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## OLR Bill Analysis

**sHB 5561 (File 445, as amended by House "A")\***

### **AN ACT CONCERNING MEDICAID RATE INCREASES FOR CERTAIN PROVIDERS.**

TABLE OF CONTENTS:

#### SUMMARY

##### § 1 — FIVE-YEAR MEDICAID PROVIDER RATE REVIEW

*Requires DSS to (1) create a five-year process to review Medicaid provider reimbursement rates and start using the process by January 1, 2027, and (2) annually report to the Appropriations and Human Services committees on the review process starting by January 15, 2028*

##### § 2 — MAPOC MEMBERSHIP

*Adds a representative of the Connecticut Dental Health Partnership's Dental Policy Advisory Council to the membership of MAPOC*

##### § 3 — 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*

##### § 4 — PAIN MANAGEMENT FOR MEDICAID BENEFICIARIES

*Requires opioid prescribers to consider the feasibility of non-opioid pain treatment options for Medicaid beneficiaries; allows DSS to adopt implementing regulations*

##### § 5 — WORKING GROUP ON COMPENSATING SPOUSES PROVIDING PERSONAL CARE ASSISTANCE

*Establishes a working group to study the feasibility of allowing spouses to be compensated for providing PCA for spouses enrolled in Medicaid home care programs*

#### **SUMMARY**

This bill makes various unrelated changes affecting Medicaid services and provider reimbursement, including the following:

1. requiring the Department of Social Services (DSS) commissioner to create a five-year process for reviewing Medicaid reimbursement rates that examines provider reimbursements and generally benchmarks rates to those for the same services paid by Medicare (§ 1);

2. adds a representative of the Connecticut Dental Health Partnership's Dental Policy Advisory Council to the membership of the Council on Medical Assistance Program Oversight (MAPOC) (§ 2);
3. 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 (§ 3);
4. requires opioid prescribers to consider the feasibility of non-opioid pain treatment options for Medicaid beneficiaries; and allows DSS to adopt implementing regulations (§ 4); and
5. establishes a working group to study the feasibility of allowing spouses to be compensated for providing personal care assistance for spouses enrolled in Medicaid home care programs (§ 5).

\*House Amendment "A" replaces the underlying bill (File 445) and adds provisions on a (1) five-year Medicaid provider rate review and (2) Personal Care Assistance (PCA) working group. It eliminates provisions on (1) Medicaid reimbursement for cognitive impairment; (2) Medicaid non-emergency dental services; (3) safety net pediatric dental clinics; (4) Medicaid reimbursement rates for optometrists, doulas, psychologists, acupuncturists, and emergency room physicians; (5) DSS payments for home health care services and homemaker-companion and meals-on-wheels providers; (6) Gaylord Specialty Care Medicaid reimbursement rate; (7) Medicaid coverage for non-opioid pain medications; (8) pain management training for opioid prescribers; (9) Medicaid reimbursement for family planning services; (10) DSS payments to non-ICF-ID (intermediate care facilities for individuals with intellectual disabilities) boarding homes; (11) reinvesting provider contract savings; (12) a study on state program services provided by nonprofits; and (13) Medicaid reimbursement for durable medical equipment, orthotics, prosthetics, and complex rehabilitation technology. It also adds one, instead of two, Connecticut Dental Partnership representatives to

MAPOC.

EFFECTIVE DATE: July 1, 2026, except provisions on (1) biomarker testing (§ 3) and (2) the PCA working group (§ 5) take effect upon passage.

**§ 1 — FIVE-YEAR MEDICAID PROVIDER RATE REVIEW**

*Requires DSS to (1) create a five-year process to review Medicaid provider reimbursement rates and start using the process by January 1, 2027, and (2) annually report to the Appropriations and Human Services committees on the review process starting by January 15, 2028*

The bill requires the DSS commissioner to create a five-year process for regularly and predictably reviewing Medicaid reimbursement rates. The process must (1) examine Medicaid provider reimbursements and (2) benchmark the rates to those for the same services paid by Medicare, when possible and under available appropriations.

It requires the commissioner to review Medicaid provider rates using this new process starting by January 1, 2027.

Under the bill, the new rate review process may include evaluating rates paid in individual parts of the Medicaid program, so long as all rates are reviewed by January 1, 2032. As part of this process, the commissioner may increase and rebase rates at the end of each calendar year using an applicable, more current Medicare base year to (1) strengthen access to care, (2) improve care quality and outcomes, and (3) reduce spending on acute care services. The commissioner must do this in consultation with the Office of Policy and Management secretary and only if funds are appropriated for this purpose.

At the end of the five-year review process, the bill requires the commissioner to start a new review using the same evaluation schedule and repeat the process every five years. As part of the process, the commissioner must consolidate existing provider and service fee schedules so that each provider is reimbursed for the same service at the same rate. When doing so, she must consider, among other things and if applicable, the most recent Medicare fee schedule for services covered by Medicare and Medicaid.

Additionally, as part of the new rate review process, the bill requires the commissioner to develop a way to accept public comment that, at least, allows people to submit written and oral comments. The commissioner must allow public members to submit these comments (1) at public meetings held at a time and place she chooses and (2) at MAPOC meetings.

Under the bill, the commissioner must annually report, starting by January 15, 2028, to the Appropriations and Human Services committees on the rate review process. The report must include (1) recommendations on appropriations needed to increase Medicaid provider rates according to the review and (2) a description of the data and methods used in making the recommendations.

## **§ 2 — MAPOC MEMBERSHIP**

*Adds a representative of the Connecticut Dental Health Partnership's Dental Policy Advisory Council to the membership of MAPOC*

The bill increases, from 50 to 51, MAPOC's membership by adding a representative of the Connecticut Dental Health Partnership's Dental Policy Advisory Council. (It does not specify who appoints this member.)

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.

## **§ 3 — 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).

#### **§ 4 — PAIN MANAGEMENT FOR MEDICAID BENEFICIARIES**

*Requires opioid prescribers to consider the feasibility of non-opioid pain treatment options for Medicaid beneficiaries; allows DSS to adopt implementing regulations*

The bill requires a prescribing practitioner who prescribes an opioid drug to treat a Medicaid beneficiary's pain to 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.

#### **§ 5 — WORKING GROUP ON COMPENSATING SPOUSES PROVIDING PERSONAL CARE ASSISTANCE**

*Establishes a working group to study the feasibility of allowing spouses to be compensated for providing PCA for spouses enrolled in Medicaid home care programs*

The bill establishes a six-member working group to study the feasibility of allowing spouses to be compensated for providing PCA for spouses enrolled in Medicaid home care programs.

Under the bill, the working group members include (1) the DSS commissioner, Office of Policy and Management secretary, and Human Services Committee chairpersons or their designees and (2) a consumer of PCA services and representative of an organization providing these services, each appointed by the Human Services Committee

chairpersons.

The bill requires the Human Services Committee chairpersons to (1) select the working group chairperson and (2) make their appointments within 30 days after the bill's passage. The chairperson must schedule the working group's first meeting within 60 days after the bill takes effect.

Under the bill, the Human Services Committee administrative staff serve in that capacity for the working group.

The bill requires the working group to report its findings and recommendations to the Human Services Committee by January 1, 2027. It terminates on the date it submits the report or January 1, 2027, whichever is later.

## **BACKGROUND**

### ***Related Bills***

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.

sSB 1, § 449, as amended by Senate Amendment "A," requires the Human Services Committee chairpersons to appoint a health care worker labor organization representative to MAPOC.

sSB 1, § 450, as amended by Senate "A," requires DSS, when reviewing Medicaid rates, to include rates required to be studied under the recent Medicaid rate study and with no corresponding Medicare code.

sSB 499 (File 488), 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)