Testimony before the Human Services Committee
Commissioner Andrea Barton Reeves
Department of Social Services
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Good Afternoon, 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.

HOUSE BILL 7101: AN ACT ESTABLISHING A COMMISSION TO STUDY A HUSKY FOR ALL SINGLE-PAYER UNIVERSAL HEALTH CARE PROGRAM.

This bill establishes a Commission to study and make recommendations concerning the establishment of a HUSKY for All Single Payer Universal Health Care Program.

The Department welcomes this Commission and appreciates the opportunity to research and explore this issue. We appreciate the work of the Human Services Committee and the Department's inclusion on this Commission. The Department would note, however, that there is no funding in the Governor's recommended budget to support the work required to develop and implement a single payer program.

HOUSE BILL 7102: AN ACT CONCERNING MATERNAL AND INFANT HEALTH CARE.

This bill requires the Office of Health Strategy, in consultation with DSS and the Department of Public Health, to develop a strategy to increase birth centers and birthing hospitals in underserved regions of the state with a high percentage of Medicaid recipients, increase Medicaid reimbursement for doulas and expand the role of fathers in supporting maternal and infant health.

DSS launched the maternity payment bundle on January 1, 2025, and started covering doulas and lactation supports services within the bundled payment. Additionally, effective January 1, 2025, DSS added coverage for stand-alone doula services for members who are not already receiving doula services through the maternity bundled payment. One of the goals of the maternity payment bundle is to improve access to quality maternal healthcare and eliminate disparities in maternal and birth outcomes. Our hope is that as the payment bundle matures, it will provide opportunities for increases in birth centers, midwifery care and birthing hospitals, especially in

rural areas. A strategy to increase birth centers and birthing hospitals in underserved regions of the state must be spearheaded by our sister agency, the Department of Public, with the Department of Social Services and other relevant agencies and organizations as collaborators. The bill's proposed rate increase for doulas is not included in the Governor's recommended budget and therefore DSS cannot support this bill.

HOUSE BILL 7103: AN ACT CONCERNING THE KATIE BECKETT WORKING GROUP RECOMMENDATIONS.

This bill proposes the implementation of numerous recommendations from the Katie Beckett Waiver Working Group, which DSS had an opportunity to participate in over the last year. DSS was able to have very meaningful interactions as a participant in the working group and was able to share a significant amount of data, as well as share the limitations that we have as an agency. While the Department appreciates the intent and understands the origin of these provisions, the Department must oppose some of the recommendations made in this bill.

Section 1 increases the maximum age for participants to access the waiver to 18. DSS supports this recommendation but suggests clarifying "under 18" because once an individual with a disability turns 18, they can access Medicaid through the HUSKY C coverage group, and no longer need the benefit provided by the Katie Beckett waiver to qualify. This will require a waiver amendment with CMS.

DSS does not support Section 2 as currently written. Several of the items requested are already available online on the DSS website. Additionally, the Department committed, in the working session, to include a dashboard with waitlist details for families. Creating a portal for waitlist participants, however, is costly and time consuming, and there is currently no mechanism for individuals to log in and track their application. Given the potential costs of developing a portal and the information that is already available or will be forthcoming in the near future, the Department does not support adding website content requirements into statute.

Section 3 proposes several recommendations regarding the creation and dissemination of an informational program brochure. The Department does not have concerns with creating the materials, but requests that the mandatory dissemination language be removed and replaced with a requirement to post the brochure on our website in order to avoid the costs associated with distribution to a vaguely-defined cohort of recipients.

Section 4 directs the Department to establish a 5-year plan to eliminate the waitlist for the Katie Beckett waiver. The Department is open to developing a plan with actionable steps that can be taken by DSS in coordination with legislative and stakeholder input. We do not feel this needs to be designated with a time frame of 5 years or be a formal submission and agree to work collaboratively. The Katie Beckett waiver will need to be amended and approved by CMS to address any changes, including what is proposed in Section 1 and items in the plan to address the waitlist. As with all waiver amendments, it will need to be approved by the Human Services and Appropriations Committees before it can be submitted to CMS. Based on the current waitlist of 331, the Department estimates the cost to eliminate the waitlist to be approximately $17.1 million in gross costs when fully annualized ($8.6 million state share). The Department has

provided the working group with the fiscal impact and needed appropriations to eliminate the waitlist. The Department is open to working on these recommendations but emphasizes that the central need is funding. The Governor's proposed budget does not include such funding.

HOUSE BILL 7104: AN ACT CONCERNING PROGRAMS TO MITIGATE THE BENEFITS CLIFF.

The Department supports Section 1 of this bill, which would disregard financial assistance an individual receives from direct transfer pilot programs, as well as stipends an individual receives as part of their participation in certain job training programs, when counting income for purposes of eligibility for the Temporary Family Assistance (TFA) program and Supplemental Nutrition Assistance Program (SNAP).

This section allows DSS to support innovative private, non-profit, academic, and philanthropic organizations as they explore new ways of advancing economic mobility and improving the health and well-being of state residents. In particular, DSS seeks to ensure that the pilot program testing of new methods to improve resident well-being through direct cash transfers is not negatively impacted by the department's concurrent provision of critical food and basic needs assistance to our low-income residents. DSS can accomplish this outcome by disregarding payments made to pilot program participants from the calculation of benefits and eligibility in TFA and SNAP.

DSS is aware of several ongoing or planned direct cash transfer pilot programs in Connecticut targeted to families and individuals with significant life challenges or opportunities for economic mobility. Pilot program participants are expected to include the families of pediatric cancer patients, housing insecure families on waitlists for shelter beds, individuals recently returning to the community from incarceration, and pregnant parents. While not all program participants are DSS clients, many of them are. In order for these programs to be able to test the impact of direct cash transfers at key life moments, it is important that participation in the pilots not lead to the disruption of other basic assistance benefits that families need.

Of note, these programs are not state-funded – rather, the transfers come from privately-funded programs, which will potentially bring in millions of new dollars to the state that otherwise may be disbursed in other states. Additionally, these benefits are temporary and research-oriented. The pilot programs that the Department is aware of are all time-limited and the proposed bill requires that they be of both a limited duration and have a defined research and evaluation component. Furthermore, the pilot programs do not negate other programmatic rules around applying for and receiving DSS benefits. DSS program beneficiaries will be required to continue to comply with program work requirements and penalties for quitting a job if they wish to maintain DSS benefits.

The second part of Section 1 seeks to disregard income that an individual would receive for participation in specific job training programs. DSS would not count such stipends as income when determining eligibility for SNAP and TFA.

Currently, if an individual is receiving DSS benefits such as SNAP or TFA, and they receive a new source of income, it would reduce their benefit amount or could potentially cause their benefits to be discontinued. The tradeoff for a one-time or limited duration job training stipend that would cause a corresponding loss of critical food and basic needs cash assistance will in many cases result in beneficiaries choosing to forgo the job training program. In order to incentivize participation in job training programs and support the economic mobility opportunities of DSS clients, this legislation would allow the Department to exclude certain job training stipends from income eligibility determinations in SNAP and TFA.

Participating members would still need to meet all other programmatic requirements in order to maintain eligibility for DSS programs.

The Department does not anticipate that the provisions in Section 1 will have any impact to the state budget, as no additional funding is being requested to provide new job stipends. To the extent that this legislation assists DSS program beneficiaries to obtain stable, long-term employment, those individuals would potentially no longer need public assistance and thus result in cost savings. Failure to pass this legislation would result in the status quo with DSS program beneficiaries less likely to participate in job training programs due to the corresponding loss of essential benefits.

HOUSE BILL 7105: AN ACT CONCERNING FORENSIC AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.

The Department of Social Services recognizes the need to monitor and ensure the financial security and stability of long-term care facilities in the State of Connecticut. As such, DSS supports the development of new mechanisms to provide the state with enhanced abilities to monitor a facility's financial stability and better equip agencies to protect the health, safety, and overall well-being of patients and residents of long-term care facilities experiencing serious financial distress.

The proposed amendments to section 17b-99a of the general statutes will more clearly define when a forensic audit will be conducted, provide that long-term care facilities may be subject to recoupment against future Medicaid funds for the costs of a forensic audit ordered by DSS, and subject a facility to civil monetary penalties for failure to cooperate with such forensic audit.

The general intent of these amendments is two-fold: (1) to prevent or identify serious financial mismanagement at facilities that may place both state funding and resident health, safety, and well-being at risk; and (2) to promote financial transparency and ensure that the state is made aware of any facility experiencing serious financial hardship and, should a forensic audit be deemed necessary, provide that the state is not liable for the entirety of the costs of such forensic audit. Ultimately, this proposal will help ensure that Medicaid funding is being properly managed and better safeguard the residents of a facility that may be experiencing serious financial distress by preventing the potential escalation of disruption to resident care as a result of fiscal mismanagement.

As the Department has seen in recent months, the closure of a nursing home can occur when a facility is facing significant financial difficulties. Such closures place the state in a difficult position of managing the closure process, protecting resident safety, and ensuring the best use of Medicaid dollars. These potentially avoidable situations place significant strain on state agency resources and might be limited through advanced financial auditing.

This proposal intends to incentivize facilities to proactively engage in responsible fiscal management and accounting while providing DSS with mechanisms to examine a facility's financial health and stability in order to protect the well-being of the residents.

As such, the Department urges passage of this bill.

HOUSE BILL 7106: AN ACT CONCERNING RECOMMENDATIONS OF AN ADVISORY COUNCIL ON WHEELCHAIR REPAIR.

This bill makes several recommendations regarding Medicaid coverage and payment for wheelchair repairs based on an advisory council on wheelchair repairs. DSS has and continues to engage with various stakeholders, including participation on the advisory council on wheelchair repair, to make improvements to our procedures to strengthen access to complex wheelchairs and the quality of these Medicaid services. This bill proposes to implement the following changes that will result in an impact to Medicaid coverage and reimbursement of wheelchairs and mobility scooters.

First, this bill proposes to add mobility scooters as an additional category of service covered by provisions of the bill, including but not limited to, prescription and prior authorization requirements, coverage and reimbursement changes for repairs and maintenance. DSS understands the addition of mobility scooters to portions of this proposed bill as this equipment provides mobility to Medicaid members who need such equipment to the same extent as a customized wheelchair. DSS notes, however, that the addition of mobility scooters will result in a fiscal impact as outlined below.

Secondly, this bill defines "emergency repair" as "repair services when a wheelchair or mobility scooter is completely inoperable on weekends and holidays and may include remote repair services if such service renders the wheelchair or mobility scooter operable." Currently, DSS provides reimbursement for repairs of medically necessary customized wheelchairs and mobility scooters when such repairs are performed in-person by a repair technician. These services are billed in 15-minute increments when a repair or nonroutine service for durable medical equipment requires the skill of a technician's labor. The current coding and reimbursement do not include "remote" repairs and would result in new expenditures to the department. DSS would need to research the need for a different reimbursement mechanism and rate to address the differences between in-person, hands-on repairs and remote repairs. Additionally, reimbursement for remote repairs will result in new expenditures which DSS cannot quantify at this time due to lack of data. These new expenditures for remote repairs are also not approved as part of the current budget, nor are they part of the Governor's recommended budget.

The proposal to provide transportation for Medicaid recipients to an authorized wheelchair or mobility scooter dealer to repair such recipient's wheelchair or mobility scooter by DSS' non-emergency medical transportation contracted transportation broker could have several impacts such as:

- Potential increased risk for injuries to Medicaid members traveling with unsafe mobility devices.
- Negatively impacting the capacity for other transportation services to be provided.
- Transportation broker unwillingness to accept liability transporting members in broken wheelchairs.
- Coverage for this service would not be reimbursable and would not be approved federally.
- Increased costs to the state that have not been budgeted.

Other provisions of this bill would require coverage for annual preventive maintenance of a Medicaid recipient's wheelchair or mobility scooter and payment for domestic overnight or express international delivery of a part needed for repairs. Currently, the department does not reimburse for annual maintenance for wheelchairs or mobility scooters. Reimbursement for repairs is reserved for issues identified by a wheelchair repair technician. Inclusion of annual preventive maintenance will be an expansion of Medicaid coverage and will result in additional expenditures. The department will also note that this section specifies coverage for preventive maintenance for wheelchairs in general without the distinction of customized wheelchairs, which has been the previous focus of the advisory council. If this bill intends to include annual preventive maintenance of all wheelchairs without specificity, in addition to mobility scooters, this will increase the fiscal impact of this proposal.

Additionally, current Medicaid regulations specify that delivery and shipping costs are included in the price for the items listed on the fee schedule and as such are not separately billable. There are additional concerns with a requirement to reimburse for domestic and international shipping which includes, but is not limited to (1) the department's ability to substantiate the amount to be reimbursed for such services, especially given that previously passed legislation eliminated the department's ability to prior authorize customized wheelchair repairs, (2) the ability to quantify, predict and budget for shipping and delivery costs for which the department does not control, (3) operational implications of providing reimbursement for shipping costs when shipments can contain multiple items or bulk shipments that may also include items for individuals not covered under Medicaid, and (4) the potential need for additional quality assurance, Medicaid management information system (MMIS) coding changes, and billing measures that may carry fiscal implications which cannot be quantified at this time.

The Department anticipates that the addition of annual preventive maintenance for wheelchairs and mobility scooters will result in increased annual gross expenditures of over $6.0 million ($3.0 million state share) in SFY 2026. Since the Department does not currently cover mobility scooters, this estimate is based on utilization of wheelchairs. There would be additional costs associated with maintenance of mobility scooters. While the addition of payment for overnight domestic or express international delivery will result in additional expenditures, DSS is not able to quantify this fiscal impact, nor any resultant additional administrative costs associated with such a proposal. The additional expenditures for annual preventive maintenance and payment for

delivery are not part of the current approved budget, nor part of the Governor's recommended budget.

Lastly, this bill proposes for DSS to inform Medicaid members using wheelchairs or mobility scooters of their rights as amended by any final legislation. DSS is supportive of informing Medicaid members of changes and can do so in the absence of legislation.

DSS continues to support ways to improve access to wheelchair repairs for Medicaid recipients and is committed to continued conversations. However, given the concerns as outlined above, DSS opposes this bill as currently drafted.

HOUSE BILL 7108: AN ACT CONCERNING AUTISM AND INTELLECTUAL DISABILITY

This bill will require extensive planning and reporting on strategies for altering the eligibility criteria and the delivery of autism services in Connecticut. The Department of Social Services (DSS) has reviewed the final report of the study commissioned by Public Act 23-137, Section 4, titled the "Evaluation of Statutory Definitions and Regulations: Intellectual Disability and Related Programs," and participated in the working group during its research period. The Department appreciates the recommendation to further study these important issues. However, this analysis will have a significant financial impact on the state, as well as an unknown impact on the availability of services for the individuals that would either fall into or out of eligibility.

As the single state Medicaid agency, it is critical for DSS to understand the fiscal and programmatic implications of proposed service eligibility expansions based on changes to the statutory definitions of "intellectual disability" and "developmental disability." Such changes would require a thorough evaluation to allow DSS to identify the various areas of impact, including the section 1915(c) home and community-based services waivers, section 1915(k) Community First Choice state plan option, state plan services for individuals with autism, services provided by our sister agency, the Department of Developmental Services, and other programs and supports.

The Department supports further evaluation to determine the feasibility of implementing the recommendations from the PA 23-137 study. However, cost, member access, and sustained commitment to existing participants and those currently waiting for services must be taken into careful consideration. Any eligibility changes must be properly resourced prior to implementation to ensure that the affected programs are able to accommodate the increased demand for services and supports. However, funding to support such a program expansion is not included in the Governor's budget.

HOUSE BILL 7109: AN ACT CONCERNING MEDICAID COVERAGE FOR APPLIED BEHAVIOR ANALYSIS SERVICES AND IMPLEMENTING CERTAIN RECOMMENDATIONS OF THE TRANSFORMING CHILDREN'S BEHAVIORAL HEALTH POLICY AND PLANNING COMMITTEE

Section 1(a)(1) requires DSS to increase rates, within available appropriations, for supervision, assessment and direct services by a board-certified behavior analyst.

The Department already covers applied behavior analysis services and, as part of that coverage, board certified behavior analysts (BCBA) can be reimbursed under our autism spectrum disorder (ASD) fee schedule under Medicaid, including direction observation and direction. Additionally, this bill would provide for a rate increase within available appropriations. Funding for these increases is not included in the Governor's recommended budget.

In July of 2024, the Department leveraged $7.0 million (state share) to provide rate increases for a comprehensive set of behavioral health codes when provided to children. The codes for in-home services for children and one code on the ASD fee schedule received a higher percentage increase than the rest of the codes. At this time, the Governor's budget does not contain additional funding to further increase these rates; therefore, the Department cannot support this section of the bill.

Section 1(a)(2) of this bill would extend coverage of applied behavior analysis services under HUSKY B, which is Connecticut's Children's Health Insurance Program (CHIP). Adding this coverage would annually cost approximately $3.7 million gross ($1.3 million state share). As this additional funding is not included in the Governor's recommended budget, DSS cannot support this change.

Section 1(a)(3) of this bill would provide Medicaid coverage for caregiver training using applied behavior analysis. DSS is unsure about the purpose of this language and believes that it is not necessary as applied behavior analysis can already incorporate some extent of caregiver training during the direct delivery of the service to the child (to the extent that the service continues to comply with all applicable requirements for covered applied behavior analysis under Medicaid for the specific provision to and benefit of a Medicaid member). If this language is intended to provide additional services beyond what is currently covered, those services would increase state costs and there is no funding for such increases in the Governor's recommended budget.

Section 1(b) requires DSS to submit a report that explains progress in expanding access to applied behavior analysis services. Access to applied behavior analysis services is a routine Medicaid state plan service available to all Medicaid eligible individuals under the age of 21. Accordingly, the Department believes the report is unnecessary and would result in an additional administrative burden to staff, diverting resources that should be focused on the provision of core services.

Section 2 requires the Office of Early Childhood (OEC) and the Department of Social Services to make recommendations for regulatory and reimbursement framework for the delivery of applied behavior analysis services. The Department often partners with OEC on various initiatives and looks forward to the opportunity to undertake this work.

Section 3 requires the Commissioner of Social Services, in consultation with the Commissioners of Mental Health and Addiction Services and Children and Families, to include in the Certified Community Behavioral Health Clinic (CCBHC) planning grant support for development of reimbursement for acuity-based care coordination services, a value-based payment model, and a

system to help providers and clients better navigate behavioral health care resources and requirements.

At this time, the Department has received a planning grant for the development of the CCBHC, inclusive of care coordination and value-based payment models. The Department believes this section can work in conjunction with existing planning efforts for CCBHC because the purpose of that planning grant is to assist the Department in the development of the model, including the payment model.

Section 4 requires the Commissioner of Social Services to consult with Yale Child Study Center to review intensive in-home child and adolescent psychiatric services (IICAPS) and other evidence- based models to deliver positive outcomes for children with behavioral health issues in a sustainable manner. DSS looks forward to working collaboratively with Yale Child Study Center to explore cost-effective models and variations of this service type.

SENATE BILL 1416: AN ACT EXPANDING LONG-TERM CARE OPTIONS FOR MEDICAID BENEFICIARIES.

The Department of Social Services appreciate the interest and support for the rebalancing of long-term services and supports (LTSS) in Medicaid. Rebalancing has been a significant focus of our department for over 10 years and we've had a longstanding relationship with our federal partners at the Centers for Medicare & Medicaid Services (CMS), and their Money Follows the Person (MFP) division whose sole responsibility is to ensure that state Medicaid programs are rebalanced so that more individuals receive their LTSS care in the community instead of institutions. DSS holds contracts with 10 non-profit agencies funding over 100 contracted staff in the community to serve out this mission, has over 30 staff dedicated to this work at the Department, and partners with numerous entities, including the Department of Developmental Services, the Department of Mental Health and Addiction Services, and UConn Health. Here is a link to the latest quarterly report with a dashboard of Connecticut's rebalancing efforts: 2024-Q4-MFP-report.pdf. One key finding of the report is that 70% of the Medicaid members receiving LTSS care are doing so in a home-and-community-based setting and only use 54% of the Medicaid LTSS budget.

With regards to Section 1(c)(2) of the bill, DSS believes that the new language is not necessary as rebalancing efforts are ongoing. The Department will be submitting the MFP Operational Protocol to CMS in April 2025. This Operational Protocol directly informs the strategic plan and is approved by CMS for enhanced federal funding, which is a substantial part of our funding to support rebalancing activities in Connecticut. DSS also suggests that Section 1(c)(2)(A) to increase outreach for the Connecticut Home Care Program for Elders (CHCPE) is not needed. In 2024, DSS had 13,569 referrals (averaging 1,130 per month) and 4,026 new CHCPE members began receiving services. Limiting outreach to one cohort is not recommended and runs counter to the MFP Operational Protocol, which includes an overarching outreach plan for all HCBS targeted populations. With regards to Section 1(c)(2)(B), the Department notes that, as written, this would have a large resource demand. DSS already offers training and outreach to municipalities and non-profit organizations on how to support their community members to complete the long-term services and support application form. If we assume a greater

responsibility beyond outreach, the Department would need additional staff to ensure the necessary staff were in place to perform the newly required duties.

For the reasons noted above, the Department does not believe this bill is needed and cannot support provisions that would result in additional costs.

SENATE BILL 1417: AN ACT CONCERNING THE ESTABLISHMENT OF A NURSING HOME WORKFORCE STANDARDS BOARD.

This bill would establish a Nursing Home Workforce Standards Board to develop recommendations for nursing home employment, training and minimum compensation standards necessary to ensure the safety and well-being of nursing home residents and workers. The Department supports the intent of this bill. Direct care staff are the backbone of nursing homes and provide vital care to residents. The Department supports exploring ways that direct care staff can be better supported in the work they perform, including access to training that would result in improved outcomes for residents.

The bill would also require that the established Nursing Home Workforce Standards Board make recommendations on employee wages. Notably, Medicaid is the largest payor for nursing homes, averaging 72% in 2023. Any increases to wages would have a direct impact to the Medicaid budget, resulting in increased state costs, as the direct care component of nursing home reimbursement adjusts every quarter under the state's Medicaid reimbursement system. While the Department appreciates language in subsection (g) of the bill that no wage recommendation would be adopted until necessary state appropriations are made, the Department notes that such additional state costs would, ultimately, need to be appropriated through the established budgetary process, which may cause confusion for employees as a wage level may have been recommended by the Workforce Standards Board, but not specifically appropriated by the full legislature and, therefore, not yet in full force and effect.

SENATE BILL 1415: AN ACT CONCERNING MEDICAID AND MEDICAID-FUNDED PROGRAMS.

Section 1 of this bill would establish a minimum wage for nursing home staff of $22.50 effective January 1, 2026, increasing to $25.00 on January 1, 2027.

This will shift costs to Medicaid and would result in significant additional costs which is not currently funded in the Governor's recommended budget. Medicaid is the largest payor of nursing homes, representing 73% of payor revenue in 2023. Medicaid reimbursement is an acuity-based reimbursement, which means that the direct care component of the Medicaid rate increases to account for more resource-intensive residents. This system is designed to ensure direct care staffing costs are recognized for the services provided to more resource-intensive residents.

By creating a minimum wage, this legislation sets a floor for nursing home staffing, which is currently unfunded and would require administrative and staffing resources in order for the Department to redesign the acuity-based reimbursement system. Further, the Medicaid program

does not typically participate in setting wages – wages are established between an employer and employee. In the past, the Medicaid program has provided temporary rate increases to provide for staff wage increases for specific reason such as COVID-19 incentive pay, union contract wage agreements or other similar one-time events. Establishing a floor for wages would require funding increases to the Department and administrative resources to understand which homes are below the floor and would need rate increases to reach the floor. This information is not currently available and would require disclosures on the part of the nursing home.

For the foregoing reasons, DSS does not support this bill.

SENATE BILL 1418: AN ACT REDUCING BARRIERS TO FOOD SECURITY.

Section 5 requires DSS to submit an 1115 Medicaid waiver to provide Medicaid coverage for food as medicine. The Department appreciates the goals of this proposal and understands the importance and the positive impact that food as medicine may have on Connecticut residents. However, the expansion considered by this legislation would have a corresponding fiscal impact to the Department, the extent of which would be dependent on the details of such coverage, the number of individuals who would be included in the coverage, and various other factors.

Moving forward with an 1115 waiver would require two sources of funding, neither of which is included in the Governor's budget. First, there is the administrative expense required to plan, apply for the waiver, and implement new services. In the two previous 1115 waivers that Connecticut has successfully applied for, DSS hired external contractors to help prepare the application, including actuarial support necessary to demonstrate compliance with federal budget neutrality requirements. A similar level of work would be needed here, resulting in increased administrative costs. Second, and more substantially, covering these additional services would require significant state resources. The Department appreciates the intent of this bill and recognizes that these interventions, if correctly targeted, have the potential to reduce state spending in the long term, however, as written, this bill will result in additional costs that are not funded in the Governor's budget.

Section 6 of the bill sets, within available appropriations, a minimum monthly Supplemental Nutrition Assistance Program (SNAP) benefit of $95 for all households. The current federal minimum monthly SNAP benefit for households of one or two people is $23. Utilizing enrollment and benefit data, there are approximately 27,200 households that received less than $95 in SNAP benefits in January 2025. To bring each of these households up to a minimum benefit level of $95, would result in additional state costs of approximately $18 million annually.

Additionally, this section requires that the Department establish a healthy food incentive (HIP) program under which SNAP recipients, who purchase fresh produce at certified farmers' markets, are credited one dollar in SNAP benefits for every dollar they spend on such purchases, not to exceed $50 monthly. Massachusetts has implemented a similar program, which provides up to $20 in monthly benefits. Looking at data from the Massachusetts HIP, 186,500 households (representing 27.6% of the total number of households receiving benefits in that state) have used the program so far in SFY 2025 for a cost of $11.1 million. Currently there are 224,000 households receiving SNAP benefits in Connecticut. If 27.6% of those households used the HIP

program each month for the full $50 as proposed in this bill, the cost to the state could be as high as $37 million annually, not including the costs of staffing for ongoing program administration.

Sections 7 and 9 of this bill appropriate $10 million to DSS in FY 2026 to support the supplemental nutrition commodities assistance program. Funding is to be directed to Connecticut Foodshare, with 15% of the funding provided to be used to purchase produce or other products from Connecticut farmers. The bill also requires that the funds appropriated for the program be increased by at least 3% each year beginning July 1, 2026, though technically there are no funds appropriated beyond a one-time allocation identified in section 9.

While DSS appreciates the legislature's interest and commitment to this program and supports the use of funding to directly support Connecticut's farmers, the Department must note that additional funding for the program, beyond the increase of $900,000 proposed in FY 2027, is not included in the Governor's recommended budget.

Section 8 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

[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

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
- 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 as outlined in Section 8 would be approximately $1.2 million.

Given the significant startup and ongoing operational costs noted above, the Department cannot support this bill.

SENATE BILL 1419: AN ACT PROHIBITING MEDICAID REIMBURSEMENT FOR HEALTH CARE PROVIDERS WHO INCLUDE TRAINING REPAYMENT AGREEMENT PROVISIONS IN CONTRACTS WITH EMPLOYEES.

This bill would prohibit DSS from providing Medicaid reimbursement to health care providers who include training repayment agreement provisions (TRAP) in contracts with their employees.

Regardless of the specific type of employment policy being regulated, DSS is not in the position to be an employment regulator, as it is not DSS' role to enforce conditions of employment between provider entities and their staff. In addition, adding such a requirement would increase administrative burden and costs for DSS, which are not funded in the Governor's budget.

Finally, there is uncertainty as to whether federal law would allow this type of restriction on Medicaid enrollment. Specifically, section 1902(a)(23) of the Social Security Act establishes that qualified providers may choose to enroll and it is unclear whether these types of restrictions would constitute as a disqualification within the meaning of the federal law.

SENATE BILL 1421: AN ACT CONCERNING MEDICAID COVERAGE FOR OBESITY TREATMENT

This bill references 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 1(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 1(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 2 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 2(d) references the strategic plan from Section 1(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 GLP-1s that are FDA approved to treat obesity, DSS does not think Section 1 of this bill 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.

HOUSE BILL 7022: AN ACT PROMOTING EQUITY IN MEDICAID COVERAGE FOR FERTILITY HEALTH CARE.

This bill would require the Department to amend the Medicaid State Plan to provide Medicaid reimbursement for fertility treatment services.

Currently, Medicaid provides reimbursement for family planning services including those that diagnose, treat, and counsel individuals of child-bearing age. Covered family planning services include, but are not limited to, reproductive health exams and lab tests to detect the presence of conditions affecting reproductive health which include infertility. The Department's current regulations for physician and hospital services prohibit reimbursement for infertility treatment services under Medicaid. This is in line with most other state Medicaid programs. (Coverage and Use of Fertility Services in the U.S. – Appendix 2: Medicaid – 9528 | KFF).

Under current federal guidance, infertility services or fertility preservation services are included within Family Planning services. The Department estimates that with an assumed Family Planning match of 90% for infertility services (including IVF) based on current federal guidance and fertility preservation services and a 50% match on prenatal, postpartum, and delivery, and the additional cost of enrolled HUSKY A children, the state costs for all services effective January 1, 2026 would result in increases of $300,000 in SFY 2026, $11.5 million in SFY 2027, and $27.1 million in SFY 2028. If no federal match is allowed on infertility services and preservation services, then it is estimated that this bill would increase costs to the state by $2.1 million in SFY 2026, $28.7 million in SFY 2027, and $46.3 million in SFY 2028. In either match scenario, the costs continue to grow as more children are added to HUSKY A with the preservation costs projected to grow each year, leveling off approximately 10 years out.

The Department anticipates that adding coverage for fertility treatment services would result in a significant increase in Medicaid expenditures and funding to cover such an expansion was not included in the Governor's recommended budget. For this reason, the Department cannot support this bill.