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)