



General Assembly

February Session, 2026

***Raised Bill No. 5561***

LCO No. 2783



Referred to Committee on HUMAN SERVICES

Introduced by:  
(HS)

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

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

1 Section 1. (*Effective July 1, 2026*) (a) As used in this section, (1)  
2 "cognitive impairment" means a deficiency in (A) short-term memory or  
3 long-term memory, (B) orientation as to person, place and time, or (C)  
4 deductive or abstract reasoning; and (2) "clinician" means a physician,  
5 physician assistant, nurse practitioner, clinical nurse specialist or  
6 certified nurse-midwife licensed to practice in the state.

7 (b) The Commissioner of Social Services shall amend the Medicaid  
8 state plan to incorporate the Medicare billing code reimbursement  
9 criteria for a cognitive assessment and care planning ordered by a  
10 clinician for a patient age sixty-four or younger who is enrolled in the  
11 Medicaid program and shows signs of cognitive impairment.

12 Sec. 2. Subsection (a) of section 17b-282c of the general statutes is  
13 repealed and the following is substituted in lieu thereof (*Effective July 1,*  
14 *2026*):

15 (a) All nonemergency dental services provided under the  
16 Department of Social Services' dental programs, as described in section  
17 17b-282b, shall be subject to prior authorization. Nonemergency  
18 services that are exempt from the prior authorization process shall  
19 include diagnostic, prevention, basic restoration procedures and  
20 nonsurgical extractions that are consistent with standard and reasonable  
21 dental practices. Payment for nonemergency dental services shall not  
22 exceed one thousand dollars per calendar year for an individual adult,  
23 provided prevention services such as oral exams and dental cleanings  
24 and services determined to be medically necessary, as defined in section  
25 17b-259b, including dentures, shall not be subject to such payment cap.  
26 Dental benefit limitations shall apply to each client regardless of the  
27 number of providers serving the client. The commissioner may recoup  
28 payments for services that are determined not to be for an emergency  
29 condition or otherwise in excess of what is medically necessary. The  
30 commissioner shall periodically, but not less than quarterly, review  
31 payments for emergency dental services and basic restoration  
32 procedures for appropriateness of payment. For the purposes of this  
33 section, "emergency condition" means a dental condition manifesting  
34 itself by acute symptoms of sufficient severity, including severe pain,  
35 such that a prudent layperson, who possesses an average knowledge of  
36 health and medicine, could reasonably expect the absence of immediate  
37 dental attention to result in placing the health of the individual, or with  
38 respect to a pregnant woman, the health of the woman or her unborn  
39 child, in serious jeopardy, cause serious impairment to body functions  
40 or cause serious dysfunction of any body organ or part.

41 Sec. 3. Subsection (a) of section 17b-282d of the general statutes is  
42 repealed and the following is substituted in lieu thereof (*Effective July 1,*  
43 *2026*):

44 (a) The Commissioner of Social Services shall modify the extent of  
45 nonemergency adult dental services provided under the Medicaid  
46 program. Such modifications shall include, but are not limited to,  
47 providing one periodic dental exam, one dental cleaning, periodontal

48 therapy and one set of bitewing x-rays each year for a healthy adult. For  
49 purposes of this section, "healthy adult" means a person twenty-one  
50 years of age or older for whom there is no evidence indicating that  
51 dental disease is an aggravating factor for the person's overall health  
52 condition.

53 Sec. 4. Subsection (c) of section 17b-28 of the 2026 supplement to the  
54 general statutes is repealed and the following is substituted in lieu  
55 thereof (*Effective July 1, 2026*):

56 (c) On and after October 31, 2017, the council shall be composed of  
57 the following members:

58 (1) The chairpersons and ranking members of the joint standing  
59 committees of the General Assembly having cognizance of matters  
60 relating to aging, human services, public health and appropriations and  
61 the budgets of state agencies, or their designees;

62 (2) Five appointed by the speaker of the House of Representatives,  
63 one of whom shall be a member of the General Assembly, one of whom  
64 shall be a community provider of adult Medicaid health services, one of  
65 whom shall be a recipient of Medicaid benefits for the aged, blind and  
66 disabled or an advocate for such a recipient, one of whom shall be a  
67 representative of the state's federally qualified health clinics and one of  
68 whom shall be a member of the Connecticut Hospital Association;

69 (3) Five appointed by the president pro tempore of the Senate, one of  
70 whom shall be a member of the General Assembly, one of whom shall  
71 be a representative of the home health care industry, one of whom shall  
72 be a primary care medical home provider, one of whom shall be an  
73 advocate for Department of Children and Families foster families and  
74 one of whom shall be a representative of the business community with  
75 experience in cost efficiency management;

76 (4) Three appointed by the majority leader of the House of  
77 Representatives, one of whom shall be an advocate for persons with

78 substance abuse disabilities, one of whom shall be a Medicaid dental  
79 provider and one of whom shall be a representative of the for-profit  
80 nursing home industry;

81 (5) Three appointed by the majority leader of the Senate, one of whom  
82 shall be a representative of school-based health centers, one of whom  
83 shall be a recipient of benefits under the HUSKY Health program and  
84 one of whom shall be a physician who serves Medicaid clients;

85 (6) Three appointed by the minority leader of the House of  
86 Representatives, one of whom shall be an advocate for persons with  
87 disabilities, one of whom shall be a dually eligible Medicaid-Medicare  
88 beneficiary or an advocate for such a beneficiary and one of whom shall  
89 be a representative of the not-for-profit nursing home industry;

90 (7) Three appointed by the minority leader of the Senate, one of  
91 whom shall be a low-income adult recipient of Medicaid benefits or an  
92 advocate for such a recipient, one of whom shall be a representative of  
93 hospitals and one of whom shall be a representative of the business  
94 community with experience in cost efficiency management;

95 (8) The executive director of the Commission on Women, Children,  
96 Seniors, Equity and Opportunity, or the executive director's designee;

97 (9) A member of the Commission on Women, Children, Seniors,  
98 Equity and Opportunity, designated by the executive director of said  
99 commission;

100 (10) A representative of the Long-Term Care Advisory Council;

101 (11) The Commissioners of Social Services, Children and Families,  
102 Public Health, Developmental Services, Aging and Disability Services  
103 and Mental Health and Addiction Services, or their designees, who shall  
104 be ex-officio nonvoting members;

105 (12) The Comptroller, or the Comptroller's designee, who shall be an  
106 ex-officio nonvoting member;

107 (13) The Secretary of the Office of Policy and Management, or the  
108 secretary's designee, who shall be an ex-officio nonvoting member;  
109 [and]

110 (14) One representative of an administrative services organization  
111 which contracts with the Department of Social Services in the  
112 administration of the Medicaid program, who shall be a nonvoting  
113 member; and

114 (15) Two representatives of the Connecticut Dental Health  
115 Partnership, appointed by the chairpersons of the joint standing  
116 committee of the General Assembly having cognizance of matters  
117 relating to human services.

118 Sec. 5. (*Effective July 1, 2026*) As used in this section, "safety net  
119 pediatric dental clinic" means a nonprofit, public or community-based  
120 provider that offers dental care to children from low-income or  
121 uninsured families, often regardless of ability to pay. The Commissioner  
122 of Social Services shall amend the Medicaid state plan to increase  
123 Medicaid rates of reimbursement for services provided by a safety net  
124 pediatric dental clinic to not less than such rates for such services  
125 provided by a federally qualified health center. Within available  
126 appropriations, the commissioner may establish a supplemental  
127 payment pool to reimburse a safety net pediatric dental clinic for  
128 uncompensated care.

129 Sec. 6. (*Effective from passage*) As used in this section, "biomarker  
130 testing" has the same meaning as provided in section 17b-278m of the  
131 general statutes. Not later than sixty days after the effective date of this  
132 section, the Commissioner of Social Services shall update the Medicaid  
133 fee schedule to include current procedural terminology and proprietary  
134 laboratory analysis codes for biomarker testing coverage required  
135 pursuant to section 17b-278m of the general statutes.

136 Sec. 7. (*Effective July 1, 2026*) The Commissioner of Social Services  
137 shall adjust rates of reimbursement under the Medicaid program so that

138 an optometrist licensed pursuant to chapter 380 of the general statutes  
139 receives the same rate as an ophthalmologist licensed pursuant to  
140 chapter 370 of the general statutes for performing the same medical  
141 service or procedure. The commissioner shall seek federal approval to  
142 amend the Medicaid state plan, if necessary, to adjust the rate of  
143 reimbursement in accordance with this section.

144       Sec. 8. (*Effective July 1, 2026*) The Commissioner of Social Services,  
145 within available appropriations, shall amend the Medicaid state plan to  
146 increase rates of reimbursement for services provided by a doula  
147 certified pursuant to chapter 377a of the general statutes, a psychologist  
148 licensed pursuant to chapter 383 of the general statutes, an  
149 acupuncturist licensed pursuant to chapter 384c of the general statutes  
150 and an emergency room physician licensed pursuant to chapter 370 of  
151 the general statutes.

152       Sec. 9. Section 17b-242 of the general statutes is repealed and the  
153 following is substituted in lieu thereof (*Effective July 1, 2026*):

154       (a) The Department of Social Services shall determine the rates to be  
155 paid to home health care agencies and home health aide agencies by the  
156 state or any town in the state for persons aided or cared for by the state  
157 or any such town. The Commissioner of Social Services shall establish a  
158 fee schedule for home health services to be effective on and after July 1,  
159 1994. The commissioner may annually modify such fee schedule if such  
160 modification is needed to ensure that the conversion to an  
161 administrative services organization is cost neutral to home health care  
162 agencies and home health aide agencies in the aggregate and ensures  
163 patient access. Utilization may be a factor in determining cost neutrality.  
164 The commissioner shall increase the fee schedule for home health  
165 services provided under the Connecticut home-care program for the  
166 elderly established under section 17b-342, effective July 1, 2000, by two  
167 per cent over the fee schedule for home health services for the previous  
168 year. On and after January 1, 2024, the commissioner shall increase the  
169 fee schedule for complex care nursing services provided to individuals

170 over the age of eighteen such that the rate of reimbursement is equal to  
171 the rate for such services provided to individuals age eighteen and  
172 under. There shall be no differential in fees paid for such services based  
173 on the age of the patient. On and after July 1, 2026, until June 30, 2031,  
174 the commissioner, within available appropriations, shall annually  
175 increase the fee schedule for all home health services by ten per cent.  
176 The commissioner [may] shall increase any fee payable to a home health  
177 care agency or home health aide agency upon the application of such an  
178 agency evidencing extraordinary costs related to (1) serving persons  
179 with AIDS; (2) high-risk maternal and child health care; (3) safety escort  
180 services for nurses making home visits; or (4) extended hour services. In  
181 no case shall any rate or fee exceed the charge to the general public for  
182 similar services. A home health care agency or home health aide agency  
183 which, due to any material change in circumstances, is aggrieved by a  
184 rate determined pursuant to this subsection may, within ten days of  
185 receipt of written notice of such rate from the Commissioner of Social  
186 Services, request in writing a hearing on all items of aggrievement. The  
187 commissioner shall, upon the receipt of all documentation necessary to  
188 evaluate the request, determine whether there has been such a change  
189 in circumstances and shall conduct a hearing if appropriate. The  
190 Commissioner of Social Services shall adopt regulations, in accordance  
191 with chapter 54, to implement the provisions of this subsection. The  
192 commissioner may implement policies and procedures to carry out the  
193 provisions of this subsection while in the process of adopting  
194 regulations, provided notice of intent to adopt the regulations is posted  
195 on the eRegulations System not later than twenty days after the date of  
196 implementing the policies and procedures. Such policies and  
197 procedures shall be valid for not longer than nine months. For purposes  
198 of this subsection, "complex care nursing services" means intensive,  
199 specialized nursing services provided to a patient with complex care  
200 needs who requires skilled nursing care at home.

201 (b) The Department of Social Services shall monitor the rates charged  
202 by home health care agencies and home health aide agencies. Such

203 agencies shall file annual cost reports and service charge information  
204 with the department.

205 (c) The home health services fee schedule shall include a fee for the  
206 administration of medication, which shall apply when the purpose of a  
207 nurse's visit is limited to the administration of medication.  
208 Administration of medication may include, but is not limited to, blood  
209 pressure checks, glucometer readings, pulse rate checks and similar  
210 indicators of health status. The fee for medication administration shall  
211 include administration of medications while the nurse is present, the  
212 pre-pouring of additional doses that the client will self-administer at a  
213 later time and the teaching of self-administration. The department shall  
214 not pay for medication administration in addition to any other nursing  
215 service at the same visit. The department may establish prior  
216 authorization requirements for this service. Before implementing such  
217 change, the Commissioner of Social Services shall consult with the  
218 chairpersons of the joint standing committees of the General Assembly  
219 having cognizance of matters relating to public health and human  
220 services. The commissioner shall monitor Medicaid home health care  
221 savings achieved through the implementation of nurse delegation of  
222 medication administration pursuant to section 19a-492e. If, by January  
223 1, 2016, the commissioner determines that the rate of savings is not  
224 adequate to meet the annualized savings assumed in the budget for the  
225 biennium ending June 30, 2017, the department may reduce rates for  
226 medication administration as necessary to achieve the savings assumed  
227 in the budget. Prior to any rate reduction, the department shall report to  
228 the joint standing committees of the General Assembly having  
229 cognizance of matters relating to appropriations and the budgets of state  
230 agencies and human services provider specific cost and utilization trend  
231 data for those patients receiving medication administration. Should the  
232 department determine it necessary to reduce medication administration  
233 rates under this section, it shall examine the possibility of establishing a  
234 separate Medicaid supplemental rate or a pay-for-performance program  
235 for those providers, as determined by the commissioner, who have

236 established successful nurse delegation programs.

237 (d) The home health services fee schedule established pursuant to  
238 subsection (c) of this section shall include rates for psychiatric nurse  
239 visits. There shall be no reduction in rates for subsequent visits by the  
240 same nurse to the same address to provide behavioral health services.

241 (e) The Department of Social Services, when processing or auditing  
242 claims for reimbursement submitted by home health care agencies and  
243 home health aide agencies shall, in accordance with the provisions of  
244 chapter 15, accept electronic records and records bearing the electronic  
245 signature of a licensed physician or licensed practitioner of a healthcare  
246 profession that has been submitted to the home health care agency or  
247 home health aide agency.

248 (f) If the electronic record or signature that has been transmitted to a  
249 home health care agency or home health aide agency is illegible or the  
250 department is unable to determine the validity of such electronic record  
251 or signature, the department shall review additional evidence of the  
252 accuracy or validity of the record or signature, including, but not limited  
253 to, (1) the original of the record or signature, or (2) a written statement,  
254 made under penalty of false statement, from (A) the licensed physician  
255 or licensed practitioner of a health care profession who signed such  
256 record, or (B) if such licensed physician or licensed practitioner of a  
257 health care profession is unavailable, the medical director of the agency  
258 verifying the accuracy or validity of such record or signature, and the  
259 department shall make a determination whether the electronic record or  
260 signature is valid.

261 (g) The Department of Social Services, when auditing claims  
262 submitted by home health care agencies and home health aide agencies,  
263 shall consider any signature from a licensed physician or licensed  
264 practitioner of a health care profession that may be required on a plan  
265 of care for home health services, to have been provided in timely fashion  
266 if (1) the document bearing such signature was signed prior to the time

267 when such agency seeks reimbursement from the department for  
268 services provided, and (2) verbal or telephone orders from the licensed  
269 physician or licensed practitioner of a health care profession were  
270 received prior to the commencement of services covered by the plan of  
271 care and such orders were subsequently documented. Nothing in this  
272 subsection shall be construed as limiting the powers of the  
273 Commissioner of Public Health to enforce the provisions of sections 19-  
274 13-D73 and 19-13-D74 of the regulations of Connecticut state agencies  
275 and 42 CFR 484.18(c).

276 (h) Any order for home health care services covered by the  
277 Department of Social Services may be issued by any licensed  
278 practitioner authorized to issue such an order pursuant to section 19a-  
279 496a. Any Department of Social Services regulation, policy or procedure  
280 that applies to a physician who orders such home health care services,  
281 including related provisions such as review and approval of care plans  
282 for home health care services, shall apply to any licensed practitioner  
283 authorized to order such home health care services pursuant to section  
284 19a-496a.

285 (i) For purposes of this section, "licensed practitioner of a healthcare  
286 profession" has the same meaning as "licensed practitioner" in section  
287 21a-244a.

288 Sec. 10. Section 17b-343 of the general statutes is repealed and the  
289 following is substituted in lieu thereof (*Effective July 1, 2026*):

290 The Commissioner of Social Services shall establish annually the  
291 maximum allowable rate to be paid by agencies for homemaker  
292 services, chore person services, companion services, respite care, meals  
293 on wheels, adult day care services, case management and assessment  
294 services, transportation, mental health counseling and elderly foster  
295 care. The Commissioner of Social Services shall prescribe uniform forms  
296 on which agencies providing such services shall report their costs for  
297 such services. Such rates shall be determined on the basis of a reasonable

298 payment for necessary services rendered. The maximum allowable rates  
299 established by the Commissioner of Social Services for the Connecticut  
300 home-care program for the elderly established under section 17b-342  
301 shall constitute the rates required under this section until revised in  
302 accordance with this section. The Commissioner of Social Services shall  
303 establish a fee schedule, to be effective on and after July 1, 1994, for  
304 homemaker services, chore person services, companion services, respite  
305 care, meals on wheels, adult day care services, case management and  
306 assessment services, transportation, mental health counseling and  
307 elderly foster care. The commissioner may annually increase the fee  
308 schedule based on an increase in the cost of services. The commissioner  
309 shall increase the fee schedule effective July 1, 2000, by not less than five  
310 per cent, for adult day care services. The commissioner shall increase the  
311 fee schedule effective July 1, 2011, by four dollars per person, per day  
312 for adult day care services. For each of the fiscal years ending June 30,  
313 2027, and June 30, 2028, the commissioner, within available  
314 appropriations, shall increase the fee schedule for homemaker-  
315 companion services by thirteen per cent. For each of the fiscal years  
316 ending June 30, 2029, June 30, 2030, and June 30, 2031, the commissioner,  
317 within available appropriations, shall increase such fee schedule by ten  
318 per cent. The commissioner shall increase the fee schedule effective July  
319 1, 2019, for meals on wheels by ten per cent over the fee schedule for  
320 meals on wheels for the previous fiscal year. Effective July 1, 2020, and  
321 annually thereafter, the commissioner may increase the fee schedule for  
322 meals on wheels providers serving participants in the Connecticut  
323 home-care program for the elderly by, at a minimum, the cost-of-living  
324 adjustment as measured by the consumer price index. Effective July 1,  
325 2026, the commissioner, within available appropriations, shall increase  
326 the fee schedule for meals on wheels providers by four and nine-tenths  
327 per cent. The commissioner may increase any fee payable to a meals on  
328 wheels provider upon the application of such provider evidencing  
329 extraordinary costs related to delivery of meals on wheels in sparsely  
330 populated rural regions of the state. Nothing contained in this section  
331 shall authorize a payment by the state to any agency for such services in

332 excess of the amount charged by such agency for such services to the  
333 general public.

334 Sec. 11. (*Effective July 1, 2026*) Within available appropriations, the  
335 Commissioner of Social Services shall increase the Medicaid  
336 reimbursement rate for Gaylord Specialty Care by two hundred six  
337 dollars per patient per day to achieve rate parity for long-term acute care  
338 hospitals in the state.

339 Sec. 12. (NEW) (*Effective July 1, 2026*) (a) As used in this section,  
340 "nonopioid drug" means a nonopioid prescription drug approved by the  
341 United States Food and Drug Administration for the treatment or  
342 management of pain.

343 (b) The Department of Social Services shall not disadvantage or  
344 discourage a nonopioid drug with respect to coverage in the Medicaid  
345 program relative to any opioid drug for the treatment or management  
346 of pain. For purposes of this section, disadvantaging or discouragement  
347 of a nonopioid drug includes, but is not limited to (1) imposing more  
348 restrictive coverage criteria on any such nonopioid drug than the least  
349 restrictive coverage criteria imposed on an opioid drug, or (2)  
350 establishing more restrictive or more extensive utilization management  
351 requirements, including, but not limited to, more restrictive or more  
352 extensive prior authorization or step therapy requirements for such  
353 nonopioid drug than the least restrictive or extensive utilization  
354 management requirements applicable to any opioid drug.

355 Sec. 13. (NEW) (*Effective July 1, 2026*) (a) As used in this section, (1)  
356 "prescribing practitioner" means a physician, dentist, podiatrist,  
357 optometrist, physician assistant, advanced practice registered nurse or  
358 nurse-midwife enrolled as a Medicaid provider who is licensed by the  
359 state and authorized to prescribe opioid drugs within the scope of such  
360 person's practice, and (2) "opioid drug" has the same meaning as  
361 provided in section 20-14o of the general statutes.

362 (b) The Commissioner of Social Services may require a prescribing

363 practitioner, as a condition for the receipt of Medicaid reimbursement  
364 for prescribing an opioid drug to a Medicaid recipient, to complete  
365 training in effective pain management, including, but not limited to: (1)  
366 Appropriate, available nonopioid alternatives for the treatment of pain,  
367 and (2) the advantages and disadvantages of the use of nonopioid  
368 treatment alternatives, considering a patient's risk of substance misuse.

369 (c) The commissioner may adopt regulations in accordance with the  
370 provisions of chapter 54 of the general statutes to implement the  
371 provisions of this section.

372 Sec. 14. (*Effective July 1, 2026*) The Commissioner of Social Services,  
373 within available appropriations, shall amend the Medicaid state plan to  
374 increase the rate of Medicaid reimbursement for providers of family  
375 planning services. For purposes of this section, "family planning  
376 services" includes, but is not limited to, contraceptives, medical exams  
377 and laboratory tests.

378 Sec. 15. Section 17b-244 of the general statutes is repealed and the  
379 following is substituted in lieu thereof (*Effective July 1, 2026*):

380 (a) The room and board component of the rates to be paid by the state  
381 to private facilities and facilities operated by regional education service  
382 centers which are licensed to provide residential care pursuant to  
383 section 17a-227, but not certified to participate in the Title XIX Medicaid  
384 program as intermediate care facilities for individuals with intellectual  
385 disabilities, shall be determined annually by the Commissioner of Social  
386 Services, except that rates effective April 30, 1989, shall remain in effect  
387 through October 31, 1989. Any facility with real property other than  
388 land placed in service prior to July 1, 1991, shall, for the fiscal year  
389 ending June 30, 1995, receive a rate of return on real property equal to  
390 the average of the rates of return applied to real property other than land  
391 placed in service for the five years preceding July 1, 1993. For the fiscal  
392 year ending June 30, 1996, and any succeeding fiscal year, the rate of  
393 return on real property for property items shall be revised every five

394 years. The commissioner shall, upon submission of a request by such  
395 facility, allow actual debt service, comprised of principal and interest,  
396 on the loan or loans in lieu of property costs allowed pursuant to section  
397 17-313b-5 of the regulations of Connecticut state agencies, whether  
398 actual debt service is higher or lower than such allowed property costs,  
399 provided such debt service terms and amounts are reasonable in  
400 relation to the useful life and the base value of the property. In the case  
401 of facilities financed through the Connecticut Housing Finance  
402 Authority, the commissioner shall allow actual debt service, comprised  
403 of principal, interest and a reasonable repair and replacement reserve  
404 on the loan or loans in lieu of property costs allowed pursuant to section  
405 17-313b-5 of the regulations of Connecticut state agencies, whether  
406 actual debt service is higher or lower than such allowed property costs,  
407 provided such debt service terms and amounts are determined by the  
408 commissioner at the time the loan is entered into to be reasonable in  
409 relation to the useful life and base value of the property. The  
410 commissioner may allow fees associated with mortgage refinancing  
411 provided such refinancing will result in state reimbursement savings,  
412 after comparing costs over the terms of the existing proposed loans. For  
413 the fiscal year ending June 30, 1992, the inflation factor used to  
414 determine rates shall be one-half of the gross national product  
415 percentage increase for the period between the midpoint of the cost year  
416 through the midpoint of the rate year. For fiscal year ending June 30,  
417 1993, the inflation factor used to determine rates shall be two-thirds of  
418 the gross national product percentage increase from the midpoint of the  
419 cost year to the midpoint of the rate year. For the fiscal years ending  
420 June 30, 1996, and June 30, 1997, no inflation factor shall be applied in  
421 determining rates. The Commissioner of Social Services shall prescribe  
422 uniform forms on which such facilities shall report their costs. Such rates  
423 shall be determined on the basis of a reasonable payment for necessary  
424 services. Any increase in grants, gifts, fund-raising or endowment  
425 income used for the payment of operating costs by a private facility in  
426 the fiscal year ending June 30, 1992, shall be excluded by the  
427 commissioner from the income of the facility in determining the rates to

428 be paid to the facility for the fiscal year ending June 30, 1993, provided  
429 any operating costs funded by such increase shall not obligate the state  
430 to increase expenditures in subsequent fiscal years. Nothing contained  
431 in this section shall authorize a payment by the state to any such facility  
432 in excess of the charges made by the facility for comparable services to  
433 the general public. The service component of the rates to be paid by the  
434 state to private facilities and facilities operated by regional education  
435 service centers which are licensed to provide residential care pursuant  
436 to section 17a-227, but not certified to participate in the Title XIX  
437 Medicaid programs as intermediate care facilities for individuals with  
438 intellectual disabilities, shall be determined annually by the  
439 Commissioner of Developmental Services in accordance with section  
440 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive  
441 a rate that is more than two per cent greater than the rate in effect for  
442 the facility on June 30, 2007, except any facility that would have been  
443 issued a lower rate effective July 1, 2007, due to interim rate status or  
444 agreement with the department, shall be issued such lower rate effective  
445 July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall  
446 receive a rate that is more than two per cent greater than the rate in effect  
447 for the facility on June 30, 2008, except any facility that would have been  
448 issued a lower rate effective July 1, 2008, due to interim rate status or  
449 agreement with the department, shall be issued such lower rate effective  
450 July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011,  
451 rates in effect for the period ending June 30, 2009, shall remain in effect  
452 until June 30, 2011, except that (1) the rate paid to a facility may be higher  
453 than the rate paid to the facility for the period ending June 30, 2009, if a  
454 capital improvement required by the Commissioner of Developmental  
455 Services for the health or safety of the residents was made to the facility  
456 during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any  
457 facility that would have been issued a lower rate for the fiscal year  
458 ending June 30, 2010, or June 30, 2011, due to interim rate status or  
459 agreement with the department, shall be issued such lower rate. For the  
460 fiscal year ending June 30, 2012, rates in effect for the period ending June  
461 30, 2011, shall remain in effect until June 30, 2012, except that (A) the

462 rate paid to a facility may be higher than the rate paid to the facility for  
463 the period ending June 30, 2011, if a capital improvement required by  
464 the Commissioner of Developmental Services for the health or safety of  
465 the residents was made to the facility during the fiscal year ending June  
466 30, 2012, and (B) any facility that would have been issued a lower rate  
467 for the fiscal year ending June 30, 2012, due to interim rate status or  
468 agreement with the department, shall be issued such lower rate. Any  
469 facility that has a significant decrease in land and building costs shall  
470 receive a reduced rate to reflect such decrease in land and building costs.  
471 The rate paid to a facility may be increased if a capital improvement  
472 approved by the Department of Developmental Services, in consultation  
473 with the Department of Social Services, for the health or safety of the  
474 residents was made to the facility during the fiscal year ending June 30,  
475 2014, or June 30, 2015, only to the extent such increases are within  
476 available appropriations. For the fiscal years ending June 30, 2016, and  
477 June 30, 2017, rates shall not exceed those in effect for the period ending  
478 June 30, 2015, except the rate paid to a facility may be higher than the  
479 rate paid to the facility for the period ending June 30, 2015, if a capital  
480 improvement approved by the Department of Developmental Services,  
481 in consultation with the Department of Social Services, for the health or  
482 safety of the residents was made to the facility during the fiscal year  
483 ending June 30, 2016, or June 30, 2017, to the extent such rate increases  
484 are within available appropriations. For the fiscal years ending June 30,  
485 2016, and June 30, 2017, and each succeeding fiscal year, any facility that  
486 would have been issued a lower rate, due to interim rate status, a change  
487 in allowable fair rent or agreement with the department, shall be issued  
488 such lower rate. For the fiscal years ending June 30, 2018, and June 30,  
489 2019, rates shall not exceed those in effect for the period ending June 30,  
490 2017, except the rate paid to a facility may be higher than the rate paid  
491 to the facility for the period ending June 30, 2017, if a capital  
492 improvement approved by the Department of Developmental Services,  
493 in consultation with the Department of Social Services, for the health or  
494 safety of the residents was made to the facility during the fiscal year  
495 ending June 30, 2018, or June 30, 2019, to the extent such rate increases

496 are within available appropriations. For the fiscal years ending June 30,  
497 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal  
498 year ending June 30, 2019, except the rate paid to a facility may be higher  
499 than the rate paid to the facility for the fiscal year ending June 30, 2019,  
500 if a capital improvement approved by the Department of  
501 Developmental Services, in consultation with the Department of Social  
502 Services, for the health or safety of the residents was made to the facility  
503 during the fiscal year ending June 30, 2020, or June 30, 2021, to the extent  
504 such rate increases are within available appropriations. For the fiscal  
505 years ending June 30, 2022, and June 30, 2023, rates shall be based upon  
506 rates in effect for the fiscal year ending June 30, 2021, inflated by the  
507 gross domestic product deflator applicable to each rate year, except the  
508 commissioner may, in the commissioner's discretion and within  
509 available appropriations, provide pro rata fair rent increases to facilities  
510 which have documented fair rent additions placed in service in the cost  
511 report years ending September 30, 2020, and September 30, 2021, that  
512 are not otherwise included in rates issued, or if a rate adjustment for a  
513 capital improvement approved by the Department of Developmental  
514 Services, in consultation with the Department of Social Services, for the  
515 health or safety of the residents was made to the facility during the fiscal  
516 year ending June 30, 2022, or June 30, 2023. For the fiscal year ending  
517 June 30, 2024, rates shall not exceed those in effect for the fiscal year  
518 ending June 30, 2023, except the rate paid to a facility may be higher  
519 than the rate paid to the facility for the fiscal year ending June 30, 2023,  
520 if a capital improvement approved by the Department of  
521 Developmental Services, in consultation with the Department of Social  
522 Services, for the health or safety of the residents was made to the facility  
523 during the fiscal year ending June 30, 2024, to the extent such rate  
524 increases are within available appropriations. For the fiscal year ending  
525 June 30, 2027, and each fiscal year thereafter, the Commissioner of Social  
526 Services, within available appropriations, shall increase rates by the  
527 most recent increase in the consumer price index for all urban  
528 consumers and base such rates on the most recent cost report filed by a  
529 facility.

530 (b) Notwithstanding the provisions of subsection (a) of this section,  
531 state rates of payment for the fiscal years ending June 30, 2018, June 30,  
532 2019, June 30, 2020, and June 30, 2021, for residential care homes and  
533 community living arrangements that receive the flat rate for residential  
534 services under section 17-311-54 of the regulations of Connecticut state  
535 agencies shall be set in accordance with section 298 of public act 19-117.  
536 For the fiscal years ending June 30, 2022, and June 30, 2023, such rates  
537 shall be based upon rates in effect for the fiscal year ending June 30,  
538 2021, inflated by the gross domestic product deflator applicable to each  
539 rate year. For the fiscal year ending June 30, 2027, and each fiscal year  
540 thereafter, the Commissioner of Social Services, within available  
541 appropriations, shall increase such rates by the most recent increase in  
542 the consumer price index for all urban consumers and base such rates  
543 on the most recent cost report filed by a facility.

544 (c) For the fiscal year ending June 30, 2024, and each subsequent fiscal  
545 year, the commissioner may, in the commissioner's discretion and  
546 within available appropriations, provide pro rata fair rent increases to  
547 facilities which have documented fair rent additions placed in service in  
548 the cost report years that are not otherwise included in rates issued.

549 (d) The Commissioner of Social Services and the Commissioner of  
550 Developmental Services shall adopt regulations in accordance with the  
551 provisions of chapter 54 to implement the provisions of this section.

552 Sec. 16. Section 4-220 of the general statutes is repealed and the  
553 following is substituted in lieu thereof (*Effective July 1, 2026*):

554 (a) As used in this section, (1) "private provider organization" and  
555 "purchase of service contract" each have the same meanings as provided  
556 in section 4-70b; (2) "health and human services" means services  
557 provided under contract with a state agency that directly support the  
558 health, safety and welfare of residents, including, but not limited to,  
559 those residents who may have conditions that include, but are not  
560 limited to, behavioral health disorders, intellectual disabilities,

561 developmental disabilities, physical disabilities and autism spectrum  
562 disorder; (3) "attempt to recover or otherwise offset" means efforts to  
563 recoup savings at the end of each fiscal year; and (4) "state agency"  
564 means the Departments of Developmental Services, Mental Health and  
565 Addiction Services, Social Services and Children and Families.

566 (b) Subject to the provisions of [subsection (c)] subsections (c) and (d)  
567 of this section, each state agency that contracts with a nonprofit private  
568 provider organization for health and human services shall allow such  
569 nonprofit organization that otherwise meets contractual requirements,  
570 including, but not limited to, its contractual obligations regarding  
571 services provided and clients served, to retain any savings from a  
572 purchase of service contract at the end of each fiscal year. No state  
573 agency shall attempt to recover or otherwise offset funds retained by  
574 such nonprofit organization from the contracted cost for services.

575 (c) Any nonprofit private provider organization allowed to retain  
576 savings under this section shall submit an application to the contracting  
577 state agency on how savings are planned to be reinvested and report to  
578 the contracting state agency on how savings will be reinvested to  
579 strengthen quality, invest in deferred maintenance and make asset  
580 improvements. The commissioner of each state agency shall prescribe  
581 the form and manner of such application form and the frequency of such  
582 reports. The commissioner of each state agency shall review an  
583 application submitted pursuant to this subsection and respond to a  
584 nonprofit private provider organization not later than ninety days after  
585 receiving such application from such provider organization. Retained  
586 funds may only be used for the purposes of strengthening quality,  
587 investing in deferred maintenance and making asset improvements. The  
588 commissioner of each state agency shall approve, disapprove or modify  
589 any application for funds in accordance with the allowable uses in this  
590 subsection and report any such approval, disapproval or modification  
591 to the Secretary of the Office of Policy and Management. Nonprofit  
592 private provider organizations providing health and human services  
593 shall be permitted to expend retained funds on programs that are

594 funded by the same state agency except as provided in subsection (d) of  
595 this section.

596 (d) Notwithstanding the provisions of subsection (c) of this section,  
597 the Secretary of the Office of Policy and Management shall authorize a  
598 nonprofit private provider organization that provides services for the  
599 Departments of Social Services and Developmental Services to reinvest  
600 savings retained pursuant to a contract with the Department of  
601 Developmental Services into services provided by such organization  
602 pursuant to a contract with the Department of Social Services.

603 ~~[(d)]~~ (e) Notwithstanding any provisions to the contrary in this  
604 section, a state agency shall not allow a nonprofit private provider  
605 organization to retain surplus funds from the contracted cost of services  
606 under a contract funded in whole, or in part, with federal funds when  
607 allowing such organization to retain such funds would jeopardize  
608 federal funding or reimbursement for such contract or when such  
609 allowance is prohibited by federal law or regulations.

610 ~~[(e)]~~ (f) The Commissioner of Social Services, in consultation with the  
611 Secretary of the Office of Policy and Management and the  
612 Commissioners of Children and Families, Mental Health and Addiction  
613 Services and Developmental Services, may undertake a study of the  
614 contracting and billing practices of such nonprofit private provider  
615 organizations to ensure compliance with all Medicaid waivers and  
616 Medicaid state plan amendments. Any study started under this  
617 subsection shall be completed not later than December 31, 2024.

618 ~~[(f)]~~ (g) Notwithstanding the provisions of subsections (a) to ~~[(e)]~~ (f),  
619 inclusive, of this section, the Commissioner of Developmental Services,  
620 in consultation with the Secretary of the Office of Policy and  
621 Management, may extend the provisions of this section to other private  
622 provider organizations with which the Department of Developmental  
623 Services contracts, provided they meet all of the requirements set forth  
624 in this section, including, but not limited to, meeting all terms and

625 conditions of their contracts for services with the Department of  
626 Developmental Services.

627       Sec. 17. (*Effective from passage*) (a) The Commissioner of Social  
628 Services, in collaboration with the Commissioners of Children and  
629 Families, Developmental Services and Mental Health and Addiction  
630 Services, shall study (1) the percentage of services under programs  
631 administered by each commissioner that are provided by nonprofit  
632 organizations, (2) rates of state reimbursement per service provided to  
633 each such organization by each agency, (3) cost of services provided by  
634 such organizations compared to the cost for such services if state  
635 agencies directly provided such services, and (4) how often such rates  
636 of reimbursement are adjusted to reflect any increase in inflation.

637       (b) Not later than January 15, 2027, the Commissioner of Social  
638 Services shall file a report, in accordance with the provisions of section  
639 11-4a of the general statutes, on the data obtained from the study  
640 pursuant to subsection (a) of this section with the joint standing  
641 committees of the General Assembly having cognizance of matters  
642 relating to appropriations and the budgets of state agencies, human  
643 services, children and public health.

644       Sec. 18. (*Effective July 1, 2026*) The Commissioner of Social Services,  
645 within available appropriations, shall increase the Medicaid rates of  
646 reimbursement for durable medical equipment, orthotics, prosthetics  
647 and supplies and complex rehabilitation technology in accordance with  
648 the Medicaid rate study commissioned by the Department of Social  
649 Services pursuant to section 1 of public act 23-186.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2026</i>	New section
Sec. 2	<i>July 1, 2026</i>	17b-282c(a)
Sec. 3	<i>July 1, 2026</i>	17b-282d(a)
Sec. 4	<i>July 1, 2026</i>	17b-28(c)

Sec. 5	<i>July 1, 2026</i>	New section
Sec. 6	<i>from passage</i>	New section
Sec. 7	<i>July 1, 2026</i>	New section
Sec. 8	<i>July 1, 2026</i>	New section
Sec. 9	<i>July 1, 2026</i>	17b-242
Sec. 10	<i>July 1, 2026</i>	17b-343
Sec. 11	<i>July 1, 2026</i>	New section
Sec. 12	<i>July 1, 2026</i>	New section
Sec. 13	<i>July 1, 2026</i>	New section
Sec. 14	<i>July 1, 2026</i>	New section
Sec. 15	<i>July 1, 2026</i>	17b-244
Sec. 16	<i>July 1, 2026</i>	4-220
Sec. 17	<i>from passage</i>	New section
Sec. 18	<i>July 1, 2026</i>	New section

**Statement of Purpose:**

To increase Medicaid rates of reimbursement for certain providers.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*