House of Representatives

General Assembly

File No. 413

January Session, 2025

Substitute House Bill No. 7191

House of Representatives, April 1, 2025

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, PLANNING AND SUSTAINABILITY.

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

Section 1. (NEW) (*Effective July 1, 2025*) (a) As used in this section, (1) "Medicaid rate study" means the study commissioned by the Department of Social Services pursuant to section 1 of public act 23-186, and (2) "five-state rate benchmark" means the average of rates for the same health care services in Maine, Massachusetts, New Jersey, New York and Oregon.

(b) Within available appropriations, the Commissioner of Social Services shall phase in increases to Medicaid provider rates in accordance with the Medicaid rate study. The commissioner shall phase in the rate increases commencing on July 1, 2025, such that by June 30, 2028, all such rates equal (1) not less than seventy-five per cent of the most recent Medicare rates for the same health care services, or (2) for such services with no corresponding Medicare rates, a percentage of the five-state benchmark that results in an equivalent rate increase.

(c) On and after June 30, 2028, the commissioner shall adjust such rates every year (1) to not less than seventy-five per cent of the most recent Medicare rates for the same health care services, (2) to an equivalent percentage of the five-state rate benchmark for such services with no corresponding Medicare rates, or (3) by increasing such rates by any percentage increase in the Medicare Economic Index, as defined in section 3 of this act, in the discretion of the commissioner.

(d) In increasing such rates and making such rate adjustments, the commissioner shall adjust provider rates for pediatric and adult health care services to achieve parity between such rates for the same health care services.

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

Sec. 2. Section 17b-245d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) On or before February 1, 2013, and on January first annually thereafter, each federally qualified health center shall file with the Department of Social Services the following documents for the previous state fiscal year: (1) Medicaid cost report; (2) audited financial statements; and (3) any additional information reasonably required by the department. Any federally qualified health center that does not use the state fiscal year as its fiscal year shall have six months from the completion of such health center's fiscal year to file **[**said**]** <u>such</u> documents with the department.

[(b) Each federally qualified health center shall provide to the Department of Social Services a copy of its original scope of project, as approved by the federal Health Resources and Services Administration,

and all subsequently approved amendments to its original scope of project. Each federally qualified health center shall notify the department, in writing, of all approvals for additional amendments to its scope of project, and provide to the department a copy of such amended scope of project, not later than thirty days after such approvals.

(c) If there is an increase or a decrease in the scope of services furnished by a federally qualified health center, the federally qualified health center shall notify the Department of Social Services, in writing, of any such increase or decrease not later than thirty days after such increase or decrease and provide any additional information reasonably requested by the department not later than thirty days after the request.

(d) The Commissioner of Social Services may impose a civil penalty of five hundred dollars per day on any federally qualified health center that fails to provide any information required pursuant to this section not later than thirty days after the date such information is due.

(e) The department may adjust a federally qualified health center's encounter rate based upon an increase or decrease in the scope of services furnished by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), following receipt of the written notification described in subsection (c) of this section or based upon the department's review of documents filed in accordance with subsections (a) and (b) of this section.**]**

(b) On or before December 31, 2025, the Department of Social Services shall rebase each federally qualified health center's encounter rates based upon such center's costs during fiscal year 2024 divided by the number of patient encounters for a particular service during the same fiscal year, provided such new encounter rate shall be not less than the encounter rate received before such rates are rebased and shall not interfere with any annual inflationary rate adjustment.

(c) The Department of Social Services shall adjust a federally qualified health center's encounter rate based upon an increase or decrease in the

scope of services furnished in a written notification to the department by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), following receipt by the department of the written notification. If a federally qualified health center experiences additional direct or indirect costs as a result of an increase in such center's scope of services, it shall request a rate adjustment based upon the increase in scope of services on forms issued by the department for such purpose. Not later than thirty days after receipt of such rate adjustment request, the department shall meet with representatives of the federally qualified health center for the purpose of reviewing the center's additional direct and indirect costs relating to the increase in scope of services. If the increase in scope of services is related to amendments approved by the federal Health Resources and Services Administration to the federally qualified health center's original scope of project, the federally qualified health center shall provide to the department a copy of such amended scope of project. Not later than thirty days after meeting with the federally qualified health center, the department shall issue a detailed rate adjustment decision relating to the increase in scope of services. In conducting such review, the department shall not consider the following factors as relevant or determinative with respect to whether the federally qualified health center incurred additional direct or indirect costs associated with the increase in scope of services: (1) The federally qualified health center's encounter rates for other service categories, including dental, behavioral health or medical services; (2) whether or not the federally qualified health center is showing a profit; (3) whether or not the federally qualified health center is in receipt of grant moneys or other third-party reimbursements; (4) whether the federally qualified health center's current encounter rates are higher or lower than encounter rates of similar federally qualified health centers; and (5) any other factor unrelated to increased costs associated with an increase in change of scope of services. A federally qualified health center may appeal the department's rate adjustment decision not later than ten days after it receives notice of the rate adjustment. Not later than ninety days after filing its rate adjustment appeal notice, the federally qualified health center shall submit its items of aggrievement

to the department. Upon review and an opportunity for the department to request any clarifying or supporting information from the federally qualified health center, the department shall issue its decision, along with its rationale, not later than one hundred twenty days after the federally qualified health center's rate adjustment request. If the department's decision is delayed, any approved rate adjustment shall be retroactive to the date on which the decision should have been issued pursuant to this subsection.

(d) If there is a decrease in the scope of services furnished by a federally qualified health center, the federally qualified health center shall notify the Department of Social Services, in writing, of any decrease and provide any additional information reasonably requested by the department not later than thirty days after the department's request. The Commissioner of Social Services may impose a civil penalty of five hundred dollars per day on any federally qualified health center that fails to provide any information relating to a decrease in services to the extent that a discontinued service is a service for which the federally qualified health center is receiving additional reimbursement as the result of a prior rate adjustment related to an increase in scope of services.

[(f)**]** (e) The Commissioner of Social Services shall implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner **[**prints**]** posts notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 3. (NEW) (*Effective January 1, 2026*) The Commissioner of Social Services shall increase rates of Medicaid reimbursement for federally qualified health centers not later than January first annually by the most recent percentage increase in the Medicare Economic Index. For purposes of this section, "Medicare Economic Index" means a measure

of inflation for physicians with respect to their practice costs and wage levels as calculated by the Centers for Medicare and Medicaid Services.

Sec. 4. (NEW) (*Effective July 1, 2025*) (a) The Council on Medical Assistance Program Oversight, established pursuant to section 17b-28 of the general statutes, shall 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 member access to high-quality care.

(b) Not later than January 15, 2026, and annually thereafter, the council shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services. The report shall include the council's recommendations on necessary appropriations to ensure Medicaid providers are compensated for 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, 2025*	New section
Sec. 2	*July 1, 2025*	17b-245d
Sec. 3	*January 1, 2026*	New section
Sec. 4	*July 1, 2025*	New section

Statement of Legislative Commissioners:
In Section 1(a), "section 1 of" was inserted before "public act 23-186" for clarity, Section 1(c) was redrafted for clarity and consistency, in Section 2(c), "by the department" was inserted after "receipt" for clarity, and in Section 3, "percentage" was inserted before "increase" for clarity.

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 26 $	FY 27 $
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 6/30/28 and adjusting the payment methodology for federally qualified health centers (FQHCs).

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). The actual cost to increase provider rates depends on the methodology used to determine how rates are phased-in during the required timeframe.

The state will incur additional costs to align adult and pediatric rates to achieve parity between rates for the same health care services. The fiscal impact for parity among all rates cannot be determined at this

time. For context, increasing adult dental rates to pediatric rates is estimated to cost approximately $12.3 million based on FY 24 data.

DSS will incur additional costs associated with rebasing FQHC encounter rates (by 12/31/25) based on 2024 cost reports and annual patient encounters. The bill also requires rather than allows DSS to adjust encounter rates based on a change in scope. The bill prohibits (1) DSS from considering certain factors when reviewing if an FQHC has incurred additional costs associated with an increase in scope of services, and (2) new encounter rates from being lower than current rates and from interfering in any annual adjustment made for inflation. The actual fiscal impact will depend on 2024 cost reports and encounter data and changes in scope. For context, more than $280 million in total Medicaid payments are made to FQHCs annually.

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

sHB 7191

AN ACT CONCERNING MEDICAID RATE INCREASES, PLANNING AND SUSTAINABILITY.

SUMMARY

This bill requires the Department of Social Services (DSS) commissioner, beginning July 1, 2025, and within available appropriations, to phase in Medicaid provider reimbursement rate increases in accordance with the Medicaid rate study (see BACKGROUND). Under the bill, by June 30, 2028, all Medicaid reimbursement rates must equal (1) at least 75% of the most recent Medicare rate for the same health care service or (2) for services without a corresponding Medicare rate, a percentage of the Medicaid rate study's five-state benchmark that results in an equivalent rate increase. Beginning June 30, 2028, the bill requires the commissioner to annually adjust rates (1) to stay aligned with these measures or (2) by any percentage increase in the Medicare Economic Index (a federally calculated inflation measure for physicians' practice costs and wage levels).

When increasing or adjusting rates, the bill requires the commissioner to give equal reimbursement for a given health care service regardless of if it is provided to an adult or pediatric patient. Additionally, the bill requires the commissioner to streamline and consolidate existing reimbursement fee schedules so that every provider is reimbursed using the same schedule. In doing so, the commissioner must incorporate, to the extent applicable, the most recent Medicare fee schedule for services covered by both Medicare and Medicaid.

The bill requires the Council on Medical Assistance Program Oversight (MAPOC; see BACKGROUND) to develop and implement an ongoing systematic review of Medicaid provider reimbursement rates to ensure rates are adequate to sustain a provider pool sufficient to

provide Medicaid members access to high-quality care. Beginning by January 15, 2026, MAPOC must annually report to the Appropriations and Human Services committees recommendations on appropriations needed to ensure Medicaid providers' compensation aligns with the bill's rate increases.

The bill also requires the DSS commissioner to, by December 1, 2025, rebase federally qualified health centers' (FQHC; see below) encounter rates. It also outlines procedures for an FQHC to (1) inform DSS of a change in scope of services and (2) appeal DSS's rate adjustment decision. Beginning January 1, 2026, the bill requires the commissioner to annually increase FQHCs' Medicaid reimbursement rates by the Medicare Economic Index's most recent percentage increase.

Lastly, the bill requires the DSS commissioner to post notice of intent to adopt regulations on the eRegulations System instead of in the Connecticut Law Journal, as under current law.

EFFECTIVE DATE: July 1, 2025, except the provision requiring DSS to annually increase FQHCs' Medicaid reimbursement rates is effective January 1, 2026

FEDERALLY QUALIFIED HEALTH CENTERS

An FQHC, also known as a community health center, is an outpatient healthcare organization that provides comprehensive primary care (including physical, mental, and dental health) and support services to underserved populations regardless of ability to pay or insurance status. The bill requires DSS to, by December 31, 2025, rebase each FQHC's encounter rate based on the center's costs for fiscal year 2024 divided by the number of patient encounters for a particular service during the same fiscal year. The new encounter rate must not (1) be lower than the rate received before rebasing or (2) interfere with any annual inflationary rate adjustment.

Additionally, under the bill, DSS must adjust an FQHC's rate upon receiving written notification of an increase or decrease in the center's scope of services. Current law allows, but does not require, DSS to do

so.

Scope of Services Increases

The bill requires an FQHC to request a rate adjustment, using forms DSS provides for this purpose, if it incurs additional direct or indirect costs from an increase in its scope of services. Within 30 days of receiving the request, DSS must meet with the FQHC's representatives to review it. If the FQHC's scope of services increase is related to an amended federally approved project, the FQHC must give DSS a copy of the project's amendment. Within 30 days after the meeting DSS must issue a rate adjustment decision.

The bill prohibits DSS from considering the following factors in determining if an FQHC has incurred additional costs from an increase in scope of services:

1. the center's encounter rates for other service categories, including dental, behavioral health, or medical services;
2. whether the center is showing a profit;
3. whether the center receives grants or other third-party reimbursements;
4. whether the center's current encounter rates are higher or lower than encounter rates of similar FQHCs; and
5. any other factor unrelated to increased costs associated with an increase in scope of services.

Under the bill, an FQHC may appeal DSS's rate adjustment decision within 10 days after receiving it. If the FQHC files an appeal, within 90 days after doing so, it must submit its aggrievement items to DSS. Upon receiving an appeal, DSS must (1) review it and request any clarifying or supporting information from the FQHC and (2) issue its decision and rationale no later than 120 days after the FQHC's rate adjustment request. If DSS's decision is delayed, any approved rate adjustment will be retroactive to the date the decision should have been issued under

the provisions of this bill.

Scope of Services Decrease

The bill requires an FQHC to (1) notify DSS in writing if there is a decrease in its scope of services and (2) provide the department any additional information within 30 days after receiving a reasonable request from the department to do so. If the request for additional information relates to a discontinued service for which the FQHC is receiving additional reimbursement due to a prior rate adjustment for an increase in scope of service, the bill authorizes DSS to impose a fine of $500 per day that the FQHC does not provide the information.

BACKGROUND

Medicaid Rate Study

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 (i.e. the five-state benchmark).

Council on Medical Assistance Program Oversight (MAPOC)

The law charges this council with monitoring and advising DSS on various aspects of the Medicaid program (CGS § 17b-28). MAPOC includes legislators, consumers, advocates, health care providers, administrative service organization representatives, and state agency personnel. It generally meets monthly and has subcommittees that meet separately.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 21 Nay 1 (03/13/2025)