CONNECTICUT
Social Services

***Testimony before the Human Services Committee***
***Commissioner Andrea Barton Reeves***
***Department of Social Services***
***March 11, 2025***

Good morning, Chairs Lesser and Gilchrest, Ranking Members Perillo and Case; and distinguished members of the Human Services Committee. I am Andrea Barton Reeves, Commissioner of the Department of Social Services. I am pleased to offer remarks on several of the bills on today's agenda.

While I may be testifying in opposition to certain bills, often due to the limitations of working within a budget that requires difficult choices, DSS is always open to discussions with the committee on each of the bills on the agenda and appreciates the opportunity to be a working partner in developing these policies.

**SENATE BILL 1481: AN ACT PROHIBITING DISCRIMINATION IN SERVICES FUNDED UNDER MEDICAID**

This bill would require a provider who is reimbursed for services under Medicaid to agree, in writing, not to discriminate against persons whose rights are protected under state law as a condition of receiving Medicaid reimbursement.

The current Medicaid provider enrollment agreement (contract) that all Medicaid providers must sign already has comprehensive language regarding the prohibition of discrimination in accordance with the laws of the United States and the State of Connecticut.

DSS would appreciate the opportunity to continue discussions with the Committee on this important subject to find ways in which we can ensure there is no discrimination to Medicaid members.

**SENATE BILL 1482: AN ACT CONCERNING AN ELDERLY NUTRITION PROGRAM.**

This bill requires that DSS, in consultation with the Commissioner of Aging and Disability Services and area agencies on aging, maximize the use of federal Supplemental Nutrition Assistance Program (SNAP) funds for nutritious meals for elderly persons living at home or in congregate housing.

SNAP serves over 479,000 Connecticut residents annually, including over 88,300 individuals age 60+. Many of these individuals qualify for the Elderly Simplified Application Project (ESAP). ESAP is a federal waiver that seeks to increase participation among the older adult low-income population facing barriers to participation by allowing DSS to extend their benefit period beyond the traditional 12 months to 36 months, allows for flexible verification requirements, and removes the requirement for a mid-certification review. Additionally, SNAP households with a member age 60+ are not subject to a gross income limit when applying for SNAP benefits, currently set at 200% FPL for all other households.

To increase awareness of the SNAP program, as required by Public Act 24-99 and as reported to the legislature in October 2024, DSS and its SNAP outreach provider, the Connecticut Association for Community Action (CAFCA), have met with the Department of Aging and Disability Services (ADS) to discuss ways to maximize SNAP to support the Elderly Nutrition Program (ENP). As a result of these meetings, CAFCA presented on SNAP outreach at the November 12, 2024, Nutrition Services Stakeholder meeting to inform the participants about SNAP and to provide referral information for SNAP and ENP.

Additionally, CAFCA has encouraged all of the state's Community Action Agencies, some of which are also elderly nutrition providers, to share the approved SNAP outreach brochure at both congregate meal sites and as part of Meals-on-Wheels deliveries.

Finally, federal regulations already allow individuals age 60+ to access prepared meals under SNAP through the Meals-on-Wheels program, as well as at communal dining facilities. Meals-on-Wheels allows individuals age 60+ or members who are housebound, physically handicapped, or otherwise disabled to the extent that they are unable to adequately prepare all their meals, and their spouses, to use SNAP benefits to purchase meals prepared for and delivered to them by a nonprofit meal delivery service authorized by United States Department of Agriculture's Food and Nutrition Service (FNS).

Similarly, individuals age 60+ and their spouses, or those receiving SSI and their spouses, may use SNAP benefits to purchase meals prepared at communal dining facilities as well as senior centers authorized by FNS.

FNS is the only entity that authorizes retailers, including Meals-on-Wheels and communal dining facilities, and there is no cost to a facility to apply.

DSS staff met with CAFCA and ADS in October 2024, to share information about the use of SNAP benefits to pay for meals provided at communal dining facilities and Meals-on-Wheels, as well as how providers can become authorized by FNS to accept SNAP benefits for the meals they provide. All attendees committed to share the payment and enrollment information broadly throughout their networks.

For these reasons, the Department believes it is already taking appropriate measures to maximize the use of federal SNAP funds for nutritious meals for elderly persons.

**SENATE BILL 1483: AN ACT CONCERNING THE PATIENT-CENTERED MEDICAL HOME-PLUS PROGRAM.**

This bill would require DSS to provide incentive payments to federally qualified health centers (FQHCs) under the Person-Centered Medical Home-Plus (PCMH+) program.

The PCMH+ program aims to improve the quality of primary care and care coordination for people who use Medicaid as their health insurance. The Department welcomes ongoing conversation about PCMH+, including potential adjustments going forward, as well as other efforts to improve healthcare outcomes and contain cost growth. The Department is in regular dialogue with FQHCs and continually works to find broad areas of agreement on how to improve the Medicaid program. This bill, however, interferes with contracts between providers and the Department, conflicts with federal requirements for the program, and would result in allocation of unbudgeted funds not eligible for federal matching funds. The Department, therefore, opposes this bill.

As background, PCMH+ is a voluntary program open for participation by both FQHC and Advance Networks of PCMH certified private primary care practices (and if applicable, hospitals and specialists). For FQHCs that decide to participate in PCMH+, facilities are paid a per-member, per-month (PMPM) payment to support enhanced care coordination activities for Medicaid members. These PMPM payments are in addition to the regular encounter rates paid to FQHCs for providing services. The encounter rates were not affected in any way by PCMH+.

As a voluntary program, the PCMH+ participating practices enter into a contract with the Department that outlines performance requirements, services, and payments. As detailed in those contracts and as set forth in the federally-approved Medicaid State Plan, the total PMPM fund is limited to a set allocation of $6.36 million based on the approved state budget. The PCMH+ contract, executed and agreed to by each participating entity, including every FQHC that participates in PCMH+, specifically provides that if the total pool of PMPM funds is reached or exceeded in a calendar month, the Department shall reduce the PMPM amounts as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in that affected performance year. In 2024, the total pool of funds was expended with the October 2024 payments and, accordingly, no PMPM payments were made in November and December 2024 as required by the contract that each FQHC had signed. While the Department understands the FQHCs' frustration that those PMPM payments could not be made for those two months, the funding had been expended and was no longer available. Therefore, DSS notified the FQHCs in October 2024 and PMPM funding resumed in January 2025 when the next allocation of $6.36 million was made available to the Department.

For the Department to issue payments for the months of November and December would require additional funding of approximately $1.3 million in the enacted budget for the current state fiscal year 2025. Furthermore, now that those months have passed, it is not possible to amend the Medicaid State Plan, or the individual executed contracts with the PCMH+ practices for calendar year 2024, to authorize those increased payments for November and December 2024, so any such additional payments would be ineligible for federal Medicaid matching funds. Going forward, in 2025, the Department adjusted the PMPM amount in order to make it much more

likely that the $6.36 million allocation will be sufficient to last for the entire year and avoid the disruption that occurred in 2024. The Department has also put in place controls to closely monitor the 2025 PMPM fund so the Department can make corrections as necessary.

While the Department supports ongoing conversation about improving primary care and healthcare outcomes, the Department must oppose this particular bill.

**SENATE BILL 1480: AN ACT CONCERNING PRIVATE EQUITY AND REAL ESTATE INVESTMENT TRUST OWNERSHIP OF HOSPITALS AND NURSING HOMES.**

This bill would require a nursing home or hospital to be free of any new ownership interests by private equity companies or real estate investment trusts recorded on and after October 1, 2025, in order to be eligible for Medicaid reimbursement in the state for health care services.

The Department supports better transparency into the ownership structure of nursing homes as we have seen increased interest in private equity in Connecticut nursing homes. Given recent events occurring with hospitals that included private equity interest, the Department is also interested in improved transparency for hospitals. Much of this testimony focuses on nursing homes because the Department has a broader role for nursing homes than hospitals: both as the primary payer for nursing homes under Medicaid and also as the agency that administers the Certificate of Need (CON) process for nursing homes. For hospitals, while Medicaid is a significant payer, it is not the primary payer for most hospitals and the CON process for hospitals is administered by the Office of Health Strategy (OHS). In addition, the Department of Public Health (DPH) administers the state licensure process for both hospitals and nursing homes and, on behalf of the federal government as the state survey and certification agency, administers the federal Medicare and Medicaid certification requirements for both hospitals and nursing homes. While increased scrutiny is needed to prevent negative outcomes for patients, practitioners, and nursing home residents, a better procedural approach to the goals of this bill would be to enhance the requirements for CON and licensure, not to make the ownership status a specific condition of Medicaid reimbursement.

According to a 2023 study conducted by the federal Department of Health and Human Services, real estate investment trusts (REITs) and private equity account for approximately 8% of the investment in health care ($100 billion). (Health Affairs Scholar, Volume 2, Issue 4, April 2024) The purpose of REITs and private equity is to generate profits for its shareholders, which often leads to cutting staffing costs, decreased health care quality, and other cost reductions. According to the aforementioned study, REIT investments were associated with a 6.25% decrease in nursing home staffing in years 2 and 3 after REIT investments. Private equity interest in nursing homes is increasing due to a variety of factors, including limited regulation, a fragmented delivery system, an aging population, and multiple avenues of profitability and cost reduction. The Department remains concerned with the increased interest by private equity in Connecticut nursing homes in light of the recent events seen within our hospital sector.

Recent federal Centers for Medicare and Medicaid Services (CMS) data shows that when a nursing home is acquired by private equity, residents are 11% more likely to have experienced a

preventable emergency department visit and 8.7% more likely to experience an avoidable hospitalization. States are also experiencing increased closure of nursing homes. Since 2020, Nebraska has seen 11 nursing homes close after they were purchased by private equity firms and Pennsylvania has seen 30 homes close since 2019 after being purchased by private equity firms. This has left states grappling with ways to support their most vulnerable populations and states are exploring various ways to address.

Because nursing homes are asset-heavy organizations, meaning their value is closely linked to real estate and facilities, nursing homes seeking investments or access to capital funding are increasingly finding themselves turning to private equity rather than seeking traditional lines of credit through financial institutions. Due to the complex nature of the industry, including high operating costs, the majority of revenue being Medicare and Medicaid which cannot be easily used as collateral, and rates of resident turnover, it is difficult for banks to assess the ability of a nursing home to repay a loan and, as a result, they are often hesitant to loan money to nursing homes. To help address this, the Department proposes working on strengthening language to require transparency when private equity is involved and to put in place guardrails around these investments. DSS also proposes working with the legislature to identify different funding options for nursing homes so they are not reliant on private equity for capital improvement projects or lines of credit.

DSS is proposing greater transparency regarding the organizational structure of these investments to identify problematic actors and recommends strengthening language under the Certificate of Need and licensure statutes in consultation with the Department of Public Health, the state agency that approves nursing home ownership. Stronger language should include oversight of the acquisition, lease, transfer, exchange, receipt of a conveyance, creation of a joint venture, or any other manner of purchase of one or more nursing homes. This strengthened financial oversight and transparency should also extend to the persons associated with these investments, whether a single person, corporation, partnership, or any other entity that is either acquiring or operating the nursing home.

DSS also supports similar enhancements to the CON and licensure statutes for hospitals, in consultation with OHS and DPH.

As written, this bill should be clarified because the appropriate place to include conditions on ownership are in the CON and licensure process. It is not clear if it is permissible to include such requirements directly as a condition of Medicaid enrollment. Section 1902(a)(23) of the Social Security Act provides that any qualified provider has the opportunity to enroll in and provide services under Medicaid and it is not clear if the category of ownership would constitute a permissible category of provider qualification.

In sum, in collaboration with OHS and DPH, the Department is in support of stronger language to improve oversight into private equity and to explore other means to help nursing homes and hospitals fund essential capital projects and infrastructure investments and looks forward to working with the legislature on proposed language to protect our most vulnerable residents.

## SENATE BILL 1479: AN ACT CONCERNING ARBITRATION AND HEALTH CARE

This bill would require the Department to prohibit enrollment of any health care provider that includes a mandatory arbitration clause with its patients. The Department understands the intent of this bill. However, DSS cannot support legislation that would make such policy a condition of Medicaid enrollment, as it is not the appropriate method of enforcing such a policy.

As background, as required by federal law, the provider enrollment agreement with Medicaid providers requires that each provider must accept Medicaid payment as payment in full and cannot additionally charge patients for Medicaid-covered services. In that context, therefore, this bill would be unnecessary. As currently written, however, this bill would apply to all of the provider's patients, which is not an appropriate role for DSS to regulate.

The Department welcomes a broader conversation with legislators and the proponents of this and other bills being proposed during this legislative session that would condition Medicaid payment or enrollment on a provider's compliance with one or more broader state policy goals not directly related to coverage and payment under Medicaid. Rather than place such conditions on DSS' administration of Medicaid payments, the Department suggests exploring an alternative approach whereby such requirements could be more effectively directed to and enforced by a state agency with an existing regulatory role and enforcement capacity for such policies. Such approach would also help minimize potential unintended consequences of this and other bills taking a comparable approach to conditioning Medicaid payment on various policies not directly related to payment and treatment because it would apply to all providers and all payers, not just Medicaid.

The DSS provider agreement already requires all providers to agree to comply with all generally applicable federal and state laws as being an expectation of being enrolled as a Medicaid provider. However, specifically conditioning Medicaid payment on one or more policies in statute is problematic because it could potentially result in some providers choosing to disenroll from Medicaid and/or reducing the number of Medicaid patients that they serve, which would make access more challenging for people who rely on Medicaid for their health care.

Given the broad priority in promoting access to services, the Department looks forward to a conversation to reconsider the procedural approach that would condition Medicaid payment alone to adherence with specific state policies that might properly be applicable to all health care providers.

## SENATE BILL 1476: AN ACT CONCERNING THE ABLE ACT

This bill updates state statutory language to align with federal statutory references associated with the ABLE Act and clarifies that qualifying contributions to ABLE accounts must be disregarded in state-administered means-tested public assistance programs to the extent permitted by federal law. As DSS already excludes such contributions to the extent permitted by federal law, the Department has no concerns with this clarifying language and supports the bill.

**SENATE BILL 1477: AN ACT CONCERNING A COVERED CONNECTICUT TRUST FUND.**

This bill would establish a separate, non-lapsing account to promote sustainability of health care services in the state through Covered CT, HUSKY Health, and subsidized coverage available through the state's health insurance exchange.

In general, non-lapsing funds for dedicated purposes are problematic because they limit the flexibility needed to implement programs, remain within approved state budgets, and ensure that necessary services are funded within available resources. In this particular context, such a fund would be challenging given the many competing needs for resources both within and outside the specific programs mentioned in this bill (HUSKY Health, which includes Connecticut's Medicaid program and Children's Health Insurance Program (CHIP), Covered CT, and the federal health insurance subsidies offered through Access Health CT).

These concerns are particularly acute given the federal proposals being discussed that, if enacted by Congress, could result in significant reductions in federal funding for one or more of those programs. Currently, the state share of funding for HUSKY and Covered CT are funded under the Medicaid account in DSS. There is no state share for the subsidies through the health insurance exchange, which are federal-only funds.

In addition, the bill indicates that the account shall contain any moneys required by law to be deposited in the account. No such funding was contemplated in the Governor's recommended budget.

For these reasons, the Department opposes this bill.

**SENATE BILL 1475: AN ACT CONCERNING FOOD DESERTS AND THE SNAP PROGRAM.**

Section 1 of this bill would require DSS to develop and implement a plan to participate in the federal Restaurant Meals Program (RMP). Under regular SNAP rules, households are not allowed to use benefits on prepared meals. The RMP is a state option that allows households where all members are homeless, older adults (age 60 or over), or disabled to use their SNAP benefits to purchase prepared meals using their SNAP EBT card at participating restaurants. States can set their own requirements for choosing how many and which restaurants they want to allow to participate in their state's RMP, however restaurants must agree to participate in this program and offer low-cost or discount meals for breakfast, lunch, and/or dinner during regular hours. Low-cost meals are defined as meals that cost less than what would be charged to customers not using SNAP, and discount meals are defined as meals already offered to certain consumers or advertised special (i.e., breakfast, lunch and/or dinner combination meals) or sale priced meals offered to all customers. In addition, these restaurants cannot charge a service gratuity or sales tax.

Currently, nine states operate an RMP on an extremely limited scale[1]. For example, in Rhode Island, which has operated an RMP since 2011, only eight Subway restaurants in two counties have chosen to participate[2]. In New York, which recently began an RMP, there are 104 participating restaurants, of which 72 could be considered a fast-food chain establishment[3]. Finally, in Arizona, which operates one of the largest RMPs, there are approximately 866 participating restaurants, of which at least 600 would be considered fast food chain establishments[4].

To operate a program, a state must have an "EBT-based solution," meaning that both the participating vendors (i.e., the participating restaurants) and the recipients who are permitted to redeem benefits at restaurants must be identified within the EBT system in order to limit participation to eligible SNAP recipients. This would require significant system modifications to both the Department's eligibility system as well as the state's EBT vendor system. In addition, the program has rigorous federally required oversight, monitoring and reporting requirements, which the Department does not currently have the staffing to fulfill.

In order to successfully implement this program, DSS would incur significant costs around contracting and reviewing eligibility for each restaurant interested in participating in the program. DSS does not currently engage in retailer onboarding, oversight, training, compliance, and monitoring, because those functions are performed directly by and at the cost of the federal Food & Nutrition Service (FNS). Should the state decide to pursue the RMP option, these functions and their associated costs would fall solely upon the state. In addition, the state will incur significant costs associated with:

- Modifying the ImpaCT integrated eligibility system to identify eligible participants and transmit this information to its EBT vendor;
- Modifying the ImpaCT eligibility system to send a change of household status to the EBT vendor to restrict access should the household become ineligible;
- Modifying the EBT vendor contract and system to identify and limit participation to only clients who are eligible;
- Modifying the EBT vendor contract and system to identify and limit participation to only authorized transactions made at approved restaurants;
- Developing a system to monitor transactions at participating restaurants for program compliance;
- Developing a system to monitor restaurant compliance to ensure they are abiding by the provisions of the approved memorandum of understanding;
- Dedicated DSS full time employees to administer the program during its start up as well as provide ongoing monitoring; and

[1] https://www.fns.usda.gov/snap/retailer/restaurant-meals-program

[2] https://dhs.ri.gov/media/8261/download?language=en

[3] https://otda.ny.gov/programs/rmp/participating-restaurants/

[4] https://dbmefaapolicy.azdes.gov/FAA5/baggage/MealsProgramRestaurants.pdf?time=1740778300204

- Providing training, outreach, and support to staff, clients, and participating or potential restaurants.

DSS estimates that total one-time costs for system changes, implementation, and outreach to establish an RMP in Connecticut would be approximately $1.2 million as well as ongoing personnel costs of approximately $400,000 in state funds annually associated with the additional staff needed to manage and operate such program.

Given the significant startup and ongoing operational costs noted above, none of which are reflected in the Governor's budget, the Department cannot support this bill.

**SENATE BILL 1473: AN ACT REQUIRING MEDICAID COVERAGE FOR FDA-APPROVED GENE THERAPIES TO TREAT SICKLE CELL DISEASE.**

This bill would require DSS to provide Medicaid coverage for gene therapies approved by the federal Food and Drug Administration (FDA) to treat sickle cell disease.

DSS welcomes the opportunity to offer cutting-edge therapy for our members with sickle cell disease. Pursuant to section 1927 of the Social Security Act, the Medicaid program is already required by federal statute to cover FDA-approved treatments from pharmaceutical manufacturers that participate in the Medicaid Drug Rebate Program, including gene therapies for sickle cell disease. http://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

In addition, the Department formally submitted a federal Centers for Medicare and Medicaid Services (CMS) application for the Cell and Gene Therapy Access Model on March 5, 2025, which would allow the state to participate in federally negotiated prices for the two FDA-approved gene therapies for the treatment of sickle cell disease. Accordingly, while DSS does not oppose the proposal, DSS would suggest the bill is not necessary.

Additionally, the Department would be pleased to provide regular updates, and as requested, on access, utilization, and costs of such therapies in the routine course of legislative communications.

**SENATE BILL 1474: AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES.**

This bill expands Medicaid coverage for weight loss drugs, requires legislative approval by the committees of cognizance of Medicaid state plan amendments not otherwise subject to legislative approval, and requires nonopioid pain management training for prescribers of opioids who receive Medicaid reimbursement.

The Department appreciates the intent of Section 1 of the bill to address obesity, however the Department has significant concerns. First the definition of "weight loss drugs" is limiting and not clinically accurate. The FDA has several approved weight loss drugs and we do not believe it is appropriate to statutorily favor particular drug classes, especially as the clinical evidence

will evolve over time. Second, the fiscal implications of this single class of drugs (GLP-1s) are far-reaching and could compromise other critical benefits offered through the Medicaid program.

The Department estimates that coverage of GLP-1 medications for weight loss would result in costs of $168 million in SFY 2026 ($65 million state share) and $110 million in SFY 2027 ($42 million state share). The Governor's recommended budget does not provide funding for this coverage. For this reason, we do not believe such coverage under the Medicaid program is sustainable at this time, however we are committed to working with stakeholders to identify fiscally responsible ways to offer services to our members with obesity, including nutritional counseling and non GLP-1 weight loss medications.

Section 2 of the proposed bill would require all Medicaid State Plan Amendments (SPAs) not currently subject to submission to the legislature under section 17b-8(a) of the general statutes to be submitted and approved by the Human Services Committee prior to federal submission. This language is administratively burdensome and significantly constrains the Department's necessary flexibility to administer the Medicaid program. Under current law in section 17b-8 of the general statutes, DSS must already submit all Medicaid waivers and all SPAs that would have required a waiver but for the Affordable Care Act to the Appropriations and Human Services Committees. Also under section 17b-28g of the general statutes, the Department must already provide notice to the Appropriations and Human Services Committees for all SPAs prior to submitting to the federal government. In addition to those state requirements, as required by federal Medicaid regulations, DSS publishes notice and has a public comment period for all SPAs that change payment methodologies.

Adding to these existing processes and requiring legislative committee submission, hearing, and approval for federal submission for all SPAs is administratively burdensome and problematic. DSS must submit SPAs to reflect many types of changes to the Medicaid program, mostly technical and routine, including updating fee schedule billing codes to conform to federal updates, implementing rate changes in accordance with the state budget and state legislation, and conforming to the various changes in federal statute, regulations, and guidance.
Adding a requirement for formal legislative committee submission, public hearing, and approval for all of these SPAs would significantly increase the administrative burden and result in administrative delays both for DSS and for the Medicaid program more broadly. In some cases, this delay would make it challenging, if not impossible, to timely implement various types of changes, potentially risking the ability to claim for federal Medicaid matching funds for specified periods of time. State plan amendments must be submitted to CMS no later than the end of the calendar quarter of the SPA's effective date. This process may delay our ability to submit SPAs within the quarter that we implement the applicable service changes, which would prohibit federal claiming on that service until a later date, which would reduce federal Medicaid matching funds that are necessary to fund the Medicaid program. This process would also impede the Department's necessary ability to administer the Medicaid program and make prompt changes to adapt to changes in state and federal policy, clinical best practices, technology changes, and program integrity. Many SPAs need to be promptly noticed, submitted, and implemented. Common examples include SPAs that implement the quarterly federal changes in billing codes and definitions, which the Department is required to implement and which are often available only a period of weeks before the mandatory implementation date. Other SPAs include those

required to comply with federal law or guidance, often in response to federal guidance only provided within weeks of the submission deadline. There are also unexpected SPAs that need to be submitted timely in response to extenuating circumstances, such as the SPA that enabled federal Medicaid matching funds for interim payments for providers whose ability to bill for claims was affected by the cyberattack against a national billing clearinghouse. While DSS is always open to ongoing conversations with legislators and other stakeholders about changes to the Medicaid program, the Department opposes this section of the bill as administratively burdensome and restricting the Department's ability to promptly adapt the Medicaid program to changing needs and requirements for the benefit of the people who rely on Medicaid for their health insurance.

While the Department appreciates the intent of Section 3 to address the overprescribing of opioid drugs, the agency does not believe that the withholding of Medicaid payments is an appropriate regulatory tool. There could be substantial unintended consequences related to access should providers ultimately elect not to enroll in Medicaid. Further, the Department lacks the investigatory and staffing resources to monitor and enforce compliance with continuing medical education requirements.

DSS opposes this bill for the reasons noted above.

**SENATE BILL 1478: AN ACT CONCERNING MEDICAID BILLING BY SCHOOL NURSES AND FOR SPECIAL EDUCATION.**

This bill would establish an interagency task force with the intent of streamlining municipal billing for Medicaid-funded school-based health services.

The Department supports the intent of this bill to expand and improve school districts' ability to bill for Medicaid covered services. The work to streamline Medicaid claiming by enrolled districts is already being undertaken pursuant to PA 24-81, which expanded the School Based Child Health (SBCH) program. Any efficiencies able to be leveraged as part of the SBCH program expansion, while still meeting the program requirements of the federal Centers for Medicare and Medicaid Services (CMS), will be reviewed and implemented. The SBCH expansion is to begin implementation July 1, 2026, subject to federal approval from CMS.

The Department welcomes continued conversation with the Committee on best approaches to expanding and streamlining SBCH billing and claiming.

**SENATE BILL 1471: AN ACT CONCERNING A PILOT PROGRAM TO PROVIDE A COMMUNITY-BASED MEMORY CARE PROGRAM.**

This bill requires that DSS establish a pilot program to provide subsidized memory care services for low-income senior citizens in the city of Hartford.

The Department would face significant challenges to develop a pilot program as required by this bill. Having a targeted catchment area prohibits Medicaid funds and DSS would need to find grant funds, which could be challenging, if not infeasible, and would take time.

While DSS agrees that community memory care services and resources are important, the Department would benefit from the opportunity to thoughtfully study this issue in greater detail in an effort to develop evidence-based services and supports prior to piloting. Currently, DSS is collaborating with the UConn Center on Aging to explore barriers to community success and nursing facility transitions for individuals living with dementia. The study analyzes how different factors are driving disparities for people living with dementia and what potential policy solutions could improve health equity for people living with disabilities through in-depth interviews with individuals eligible for the Money Follows the Person (MFP) program and their informal caregivers, focus groups and surveys with professionals involved in the MFP program, and statistical analysis of a large group of Connecticut Medicaid nursing facility residents.

The research from such study will directly inform and allow DSS to provide more substantive recommendations to the Human Services Committee. DSS respectfully requests that the legislation be amended to require the Department to conduct a feasibility study and report to the legislature by January 31, 2026.

**SENATE BILL 1472: AN ACT CONCERNING MEDICAID-FUNDED SERVICES IN THE DEPARTMENT OF DEVELOPMENTAL DISABILITIES' REGIONAL CENTERS.**

This bill would require the Department of Developmental Services (DDS), in consultation with the Department of Social Services (DSS), to open DDS' regional centers to new applicants by January 1, 2026, and file a report to the legislature by July 1, 2026, regarding the number of new applicants at the regional centers, number of applicants accepted, the cost to the state for accepted applicants, and state appropriations needed to accommodate all interested applicants.

DSS welcomes the opportunity to consult with DDS on improving access and services for this population. However, we respectfully note that this bill would result in a significant expansion of services and an associated increase in costs that have not been contemplated in the Governor's budget. As such, DSS cannot support this legislation.

**SENATE BILL 1470: AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR COMMUNITY HEALTH WORKER SERVICES.**

This bill would require DSS to provide updates twice annually – rather than on an annual basis – with regards to the Department's progress in designing and implementing a Medicaid reimbursement program for community health workers (CHWs).

DSS currently provides access to CHWs through its medical administrative services organization, Community Health Network of Connecticut (CHNCT), the newly launched maternity bundle program, and the Integrated Care for Kids (InCK) program. Additionally, DSS recently implemented a test-and-learn initiative to track and monitor the results of the use of CHWs through CHNCT; preliminary results are expected to be available during the first quarter of 2026.

Additionally, in 2024, DSS convened a work group comprised of 15 members, including 5 CHWs and 10 individuals representing various organizations, advocates, and Medicaid

beneficiaries. The work group engaged in virtual meetings in order to obtain feedback on various topics related to the development of a CHW coverage policy. This feedback, which was published in a final summary report submitted to the legislature, will be used to evaluate and strategize ways to further incorporate the use of CHWs into the Medicaid program, particularly as new Medicaid programs and reimbursement methodologies are developed or redesigned, within available appropriations. In addition to the work group summary report, as required by Public Act 23-186, DSS continues to report annually to the legislature regarding the status of CHW coverage under Medicaid. DSS would suggest that such frequent reporting would not provide any additional information than the current annual report. However, DSS looks forward to continuing the conversation on this issue in an effort to better understand the Committee's concerns with the current amount of information being provided.

**SENATE BILL 807: AN ACT CONCERNING THE ELIMINATION OF ASSET LIMITS FOR HUSKY C BENEFICIARIES OVER A FIVE-YEAR PERIOD.**

This bill requires the Department of Social Services to phase-out the asset limits for HUSKY C over a five-year period. HUSKY C provides health coverage to Connecticut residents who are 65 years of age or older, and/or who are blind or have a disability. The asset limits are currently $1,600 for a single adult and $2,400 for a married couple.

While the Department is generally supportive of efforts to address the affordability and accessibility of health care coverage, this expansion of Medicaid would require a significant amount of funding that is not contemplated in the Governor's recommended budget.

State costs are projected to be approximately $20.5 million ($41 million after factoring in the federal share) in SFY 2026 if the asset limit is increased from $1,600 to $10,000 for an unmarried person, and from $2,400 to $15,000 for married persons. The State costs for SFY 2027 are projected to be approximately $60 million ($120 million after factoring in the federal share) This estimate does not include costs related to long term services and supports nor does it factor in the significant administrative costs to support the increased volume in program enrollment that would result from these changes.

Costs will continue to increase significantly in subsequent years as the bill increases the asset limits further from FY 2027 through FY 2029, with the asset limits fully eliminated beginning in FY 2030. The Department would also incur significant administrative costs to support the increased volume in program enrollment that would result from these changes.

Given the extensive, unsustainable costs involved and the fact that such costs are not included in the Governor's recommended budget, the Department opposes this bill.

**SENATE BILL 806: AN ACT EXPANDING MEDICAID COVERAGE FOR TREATMENT OF CERTAIN EMERGENCY MEDICAL CONDITIONS.**

This bill would (1) establish a new definition for "emergency medical condition," (2) require DSS to expand emergency Medicaid coverage for treatment of specified emergency medical

conditions, and (3) establish an administrative system for persons to apply in advance for emergency Medicaid coverage.

DSS appreciates the intent of this bill but has concerns about aspects of the proposal that do not align with federal laws that limit the state's ability to obtain federal Medicaid reimbursement for services provided to this population as well as the costs of any program expansion that is not funded in the Governor's recommended budget.

Federal regulations at 42 CFR 440.255 provide that individuals who meet all Medicaid requirements except for immigration status will be eligible only for limited emergency medical services "required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;
(ii) Serious impairment to bodily functions; or
(iii) Serious dysfunction of any bodily organ or part."

A wide range of conditions or diagnoses are already covered by emergency Medicaid because such coverage is based upon the emergent status of the event and not the specific diagnosis. As a result, the vast majority of emergency Medicaid services are provided through inpatient emergency admissions. Correspondingly, the state does not routinely cover outpatient services, except for dialysis and related services needed as a result of end stage renal disease, nor do we cover chronic condition "management" as an outpatient service because this would not be in line with the federal definition of emergency Medicaid. Any services provided that do not comply with the federal definition would not qualify for federal Medicaid reimbursement and would require the state to cover all such costs, which would be significant. For context, the average gross cost for existing emergency Medicaid services is approximately $34 million annually. The Governor's recommended budget does not include funding to support such an expansion.

Finally, the bill requires DSS to establish an administrative system for persons to apply in advance for emergency Medicaid coverage for conditions that could be treated in outpatient settings, rather than in hospital emergency departments. While DSS appreciates the intent to streamline the application process for beneficiaries, extensive funding would be required to support both personnel and changes across multiple eligibility and claims payment systems for implementation. These costs are projected to be at least $250,000 to support system modifications plus staff resources of $50,000. These additional costs were not included in the Governor's recommended budget.

For the reasons noted above, DSS cannot support this bill.

**SENATE BILL 805: AN ACT REQUIRING NURSING HOMES TO SPEND NOT LESS THAN EIGHTY PER CENT OF REVENUES ON DIRECT PATIENT CARE.**

This bill requires nursing home facilities to spend at least 80% of Medicaid, Medicare, and all other forms of patient revenue on direct care costs. The Department supports the overall intent of

the bill to provide supports to direct resident care but, as written, believes the bill will have unintended, adverse consequences on total resident care. Connecticut's Medicaid nursing home acuity reimbursement aligns Medicaid spending with the anticipated resource needs of the resident and provides incentives for nursing homes to admit and provide for persons in need of comparatively greater level of care. In 2022, the legislature supported the Department in transitioning Medicaid reimbursement to an acuity-based system, recognizing the importance of: (1) supporting a meaningful continuum of long-term services and supports; (2) aligning Medicaid payments with the acuity of a facility's residents; and (3) preparing providers for value-based payment approaches.

Beginning July 1, 2024, Medicaid reimbursement now fully adjusts to meet the direct care needs of the resident. Acuity-based reimbursement is specifically designed to increase the direct care spend to align with the higher costs to support high-acuity residents and their individual care plans. This bill would inherently undercut the acuity-based reimbursement method and represent a conflicting reimbursement methodology to the now-established acuity-based reimbursement methodology. Making that type of change is both unnecessary and counterproductive since the acuity-based reimbursement is specifically developed and designed to target direct care resources based on the individual care plan of the resident.

This bill would require nursing homes and the Department to track separately revenue from each payor source and monitor the levels of reimbursement from not only Medicaid, but Medicare and private pay, to ensure that 80% is spent on direct care costs. This would require changes to accounting systems to segregate the incoming revenue into separate accounts, and track the outgoing payments cross walked to payroll. This would also require additional Department audit staff and reimbursement staff to track the patient revenue from by payor source. Further, the bill would require the Commissioner to reduce the Medicaid rate for any home that was not in compliance. This would negatively and disproportionately impact Medicaid residents as Medicaid is the majority payor for nursing homes (73% in 2023). Under this bill, if a home is potentially not in compliance with Medicare revenue, the impact would be on the Medicaid rate and not on the revenue source negatively impacting Medicaid. Further, Medicaid has no authority over other payor sources and use of those funds. This would be overreach on the part of Medicaid into other payors and would have a greater impact on residents whose care is covered by Medicaid than residents whose care is funded by other payment sources.

This bill also fails to address other important costs that support resident care in addition to acute direct care as defined in this bill. Medicaid nursing home reimbursement is comprised of five allowable cost components: (1) direct; (2) indirect; (3) capital; (4) administrative and general; and (5) property or fair rent. Each of these five cost components plays an important role in the delivery of total care to nursing home residents. Medicaid may only reimburse for these allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal statutes and regulations. The Department conducts reviews of annual cost report submissions to determine which costs are allowable and which are unallowable for Medicaid reimbursement purposes.

As written, the bill would require 80% of Medicaid funding to be spent solely on the direct care component, which is defined in the bill as "hands-on care provided to a facility resident by

nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care." This would leave only 20% remaining for the other vital nursing home services that support total resident needs, including: (i) dietary staff, food, housekeeping staff, laundry services, and resident supplies; (ii) capital costs such as moveable equipment needed for care; (iii) administrative and general costs such as facility maintenance and plant operation expenses; and (iv) property or fair rent to incentivize facility improvements and building upgrades.

The 80% requirement proposed in this bill would only leave 20% remaining to cover costs that currently account for 49% of the total spend in nursing homes, leaving a shortfall for those important costs such as laundry, food, housekeeping, maintenance and equipment. To put this in financial terms, in 2022, approximately $704 million was spent on direct care and $677 million was spent on the four other necessary cost categories in nursing homes. Under this bill, only 20%, or $276 million would be allowed for other non-direct care costs, leaving a shortfall of over $400 million that would no longer be covered. This would result in a substantial fiscal impact to both nursing homes and the state because nursing homes would likely seek hardship rate relief for those indirect costs.

Forced percentage spending was attempted in New York State which resulted in multiple lawsuits over several years. The end result was the nursing homes and New York negotiating a settlement to resolve disputes that included the state providing additional Medicaid funds for a rebasing, a quality program, and increased staffing ratios. Given challenges faced by New York, the Department proposes exploring lessons learned from our sister states to discuss possible options.

For these reasons, DSS cannot support this bill. However, the Department appreciates the opportunity to continue working with the legislature and stakeholders to promote quality care in the long-term care setting that best supports their particular needs.

**SENATE BILL 11: AN ACT CONCERNING PRESCRIPTION DRUG ACCESS AND AFFORDABILITY.**

This bill seeks to address availability and affordability of prescription drugs through various policies.

**Section 7** requires nursing home facilities to spend at least 80% of Medicaid, Medicare, and all other forms of patient revenue on direct care costs. The Department supports the overall intent of Section 7 to provide supports to direct resident care but, as written, believes this language will have unintended, adverse consequences on total resident care. Connecticut's Medicaid nursing home acuity reimbursement aligns Medicaid spending with the anticipated resource needs of the resident and provides incentives for nursing homes to admit and provide for persons in need of comparatively greater level of care. In 2022, the legislature supported the Department in transitioning Medicaid reimbursement to an acuity-based system, recognizing the importance of: (1) supporting a meaningful continuum of long-term services and supports; (2) aligning

Medicaid payments with the acuity of a facility's residents; and (3) preparing providers for value-based payment approaches.

Beginning July 1, 2024, Medicaid reimbursement now fully adjusts to meet the direct care needs of the resident. Acuity-based reimbursement is specifically designed to increase the direct care spend to align with the higher costs to support high-acuity residents and their individual care plans. This section would inherently undercut the acuity-based reimbursement method and represent a conflicting reimbursement methodology to the now-established acuity-based reimbursement methodology. Making that type of change is both unnecessary and counterproductive since the acuity-based reimbursement is specifically developed and designed to target direct care resources based on the individual care plan of the resident.

This Section would require nursing homes and the Department to track separately revenue from each payor source and monitor the levels of reimbursement from not only Medicaid, but Medicare and private pay, to ensure that 80% is spent on direct care costs. This would require changes to accounting systems to segregate the incoming revenue into separate accounts, and track the outgoing payments cross walked to payroll. This would also require additional Department audit staff and reimbursement staff to track the patient revenue from by payor source. Further, the Section would require the Commissioner to reduce the Medicaid rate for any home that was not in compliance. This would negatively and disproportionately impact Medicaid residents as Medicaid is the majority payor for nursing homes (73% in 2023). Under this bill, if a home is potentially not in compliance with Medicare revenue, the impact would be on the Medicaid rate and not on the revenue source negatively impacting Medicaid. Further, Medicaid has no authority over other payor sources and use of those funds. This would be overreach on the part of Medicaid into other payors and would have a greater impact on residents whose care is covered by Medicaid than residents whose care is funded by other payment sources.

This Section also fails to address other important costs that support resident care in addition to acute direct care as defined in this Section. Medicaid nursing home reimbursement is comprised of five allowable cost components: (1) direct; (2) indirect; (3) capital; (4) administrative and general; and (5) property or fair rent. Each of these five cost components plays an important role in the delivery of total care to nursing home residents. Medicaid may only reimburse for these allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal statutes and regulations. The Department conducts reviews of annual cost report submissions to determine which costs are allowable and which are unallowable for Medicaid reimbursement purposes.

As written, Section 7 would require 80% of Medicaid funding to be spent solely on the direct care component, which is defined by this Section as "hands-on care provided to a facility resident by nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care." This would leave only 20% remaining for the other vital nursing home services that support total resident needs, including: (i) dietary staff, food, housekeeping staff, laundry services, and resident supplies; (ii) capital costs such as moveable equipment needed for care; (iii) administrative and general costs such as facility maintenance

and plant operation expenses; and (iv) property or fair rent to incentivize facility improvements and building upgrades.

The 80% requirement proposed in this Section would only leave 20% remaining to cover costs that currently account for 49% of the total spend in nursing homes, leaving a shortfall for those important costs such as laundry, food, housekeeping, maintenance and equipment. To put this in financial terms, in 2022, approximately $704 million was spent on direct care and $677 million was spent on the four other necessary cost categories in nursing homes. Under this bill, only 20%, or $276 million would be allowed for other non-direct care costs, leaving a shortfall of over $400 million that would no longer be covered. This would result in a substantial fiscal impact to both nursing homes and the state because nursing homes would likely seek hardship rate relief for those indirect costs.

Forced percentage spending was attempted in New York State which resulted in multiple lawsuits over several years. The end result was the nursing homes and New York negotiating a settlement to resolve disputes that included the state providing additional Medicaid funds for a rebasing, a quality program, and increased staffing ratios. Given challenges faced by New York, the Department proposes exploring lessons learned from our sister states to discuss possible options.

For these reasons, DSS cannot support this Section. However, the Department appreciates the opportunity to continue working with the legislature and stakeholders to promote quality care in the long-term care setting that best supports their particular needs.

**Section 8** would (1) establish a new definition for "emergency medical condition," (2) require DSS to expand emergency Medicaid coverage for treatment of specified emergency medical conditions, and (3) establish an administrative system for persons to apply in advance for emergency Medicaid coverage.

DSS appreciates the intent of this Section but has concerns about aspects of the proposal that do not align with federal laws that limit the state's ability to obtain federal Medicaid reimbursement for services provided to this population as well as the costs of any program expansion that is not funded in the Governor's recommended budget.

Federal regulations at 42 CFR 440.255 provide that individuals who meet all Medicaid requirements except for immigration status will be eligible only for limited emergency medical services "required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;
(ii) Serious impairment to bodily functions; or
(iii) Serious dysfunction of any bodily organ or part."

A wide range of conditions or diagnoses are already covered by emergency Medicaid because such coverage is based upon the emergent status of the event and not the specific diagnosis. As a

result, the vast majority of emergency Medicaid services are provided through inpatient emergency admissions. Correspondingly, the state does not routinely cover outpatient services, except for dialysis and related services needed as a result of end stage renal disease, nor do we cover chronic condition "management" as an outpatient service because this would not be in line with the federal definition of emergency Medicaid. Any services provided that do not comply with the federal definition would not qualify for federal Medicaid reimbursement and would require the state to cover all such costs, which would be significant. For context, the average gross cost for existing emergency Medicaid services is approximately $34 million annually. The Governor's recommended budget does not include funding to support such an expansion.

Finally, this Section requires DSS to establish an administrative system for persons to apply in advance for emergency Medicaid coverage for conditions that could be treated in outpatient settings, rather than in hospital emergency departments. While DSS appreciates the intent to streamline the application process for beneficiaries, extensive funding would be required to support both personnel and changes across multiple eligibility and claims payment systems for implementation. These costs are projected to be at least $250,000 to support system modifications plus staff resources of $50,000. These additional costs were not included in the Governor's recommended budget.

**Section 9** of the bill requires DSS to phase-out the asset limits for HUSKY C over a five-year period. HUSKY C provides health coverage to Connecticut residents who are 65 years of age or older, and/or who are blind or have a disability. The asset limits are currently $1,600 for a single adult and $2,400 for a married couple.

While the Department is generally supportive of efforts to address the affordability and accessibility of health care coverage, this expansion of Medicaid would require a significant amount of funding that is not contemplated in the Governor's recommended budget.

State costs are projected to be approximately $20.5 million ($41 million after factoring in the federal share) in SFY 2026 if the asset limit is increased from $1,600 to $10,000 for an unmarried person, and from $2,400 to $15,000 for married persons. The State costs for SFY 2027 are projected to be approximately $60 million ($120 million after factoring in the federal share). This estimate does not include costs related to long term services and supports nor does it factor in the significant administrative costs to support the increased volume in program enrollment that would result from these changes.

Costs will continue to increase significantly in subsequent years as the bill increases the asset limits further from FY 2027 through FY 2029, with the asset limits fully eliminated beginning in FY 2030. The Department would also incur significant administrative costs to support the increased volume in program enrollment that would result from these changes.

Given the extensive, unsustainable costs involved and the fact that such costs are not included in the Governor's recommended budget, the Department opposes this Section.

**Sections 13 and 14** reference coverage of generic forms of glucagon-like peptide (GLP-1) prescription drugs approved by the FDA to treat obesity or diabetes. Currently there are two

generic GLP-1s approved by the federal Food and Drug Administration (FDA) to treat type 2 diabetes and we cover both. There are no generic GLP-1s that are FDA approved to treat obesity at this time.

Section 13(a) requires the Commissioner of Social Services to petition the Secretary of the U.S. Department of Health and Human Services (HHS) to authorize generic, lower cost forms of GLP-1s approved by the FDA to treat obesity or diabetes. It is unclear exactly what this means and if it is necessary. We already cover medications for diabetes – both brand name and generic forms. Coverage of weight loss medications is optional under 42 U.S.C. 1396r–8 and we do not allow for coverage in our state plan at this time. A Medicaid State Plan amendment would be the pathway required to request federal approval to add Medicaid coverage of this class of drugs. For example, DSS intends to amend the prescription drug section of the Medicaid State Plan to add two oral medications approved by the FDA for weight loss. There is no need to "petition" the Secretary of Health and Human Services to amend our State Plan; DSS would simply submit a Medicaid State Plan amendment to the Centers for Medicare and Medicaid Services within HHS. As noted above, there are currently no generic FDA approved GLP-1s to treat obesity so an amendment to add these would be premature at this time.

Section 13(c) speaks to the development of a strategic plan to maximize access to and minimize the cost of these drugs. We currently cover medications for diabetes and have agreements in place with manufacturers to minimize the cost of these drugs. A similar process is already followed for all medications that we cover. Given the processes in place, the Department does not believe a strategic plan is needed.

Section 14 establishes an advisory committee to study ways to maximize access to cost-effective prescription drugs approved by the FDA to treat obesity and make recommendations to the Commissioner. It does not speak to prescription drugs to treat diabetes, nor does it reference generics. The Department always welcomes advice and input on strategies to be cost-effective and strongly supports an advisory committee. The Department recommends allowing the advisory committee to proceed before requirements of coverage be dictated.

Section 14(d) references the strategic plan from Section 13(c). As previously mentioned, this plan is unnecessary as DSS already has a process in place.

As DSS currently covers generic GLP-1s that are FDA approved to treat diabetes and there are no generic GLP-1s that are FDA approved to treat obesity, DSS does not think Section 13 is necessary. The Department strongly supports establishing an advisory committee and would be happy to participate to inform the most effective and efficient path forward for weight loss treatment, including medication.

**Section 15** expands Medicaid coverage for weight loss drugs, requires legislative approval by the committees of cognizance of Medicaid state plan amendments not otherwise subject to legislative approval, and requires nonopioid pain management training for prescribers of opioids who receive Medicaid reimbursement.

The Department appreciates the intent of subsection (b) to address obesity, however the Department has significant concerns. First the definition of "weight loss drugs" is limiting and not clinically accurate. The FDA has several approved weight loss drugs and we do not believe it is appropriate to statutorily favor particular drug classes, especially as the clinical evidence will evolve over time. Second, the fiscal implications of this single class of drugs (GLP-1s) are far-reaching and could compromise other critical benefits offered through the Medicaid program.

The Department estimates that coverage of GLP-1 medications for weight loss would result in costs of $168 million in SFY 2026 ($65 million state share) and $110 million in SFY 2027 ($42 million state share). The Governor's recommended budget does not provide funding for this coverage. For this reason, we do not believe such coverage under the Medicaid program is sustainable at this time, however we are committed to working with stakeholders to identify fiscally responsible ways to offer services to our members with obesity, including nutritional counseling and non GLP-1 weight loss medications.

**Section 20** would set various requirements related to the coverage of insulin. The Department understands the intent of this bill to enable insurance coverage for no-cost insulin at the lowest wholesale acquisition cost. The Department already covers insulin for people who use Medicaid for health insurance and does not require any cost-sharing. The language in subsection (b) assumes a commercial insurance plan structure, so the Department would suggest clarifying language in the definitions section to confirm that this section does not apply to Medicaid.

With regards to **Sections 28 to 36** of the bill, the Department is in support of overlapping provisions related to the drug importation study also contained in the Governor's Prescription Affordability bill, HB 6870.

The Department of Social Services (DSS), as the state Medicaid agency, currently spends over $1 billion in gross expenditures on prescription medication on an annual basis. Even though the Department actively pursues and is successful in securing federal rebates and manufacturer supplemental rebates whenever possible, prescription medication costs are increasing, and our overall rebate percentage is decreasing.

DSS is aware that the federal Food and Drug Administration (FDA) has set forth a process under section 804 of the Federal Food, Drug, and Cosmetic Act (FD&C Act) that allows importation of certain prescription drugs from Canada to: "significantly reduce the cost of these drugs to the American consumer, without imposing additional risk to public health and safety."

The prescription drug importation feasibility pathway contained in this bill, to be conducted by the Department of Consumer Protection, will help DSS understand the opportunities to reduce pharmaceutical costs and will support efforts to focus more on prevention and wellness-based approaches that can contain costs and improve outcomes for our members in the long term. It will also help identify the operational and safety factors that should be considered for a future implementation strategy, as well as best practices and lessons learned from other states that have explored prescription drug importation from Canada, including Florida, specifically for the Medicaid program.

**HOUSE BILL 7192: AN ACT IMPLEMENTING RECOMMENDATIONS OF THE BIPARTISAN DRUG TASK FORCE.**

The Department appreciates the opportunity to have participated in the bipartisan drug task force, including various subcommittees of the task force. Likewise, the Department looks forward to participating in future discussions about how best to address prescription drug access, cost containment, and quality. In particular, we look forward to understanding the opportunities to improve prescription affordability through Canadian drug importation as outlined in the governor's prescription affordability bill, HB 6870.

The Department will continue to engage and provide recommendations on maximizing the benefits to the Medicaid program and the people we serve for any potential changes in the state's policies regarding prescription drugs. As an example, the Department would be happy to participate in the task force to study emergency preparedness and mitigation strategies for prescription drug shortages as set forth in section 15 of this bill.

**HOUSE BILL 7188: AN ACT CONCERNING HOMELESSNESS AND THE CHESS PROGRAM.**

Section 1 of this bill requires the Department of Housing (DOH) to prioritize housing vouchers (state and federal) for recipients of the Connecticut Housing Engagement and Support Services (CHESS) initiative under Medicaid. Section 2 of this bill establishes a new legislative oversight committee for homeless persons and would require the Commissioners of Housing and Social Services to file quarterly reports and to seek approval from such committee prior to making any changes to services for homeless persons.

The Department appreciates the intent of this bill to bolster housing and other supports for people experiencing homelessness. Per recent DSS review into the CHESS initiative, DSS has learned that there have been various operational and logistical challenges with the implementation of CHESS. As such, The Department is recommending that the state sunset the CHESS program as we know it and transition the housed members to the Department of Mental Health and Addiction Services (DMHAS). The Department continues to work with our partnering state agencies in helping to address the challenges of homelessness, including DOH and DMHAS, all of whom participated in writing said report. The Department also participates in the Interagency Council on Homelessness, which aims to enhance collaboration among agencies to improve housing opportunities and services for people experiencing homelessness.

The Department welcomes ongoing conversations with legislators, providers, and other stakeholders on best approaches to improving the service system for people experiencing homelessness. These conversations are important to help inform further revisions to this bill. In particular, the Department is not in a position to comment on the availability of housing vouchers administered by DOH and would defer to DOH to detail the availability of vouchers. As currently written, the language in section 1 is very prescriptive in only allowing prioritizing for recipients of CHESS. Especially given the challenges with CHESS noted in the report referenced above, it is important that any such language be sufficiently flexible to enable such

vouchers to be used in the most effective manner possible, not dependent on the specific nature of the CHESS initiative.

Section 2 would also benefit from some substantial revisions. More broadly, while the Department is open to further discussions and forums regarding services for homelessness, any oversight council would ideally coordinate with other existing committees (such as the Interagency Council on Homelessness) and also engage with a variety of stakeholders. As currently written, this committee includes legislators but does not include any other stakeholders, including the state agencies, service providers, and people experiencing homelessness.

Most challenging, the language in section 2(c) would require DOH or DSS, as applicable, to receive approval from such committee prior to making changes to services. This language is problematic because it is overly prescriptive and administratively burdensome. Both DSS and DOH need the flexibility to adapt services to current need, state and federal requirements, and available resources. It would impair that key agency flexibility to require approval from this new oversight committee for any changes to their programs and services. As important context, section 17b-8(a) of the General Statutes already requires legislative committee approval for changes to the Medicaid services under CHESS because the CHESS Medicaid State Plan provisions under section 1915(i) of the Social Security Act would have required a waiver but for the Affordable Care Act and the section 1915(b)(4) selective provider contracting waiver for CHESS is a Medicaid waiver.

For these reasons, while the Department cannot support the bill as currently written, we welcome further conversations on how best to improve services for people experiencing homelessness.

**HOUSE BILL 7191: AN ACT CONCERNING MEDICAID RATE INCREASES, PLANNING, AND SUSTAINABILITY**

While the Department appreciates the intent of Section 1 of this bill, it is duplicative of work currently being performed. The Medicaid Rate Study is a data driven review of rate parity for Connecticut Medicaid rates when compared to Medicare or peer states. Rate studies are not intended to make specific recommendations with respect to dollar amounts or recommendations for policy changes. Instead, rate studies are one tool the Department is using to identify areas of the program that require further analysis and examinations for future changes. This bill would require Medicaid rate increases to 75% of the rate study findings but this would not necessarily be efficient or appropriate to provide blanket increases for the entire program. Ultimately, any investments in Medicaid rate increases must be targeted to access needs and improved outcomes for the Medicaid participants. In addition, funding for increases at that level is not included in the Governor's recommended budget.

Instead, the Department is focusing on areas of the rate study that showed the greatest disparity. DSS is currently developing recommendations in hopes of continuing the conversation with the legislature on the best path forward. These recommendations include rate adjustments that target quality outcomes for members. Blanket rate increases do not target spend where the greatest need is, nor does this approach support quality or services that are most vital to member need. The Department is working to identify which services support member care for targeted

increases to ensure funding is used most efficiently and for member need. With regards to Section 1(e) of the bill, DSS is currently undergoing such work.

The Department also opposes Section 2 of this bill. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L 106-554) ("BIPA") created a "prospective payment system" (PPS) for FQHCs in all states and territories. Federal authority allows states to develop a "change in scope" process for FQHCs to adjust their reimbursement to reflect changes in practice or services. The Department has been attempting to actively engage with the FQHCs to revise the current change in scope process and, given the agency's attempts at ongoing discussions during an exceptionally challenging and unpredictable national fiscal landscape, believes this section runs counter to a constructive review of FQHC rates in a fiscally responsible and sustainable manner. In addition, rebasing encounter rates would require a Medicaid State Plan amendment from the federal Centers for Medicare and Medicaid Services (CMS) for federal claiming purposes. Rebasing using 2024 cost reports, as proposed, is infeasible for two reasons. First, 2024 cost reports have not yet been filed and, second, they must be audited. Filings and audits cannot be completed within the timeframe proposed in this bill. DSS is required to ensure the validity of any costs used in a rebasing for federal claiming purposes. Relying on unaudited cost reports for rebasing would risk the state's ability to claim federal matching funds.

Section 2 of the bill would also eliminate the current requirements under section 17b-245d for FQHCs to timely notify the Department of changes in scope of services or project approvals by the federal Health Resources and Services Administration (HRSA) by repealing subsections (b) through (e) of the current statute. The repeal of such notification requirements would result in unpredictable and large requests for rate adjustments for purported changes in scope that may have occurred many years prior that, by definition, would be impossible to place into any budgetary projections for an upcoming fiscal year. Notably, these costs would be <u>in addition</u> to the increases already included in the FQHCs' annual Medicare Economic Index (MEI) inflationary adjustments; an annual rate enhancement that other healthcare providers do not receive. While the Department continues to review its provider rates in a fiscally responsible and sustainable way, these proposed changes would introduce substantial fiscal instability into the state budget, making it extremely difficult, if not impossible, for the state (or any person or entity relying on Medicaid funding) to plan and project fiscal appropriations to address the ongoing needs of our residents and healthcare providers.

Lastly, the Department also opposes Section 3 of this bill because it is not funded in the Governor's recommended budget. Federal law requires states to increase the FQHC PPS rate annually by the MEI inflation factor established by the federal government. Rates are currently increased annually at the start of the federal fiscal year (November 1). Shifting the date in which the index is applied to January 1st would require funding which is not currently accounted for in the Governor's recommended budget.

For these reasons, DSS opposes this bill.

**HOUSE BILL 7189: AN ACT CONCERNING MEDICAID COST SAVINGS.**

This bill requires the Department to review the current policy and requirements regarding nurse delegation for medication administration and potential cost savings related to the expansion of nurse delegation. DSS is to prepare and submit a report to the Human Services and Public Health Committees by October 1, 2025.

The Department supports the initiative to study and learn more about medication administration and the impacts delegation may have to nursing homes as well as other settings where Medicaid is the payer for medication administration. This study would also provide a helpful opportunity to better understand potential cost savings. If this bill moves forward, the Department intends to engage with various stakeholders in this review. In order to ensure the Department has sufficient time for a thorough review, the Department recommends that the due date for the report be moved to January 31, 2026.

**SENATE BILL 1251: AN ACT IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS FOR HEALTH AND HUMAN SERVICES**

DSS supports the Governor's recommendations for health and human services. Detailed below are the provisions that directly impact the Department:

**Sections 2 and 3** of the bill maintains current benefits levels for the state-administered general assistance program (SAGA) and the state supplement to the federal Supplemental Security Income Program (State Supplement) for state fiscal years 2026 and 2027. Current statute provides recipients of SAGA and State Supplement cash assistance a state-funded cost of living adjustment on July 1 of each year. This bill maintains the existing assistance levels. Savings of $1.7 million in FY 2026 and $3.3 million in FY 2027 are anticipated.

**Sections 4 and 5** of the bill repeal the one-time domestic violence benefit established pursuant to Public Act 21-78. DSS has encountered numerous operational and design challenges associated with determining eligibility and administering this one-time domestic violence benefit. Additionally, there was no funding added when the legislation was passed as it was expected to have a minimal fiscal impact. Since that time, however, costs have continued to climb with expenditures totaling $2.9 million in FY 2024 and projected costs of $4.0 million in FY 2025—resulting in significant deficiencies in DSS' SAGA account.

To address these challenges, the Governor's budget eliminates funding for this benefit under the SAGA account and restructures the program to support victims of domestic violence directly through the Connecticut Coalition Against Domestic Violence (CCADV). As part of this restructuring effort, the Governor's budget provides increased funding to CCADV of $1.5 million in both FY 2026 and FY 2027. This increase will allow CCADV to expand their domestic violence support and allow the state to more appropriately and efficiently administer domestic violence assistance by further utilizing CCADV's infrastructure and expertise in supporting residents experiencing domestic violence. Savings of $4.0 million in FY 2026 and FY 2027 are anticipated.

**Section 6** eliminates coverage of weight loss medications for obesity only. Although Public Act 23-94 requires DSS to cover weight loss medications for individuals with severe obesity, funding for the costs of such drugs was not included in the enacted budget. With Medicaid costs soaring hundreds of millions beyond budgeted levels and given complications regarding the state's ability to receive supplemental rebates on the newer GLP-1 drugs such as Wegovy and Zepbound (for non-diabetic members) under the current BMI criteria, DSS is moving forward with coverage of nutritional counseling in early 2025 and exploring additional programs to assist with weight loss. Given the significant cost of the newer GLP-1 drugs and the fact that they are generally lifelong drugs that must be taken continuously to maintain weight loss, this bill removes this coverage when prescribed only for weight loss. The bill maintains coverage of weight loss drugs for Medicaid members with type 2 diabetes, as well as when prescribed for the treatment of comorbid conditions, subject to prior authorization and step therapy when clinically appropriate. Given the nature of these medications and the interplay with dietary and nutritional counseling, as well as budgetary considerations, the bill provides for a step therapy period of up to 180 days, when applicable, to support additional agency flexibility in covering certain medications in this developing area. The language also aligns with the recent expansion of coverage of Wegovy when prescribed to reduce the risk of a major adverse cardiac event. Recognizing that several payers have been forced to either stop or drastically modify the clinical criteria for GLP-1s due to the high cost of these drugs, it is essential that DSS move forward with a thoughtful approach that takes into account appropriate clinical guidelines and fiscal accountability and does not risk putting the department in a position of having to reverse an expansion due to lack of funding. Savings of $28.8 million in FY 2026 and $16.9 million in FY 2027 ($72.0 million in FY 2026 and $42.1 million in FY 2027 after factoring in the federal share), with savings figures higher in FY 2026 due to the six-month lag in receipt of federal rebates.

*Note: These savings figures reflect what was assumed in the Governor's budget. DSS' updated estimate, after factoring in savings from averted complications related to obesity such as high blood, pressure, coronary issues, etc., projects costs of over $65.0 million in FY 2026 and $42.4 million in FY 2027, which is more than double what had been assumed in the Governor's baseline budget.*

**Sections 7, 8 and 10** maintain current rates for residential care homes and rated housing facilities. Under current statute, DSS is required to annually determine rates for residential care homes and rated housing facilities. Per DSS' regulations, rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates these rate increases over the biennium and, for rated housing facilities that choose not to submit annual cost reports, maintains the minimum flat rate at current levels. Savings of $1.8 million in FY 2026 and $4.8 million in FY 2027 are anticipated.

**Section 9** maintains current rates for intermediate care facilities. To comply with current statute, the baseline budget includes an inflationary adjustment in FY 2027 for intermediate care facilities for individuals with intellectual disabilities. DSS is required to provide inflationary increases barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates this increase in FY 2027. Note: Pursuant to Public Act 23-204, no inflationary factor

is to be applied in FY 2026, the final year of the rebasing of these rates. Savings of $1.0 million in FY 2027 ($2.2 million in FY 2027 after factoring in the federal share) are anticipated.

**Sections 11 and 12** maintain current rates that reflect full implementation of the acuity based reimbursements for nursing homes. To comply with current statute, the baseline budget includes an inflationary adjustment in each year of the biennium for nursing homes. DSS is required to provide these inflationary increases barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates these increases over the biennium. Savings of $14.0 million in FY 2026 and $36.5 million in FY 2027 ($30.3 million in FY 2026 and $79.0 million in FY 2027 after factoring in the federal share) are anticipated. Further, a rerun of the nursing home average rates updated post the rate study show Connecticut compares more favorably to peer states seeing the average rate increase with the implementation of acuity reimbursement.

**Section 13** restructures cost sharing under the state-funded home care program. The state-funded home care program helps older adults who are frail enough to require nursing home care remain at home and avoid being unnecessarily institutionalized with participants currently required to pay a flat percentage of their monthly care costs. The required cost share has varied over the years – in FY 2016, it was increased from 7% to 9%, but was reduced to 4.5% in FY 2022, and then further reduced to 3% in FY 2023. This bill modifies the current structure by increasing the cost share from 3% to 5% but instituting a monthly cap of $175. This change will encourage those with higher needs to take advantage of additional help without incurring more costs while also resulting in modest cost savings to the state. Savings of $400,000 in FY 2026 and $500,000 in FY 2027 are anticipated.

**Section 14** maintains MED-Connect income and asset limits at April 2025 levels. Public Act 24-81 expanded the Medicaid for Employees with Disabilities Program (MED-Connect), which provides Medicaid coverage to employees with disabilities. Specifically, it required DSS to (1) increase the income limits from $75,000 to $85,000 and double the asset limit (to $20,000 for individuals and $30,000 for couples) effective April 1, 2025, and (2) phase in the elimination of income and asset limits over four years beginning July 1, 2026, by annually increasing the income limit by $10,000 and the asset limit by $10,000 for individuals and $15,000 for couples, with all income and asset limits to be lifted effective July 1, 2029. When fully annualized in FY 2030, this expansion in coverage is projected to result in state costs of over $8.3 million ($16.6 million after factoring in the federal share). Given the significant costs, this bill maintains the income and asset limits at those levels that will be in place effective April 1, 2025. Savings of $1.0 million in FY 2027 ($2.1 million after factoring in the federal share) are anticipated.