Testimony before the Human Services Committee
Commissioner Andrea Barton Reeves
Department of Social Services
February 27, 2025

Good morning, Chairs Lesser and Gilchrest, Ranking Members Harding 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.

SENATE BILL 1359: AN ACT CONCERNING VARIOUS REVISIONS TO STATUTES CONCERNING THE DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services' legislative proposal contains a number of technical revisions to DSS statutes, as well as federally required updates, minor program changes, and corrections to prior legislation.

Section 1: Allows DSS to develop a child support enforcement system that supports automated administrative enforcement in interstate cases (AEI), as required by federal law. DSS is in the process of replacing its outdated child support enforcement computer system. Federal law requires each state child support agency to assist another state with certain asset seizures based on overdue support, even if the underlying support order is not registered in the state in which the request is made. Current law in Connecticut requires an out-of-state support order to be registered in Connecticut before DSS' Office of Child Support Services (OCSS) and Support Enforcement Services (SES) within the Judicial Branch can take such enforcement action.

This legislative change will remove the statutory barrier to allowing OCSS and SES to provide AEI supports to other states when the underlying support order is not registered in Connecticut, ensuring the state is in compliance with federal requirements and clarifying the process for implementation in the state's new child support enforcement computer system.

Section 2: Updates the general statutes to conform with federal law relating to modification of child support orders. Specifically, under federal law, all child support orders must be based on an obligor's current income and ability to pay. Federal law does not allow states to treat incarceration as voluntary unemployment; thus, an incarcerated individual must be eligible for a downward modification of his or her child support order based on a loss of income and ability to earn caused by incarceration.

While DSS does have a process to facilitate downward modifications of existing child support orders due to incarceration, current Connecticut law provides: "Downward modification of an existing support order based solely on a loss of income due to incarceration or institutionalization *shall not* be granted in the case of a child support obligor who is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order." Our federal partners have notified the agency that this exception for individuals incarcerated for an offense against the custodial party or child is not permitted and that we must amend state law to remove the exception in order to come into compliance with federal law. As such, DSS is requesting this change in state law to conform with federal law.

Section 3: Currently, assisted living facilities in the state are required to post, in a prominent place in their facility, a resident's bill of rights, including the contact information for the Department of Public Health and the State Long-Term Care Ombudsman. This proposal would require such posting to also include information about how to make a report to DSS' Protective Services for the Elderly program concerning the suspected abuse, neglect, exploitation, or abandonment of an elderly person. DSS believes this information should be readily available at facilities and could result in additional referrals to DSS and ultimately added protections for vulnerable state residents.

Section 4: Per section 9 of Public Act 24-82, DSS must begin staggering SNAP distributions by March 1, 2026. The Department is also required to report by April 1, 2026, and annually thereafter, on the implementation of the staggered benefits. DSS respectfully suggests that, upon the implementation of the staggering of benefits, there will be no new information to report to the legislature beyond the initial report. As such, DSS requests the statute be revised to repeal the annual reporting requirement, while maintaining the requirement for the initial report after implementation.

Section 5: Clarifies that any rate increases to allowable operating costs, excluding fair rent, for community living arrangements are to be based on the Gross Domestic Product (GDP) deflator when funding is specifically appropriated. The GDP deflator is an inflation factor calculated quarterly by the U.S. Department of Commerce's Bureau of Economic Analysis. The GDP deflator is used by many companies and government agencies (state and federal) as a measure of inflation in the prices of goods and services produced in the United States. Since the prices of goods and services change all the time – up or down – the GDP deflator is a recognized way of looking beyond individual price tags to measure overall inflation (or deflation) for goods and services over time. In Medicaid rate setting practices, the GDP deflator is a permissible measure to use when legislation allows for inflation of rates. An appropriation by the legislature is required to increase Medicaid rates for the recognition of inflation and, when legislation allows, the GDP deflator is already the commonly used factor for nursing homes, intermediate care facilities, and residential care homes.

Section 6: Prior to 2015, the autism waiver was administered by the Department of Developmental Services (DDS). As part of the administration of the waiver, DDS required that providers consult the DDS Abuse and Neglect Registry prior to hiring staff. The DDS Abuse and Neglect Registry is not a public-facing database, and an entity can only obtain access if authorized to do so by statute. As such, section 17a-247b of the general statutes permits

employers whose employees provide services to individuals who receive services or funding from DDS to have access to the DDS Abuse and Neglect Registry.

In 2015, responsibility for the autism waiver transferred to the Department of Social Services. However, section 17a-247b was not updated to reflect that employers whose employees provide services to participants in DSS' autism waiver should have access to the DDS Abuse and Neglect Registry. Thus, DSS providers are currently unable to consult the registry when making hiring decisions. This proposal seeks to affirmatively grant access to the registry for these DSS providers. Aligning the statute to cover providers serving individuals with autism meets the intent of the original statute and affords additional protections to individuals with Autism.

DSS urges passage of this legislation.

SENATE BILL 1360: AN ACT REQUIRING LEGISLATIVE CONFIRMATION OF THE APPOINTMENT OF THE DEPARTMENT OF SOCIAL SERVICES' MEDICAID DIRECTOR.

This bill would require the DSS Commissioner to nominate a Medicaid director for appointment by the Governor subject to the legislative confirmation process described in section 4-7 of the general statutes. Further, the legislation would designate the current Medicaid Director as serving in an interim capacity until such time as that appointment is confirmed or denied by the legislature.

The Medicaid director, working collaboratively with Commissioner and the Office of the Governor, sets priorities and establishes goals for the program.

The role of the Medicaid director requires special expertise and in-depth knowledge of the Medicaid program. This experience and knowledge is often derived through years of work within the Medicaid space. The Connecticut Medicaid program will also benefit greatly from the continuity of a Medicaid director who has experience and expertise with the state's program. Medicaid is a highly complex federal and state partnership with arcane and complicated policies that are changing and compounded year over year. It is also a highly technical program that requires deep knowledge of healthcare policy, administration, and federal financing principles.

A politically appointed Medicaid director does not lend itself to the stability and consistency that the Medicaid program needs to operate. Prolonged vacancies or interim leadership due to changes in administration or confirmation delays could hinder the implementation of time-sensitive initiatives as well as slow decision-making and responsiveness to emerging challenges, such as federal funding cuts or changes to eligibility requirements.

Further, DSS is concerned with the risks to the Medicaid program should a political appointee desire to be the Medicaid director without the appropriate qualifications to do so. Political appointees do not necessarily have the requisite expertise and background to make informed decisions regarding the Medicaid program. Additionally, the politicization of Medicaid leadership could undermine the impartiality needed to balance federal compliance, state priorities, and diverse stakeholder needs. This could potentially prioritize political alignment over expertise and discourage qualified civil servants who prefer less politicized positions.

Lastly, DSS has concerns with the process and timeliness for filling such position through the legislative process. Were DSS to require a nominee to proceed through a nomination and legislative hearing process, the time to hire a new Medicaid director could be harmful to the daily operations of the Department.

The goals of the Department are to ensure that our staff, with our Medicaid director among those at the forefront, have the requisite experience, expertise, and impartiality, to successfully run the Medicaid program for our members. Requiring legislative oversight and confirmation in this process would not put the Department in the position to hire the most qualified individual and would potentially create challenging delays in filling this important position.

For these reasons, the Department strongly opposes Senate Bill 1360.

SENATE BILL 1358: AN ACT CONCERNING EQUITABLE COMPENSATION FOR STATE-CONTRACTED NONPROFIT HUMAN SERVICES PROVIDERS

This bill would require the Secretary of the Office of Policy and Management (OPM) to conduct reviews of the level of services provided by nonprofit human services providers to determine whether the rates such providers are paid to deliver services adequately compensates such providers, review the reporting requirements of nonprofit human services providers with the intent of eliminating and consolidating duplicative reports, and require payment for any services provided pursuant to a purchase of service contract not later than thirty days after the delivery of services.

Section 3 of the bill requires all state agencies to make payment to private provider organizations not later than thirty days after the receipt of any services provided pursuant to a purchase of service contract. DSS recognizes the importance of timely reimbursement to providers and makes every effort to do so. However, it is not always administratively feasible to pay providers within thirty days of each service, especially when requests for payment may be delayed by the provider, or there are necessary validation steps, such as time and effort validations, as well as the collection of supporting materials that must be gathered and verified prior to the issuance of payment.

For these reasons, DSS must oppose this legislation.

SENATE BILL 1122: AN ACT REQUIRING ANNUAL PERFORMANCE AUDITS OF MEDICAID-FUNDED PROGRAMS BY THE AUDITORS OF PUBLIC ACCOUNTS.

This bill requires the Connecticut State Auditors of Public Accounts (APA) to complete at least two performance audits of Medicaid-funded programs annually.

Currently, the APA performs periodic performance audits of the Department and our programs throughout the year. For example, recent audits include a review of the Department's Protective Services for the Elderly program, oversight of Connecticut's assisted living facilities, and other various programs.

While DSS has no concerns participating in such audits, the agency would like to note that the process can be laborious and uses a significant amount of staff resources. These audits would be in addition to the annual Statewide Single Audit and the biennial departmental audit pursuant to section 2-90 of the general statutes. Lastly, the Department also notes that, as we fund many of our sister state agencies through Medicaid, such audits would also have a negative impact on the resources and staffing commitments of any state agency that administers a program funded by Medicaid.

Were this bill to move forward, DSS would respectfully request that the language be revised to include a cap on the number of performance audits per year, so that not more than four audits are requested of the Department and our sister agencies on an annual basis.

Thank you for your consideration of the Department's request.

SENATE BILL 985: AN ACT CONCERNING LEGISLATIVE APPROVAL FOR CHANGES TO THE HUSKY HEALTH PROGRAM REIMBURSEMENT AND CARE DELIVERY MODEL.

This bill proposes a new legislative approval process should the department wish to "change the fee-for-service Medicaid payment model to a managed care payment model." Further, the bill removes existing provisions that authorize the department to procure for managed care services or enter into "per capita" contracts with healthcare entities. Additionally, the bill removes outdated language related to the Medical Assistance Program Oversight Committee's (MAPOC) composition and strikes references to managed care in various other provisions.

While DSS understands the intent of this bill and supports transparency and oversight for major changes to the Connecticut Medicaid program's delivery system, as currently written, this bill is vague, overbroad, administratively burdensome, and unnecessary. In particular, the undefined terms "fee-for-service Medicaid payment model" and "managed care payment model" are vague and potentially open to multiple interpretations. Depending on the interpretation of these vague terms, the bill could restrict the flexibility of the department to pursue evidence-based payment and care delivery models that have shown substantial promise in improving healthcare outcomes on a cost-effective basis simply because a particular element of a proposal might be considered to deviate from a narrow reading of a fee-for-service payment method and/or be considered a "managed care payment model." As written, this bill could therefore potentially affect a wide variety of proposals, even if there is no change to a comprehensive capitated managed care delivery system.

In December 2024, DSS issued a Medicaid Landscape Analysis, which comprehensively reviewed the published scientific literature on Medicaid managed care and, based on an analysis across various factors, recommended that Connecticut Medicaid not move to a comprehensive capitated managed care delivery system at this time. The analysis identified several areas of improvement in managing costs and improving outcomes related to individuals dually eligible for Medicare and Medicaid, institutional and home and community-based services (HCBS) long-term services and supports (LTSS), prescription drugs, and management of acute and chronic

conditions. In each of these areas, the Department needs the flexibility to explore and implement initiatives that simultaneously manage costs and outcomes, some of which may potentially be labeled as a "managed care payment model," even though none of the models under active consideration would constitute transitioning the program to comprehensive capitated managed care.

For example, the Program of All-Inclusive Care for the Elderly (PACE) is a federally sponsored evidence-based program that provides full-spectrum holistic care for members age 55 and older that are dual-eligible individuals and meet specified eligibility requirements. PACE has managed care components, including that PACE provider sites receive a capitated payment to provide and arrange for eligible members' Medicare and Medicaid-covered services. Public Act 23-30 authorizes DSS to implement PACE. DSS is conducting a feasibility study to explore this model and determine if PACE would work in Connecticut; the interim report is posted at this link: pace-interim-report.pdf. The current version of this legislation could limit or potentially restrict our ability to implement this program.

The current broad wording of this bill could also potentially be interpreted to limit DSS' ability to explore and implement other payment model changes designed to improve healthcare outcomes and contain cost growth to the extent that some of the changes may be considered to use a "managed care payment model." For example, DSS convened the Primary Care Program Advisory Committee, which, through a multi-year, stakeholder-driven process, developed a primary care model centered on key domains and specific performance measures. This model is supported by a hybrid population-based payment approach designed to enhance practices' ability to engage in care coordination, improve chronic disease management, integrate behavioral health, and address health-related social needs. DSS anticipates that any proposal implementing this recommendation would very much remain within Connecticut Medicaid's current managed fee-for-service delivery system, although some of the payment mechanisms would likely use various types of payment models to encourage improved healthcare outcomes and cost growth containment. That work builds on the current DSS Person-Centered Medical Home Plus (PCMH+) program, which helps improve primary care access and outcomes using a combination of monthly payments and shared savings incentive payments.

In these and other contexts, the process set up by this bill would be administratively burdensome, resulting in significant delay and increased administrative expenses. DSS remains committed to ongoing transparency and discussions with legislators and other stakeholders regarding the Medicaid program, especially for any change as significant as a potential transition to comprehensive capitated managed care, although, again, such a change is not being recommended at this time. There are already many forums for these conversations, such as MAPOC, which are much more flexible and efficient than the process set forth in this bill.

Finally, this bill is unnecessary because current statute already provides significant legislative oversight for major changes to the Medicaid program. In particular, C.G.S. section 17b-8 requires DSS to submit any Medicaid waiver (and any Medicaid State Plan amendment that would have required a waiver but for the Affordable Care Act) for approval to the General Assembly's Appropriations and Human Services Committees prior to federal submission. Although the details would depend on the type of structure, in many scenarios, a transition to

comprehensive managed care would require a federal Medicaid waiver under section 1915(b) or section 1115 of the Social Security Act, either of which would need legislative committee approval under C.G.S. section 17b-8.

For these reasons, the Department strongly opposes this bill.

HOUSE BILL 7024: AN ACT CONCERNING MEDICAID COVERAGE FOR ALLERGY PREVENTION.

This bill proposes to add Medicaid coverage for allergen introduction dietary supplements for infants enrolled in the Medicaid program to help prevent common food allergies, including, but not limited to, allergies to peanuts, eggs and dairy products.

Early introduction of food allergens to prevent development of food allergies is endorsed by the American Academy of Pediatrics and the American Academy of Allergy, Asthma & Immunology. Research has shown that early introduction can reduce but not always prevent development of food allergies as development of food allergies is multifactorial.[1] For a majority of infants, introduction of food allergens can be accomplished with household foods and there is not a medically indicated need to expend additional funds on a supplement. While there are numerous commercial products marketed to parents and providers, there is no evidence demonstrating superiority of supplements over less expensive foods such as a taste of yogurt, a bit of scrambled egg, or a smear of peanut butter mixed into a pureed fruit. In an article published in *Pediatrics*, the journal of the American Academy of Pediatrics, the authors state "With these marketed across the world, caregivers may be led to believe that these commercial products are necessary to prevent food allergy, or that they are safer than giving actual food to their infants. This adds a layer of confusion and mixed messaging that parents have to navigate as they try to understand and incorporate food allergens into their infant's diet."[2]

The estimated annual state cost for these dietary supplements would be $3.3 million. Because there is not an evidence-based medical need for these products over less expensive natural food sources and given that there would be a significant fiscal cost to cover these supplements that is not accounted for in the Governor's budget, DSS cannot support this bill.

[1] Soriano VX, Peters RL, Moreno-Betancur M, et al. Association between earlier introduction of peanut and prevalence of peanut allergy in infants in Australia. *JAMA*. 2022;328(1):48–56

[2] Elissa M. Abrams, Marcus Shaker, David Stukus, Douglas P. Mack, Matthew Greenhawt; Updates in Food Allergy Prevention in Children. *Pediatrics* November 2023; 152 (5): e2023062836. 10.1542/peds.2023-062836

HOUSE BILL 7026: AN ACT CONCERNING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM.

Since 1991, the State of Connecticut has had a moratorium on the addition of new skilled nursing home facilities and the addition of beds to a current facility. The goal of this moratorium has been to right-size the state's nursing home population and excess bed capacity by redirecting

individuals into the community rather than into institutional care settings. DSS has been successful in both reducing costs as a result of keeping individuals out of institutional settings and, more importantly, keeping our members in their homes and in their communities.

However, due to the global pandemic, the state's right-sizing and rebalancing goals are no longer aligned, and the need for additional nursing home bed capacity may arise in the future in certain rural areas of the state where the number of available beds may no longer be adequate to support demand. The Department's proposal would allow for the addition of new nursing home beds – with an emphasis on nontraditional, small-house style facilities – into specific geographic areas to address acute access concerns. This language in part aims to update the right-sizing and rebalancing goals to ensure the state does not encounter a scenario where there are not an adequate number of beds for our members.

The legislation provides the Department with flexibility to assess the bed-capacity need in the state to determine whether allowances should be made for the addition of new beds. The proposal contains criteria and requirements that ensure beds are only added when needed and will prevent the unnecessary expansion of beds. Specifically, if a geographic region reaches occupancy above 96% for a minimum of two quarters, the Department will then be able to explore adding beds to meet demand.

The Department wants to be clear that this limited exception to the moratorium is not intended to be an often-used mechanism. Rather, the state would only authorize new beds under extreme need and circumstances. Further, DSS will retain authority to utilize the Certificate of Need (CON) process to carefully evaluate geographic areas to determine the need for new beds and to permit such beds only if absolutely necessary to maintain access for Medicaid members. This controlled process will ensure the state does not overbed certain areas or add too many beds to the overall system that cannot be filled. Lastly, mechanisms will remain in place should too many beds be added through this exception. DSS will continue to have levers through the rate setting system to ensure that any facility with excess beds be incentivized to maintain occupancy or, alternatively, delicense beds if they are unable to be filled.

This proposal is not expected to have any immediate fiscal impact to the state. If a decision is made that new beds are needed for a particular geographic area, the Department will thoroughly review each request, and the CON process will be used to make a final determination on how to proceed. Medicaid will not see an increase in costs due to the addition of beds to a region since costs associated with members needing care will already be reflected in the system – if a resident needs nursing home level of care, they will require that care no matter where the bed is located. Any addition of beds to a geographic area will simply be to ensure residents can stay within their communities should the need arise. Any fiscal impact for the building of a new facility will be reviewed through the CON process and only costs applicable to Medicaid will be considered. Any costs not associated with direct care or not allowable under Medicaid reimbursement rules would be disallowed.

While there is currently no anticipated need for additional beds in the state, and no imminent expansion were this proposal to pass, this proposal allows DSS to be proactive and forward-

thinking to develop a process for expansion of nursing home beds should a region of the state experience access needs.

DSS urges passage of this bill.

HOUSE BILL 7023: AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR SUBSTANCE ABUSE COACHES AND MENTAL HEALTH COUNSELORS UNDER A PEER SUPPORT TREATMENT MODEL.

This bill requires the Commissioner to amend the Medicaid state plan to integrate peer support service into care teams funded under the medical assistance program and provide Medicaid reimbursement to peer support specialists for such services.

Recognizing the important work of peers within the substance use disorder treatment continuum, DSS currently allows for the reimbursement of peer support services within the per diem rate for residential substance use disorder treatment.

There are also additional areas in which Connecticut's Medicaid program currently uses peer support services. Peer support specialists are longstanding, valued members of the Intensive Care Management teams that are affiliated with Connecticut Medicaid's behavioral health administrative services organization, Carelon. These individuals bring lived experience with behavioral health conditions and substance use disorder to inform their work with members who are grappling with similar challenges. Further, the federally qualified health centers (FQHCs), also known as community health centers, and advanced networks that include primary care provider practices that are participating entities in DSS' Person-Centered Medical Home Plus (PCMH+) initiative, have incorporated community health workers, some of whom provide peer support, into their care teams. This has helped to further goals around meaningful integration of behavioral health services within primary care. DSS has held the view that it is most suitable to use value-based payment arrangements, as opposed to fee-for-service payment, as a means of enabling local providers to support the costs of community health workers, including peer support specialists, in their work.

Examples where DSS is currently supporting community health worker or peer models include:

- PCMH+, where we pay health centers a per member per month care coordination payment
- Substance Use Disorder (SUD) residential treatment per diem rate, where providers may utilize community health workers or peer recovery coaches
- Integrated Care for Kids (InCK), a New Haven based care coordination model

The Department is also exploring community health workers/peers under the following programs:

- Home visiting (collaborating with the Office of Early Childhood and the Office of Health Strategy)
- Justice-involved demonstration waiver
- Care coordination, inclusive of chronic disease care management models, and the Certified Community Behavioral Health Clinics (CCBHC) model

Further, DSS is in phase 2 of testing the effectiveness of community health workers in connecting unattributed members to primary care providers through a "Test & Learn" initiative under our medical administrative services organization's performance targets. The goal of the Test & Learn is to build rigorous evidence and enable data-driven decision making for the Medicaid program. The phase 2 results will help us to act on either refining the model or scaling out the program to the entire population and not just unattributed members.

While DSS strongly supports the concept and practice of including peer support specialists within care teams, it must respectfully oppose this bill as drafted. The Governor's budget does not provide funding for additional coverage of peer support services beyond those already incorporated into current coverage under the Medicaid State Plan, including within the per diem rate for residential substance use disorder services referenced above.

For the reasons noted above, the Department must oppose this bill.

HOUSE BILL 7021: AN ACT CONCERNING FUNDING FOR NUTRITION ASSISTANCE.

This bill appropriates $10 million to DSS in FY 2026 to support the supplemental nutrition commodities assistance program. Funding is to be directed to CT 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 in section 2 of the bill be increased by at least 3% each year beginning July 1, 2026, though technically there are no funds appropriated for FY 2027 in section 2.

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 and, as such, the Department cannot support this legislation at this time.

HOUSE BILL 6937: AN ACT CONCERNING MEDICAID COVERAGE FOR MEDICALLY NECESSARY CHILDREN'S DIAPERS.

For the purposes of this bill, the provision of diapers to a child is deemed to be medically necessary when it would prevent or ameliorate severe and persistent diaper dermatitis, urinary tract infection, or other disease of the skin, or another health condition, including a developmental, psychiatric, or neurological condition that results in an unusual need to void or delayed developmentally appropriate toileting behavior.

The bill requires DSS to provide Medicaid coverage of diapers for children from birth to age 3 who fit the above definition of medical necessity for diapers. DSS is also required to report to the committee the number of individuals with medical necessity, the cost for Medicaid coverage of diapers for such children, and any estimated long-term savings for potential health care conditions averted by this Medicaid coverage of diapers.

Currently, the Department provides coverage of diapers under Medicaid for children ages 3 years and older when the diapers are medically necessary for the management of incontinence associated with a medical condition and based on the individual needs of each member, consistent with federal Medicaid regulations in 42 C.F.R. § 440.70(b)(3)(i), which limit medical supplies to those "that are required to address an individual medical disability, illness or injury." Additionally, to the extent required pursuant to federal law in section 1905(r)(5) of the Social Security Act regarding early and periodic screening, diagnostic, and treatment (EPSDT) services, the Department provides coverage of diapers under Medicaid for any child under age 21 that meets the definition of medical necessity on a case-by-case basis, considering the particular needs of the child.

DSS recently studied the practices of other states and any relevant Medicaid waivers that would provide broad diaper coverage. Coverage under an 1115 demonstration waiver was recently approved by the U.S. Centers for Medicare and Medicaid (CMS) for both Delaware and Tennessee. However, it should be noted that diaper coverage was submitted as part of much larger and broader demonstration waiver programs and, as such, would not guarantee CMS approval for Connecticut. For example, Tennessee's unique approach to funding the coverage of diapers is not a viable option for Connecticut to emulate because the current structure of the 1115 demonstration waivers in Connecticut do not result in federal savings that could be redirected for this purpose. Additionally, these CMS approvals were issued under the prior federal administration, making it unclear what, if any, type of federal 1115 approval pathway might be viable for diapers under the current administration.

In conducting this research, DSS modeled the cost of providing Medicaid coverage of diapers. The total gross expenditures that DSS estimates to implement this legislation is at a minimum $31 million, with an approximate state share of $16 million, annually based on September 2024 enrollment data. This estimate reflects utilization among children ages 0-3 years with a reported diagnosis of dermatitis, urinary tract infections, and/or skin conditions that would warrant the provision of diapers and assumes a cost per diaper based on the medical surgical supplies fee schedule, effective April 1, 2024. Reports from the Journal of the American Medical Association were used to obtain rates for these diagnoses among young children.

As currently written, however, the bill is expected to result in much higher costs than these projections because, rather than relying on the statutory definition of medical necessity for the Medicaid program in C.G.S. section 17b-259b(a), this bill would require coverage simply based on a determination by an applicable clinician that providing diapers would prevent or ameliorate one or more of the referenced conditions. Since the language would enable coverage based simply on a determination that diapers were necessary to prevent or ameliorate one of the specified conditions, potentially all children under age 3 on Medicaid could qualify for coverage, which would result in costs of over $123 million, with an estimated state share of approximately $64 million.

Additionally, this fiscal estimate is limited to the estimated expenditures for the diaper product and does not include the estimated additional expenditures of approximately $400,000 related to additional quality assurance measures and increased administrative costs related to utilization

management requirements and updates to the Medicaid Management Information System (MMIS).

While the Department appreciates the intent of this legislation, because these costs are not incorporated in the Governor's recommended budget, DSS cannot support this bill.