reimbursement per service provided to each such organization by each agency, (3) cost of services provided by such organizations compared to the cost for such services if state agencies directly provided such services, and (4) how often such rates of reimbursement are adjusted to reflect any increase in inflation.

(b) Not later than January 15, 2027, the Commissioner of Social Services shall file a report, in accordance with the provisions of section 11-4a of the general statutes, on the data obtained from the study

pursuant to subsection (a) of this section with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services, children and public health.

Sec. 18. (*Effective July 1, 2026*) The Commissioner of Social Services, within available appropriations, shall increase the Medicaid rates of reimbursement for durable medical equipment, orthotics, prosthetics and supplies and complex rehabilitation technology in accordance with the Medicaid rate study commissioned by the Department of Social Services pursuant to section 1 of public act 23-186.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *July 1, 2026* | New section |
| Sec. 2 | *July 1, 2026* | 17b-282c(a) |
| Sec. 3 | *July 1, 2026* | 17b-282d(a) |
| Sec. 4 | *July 1, 2026* | 17b-28(c) |
| Sec. 5 | *July 1, 2026* | New section |
| Sec. 6 | *from passage* | New section |
| Sec. 7 | *July 1, 2026* | New section |
| Sec. 8 | *July 1, 2026* | New section |
| Sec. 9 | *July 1, 2026* | 17b-242 |
| Sec. 10 | *July 1, 2026* | 17b-343 |
| Sec. 11 | *July 1, 2026* | New section |
| Sec. 12 | *July 1, 2026* | New section |
| Sec. 13 | *July 1, 2026* | New section |
| Sec. 14 | *July 1, 2026* | New section |
| Sec. 15 | *July 1, 2026* | 17b-244 |
| Sec. 16 | *July 1, 2026* | 4-220 |
| Sec. 17 | *from passage* | New section |
| Sec. 18 | *July 1, 2026* | New section |

***Statement of Legislative Commissioners:***

In Section 1(a)(2), "nurse practitioner" was changed to "advanced practice registered nurse" for accuracy; in Section 5, "(NEW)" was inserted before the text for consistency with standard drafting conventions, and "often regardless of ability to pay" was changed to

"regardless of ability to pay" for clarity; and in Section 12(b)(2), "extensive" was changed to "least extensive" for clarity.

***HS*** *Joint Favorable Subst.*

*The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.*

## *OFA Fiscal Note*

### *State Impact:*

| Agency Affected | Fund-Effect | FY 27 $ | FY 28 $ |
|---|---|---|---|
| Social Services, Dept. | GF - Cost | $35.4 million | $39.4 million |
| Social Services, Dept. | GF - Cost | See Below | See Below |

Note: GF=General Fund

### *Municipal Impact:* None

### *Explanation*

The bill results in increased costs to the Department of Social Services (DSS) associated with increasing various provider rates under Medicaid, as described by relevant sections below.

**Section 2** results in a cost to DSS of approximately $350,000 in FY 27 and FY 28 due to excluding prevention services from the annual cap on Medicaid dental payments.

**Section 3** may result in a cost to the extent that adding periodontal therapy to Medicaid nonemergency dental services for healthy adults expands coverage beyond current practice.

**Section 5** results in a cost to increase Medicaid rates for services provided by a safety net pediatric dental clinic to not less than the rates for such services provided by a federally qualified health center (FQHC). The extent of the state cost is dependent on the Medicaid rates established and associated utilization. For context, the current average FQHC dental rate is $204 per visit.

The bill also allows DSS to establish a supplemental payment pool to reimburse a safety net pediatric dental clinic for uncompensated care, resulting in a potential cost should DSS choose to fund such pool.

**Section 7** results in a cost to increase Medicaid rates for optometrists to equal rates paid for ophthalmologists. Based on the average cost per unit of service, optometrist rates would increase from approximately $42 per unit of service to $98 per unit, resulting in increased state costs of approximately $14.5 million in FY 27 and $15.8 million in FY 28.

**Section 8** results in a cost to increase Medicaid rates for services provided by a doula, psychologist, acupuncturist and an emergency room physician. The extent of the cost is based on the applied increases, which are not specified in the bill.

**Section 9** requires DSS to annually increase the fee schedule for all home health services by 10% from 7/1/26 through 6/30/31, resulting in costs of approximately $9 million in FY 27 and $11.1 million in FY 28 growing to approximately $16.2 million in FY 31.

This section also results in costs of approximately $2.5 million in FY 27 and $2.8 million in FY 28 due to prohibiting a reduction in home health rates for subsequent visits by the same psychiatric nurse to the same address to provide behavioral health services.

The bill results in additional costs associated with requiring rather than allowing DSS to increase payments for certain extraordinary costs, to the extent they would not have otherwise done so.

**Section 10** results in costs of $2.5 million in FY 27 and $2.8 million in FY 28 due to increasing the fee schedule for homemaker-companion services by 13% in each year. The bill requires rates to be increased by 10% each year for FY 29 through FY 31, resulting in costs of approximately $2.6 million in FY 29, $3.1 million in FY 30 and $3.7 million in FY 31.

This section results in additional costs of $240,500 in FY 27 and $285,700 in FY 28 due to increasing the fee schedule for meals on wheels

providers by 4.9% in FY 27.

**Section 11** results in a cost of $506,900 in FY 27 and FY 28 to increase the Medicaid rate for Gaylord Specialty Care by two hundred six dollars per patient per day.

**Section 12** prohibits DSS from taking certain actions related to the use of non-opioid drugs compared to opioid drugs for pain management or treatment. To the extent the provisions result in changes in utilization or use of specific drugs, DSS will experience a fiscal impact that cannot be determined at this time.

**Section 13** allows DSS to require a practitioner prescribing an opioid drug to a Medicaid recipient, to complete training in effective pain management, as a condition of receiving the associated Medicaid payment. This may result in savings to the extent providers do not participate in the training and DSS chooses to withhold payment.

**Section 14** results in a cost to increase Medicaid rates for providers of family planning services. The extent of the cost is dependent on the applied increase, which is not specified in the bill.

**Section 15** results in a cost to annually increase rates for certain facilities beginning in FY 27. The extent of the cost is dependent on the base rates, as determined by the most recent cost report filed by a facility, and the most recent increase in the consumer price index for all urban consumers.

**Section 18** results in a cost of approximately $5.8 million in FY 27 and FY 28 associated with increasing certain rates in accordance with the Medicaid rate study supported by PA 23-186. Costs reflect increased rates for durable medical equipment and ($2 million) and prosthetics and orthotics ($1.8 million).[1]

[1] While the bill requires that rates for supplies and complex rehabilitation technology be increased in accordance with the rates study, the benchmark summary analysis shows that (1) no net funding is needed to meet the study benchmarks for supplies, and (2) no specific reference is made to complex rehab technology.

The bill makes technical, conforming and other changes that have no fiscal impact.

### *The Out Years*

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation and Medicaid rate increases discussed above.

**OLR Bill Analysis**

**sHB 5561**

***AN ACT CONCERNING MEDICAID RATE INCREASES FOR CERTAIN PROVIDERS.***

TABLE OF CONTENTS:

Requires the DSS commissioner to adjust Medicaid reimbursement rates for optometrists so that they equal ophthalmologist rates and seek federal approval to amend the Medicaid state plan if needed to do so

§ 8 — MEDICAID REIMBURSEMENT RATES FOR DOULAS, PSYCHOLOGISTS, ACUPUNCTURISTS, AND EMERGENCY ROOM PHYSICIANS

Requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for certified doulas and licensed psychologists, acupuncturists, and emergency room physicians

§ 9 — DSS PAYMENTS FOR HOME HEALTH CARE SERVICES

Requires the DSS commissioner, within available appropriations, to increase fees it pays for all home health services by 10% per year for six years; prohibits DSS from reducing rates for psychiatric nurses who make subsequent visits to the same address to provide behavioral health services; specifies that add-on payments for escort services are for safety escorts for nurses making home visits

§ 10 — DSS PAYMENTS FOR HOMEMAKER-COMPANION AND MEALS-ON-WHEELS PROVIDERS

Requires the DSS commissioner, within available appropriations, to increase the fee schedules for (1) homemaker-companion services from fiscal years 27 through 31 and (2) meals-on-wheels providers starting July 1, 2026

§ 11 — GAYLORD SPECIALTY CARE MEDICAID REIMBURSEMENT RATE

Requires the DSS commissioner, within available appropriations, to increase the Medicaid daily reimbursement rate for Gaylord Specialty Care by $206 per patient to achieve rate parity with other long-term acute care hospitals in Connecticut

§ 12 — MEDICAID COVERAGE FOR NON-OPIOID PAIN MEDICATIONS

Prohibits DSS from disadvantaging or discouraging Medicaid coverage of non-opioid drugs for pain management or treatment compared to opioid drugs

§ 13 — PAIN MANAGEMENT TRAINING FOR OPIOID PRESCRIBERS

Authorizes the DSS commissioner to require a prescribing practitioner, as a condition of Medicaid reimbursement, to complete training in effective pain management; requires prescribers to

consider the feasibility of non-opioid pain treatment options; and allows DSS to adopt implementing regulations

§ 14 — MEDICAID REIMBURSEMENT FOR FAMILY PLANNING SERVICES

Requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for family planning services

§ 15 — DSS PAYMENTS TO NON-ICF-ID BOARDING HOMES

Starting with FY 27, requires the DSS commissioner, within available appropriations, to increase rates for non-ICF-ID boarding homes and residential care homes and community living arrangements that receive the flat rate for residential services

§ 16 — REINVESTING NONPROFIT PROVIDER CONTRACT SAVINGS

Authorizes the OPM secretary to allow nonprofit provider organizations that provide services for DDS and DSS to reinvest the savings they retained under a purchase of service contract with DDS into a contract with DSS

§ 17 — STUDY ON STATE PROGRAM SERVICES PROVIDED BY NONPROFITS

Requires the DSS commissioner, in collaboration with other state agencies, to study the cost of state program services provided by nonprofit providers and report to the legislature by January 15, 2027

§ 18 — MEDICAID REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS, AND COMPLEX REHABILITATION TECHNOLOGY

Requires the DSS commissioner, within available appropriations, to increase Medicaid reimbursement rates for durable medical equipment, orthotics, prosthetics and supplies, and complex rehabilitation technology

## SUMMARY

This bill makes various changes to human services-related statutes as described in the section-by-section analysis below.

EFFECTIVE DATE: July 1, 2026, except that provisions on (1) biomarker testing (§ 6) and (2) a study on nonprofit provider service costs (§ 17) take effect upon passage.

## § 1 — MEDICAID REIMBURSEMENT FOR COGNITIVE IMPAIRMENT

*Requires DSS to amend the Medicaid state plan to incorporate Medicare billing code criteria for cognitive assessment and care planning for beneficiaries under age 65 who are showing signs of cognitive impairment*

The bill requires the Department of Social Services (DSS) commissioner to amend the Medicaid state plan to incorporate Medicare's billing code reimbursement criteria for a cognitive assessment and care planning ordered by a clinician for a Medicaid beneficiary who is under age 65 and showing signs of cognitive impairment.

Under the bill, someone with cognitive impairment is deficient in (1) short- or long-term memory; (2) orientation to a person, place, or time; or (3) deductive or abstract reasoning. A clinician is a Connecticut-credentialed physician, physician assistant, advanced practice registered nurse, clinical nurse specialist, or certified nurse-midwife.

## §§ 2 & 3 — MEDICAID NON-EMERGENCY DENTAL SERVICES

*Excludes dental prevention services, such as oral exams and cleanings, from existing law's $1,000 annual cap on non-emergency dental services for adults; adds annual periodontal therapy to the list of non-emergency dental services Medicaid covers for healthy adults*

The bill excludes dental prevention services, such as oral exams and cleanings, from existing law's $1,000 annual cap on Medicaid non-emergency adult dental services for beneficiaries.

Additionally, it expands Medicaid coverage of non-emergency dental services for healthy adults to include annual periodontal therapy. Existing law already covers one periodic dental examination and tooth cleaning, and one set of bitewing x-rays, each year.

Under existing law, unchanged by the bill, a "healthy adult" is someone ages 21 or older with no evidence of dental disease.

## § 4 — MAPOC MEMBERSHIP

*Adds two representatives of the Connecticut Dental Health Partnership to the membership of the Council on Medical Assistance Program Oversight*

The bill increases, from 50 to 52, the membership of the Council on Medical Assistance Program Oversight (MAPOC). It does so by adding

two representatives of the Connecticut Dental Health Partnership, each appointed by the Human Services chairpersons.

By law, this council must advise DSS on various aspects of the Medicaid program. MAPOC includes legislators, consumers, advocates, health care providers, administrative service organization representatives, and state agency personnel.

## § 5 — SAFETY NET PEDIATRIC DENTAL CLINIC

*Requires the DSS commissioner to amend the Medicaid state plan to increase reimbursement rates for safety net pediatric dental clinics so that they at least equal rates for federally qualified health centers; authorizes the commissioner to establish a supplemental payment pool to reimburse clinics for uncompensated care*

The bill requires the DSS commissioner to amend the Medicaid state plan to increase reimbursement rates for services provided by safety net pediatric dental clinics so that they are at least equal to those of federally qualified health centers.

It also authorizes the commissioner, within available appropriations, to establish a supplemental payment pool to reimburse these clinics for uncompensated care.

Under the bill, a "safety net pediatric dental clinic" is a nonprofit, public, or community-based provider that offers dental care to low-income or uninsured children, regardless of their ability to pay.

## § 6 — BIOMARKER TESTING

*Requires the DSS commissioner to report to the Human Services Committee on prior authorization requirements for Medicaid coverage of biomarker testing and how many beneficiaries were approved for this testing in FY 26*

The bill requires the DSS commissioner, by October 1, 2026, to report to the Human Services Committee on (1) prior authorization requirements for Medicaid coverage of biomarker testing, including their impact on beneficiary access, and (2) how many received approval for Medicaid coverage for this testing in FY 26.

Existing law requires DSS, to the extent federal law allows, to cover medically necessary biomarker testing to diagnose, treat, manage, or monitor a beneficiary's medical condition. Biomarker testing is the

analysis of a patient's tissue, blood, or other biospecimen for biomarkers, which are characteristics, like a gene mutation or protein expression, that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention for a disease or condition (CGS § 17b-278m).

## § 7 — MEDICAID REIMBURSEMENT RATES FOR OPTOMETRISTS

*Requires the DSS commissioner to adjust Medicaid reimbursement rates for optometrists so that they equal ophthalmologist rates and seek federal approval to amend the Medicaid state plan if needed to do so*

The bill requires the DSS commissioner to adjust Medicaid reimbursement rates for licensed optometrists so that they equal those of licensed ophthalmologists for performing the same medical service or procedure. It requires the commissioner to seek federal approval to amend the Medicaid state plan, if needed to adjust the rates.

## § 8 — MEDICAID REIMBURSEMENT RATES FOR DOULAS, PSYCHOLOGISTS, ACUPUNCTURISTS, AND EMERGENCY ROOM PHYSICIANS

*Requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for certified doulas and licensed psychologists, acupuncturists, and emergency room physicians*

The bill requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for certified doulas and licensed psychologists, acupuncturists, and emergency room physicians.

## § 9 — DSS PAYMENTS FOR HOME HEALTH CARE SERVICES

*Requires the DSS commissioner, within available appropriations, to increase fees it pays for all home health services by 10% per year for six years; prohibits DSS from reducing rates for psychiatric nurses who make subsequent visits to the same address to provide behavioral health services; specifies that add-on payments for escort services are for safety escorts for nurses making home visits*

The bill requires the DSS commissioner, within available appropriations, to annually increase by 10%, the fees that the department pays home health care agencies and home health aide agencies for all home health services from July 1, 2026, through June 30, 2031.

Existing law, unchanged by the bill, allows DSS to annually increase these fees for home care services, which are set by schedule, based on increases in service costs. The state's rate for these services cannot exceed that charged to the public.

By law, the department's home health fee schedule must include fees for nurses who make home visits solely to administer medications. This schedule must also include rates for psychiatric nurse visits. The bill prohibits DSS from reducing rates for a nurse who makes subsequent visits to the same address to provide behavioral health services.

Under current law, the DSS commissioner may increase payments ("add-on" payments) to home health care agencies and home health aide agencies that apply with evidence of extraordinary costs related to (1) serving people with AIDS, (2) high-risk maternal and child health care, (3) escort services, or (4) extended hour services. The bill requires, rather than allows, the commissioner to make these add-on payments and specifies that payments for escort services are solely for safety escorts for nurses making home visits.

### *Background — Related Bill*

HB 5484 (File 392), favorably reported by the Human Services Committee, requires the DSS commissioner, starting July 1, 2026, to increase home health care fees the department pays for certain home care providers who provide non-emergency medical transport to Medicaid beneficiaries.

## § 10 — DSS PAYMENTS FOR HOMEMAKER-COMPANION AND MEALS-ON-WHEELS PROVIDERS

*Requires the DSS commissioner, within available appropriations, to increase the fee schedules for (1) homemaker-companion services from fiscal years 27 through 31 and (2) meals-on-wheels providers starting July 1, 2026*

The bill requires the DSS commissioner, within available appropriations, to increase the fee schedule for homemaker-companion services as follows: (1) by 13% in fiscal years 27 and 28 and (2) by 10% in fiscal years 29 through 31.

It also requires the commissioner, within available appropriations, to

increase the fee schedule for meals-on-wheels providers by 4.9% starting July 1, 2026.

### *Background — Related Bill*

sSB 497, favorably reported by the Human Services Committee, requires, rather than allows, DSS to annually increase meals-on-wheels provider rates for the Connecticut Home Care Program for Elders.

## § 11 — GAYLORD SPECIALTY CARE MEDICAID REIMBURSEMENT RATE

*Requires the DSS commissioner, within available appropriations, to increase the Medicaid daily reimbursement rate for Gaylord Specialty Care by $206 per patient to achieve rate parity with other long-term acute care hospitals in Connecticut*

The bill requires the DSS commissioner, within available appropriations, to increase the Medicaid reimbursement rate for Gaylord Specialty Care by $206 per patient per day so that the rate equals those for other long-term acute care hospitals in the state.

Gaylord Specialty Care is a nonprofit long-term acute care hospital that provides inpatient and outpatient medical rehabilitation for complex illness and traumatic injuries.

## § 12 — MEDICAID COVERAGE FOR NON-OPIOID PAIN MEDICATIONS

*Prohibits DSS from disadvantaging or discouraging Medicaid coverage of non-opioid drugs for pain management or treatment compared to opioid drugs*

The bill prohibits DSS from disadvantaging or discouraging Medicaid coverage of non-opioid drugs compared to opioid drugs for pain management or treatment. This includes (1) imposing coverage criteria on non-opioid drugs that is more restrictive than the least restrictive criteria placed on opioid drugs or (2) establishing more restrictive or extensive utilization management requirements (for example, more restrictive or extensive prior authorization or step therapy requirements).

## § 13 — PAIN MANAGEMENT TRAINING FOR OPIOID PRESCRIBERS

*Authorizes the DSS commissioner to require a prescribing practitioner, as a condition of Medicaid reimbursement, to complete training in effective pain management; requires*

*prescribers to consider the feasibility of non-opioid pain treatment options; and allows DSS to adopt implementing regulations*

The bill authorizes the DSS commissioner to require a prescribing practitioner, as a condition of Medicaid reimbursement, to complete training in effective pain management, including (1) appropriate, available non-opioid alternatives to treat pain and (2) the advantages and disadvantages of using these alternatives, considering a patient's risk of substance misuse.

Under the bill, a prescribing practitioner who prescribes an opioid drug to treat a Medicaid beneficiary's pain must consider the feasibility of non-opioid treatment options, such as chiropractic treatment, spinal cord stimulation, massage therapy, acupuncture, and physical therapy.

The bill allows the commissioner to adopt regulations to implement these requirements.

Under the bill, a prescribing practitioner is a physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse, or nurse midwife authorized to prescribe opioid drugs within their scope of practice.

## § 14 — MEDICAID REIMBURSEMENT FOR FAMILY PLANNING SERVICES

*Requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for family planning services*

The bill requires the DSS commissioner, within available appropriations, to amend the Medicaid state plan to increase reimbursement rates for family planning services providers. Under the bill, these services include, among other things, contraceptives, medical examinations, and laboratory tests.

## § 15 — DSS PAYMENTS TO NON-ICF-ID BOARDING HOMES

*Starting with FY 27, requires the DSS commissioner, within available appropriations, to increase rates for non-ICF-ID boarding homes and residential care homes and community living arrangements that receive the flat rate for residential services*

Starting with fiscal year 2027, the bill requires the DSS commissioner, within available appropriations, to increase:

1. room and board rates for community living arrangements and community companion homes and similar facilities operated by regional educational services centers that are licensed to provide residential care for people with certain disabilities but not certified as intermediate care facilities with intellectual disabilities (ICF-ID) and

2. state payment rates for residential care homes, community living arrangements, and community companion homes that receive the flat rate for residential services (state regulations allow these facilities to be paid a flat rate rather than a rate based on their submitted cost reports (Conn. Agencies Regs., § 17-311-54).

Under the bill, the commissioner must increase the rates by the most recent increase in the consumer price index for urban consumers, based on facilities' most recent cost report filings. (In practice, the flat rates described above are currently not based on cost report filings.)

### *Background — Related Bills*

sHB 5357, favorably reported by the Human Services Committee, makes various changes affecting residential care home rates.

sHB 5358, favorably reported by the Human Services Committee, requires DSS to rebase rates every two years for community living arrangements and community companion homes.

## § 16 — REINVESTING NONPROFIT PROVIDER CONTRACT SAVINGS

*Authorizes the OPM secretary to allow nonprofit provider organizations that provide services for DDS and DSS to reinvest the savings they retained under a purchase of service contract with DDS into a contract with DSS*

Existing law generally requires DSS and certain other state agencies to allow nonprofit private provider organizations that provide health and human services to retain any savings from a purchase of service contract at the end of each fiscal year, so long as the organization otherwise meets contractual requirements.

Regardless of this law, the bill authorizes the Office of Policy and

Management (OPM) secretary to allow nonprofit provider organizations that provide services for the Department of Developmental Services (DDS) and DSS to reinvest the savings they retained under a purchase of service contract with DDS into a contract with DSS.

As under existing law, providers cannot retain savings if (1) the contract is federally funded and (2) it is prohibited by federal law or regulations or would jeopardize federal funding.

By law, a "purchase of service contract" is a contract between a state agency and private provider organization for direct health and human services for agency clients. It generally excludes administrative or clerical services; material goods, training, or consulting services; or contracts with individuals (CGS § 4-70b(1)).

## § 17 — STUDY ON STATE PROGRAM SERVICES PROVIDED BY NONPROFITS

*Requires the DSS commissioner, in collaboration with other state agencies, to study the cost of state program services provided by nonprofit providers and report to the legislature by January 15, 2027*

The bill requires the DSS commissioner, in collaboration with the commissioners of children and families, developmental services, and mental health and addiction services, to study the following:

1. the percentage of services under these departments' programs that are provided by nonprofits;

2. state reimbursement rates for each service these nonprofits provide;

3. a comparison of the cost of services when provided by nonprofits versus the state agencies directly; and

4. how often reimbursement rates are adjusted for inflation.

Under the bill, the DSS commissioner must report the study's data to the Appropriations, Childrens, Human Services, and Public Health committees by January 15, 2027.

## § 18 — MEDICAID REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS, AND COMPLEX REHABILITATION TECHNOLOGY

*Requires the DSS commissioner, within available appropriations, to increase Medicaid reimbursement rates for durable medical equipment, orthotics, prosthetics and supplies, and complex rehabilitation technology*

The bill requires the DSS commissioner, within available appropriations, to increase Medicaid reimbursement rates for durable medical equipment, orthotics, prosthetics and supplies, and complex rehabilitation technology (for example wheelchairs, adaptive seating, and other mobility devices), according to the rate study DSS commissioned under PA 23-186.

More specifically, legislation passed in 2023 directed DSS to study Connecticut's Medicaid reimbursement rates, which have not been broadly adjusted since 2007. A study team, hired by DSS, compared Medicaid reimbursement rates to Medicare reimbursement rates for the same service code, or, for services without a corresponding Medicare code, the average Medicaid reimbursement rates across Maine, Massachusetts, New Jersey, New York, and Oregon (the five-state benchmark).

### *Background — Related Bill*

SB 499, favorably reported by the Human Services Committee, requires DSS to phase-in rate increases that are in accordance with the Medicaid rate study.

## COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 23 Nay 0 (03/19/2026)