



General Assembly

Substitute Bill No. 5561

February Session, 2026



AN ACT CONCERNING MEDICAID RATE INCREASES FOR CERTAIN PROVIDERS.

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

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

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

12 Sec. 2. Subsection (a) of section 17b-282c of the general statutes is
13 repealed and the following is substituted in lieu thereof (*Effective July 1,*
14 *2026*):

15 (a) All nonemergency dental services provided under the
16 Department of Social Services' dental programs, as described in section
17 17b-282b, shall be subject to prior authorization. Nonemergency

18 services that are exempt from the prior authorization process shall
19 include diagnostic, prevention, basic restoration procedures and
20 nonsurgical extractions that are consistent with standard and reasonable
21 dental practices. Payment for nonemergency dental services shall not
22 exceed one thousand dollars per calendar year for an individual adult,
23 provided prevention services such as oral exams and dental cleanings
24 and services determined to be medically necessary, as defined in section
25 17b-259b, including dentures, shall not be subject to such payment cap.
26 Dental benefit limitations shall apply to each client regardless of the
27 number of providers serving the client. The commissioner may recoup
28 payments for services that are determined not to be for an emergency
29 condition or otherwise in excess of what is medically necessary. The
30 commissioner shall periodically, but not less than quarterly, review
31 payments for emergency dental services and basic restoration
32 procedures for appropriateness of payment. For the purposes of this
33 section, "emergency condition" means a dental condition manifesting
34 itself by acute symptoms of sufficient severity, including severe pain,
35 such that a prudent layperson, who possesses an average knowledge of
36 health and medicine, could reasonably expect the absence of immediate
37 dental attention to result in placing the health of the individual, or with
38 respect to a pregnant woman, the health of the woman or her unborn
39 child, in serious jeopardy, cause serious impairment to body functions
40 or cause serious dysfunction of any body organ or part.

41 Sec. 3. Subsection (a) of section 17b-282d of the general statutes is
42 repealed and the following is substituted in lieu thereof (*Effective July 1,*
43 *2026*):

44 (a) The Commissioner of Social Services shall modify the extent of
45 nonemergency adult dental services provided under the Medicaid
46 program. Such modifications shall include, but are not limited to,
47 providing one periodic dental exam, one dental cleaning, periodontal
48 therapy and one set of bitewing x-rays each year for a healthy adult. For
49 purposes of this section, "healthy adult" means a person twenty-one
50 years of age or older for whom there is no evidence indicating that
51 dental disease is an aggravating factor for the person's overall health

52 condition.

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

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

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

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

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

76 (4) Three appointed by the majority leader of the House of
77 Representatives, one of whom shall be an advocate for persons with
78 substance abuse disabilities, one of whom shall be a Medicaid dental
79 provider and one of whom shall be a representative of the for-profit
80 nursing home industry;

81 (5) Three appointed by the majority leader of the Senate, one of whom

82 shall be a representative of school-based health centers, one of whom
83 shall be a recipient of benefits under the HUSKY Health program and
84 one of whom shall be a physician who serves Medicaid clients;

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

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

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

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

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

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

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

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

110 (14) One representative of an administrative services organization

111 which contracts with the Department of Social Services in the
112 administration of the Medicaid program, who shall be a nonvoting
113 member; and

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

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

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

140 Sec. 7. (*Effective July 1, 2026*) The Commissioner of Social Services
141 shall adjust rates of reimbursement under the Medicaid program so that
142 an optometrist licensed pursuant to chapter 380 of the general statutes

143 receives the same rate as an ophthalmologist licensed pursuant to
144 chapter 370 of the general statutes for performing the same medical
145 service or procedure. The commissioner shall seek federal approval to
146 amend the Medicaid state plan, if necessary, to adjust the rate of
147 reimbursement in accordance with this section.

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

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

158 (a) The Department of Social Services shall determine the rates to be
159 paid to home health care agencies and home health aide agencies by the
160 state or any town in the state for persons aided or cared for by the state
161 or any such town. The Commissioner of Social Services shall establish a
162 fee schedule for home health services to be effective on and after July 1,
163 1994. The commissioner may annually modify such fee schedule if such
164 modification is needed to ensure that the conversion to an
165 administrative services organization is cost neutral to home health care
166 agencies and home health aide agencies in the aggregate and ensures
167 patient access. Utilization may be a factor in determining cost neutrality.
168 The commissioner shall increase the fee schedule for home health
169 services provided under the Connecticut home-care program for the
170 elderly established under section 17b-342, effective July 1, 2000, by two
171 per cent over the fee schedule for home health services for the previous
172 year. On and after January 1, 2024, the commissioner shall increase the
173 fee schedule for complex care nursing services provided to individuals
174 over the age of eighteen such that the rate of reimbursement is equal to
175 the rate for such services provided to individuals age eighteen and

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

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

209 (c) The home health services fee schedule shall include a fee for the

210 administration of medication, which shall apply when the purpose of a
211 nurse's visit is limited to the administration of medication.
212 Administration of medication may include, but is not limited to, blood
213 pressure checks, glucometer readings, pulse rate checks and similar
214 indicators of health status. The fee for medication administration shall
215 include administration of medications while the nurse is present, the
216 pre-pouring of additional doses that the client will self-administer at a
217 later time and the teaching of self-administration. The department shall
218 not pay for medication administration in addition to any other nursing
219 service at the same visit. The department may establish prior
220 authorization requirements for this service. Before implementing such
221 change, the Commissioner of Social Services shall consult with the
222 chairpersons of the joint standing committees of the General Assembly
223 having cognizance of matters relating to public health and human
224 services. The commissioner shall monitor Medicaid home health care
225 savings achieved through the implementation of nurse delegation of
226 medication administration pursuant to section 19a-492e. If, by January
227 1, 2016, the commissioner determines that the rate of savings is not
228 adequate to meet the annualized savings assumed in the budget for the
229 biennium ending June 30, 2017, the department may reduce rates for
230 medication administration as necessary to achieve the savings assumed
231 in the budget. Prior to any rate reduction, the department shall report to
232 the joint standing committees of the General Assembly having
233 cognizance of matters relating to appropriations and the budgets of state
234 agencies and human services provider specific cost and utilization trend
235 data for those patients receiving medication administration. Should the
236 department determine it necessary to reduce medication administration
237 rates under this section, it shall examine the possibility of establishing a
238 separate Medicaid supplemental rate or a pay-for-performance program
239 for those providers, as determined by the commissioner, who have
240 established successful nurse delegation programs.

241 (d) The home health services fee schedule established pursuant to
242 subsection (c) of this section shall include rates for psychiatric nurse
243 visits. There shall be no reduction in rates for subsequent visits by the

244 same nurse to the same address to provide behavioral health services.

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

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

265 (g) The Department of Social Services, when auditing claims
266 submitted by home health care agencies and home health aide agencies,
267 shall consider any signature from a licensed physician or licensed
268 practitioner of a health care profession that may be required on a plan
269 of care for home health services, to have been provided in timely fashion
270 if (1) the document bearing such signature was signed prior to the time
271 when such agency seeks reimbursement from the department for
272 services provided, and (2) verbal or telephone orders from the licensed
273 physician or licensed practitioner of a health care profession were
274 received prior to the commencement of services covered by the plan of
275 care and such orders were subsequently documented. Nothing in this
276 subsection shall be construed as limiting the powers of the

277 Commissioner of Public Health to enforce the provisions of sections 19-
278 13-D73 and 19-13-D74 of the regulations of Connecticut state agencies
279 and 42 CFR 484.18(c).

280 (h) Any order for home health care services covered by the
281 Department of Social Services may be issued by any licensed
282 practitioner authorized to issue such an order pursuant to section 19a-
283 496a. Any Department of Social Services regulation, policy or procedure
284 that applies to a physician who orders such home health care services,
285 including related provisions such as review and approval of care plans
286 for home health care services, shall apply to any licensed practitioner
287 authorized to order such home health care services pursuant to section
288 19a-496a.

289 (i) For purposes of this section, "licensed practitioner of a healthcare
290 profession" has the same meaning as "licensed practitioner" in section
291 21a-244a.

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

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

309 care, meals on wheels, adult day care services, case management and
310 assessment services, transportation, mental health counseling and
311 elderly foster care. The commissioner may annually increase the fee
312 schedule based on an increase in the cost of services. The commissioner
313 shall increase the fee schedule effective July 1, 2000, by not less than five
314 per cent, for adult day care services. The commissioner shall increase the
315 fee schedule effective July 1, 2011, by four dollars per person, per day
316 for adult day care services. For each of the fiscal years ending June 30,
317 2027, and June 30, 2028, the commissioner, within available
318 appropriations, shall increase the fee schedule for homemaker-
319 companion services by thirteen per cent. For each of the fiscal years
320 ending June 30, 2029, June 30, 2030, and June 30, 2031, the commissioner,
321 within available appropriations, shall increase such fee schedule by ten
322 per cent. The commissioner shall increase the fee schedule effective July
323 1, 2019, for meals on wheels by ten per cent over the fee schedule for
324 meals on wheels for the previous fiscal year. Effective July 1, 2020, and
325 annually thereafter, the commissioner may increase the fee schedule for
326 meals on wheels providers serving participants in the Connecticut
327 home-care program for the elderly by, at a minimum, the cost-of-living
328 adjustment as measured by the consumer price index. Effective July 1,
329 2026, the commissioner, within available appropriations, shall increase
330 the fee schedule for meals on wheels providers by four and nine-tenths
331 per cent. The commissioner may increase any fee payable to a meals on
332 wheels provider upon the application of such provider evidencing
333 extraordinary costs related to delivery of meals on wheels in sparsely
334 populated rural regions of the state. Nothing contained in this section
335 shall authorize a payment by the state to any agency for such services in
336 excess of the amount charged by such agency for such services to the
337 general public.

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

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

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

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

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

373 (c) A prescribing practitioner who prescribes an opioid drug for the
374 treatment of a Medicaid beneficiary's pain shall consider the feasibility

375 of nonopioid treatment options, including, but not limited to,
376 chiropractic treatment, spinal cord stimulation, massage therapy,
377 acupuncture and physical therapy.

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

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

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

389 (a) The room and board component of the rates to be paid by the state
390 to private facilities and facilities operated by regional education service
391 centers which are licensed to provide residential care pursuant to
392 section 17a-227, but not certified to participate in the Title XIX Medicaid
393 program as intermediate care facilities for individuals with intellectual
394 disabilities, shall be determined annually by the Commissioner of Social
395 Services, except that rates effective April 30, 1989, shall remain in effect
396 through October 31, 1989. Any facility with real property other than
397 land placed in service prior to July 1, 1991, shall, for the fiscal year
398 ending June 30, 1995, receive a rate of return on real property equal to
399 the average of the rates of return applied to real property other than land
400 placed in service for the five years preceding July 1, 1993. For the fiscal
401 year ending June 30, 1996, and any succeeding fiscal year, the rate of
402 return on real property for property items shall be revised every five
403 years. The commissioner shall, upon submission of a request by such
404 facility, allow actual debt service, comprised of principal and interest,
405 on the loan or loans in lieu of property costs allowed pursuant to section
406 17-313b-5 of the regulations of Connecticut state agencies, whether

407 actual debt service is higher or lower than such allowed property costs,
408 provided such debt service terms and amounts are reasonable in
409 relation to the useful life and the base value of the property. In the case
410 of facilities financed through the Connecticut Housing Finance
411 Authority, the commissioner shall allow actual debt service, comprised
412 of principal, interest and a reasonable repair and replacement reserve
413 on the loan or loans in lieu of property costs allowed pursuant to section
414 17-313b-5 of the regulations of Connecticut state agencies, whether
415 actual debt service is higher or lower than such allowed property costs,
416 provided such debt service terms and amounts are determined by the
417 commissioner at the time the loan is entered into to be reasonable in
418 relation to the useful life and base value of the property. The
419 commissioner may allow fees associated with mortgage refinancing
420 provided such refinancing will result in state reimbursement savings,
421 after comparing costs over the terms of the existing proposed loans. For
422 the fiscal year ending June 30, 1992, the inflation factor used to
423 determine rates shall be one-half of the gross national product
424 percentage increase for the period between the midpoint of the cost year
425 through the midpoint of the rate year. For fiscal year ending June 30,
426 1993, the inflation factor used to determine rates shall be two-thirds of
427 the gross national product percentage increase from the midpoint of the
428 cost year to the midpoint of the rate year. For the fiscal years ending
429 June 30, 1996, and June 30, 1997, no inflation factor shall be applied in
430 determining rates. The Commissioner of Social Services shall prescribe
431 uniform forms on which such facilities shall report their costs. Such rates
432 shall be determined on the basis of a reasonable payment for necessary
433 services. Any increase in grants, gifts, fund-raising or endowment
434 income used for the payment of operating costs by a private facility in
435 the fiscal year ending June 30, 1992, shall be excluded by the
436 commissioner from the income of the facility in determining the rates to
437 be paid to the facility for the fiscal year ending June 30, 1993, provided
438 any operating costs funded by such increase shall not obligate the state
439 to increase expenditures in subsequent fiscal years. Nothing contained
440 in this section shall authorize a payment by the state to any such facility
441 in excess of the charges made by the facility for comparable services to

442 the general public. The service component of the rates to be paid by the
443 state to private facilities and facilities operated by regional education
444 service centers which are licensed to provide residential care pursuant
445 to section 17a-227, but not certified to participate in the Title XIX
446 Medicaid programs as intermediate care facilities for individuals with
447 intellectual disabilities, shall be determined annually by the
448 Commissioner of Developmental Services in accordance with section
449 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive
450 a rate that is more than two per cent greater than the rate in effect for
451 the facility on June 30, 2007, except any facility that would have been
452 issued a lower rate effective July 1, 2007, due to interim rate status or
453 agreement with the department, shall be issued such lower rate effective
454 July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall
455 receive a rate that is more than two per cent greater than the rate in effect
456 for the facility on June 30, 2008, except any facility that would have been
457 issued a lower rate effective July 1, 2008, due to interim rate status or
458 agreement with the department, shall be issued such lower rate effective
459 July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011,
460 rates in effect for the period ending June 30, 2009, shall remain in effect
461 until June 30, 2011, except that (1) the rate paid to a facility may be higher
462 than the rate paid to the facility for the period ending June 30, 2009, if a
463 capital improvement required by the Commissioner of Developmental
464 Services for the health or safety of the residents was made to the facility
465 during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any
466 facility that would have been issued a lower rate for the fiscal year
467 ending June 30, 2010, or June 30, 2011, due to interim rate status or
468 agreement with the department, shall be issued such lower rate. For the
469 fiscal year ending June 30, 2012, rates in effect for the period ending June
470 30, 2011, shall remain in effect until June 30, 2012, except that (A) the
471 rate paid to a facility may be higher than the rate paid to the facility for
472 the period ending June 30, 2011, if a capital improvement required by
473 the Commissioner of Developmental Services for the health or safety of
474 the residents was made to the facility during the fiscal year ending June
475 30, 2012, and (B) any facility that would have been issued a lower rate
476 for the fiscal year ending June 30, 2012, due to interim rate status or

477 agreement with the department, shall be issued such lower rate. Any
478 facility that has a significant decrease in land and building costs shall
479 receive a reduced rate to reflect such decrease in land and building costs.
480 The rate paid to a facility may be increased if a capital improvement
481 approved by the Department of Developmental Services, in consultation
482 with the Department of Social Services, for the health or safety of the
483 residents was made to the facility during the fiscal year ending June 30,
484 2014, or June 30, 2015, only to the extent such increases are within
485 available appropriations. For the fiscal years ending June 30, 2016, and
486 June 30, 2017, rates shall not exceed those in effect for the period ending
487 June 30, 2015, except the rate paid to a facility may be higher than the
488 rate paid to the facility for the period ending June 30, 2015, if a capital
489 improvement approved by the Department of Developmental Services,
490 in consultation with the Department of Social Services, for the health or
491 safety of the residents was made to the facility during the fiscal year
492 ending June 30, 2016, or June 30, 2017, to the extent such rate increases
493 are within available appropriations. For the fiscal years ending June 30,
494 2016, and June 30, 2017, and each succeeding fiscal year, any facility that
495 would have been issued a lower rate, due to interim rate status, a change
496 in allowable fair rent or agreement with the department, shall be issued
497 such lower rate. For the fiscal years ending June 30, 2018, and June 30,
498 2019, rates shall not exceed those in effect for the period ending June 30,
499 2017, except the rate paid to a facility may be higher than the rate paid
500 to the facility for the period ending June 30, 2017, if a capital
501 improvement approved by the Department of Developmental Services,
502 in consultation with the Department of Social Services, for the health or
503 safety of the residents was made to the facility during the fiscal year
504 ending June 30, 2018, or June 30, 2019, to the extent such rate increases
505 are within available appropriations. For the fiscal years ending June 30,
506 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal
507 year ending June 30, 2019, except the rate paid to a facility may be higher
508 than the rate paid to the facility for the fiscal year ending June 30, 2019,
509 if a capital improvement approved by the Department of
510 Developmental Services, in consultation with the Department of Social
511 Services, for the health or safety of the residents was made to the facility

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

539 (b) Notwithstanding the provisions of subsection (a) of this section,
540 state rates of payment for the fiscal years ending June 30, 2018, June 30,
541 2019, June 30, 2020, and June 30, 2021, for residential care homes and
542 community living arrangements that receive the flat rate for residential
543 services under section 17-311-54 of the regulations of Connecticut state
544 agencies shall be set in accordance with section 298 of public act 19-117.
545 For the fiscal years ending June 30, 2022, and June 30, 2023, such rates

546 shall be based upon rates in effect for the fiscal year ending June 30,
547 2021, inflated by the gross domestic product deflator applicable to each
548 rate year. For the fiscal year ending June 30, 2027, and each fiscal year
549 thereafter, the Commissioner of Social Services, within available
550 appropriations, shall increase such rates by the most recent increase in
551 the consumer price index for all urban consumers and base such rates
552 on the most recent cost report filed by a facility.

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

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

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

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

575 (b) Subject to the provisions of [subsection (c)] subsections (c) and (d)
576 of this section, each state agency that contracts with a nonprofit private
577 provider organization for health and human services shall allow such

578 nonprofit organization that otherwise meets contractual requirements,
579 including, but not limited to, its contractual obligations regarding
580 services provided and clients served, to retain any savings from a
581 purchase of service contract at the end of each fiscal year. No state
582 agency shall attempt to recover or otherwise offset funds retained by
583 such nonprofit organization from the contracted cost for services.

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

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

610 [(d)] (e) Notwithstanding any provisions to the contrary in this

611 section, a state agency shall not allow a nonprofit private provider
612 organization to retain surplus funds from the contracted cost of services
613 under a contract funded in whole, or in part, with federal funds when
614 allowing such organization to retain such funds would jeopardize
615 federal funding or reimbursement for such contract or when such
616 allowance is prohibited by federal law or regulations.

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

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

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

644 (b) Not later than January 15, 2027, the Commissioner of Social
645 Services shall file a report, in accordance with the provisions of section
646 11-4a of the general statutes, on the data obtained from the study
647 pursuant to subsection (a) of this section with the joint standing
648 committees of the General Assembly having cognizance of matters
649 relating to appropriations and the budgets of state agencies, human
650 services, children and public health.

651 Sec. 18. (Effective July 1, 2026) The Commissioner of Social Services,
652 within available appropriations, shall increase the Medicaid rates of
653 reimbursement for durable medical equipment, orthotics, prosthetics
654 and supplies and complex rehabilitation technology in accordance with
655 the Medicaid rate study commissioned by the Department of Social
656 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.*