



# Senate

General Assembly

**File No. 488**

February Session, 2026

Substitute Senate Bill No. 499

*Senate, April 7, 2026*

The Committee on Human Services reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## ***AN ACT CONCERNING MEDICAID RATE INCREASES.***

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

1 Section 1. (NEW) (*Effective July 1, 2026*) (a) As used in this section, (1)  
2 "Medicaid rate study" means the study commissioned by the  
3 Department of Social Services pursuant to section 1 of public act 23-186,  
4 (2) "five-state rate benchmark" means the average of rates for the same  
5 health care services in Maine, Massachusetts, New Jersey, New York  
6 and Oregon, and (3) "Medicare Economic Index" means a measure of  
7 inflation for physicians with respect to their practice costs and wage  
8 levels as calculated by the Centers for Medicare and Medicaid Services.

9 (b) Within available appropriations, the Commissioner of Social  
10 Services shall phase in increases to Medicaid provider rates in  
11 accordance with the Medicaid rate study. The commissioner shall phase  
12 in the rate increases commencing on July 1, 2026, such that by June 30,  
13 2029, all such rates equal (1) not less than seventy-five per cent of the  
14 most recent Medicare rates for the same health care services, or (2) for  
15 such services with no corresponding Medicare rates, a percentage of the

16 five-state rate benchmark that results in an equivalent rate increase.

17 (c) On and after June 30, 2029, the commissioner shall adjust such  
18 rates every year (1) to not less than seventy-five per cent of the most  
19 recent Medicare rates for the same health care services, (2) to an  
20 equivalent percentage of the five-state rate benchmark for such services  
21 with no corresponding Medicare rates, or (3) by increasing such rates by  
22 any percentage increase in the Medicare Economic Index.

23 (d) Any review or rebasing of Medicaid rates shall include those rates  
24 (1) required to be studied pursuant to the Medicaid rate study; and (2)  
25 with no corresponding (A) Medicare rate for the same health care  
26 service, or (B) average five-state rate benchmark rate included in the  
27 Medicaid rate study. If any one state within the five-state rate  
28 benchmark group has a corresponding rate for the same or substantially  
29 similar health care service, such rate shall be used for comparison in  
30 such review.

31 (e) The commissioner shall streamline and consolidate existing fee  
32 schedules used for provider or service reimbursement so that every  
33 provider is reimbursed using the same fee schedule. In streamlining and  
34 consolidating existing fee schedules, the commissioner shall  
35 incorporate, to the extent applicable, the most recent Medicare fee  
36 schedule for services covered by Medicare as well as Medicaid.

37 Sec. 2. (NEW) (*Effective July 1, 2026*) (a) The Council on Medical  
38 Assistance Program Oversight, established pursuant to section 17b-28  
39 of the general statutes, shall develop and implement an ongoing  
40 systemic review of Medicaid provider reimbursement rates to ensure  
41 rates are adequate to sustain a sufficient provider pool to provide  
42 Medicaid member access to high-quality care.

43 (b) Not later than January 15, 2027, and annually thereafter, the  
44 council shall file a report, in accordance with the provisions of section  
45 11-4a of the general statutes, with the joint standing committees of the  
46 General Assembly having cognizance of matters relating to  
47 appropriations and the budgets of state agencies and human services.

48 The report shall include the council's recommendations on necessary  
 49 appropriations to ensure Medicaid providers are compensated for  
 50 health care services in accordance with section 1 of this act.

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	New section

**Statement of Legislative Commissioners:**

In Section 1(b) and (d), "five-state benchmark" or "benchmark" was changed to "five-state rate benchmark" and "public act 23-186" was changed to "the Medicaid rate study" for consistency with the defined term.

**HS**            *Joint Favorable Subst. -LCO*

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	See Below	See Below

Note: GF=General Fund

**Municipal Impact:** None

**Explanation**

The bill results in a significant cost to the Department of Social Services due to phasing-in increases to Medicaid provider rates by 6/30/29.

The bill requires that Medicaid rates for various providers be increased to (1) 75% of the Medicare rate for similar services, or (2) to a similar percentage increase based on the five-state benchmark included in the Medicaid rate study supported by PA 23-186. For context, the study reviewed costs to adjust Medicaid rates to 80% of the Medicare fee schedule and five-state rates for Maine, Massachusetts, New Jersey, New York and Oregon. Based on those factors, state costs are estimated at approximately \$150 million when annualized, with additional annual increases incurred to reflect updated fee schedules, benchmarks, or increases in the Medicare Economic Index (MEI).

For purposes of an example, the table below details state costs by fiscal year if each set of rate increases is supported by equal annualized funding.

Example: Phase-in of Medicaid Provider Rates ( <i>state share, \$ in millions</i> )			
	FY 27	FY 28	FY 29
Year 1 Costs	50.0	50.0	50.0
Year 2 Costs	-	50.0	50.0
Year 3 Costs	-	-	50.0
<b>Total</b>	<b>50.0</b>	<b>100.0</b>	<b>150.0</b>
- assumes rate increases are effective July 1 of each year.			

The actual annual cost to increase rates depends on the provider group under review and associated funding necessary to meet the benchmark, within the required timeframe.

### ***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to the Medicare fee schedule, five-state rate benchmarks, or any percentage increase in MEI.

**OLR Bill Analysis****sSB 499*****AN ACT CONCERNING MEDICAID RATE INCREASES.*****SUMMARY**

This bill requires the Department of Social Services (DSS) commissioner to increase Medicaid provider rates, within available appropriations, in accordance with the Medicaid rate study required under PA 23-186. Among other things, the study generally recommends using (1) Medicare as a benchmark or (2) other states' Medicaid rates to update rates initially and adopting an independent rate model for future years. DSS must phase in these rate increases starting July 1, 2026, through June 30, 2029, and then make annual rate adjustments after that date.

The bill also requires the DSS commissioner to streamline and consolidate existing fee schedules used for provider or service reimbursement so that the same fee schedule is used to reimburse every provider. The bill requires her, to the extent applicable, to incorporate the most recent Medicare fee schedule for services covered by both Medicare and Medicaid.

Lastly, the bill requires the Council on Medical Assistance Program Oversight (MAPOC) to develop and implement an ongoing systemic review of Medicaid provider reimbursement rates to ensure rates are adequate to sustain a sufficient provider pool to provide Medicaid enrollees access to high-quality care. The bill also requires MAPOC to report annually, starting by January 15, 2027, to the Appropriations and Human Services committees on its recommendations for appropriations needed to ensure Medicaid provider compensation meets the bill's requirements.

EFFECTIVE DATE: July 1, 2026

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## MEDICAID PROVIDER RATE CHANGES

### ***Rate Increase Phase-in***

The bill requires the DSS commissioner to phase in Medicaid provider rate increases in a way so that by June 30, 2029, the rates for all providers are equal to:

1. at least 75% of the most recent Medicare rates for the same health care services, or,
2. for services with no corresponding Medicare rates, a percentage of the five-state rate benchmark that results in an equivalent rate increase.

Under the bill, the “five-state rate benchmark” is the average of the rates for the same health care services in Maine, Massachusetts, New Jersey, New York, and Oregon.

### ***Annual Adjustments***

Starting June 30, 2029, the bill requires the DSS commissioner to adjust the Medicaid provider rates annually either according to the two requirements described above for the end of the phase-in or by increasing the rates by any percentage increase in the “Medicare Economic Index,” which is a measure of inflation for physicians’ practice costs and wage levels as calculated by the federal Centers for Medicare and Medicaid Services.

### ***Rate Review or Rebasing***

The bill requires any review or rebasing of Medicaid rates to include those rates that (1) had to be studied as part of the Medicaid rate study required under PA 23-186 and (2) have no corresponding (a) Medicare rate or (b) average five-state benchmark rate in the PA 23-186 study. If Maine, Massachusetts, New Jersey, New York, or Oregon has a corresponding rate for the same or a substantially similar health care service, the bill requires that rate to be included in the review for comparison.

By law, PA 23-186 required a two-part study of Medicaid rates, with

the first part examining rates for physician specialists, dentists, and behavioral health providers and the second part examining all other aspects of the Medicaid program, including ambulance services, federally qualified health centers, specialty hospitals, complex nursing care, and methadone maintenance.

**BACKGROUND**

***Related Bill***

sHB 5561, favorably reported by the Human Services Committee, requires rate increases for specific providers, including certain dental clinics, psychologists, and emergency room physicians, among others.

**COMMITTEE ACTION**

Human Services Committee

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