OLR Bill Analysis

sHB 5561

AN ACT CONCERNING MEDICAID RATE INCREASES FOR CERTAIN PROVIDERS.

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§ 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

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)