General Assembly **Substitute Bill No. 7191**

January Session, 2025

* HB07191HS 031725 *

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 Section 17b-245d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):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