

2026 Connecticut Medicaid-Related Legislation

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Issue

Provide an overview of Connecticut Medicaid-related legislation enacted during the 2026 legislative session.

Summary

During the 2026 regular session, the Connecticut legislature passed several provisions affecting various Medicaid components, such as benefits, hospital payments, provider reimbursement rates, and prescription drugs. We provide brief summaries of these provisions below. (Please note, we did not include laws affecting Covered Connecticut, which is funded in part through a Medicaid waiver.)

Benefits

Biomarker Testing

Existing law requires the Department of Social Services (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 analyzes a patient's tissue, blood, or other biospecimen for biomarkers (for example, genes or proteins) that may indicate the presence of a disease or condition, help plan treatment, or determine how well a treatment is working.

A new law 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 beneficiaries received approval for Medicaid coverage for this testing in FY 26 ([PA 26-146](#), § 3, effective upon passage).

Inpatient Hospice Pilot Program

This session, the legislature required DSS to develop a pilot program to identify and use a licensed hospice facility that provides a hospital level of care (“short-term hospital special hospice”) to treat Medicaid patients with advanced illness who (1) are eligible for hospice, (2) are clinically complex and high acuity, and (3) cannot be safely managed at home or in a nursing home. DSS must implement the pilot program by December 30, 2027, within funds specifically appropriated for this purpose.

Under the new law, DSS must report by January 15, 2027, to the Appropriations, Human Services, and Public Health committees on the pilot program’s development, including any potential savings, as well as legislative and funding recommendations ([PA 26-71](#), effective July 1, 2026).

Pain Management for Medicaid Beneficiaries

A new law 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.

Under the act, 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 ([PA 26-146](#), § 4, effective July 1, 2026).

Councils, Studies, and Working Groups

HUSKY C Report

A new law requires the DSS commissioner to report annually on HUSKY C (Medicaid for seniors aged 65 and older and people who are blind or disabled), starting by October 1, 2027, and continuing until October 1, 2032, to the Appropriations and Human Services committees. The report must include (1) the number of people eligible for HUSKY C for the previous fiscal year, (2) the number of people found ineligible for HUSKY C for exceeding the asset limit and the amount by which assets exceeded the limit, and (3) projected costs the state would incur in the next fiscal year if asset limits were increased ([PA 26-72](#), § 12, effective July 1, 2026).

MAPOC Membership

New legislation increased, from 50 to 52, the Council on Medical Assistance Program Oversight's (MAPOC) membership by adding one representative each of (1) the Connecticut Dental Health Partnership's Dental Policy Advisory Council and (2) a health care worker labor organization.

By law, this council advises DSS on various aspects of the Medicaid program and includes legislators, consumers, advocates, health care providers, administrative service organization representatives, and state agency personnel ([PA 26-146](#), § 2, and [PA 26-68](#), § 449, effective July 1, 2026).

Medicaid Value-Based Working Group

This session, the legislature created a Medicaid Value-Based Payment Working Group to collaboratively design, evaluate readiness for, and recommend scalable, voluntary, value-based payment models for the Medicaid population. These payment models must advance quality, cost efficiency, access, health system sustainability, and health equity across the health care delivery system. Any value-based payment model developed under the new law must be voluntary for participating providers.

Under the act, the working group must submit its recommendations to the Human Services and Public Health committees by January 1, 2028 ([PA 26-68](#), § 370, effective July 1, 2026).

Study on Palliative and Hospice Care in Litchfield County

A new law requires the DSS commissioner, in consultation with the public health commissioner, to study the need for palliative and hospice care services in Litchfield County. When doing so, she must consider any findings of the Palliative Care Advisory Council.

Under the act, the DSS commissioner must report on the study to the Human Services and Public Health committees by January 1, 2027. If the study finds there is a need for these services, the new law allows the DSS commissioner, within available appropriations, to implement a pilot program in Litchfield County to provide them. The commissioner must maximize available federal funding and may amend the Medicaid state plan or seek a Medicaid waiver to do so ([SA 26-27](#), effective upon passage).

UConn Health Center (UHC) Medicaid Report

This session, the legislature required UHC to report, by January 15, 2027, to the governor and the Appropriations, Higher Education and Employment Advancement, Human Services, and Public

Health committees on at least the following: (1) the most recent payer mix for health center services; (2) increasing access to specialists for Medicaid enrollees; and (3) efforts made to increase the proportion of Medicaid days, including increasing the census in the adolescent psychiatric unit and inpatient services provided to people incarcerated in Department of Correction facilities ([PA 26-68](#), § 452, effective upon passage).

Working Group on Compensating Spouses Providing Personal Care Assistance

New legislation established a six-member 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. The working group must report its findings and recommendations to the Human Services Committee by January 1, 2027([PA 26-146](#), § 5, effective upon passage).

Hospitals

Hospital Supplemental Payments

Existing law generally requires DSS to establish supplemental pools in accordance with a settlement agreement that ends in FY 26. Prior law required DSS to pay \$708.3 million in Medicaid supplemental payments to hospitals for FY 27. For FY 28 and after, prior law required the total payments to be increased by an additional \$25 million over the previous year if the total amount of the hospital provider tax collected for that year, across all hospitals subject to the tax, increased by at least \$25 million over the previous year.

The budget act eliminates these requirements and instead establishes several supplemental payment pools and sets a payment schedule for each pool, beginning for FY 27, and establishes a hospital supplemental payment account that DSS must use to make these supplemental payments.

Generally, supplemental payment pools are hospitals grouped for purposes of receiving Medicaid supplemental payments. The act creates five inpatient supplemental payment pools (a general pool, and separate pools for small hospitals, mid-sized hospitals, independent mid-sized hospitals, and large hospitals); three outpatient supplemental payment pools (a general pool, and separate pools for mid-sized hospitals and independent mid-sized hospitals); and two other supplemental pools (one for physicians and mid-level practitioners and one for faculty practice plans). It also sets requirements for various disproportionate share hospital (DSH) payments, among other things ([PA 26-68](#), § 363, as amended by [PA 26-76](#), § 83, both effective July 1, 2026).

Hospital Supplemental Payment Account Reports

This session, the legislature required the DSS commissioner, starting by January 1, 2027, to annually report to the Appropriations; Finance, Revenue and Bonding; and Public Health committees on the collection of funds for deposit in the hospital supplemental payment account and how the account's funds were used during the prior calendar year. This account is used by DSS to make Medicaid supplemental payments to hospitals, hospital-affiliated medical groups, and faculty practice plans ([PA 26-68](#), § 248 as amended by [PA 26-76](#), § 33, both effective upon passage).

UCHC Medicaid Revenue Diversion

A new law requires DSS, starting in FY 26, to divert a specified amount of federal Medicaid revenue from disproportionate share hospital claims at UConn's John Dempsey Hospital. Specifically, DSS must divert an amount the OPM secretary sets, up to a maximum of \$15 million for each hospital the UConn Health Center Joint Venture Initiative (UCHC-JVI) owns and operates at any time during the fiscal year. This revenue must be diverted and transferred to UCHC to support UCHC-JVI's operational costs.

Among other things, the act also appropriates \$1.5 million to DSS in FY 27 to allow for the expansion of UCHC's Medicaid physician supplemental payment and correspondingly reduces its appropriation for operating expenses by this same amount ([PA 26-68](#), §§ 211-214, most provisions effective upon passage).

Prescription Drugs

Medicaid Preferred Drug List and Antiretroviral Drugs

This session, the legislature added antiretroviral drugs to the Medicaid preferred drug list. This allows the state to negotiate supplemental rebates with drug manufacturers for them. (Antiretroviral drugs are used to prevent and treat HIV.)

By law, DSS, in consultation with the Medicaid Pharmaceutical and Therapeutics Committee, may establish a preferred drug list (formulary) that limits the number of drugs that may be dispensed under the Medicaid program. Nonpreferred drugs in the drug classes included on the preferred drug list are subject to prior authorization. Under prior law, classes of antiretroviral drugs were exempt from prior authorization requirements and could not be included on preferred drug lists ([PA 26-68](#), § 443, effective July 1, 2026).

Periodic Review of Medicaid Prescription Drugs

A new law authorizes the DSS commissioner to periodically review available data on the clinical effectiveness of Medicaid-covered outpatient prescription drugs that are projected to exceed, after factoring in rebates, (1) a per-consumer net cost of \$25,000 per year or (2) an aggregate annual cost to the program of \$10 million. The commissioner may, within available appropriations, contract with a third party to conduct a comparative effectiveness review of any of these prescription drugs.

The act excludes from this review any brand-name prescription drug or biologic designated under federal law for a rare disease or condition and for which the only approved indication is for one or more rare diseases or conditions.

Under the new law, the results of the review may be made public and shared with any entity or multi-state prescription drug purchasing collaborative that Connecticut is a member of to help negotiate additional supplemental rebate agreements beyond those required under federal law ([PA 26-68](#), § 444, effective July 1, 2026).

Provider Rates

Emergency Medical Transportation Medicaid Reimbursement

This session, the legislature set requirements for how DSS calculates mileage to reimburse ambulance services under the state medical assistance program (which includes Medicaid). Specifically, the new law requires the DSS commissioner to calculate out-of-district mileage for these services based on an ambulance's distance traveled with the patient onboard from the point of patient pickup to the destination, rounded to the nearest one-tenth of a mile.

Under the act, an ambulance service may use any reasonable and verifiable method to document mileage, including global positioning system (GPS) data, navigation or dispatch computer systems, or commercially available mapping routing programs and must keep mileage documents in patient care records ([PA 26-88](#), effective July 1, 2026).

Five-Year Medicaid Provider Rate Review

A new law 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; (2) benchmark the rates to those for the same services paid by Medicare, when possible given available appropriations; and (3) allow for public comment.

It also requires the commissioner to (1) start reviewing Medicaid provider rates using this new process by January 1, 2027, and (2) annually report on the new process, starting by January 15, 2028, to the Appropriations and Human Services committees ([PA 26-146](#), § 1, effective July 1, 2026).

ICF-IID Rates

A new law increases reimbursement for intermediate care facilities for people with intellectual disabilities (ICF-IID). Prior law required DSS to set FY 26 rates at 1.4% higher than the facility's calculated rate and set a schedule for rate increase in subsequent years. The act requires DSS to set FY 26 rates at 3.4% higher than the facility's calculated rate and increases scheduled rate increase in future years ([PA 26-1](#), § 64, effective upon passage).

Medicaid Provider Audits

New legislation limits the circumstances under which DSS can determine overpayment or underpayment by extrapolation when auditing Medicaid provider claims. By law, extrapolation means determining an unknown value by projecting the results of a review of a sample of claims to the entire population of claims from which the sample was drawn.

More specifically, the act allows DSS to make these findings based on extrapolation if the total net amount of the extrapolated overpayment calculated from a statistically valid sampling and extrapolation method exceeds 2.75%, instead of 1.75%, of total claims paid to the provider for the audit period ([PA 26-143](#), effective October 1, 2026).

Non-Emergency Medical Transportation Study

A new law requires the DSS commissioner to study Medicaid Non-Emergency Medical Transportation reimbursement rates and service availability. She must report her findings to the Human Services and Public Health committees by February 1, 2027 ([PA 26-151](#), § 3, effective upon passage).

Nursing Home Medicaid Reimbursement

This session, the legislature made several changes to laws on Medicaid reimbursement for nursing homes. Among other things, a new law (1) establishes an enhanced Medicaid performance payment for nursing homes that improve their quality-based metrics; (2) requires DSS, starting in FY 29, to pay this enhanced payment from an annual pool of \$10 million; (3) requires DSS to phase in the federal Patient Driven Payment Model (PDPM) for nursing home resident assessments; (4) establishes enhanced payments for homes whose payor mixes are more than 75% Medicaid

residents; and (5) allows DSS to recalculate Medicaid reimbursement rates outside of the normal schedule to address certain circumstances that may interfere with a home's ability to meet patient day requirements ([PA 26-68](#), §§ 446 & 447, most provisions effective upon passage).

Peer Support Specialists

A new law requires the DSS commissioner to (1) evaluate how peer support specialists are reimbursed, supervised, and trained and (2) make recommendations on how to structure a reimbursement system to better integrate this work into the state medical assistance program, which includes Medicaid and the state Children's Health Insurance Program ([PA 26-72](#), § 13, effective upon passage).

Personal Care Attendant Fiscal Intermediary Reports

Beginning with information from the quarter starting April 1, 2024, a new law requires DSS to file quarterly reports with the Human Services and Labor and Public Employees committees related to the fiscal intermediary that contracts with the department to provide payroll, taxes, and administrative services for self-directed home care programs. These are Medicaid-funded programs that allow a consumer to hire a personal care attendant ([PA 26-12](#), § 17, effective July 1, 2026).

Rate Increase for Family Planning Clinics

This session, the legislature required the DSS commissioner to amend the Medicaid state plan to increase reimbursement rates for licensed family planning clinics and give at least \$500,000 in Medicaid state share funds to do so. The commissioner must use funds appropriated for family planning services for FY 27 for this purpose ([PA 26-68](#), § 448, effective July 1, 2026).

Rate Parity for Optometrists

New legislation requires the DSS commissioner to adjust Medicaid reimbursement rates for licensed optometrists so that they equal those of licensed physicians (presumably, ophthalmologists) for performing the same medical service or procedure in Current Procedural Terminology (CPT) codes 92004 (new patient comprehensive eye examinations), 92014 (existing patient comprehensive eye examinations), 92015 (determining eye refractions), and 92250 (computerized corneal topography). It requires the commissioner to seek federal approval to amend the Medicaid state plan if needed to adjust the rates ([PA 26-76](#), § 40, effective upon passage).

Rate Reviews

A new law requires the DSS commissioner, when reviewing Medicaid rates, to include rates required to be studied under the Medicaid rate study established under [PA 23-186](#) with no

corresponding (1) Medicare rate for the same health care service or (2) average five-state rate benchmark included in the Medicaid rate study. If any state within the Medicaid rate study's five-state rate benchmark group (Maine, Massachusetts, New Jersey, New York, and Oregon) has a corresponding rate for the same or a substantially similar health care service, the DSS commissioner must use this rate for comparison in her review. If two or more states in the benchmark group have corresponding rates, the commissioner must use an average of these rates for comparison.

Additionally, when setting Medicaid behavioral health service reimbursement rates, the act requires the commissioner to include medication administration services by licensed home health care agencies to people with psychiatric diagnoses under a care plan that is (1) developed and supervised by a licensed behavioral health clinician or prescriber and (2) overseen by the state's behavioral health administrative services organization (currently Carelon Behavioral Health CT) ([PA 26-68](#), § 450, effective July 1, 2026).

Work and Community Engagement Requirements

Medical Frailty Assessments

To the extent needed to verify exemptions from SNAP work requirements and Medicaid community engagement requirements under federal law, a new law requires the DSS commissioner to identify parameters for an effective assessment of “medical frailty” for a Medicaid recipient or applicant. The act allows her to consider existing definitions in state or federal laws, definitions in other states, and medical codes used to identify pertinent diagnoses. It also requires the commissioner to maximize the use of this information and medical codes to effectuate ex parte eligibility determinations to the extent federal law allows. The commissioner must give regular updates on the parameters to MAPOC ([PA 26-68](#), § 458, effective upon passage).

Safety Net Mitigation Working Group

A new law establishes a safety net mitigation working group to advise on, monitor, and coordinate the state's response to significant changes to federal law or policy that impact public health, social services, or other safety net programs. The working group must report annually, starting by February 1, 2027, and continuing until February 1, 2029, to the Appropriations, Housing, Human Services, and Insurance and Real Estate committees. Among other things, reports must include information on how work and community engagement requirements for Medicaid and the Supplemental Nutrition Assistance Program (SNAP) are being implemented and the impact of these requirements on program beneficiaries ([PA 26-68](#), § 457, effective upon passage).

Miscellaneous

DDS Abuse and Neglect Registry Access

Existing law requires the Department of Developmental Services (DDS) to maintain a registry of certain former employees who were fired from or left their jobs due to substantiated abuse or neglect and makes the registry available to specified agencies, employers, and charitable organizations. A new law additionally requires DDS to make the registry available to employers of service providers for people who get services or funding from DSS' Medicaid waiver for autism spectrum disorder ([PA 26-72](#), § 3, effective upon passage).

Legislative Review of Medicaid State Plan Amendments

By law, the DSS commissioner must submit federal waiver applications, renewals, and amendments and certain Medicaid state plan amendments (SPAs) to the Appropriations and Human Services committees before submitting them to the federal government for approval. This session, the legislature extended this requirement to any proposed SPA to provide medical assistance through a Medicaid managed care organization, except for medical assistance provided through a Basic Health Program authorized under the federal Affordable Care Act ([PA 26-68](#), § 459, effective July 1, 2026).

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