



General Assembly

January Session, 2025

Substitute Bill No. 7191



***AN ACT CONCERNING MEDICAID RATE INCREASES, PLANNING
AND SUSTAINABILITY.***

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

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

7 (b) Within available appropriations, the Commissioner of Social
8 Services shall phase in increases to Medicaid provider rates in
9 accordance with the Medicaid rate study. The commissioner shall phase
10 in the rate increases commencing on July 1, 2025, such that by June 30,
11 2028, all such rates equal (1) not less than seventy-five per cent of the
12 most recent Medicare rates for the same health care services, or (2) for
13 such services with no corresponding Medicare rates, a percentage of the
14 five-state benchmark that results in an equivalent rate increase.

15 (c) On and after June 30, 2028, the commissioner shall adjust such
16 rates every year (1) to not less than seventy-five per cent of the most
17 recent Medicare rates for the same health care services, (2) to an
18 equivalent percentage of the five-state rate benchmark for such services
19 with no corresponding Medicare rates, or (3) by increasing such rates by

20 any percentage increase in the Medicare Economic Index, as defined in
21 section 3 of this act, in the discretion of the commissioner.

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

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

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 Section 17b-245d of the general statutes is repealed and the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

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

44 [(b) Each federally qualified health center shall provide to the
45 Department of Social Services a copy of its original scope of project, as
46 approved by the federal Health Resources and Services Administration,
47 and all subsequently approved amendments to its original scope of
48 project. Each federally qualified health center shall notify the
49 department, in writing, of all approvals for additional amendments to
50 its scope of project, and provide to the department a copy of such
51 amended scope of project, not later than thirty days after such

52 approvals.

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

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

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

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

77 (c) The Department of Social Services shall adjust a federally qualified
78 health center's encounter rate based upon an increase or decrease in the
79 scope of services furnished in a written notification to the department
80 by the federally qualified health center, in accordance with 42 USC
81 1396a(bb)(3)(B), following receipt by the department of the written
82 notification. If a federally qualified health center experiences additional
83 direct or indirect costs as a result of an increase in such center's scope of

84 services, it shall request a rate adjustment based upon the increase in
85 scope of services on forms issued by the department for such purpose.
86 Not later than thirty days after receipt of such rate adjustment request,
87 the department shall meet with representatives of the federally qualified
88 health center for the purpose of reviewing the center's additional direct
89 and indirect costs relating to the increase in scope of services. If the
90 increase in scope of services is related to amendments approved by the
91 federal Health Resources and Services Administration to the federally
92 qualified health center's original scope of project, the federally qualified
93 health center shall provide to the department a copy of such amended
94 scope of project. Not later than thirty days after meeting with the
95 federally qualified health center, the department shall issue a detailed
96 rate adjustment decision relating to the increase in scope of services. In
97 conducting such review, the department shall not consider the
98 following factors as relevant or determinative with respect to whether
99 the federally qualified health center incurred additional direct or
100 indirect costs associated with the increase in scope of services: (1) The
101 federally qualified health center's encounter rates for other service
102 categories, including dental, behavioral health or medical services; (2)
103 whether or not the federally qualified health center is showing a profit;
104 (3) whether or not the federally qualified health center is in receipt of
105 grant moneys or other third-party reimbursements; (4) whether the
106 federally qualified health center's current encounter rates are higher or
107 lower than encounter rates of similar federally qualified health centers;
108 and (5) any other factor unrelated to increased costs associated with an
109 increase in change of scope of services. A federally qualified health
110 center may appeal the department's rate adjustment decision not later
111 than ten days after it receives notice of the rate adjustment. Not later
112 than ninety days after filing its rate adjustment appeal notice, the
113 federally qualified health center shall submit its items of aggrievement
114 to the department. Upon review and an opportunity for the department
115 to request any clarifying or supporting information from the federally
116 qualified health center, the department shall issue its decision, along
117 with its rationale, not later than one hundred twenty days after the
118 federally qualified health center's rate adjustment request. If the

119 department's decision is delayed, any approved rate adjustment shall be
120 retroactive to the date on which the decision should have been issued
121 pursuant to this subsection.

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

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

142 Sec. 3. (NEW) (*Effective January 1, 2026*) The Commissioner of Social
143 Services shall increase rates of Medicaid reimbursement for federally
144 qualified health centers not later than January first annually by the most
145 recent percentage increase in the Medicare Economic Index. For
146 purposes of this section, "Medicare Economic Index" means a measure
147 of inflation for physicians with respect to their practice costs and wage
148 levels as calculated by the Centers for Medicare and Medicaid Services.

149 Sec. 4. (NEW) (*Effective July 1, 2025*) (a) The Council on Medical
150 Assistance Program Oversight, established pursuant to section 17b-28

151 of the general statutes, shall develop and implement an ongoing
152 systemic review of Medicaid provider reimbursement rates to ensure
153 rates are adequate to sustain a sufficient provider pool to provide
154 Medicaid member access to high-quality care.

155 (b) Not later than January 15, 2026, and annually thereafter, the
156 council shall file a report, in accordance with the provisions of section
157 11-4a of the general statutes, with the joint standing committees of the
158 General Assembly having cognizance of matters relating to
159 appropriations and the budgets of state agencies and human services.
160 The report shall include the council's recommendations on necessary
161 appropriations to ensure Medicaid providers are compensated for
162 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	<i>July 1, 2025</i>	New section
Sec. 2	<i>July 1, 2025</i>	17b-245d
Sec. 3	<i>January 1, 2026</i>	New section
Sec. 4	<i>July 1, 2025</i>	New section

HS *Joint Favorable Subst. -LCO*

APP *Joint Favorable*