



*Testimony before the Human Services Committee  
Commissioner Andrea Barton Reeves  
Department of Social Services  
March 10, 2026*

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.

**SENATE BILL 429: AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY MEDICAL TRANSPORTATION.**

Currently, ambulances and DSS' non-emergency medical transportation provider, MTM, Inc., are using GPS to calculate the exact mileage traveled for each trip provided to members. However, the current reimbursement system used by DSS was developed before GPS was widely available and uses point-to-point calculations to determine mileage traveled.

This proposal would clarify in statute that DSS is to calculate mileage reimbursement using GPS coordinates to determine the distance traveled for each trip.

After internal review, DSS does not believe this change would result in any additional costs and thus DSS does not oppose the legislation.

**SENATE BILL 431: AN ACT CONCERNING PALLIATIVE AND HOSPICE CARE IN LITCHFIELD COUNTY.**

The Department appreciates the Committees' commitment to palliative and hospice care, especially in more rural regions of the state. This bill would require DSS to study and report on whether there is a need for additional services in the northwest region of Connecticut.

The Department sees value in a study and report to learn more about the possible needs of palliative and hospice care. DSS respectfully requests the report submission date be moved to January 31, 2027, to allow the Department additional time to conduct its review.

DSS supports this legislation.

**SENATE BILL 432: AN ACT DISREGARDING THE CASH VALUE OF LIFE INSURANCE POLICIES IN ELIGIBILITY DETERMINATIONS FOR CERTAIN PUBLIC ASSISTANCE PROGRAMS.**

This bill would require the Department to exclude the cash value of life insurance policies when making eligibility determinations for Medicaid, including for those in long-term care, the State Administered General Assistance (SAGA) program, the Temporary Family Assistance (TFA) program, and the State Supplement program.

The cash surrender value of a life insurance policy is the net amount of money a policyholder receives upon cancelling a permanent life insurance policy before it matures or an insured event occurs. It is calculated as the accumulated cash value minus any surrender charges, fees, and outstanding policy loans. Such funds are routinely considered when determining eligibility for public benefit programs because they are accessible liquid assets that can be used to pay for immediate needs that might otherwise be borne by the pertinent public assistance program.

This bill would expand eligibility and increase program costs. Such costs are not funded in the Governor's recommended budget. Accordingly, the Department cannot support this bill.

### **SENATE BILL 433: AN ACT EXPANDING LONG-TERM CARE OPTIONS.**

The Department of Social Services appreciates 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. 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. One key finding of the report is that 71% of the Medicaid members receiving LTSS care are doing so in a home-and-community-based setting and only use 60% 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 submitted the MFP Operational Protocol to CMS in April 2025. This Operational Protocol directly informs the strategic plan and drives the enhanced federal funding from CMS, 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 2025, DSS had 14,021 referrals (averaging 1,168 per month) and 4,182 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 home and community-based services (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 supports application form. If we assume a greater responsibility beyond outreach, the Department will need additional staff to ensure the necessary staff were in place to perform the newly required duties.

The department also believes that Section 2 of this bill is unnecessary as [CGS 17b-337](#) currently requires the LTC Planning Committee, of which DSS along with nine sister state agencies is a member, to submit a three-year Long Term Care Plan and annual rebalancing report containing the requested information to the legislature. The most recent Long-Term Care Plan was submitted on January 1, 2025, and the most recent annual rebalancing report was just submitted on January 1, 2026. The LTC Planning Committee is also in the middle of a two-year planning and development process for next Long Term Care Plan due January 1, 2028, and is engaging in extensive stakeholder outreach and research to refresh the data and recommendations and track progress towards implementation of the recommendations in the current plan spanning the period of January 1, 2025 – December 31, 2027. Additionally, the Long-Term Care Planning Committee does not have the resources to develop a third unfunded report, with this level of information, especially not by the required deadline of December 1, 2026.

For the reasons noted above, the Department does not believe this bill is needed, and DSS cannot support provisions that would result in unbudgeted costs. DSS would appreciate the opportunity to meet with the proponents of this bill to review the ongoing rebalancing efforts within the Department and discuss opportunities for future efforts in this space.

#### **HOUSE BILL 5480: AN ACT CONCERNING PEER SUPPORT SERVICES UNDER THE MEDICAID PROGRAM.**

This bill requires the Commissioner to amend the Medicaid state plan to integrate peer support services 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 (SUD) treatment continuum, DSS currently allows for the reimbursement of peer support services within the per diem rate for residential SUD 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 strongly believes that it is most suitable to use value-based payment arrangements, as opposed to fee-for-service payments, 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; and the SUD residential treatment per diem rate, where providers may utilize community health workers or peer recovery coaches.

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; and
- Care coordination, inclusive of chronic disease care management models.

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 cannot support this bill. 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 SUD services referenced above. DSS also believes that reimbursement for community health worker and peer supports is best addressed by enhancing care teams with community health workers or peers for services such as primary care and behavioral health, through a value-based payment model. As the Department continues to plan and implement value-based payment models, community health workers and peers will be considered as part of the reimbursement model.

**HOUSE BILL 5481: AN ACT CONCERNING MEDICAL ASSISTANCE FOR PATIENTS RECEIVING HOSPICE CARE AT A SHORT-TERM HOSPICE SPECIALTY HOSPITAL OR A HOSPICE FACILITY.**

This bill would require DSS, within available appropriations, to provide reimbursement for room and board costs for Medicaid recipients receiving care from short-term hospice specialty hospitals, or hospice facilities, and report on any savings realized by treatment received at such facilities.

Medicaid has strict prohibitions against paying room and board in many circumstances. As such, DSS cautions against broad coverage of room and board costs without further review of available Medicaid coverage.

The Department would respectfully request an opportunity to study and research this issue to a greater extent to help determine whether Medicaid is permitted to pay for room and board in such facilities.

## **HOUSE BILL 5482: AN ACT CONCERNING TWELVE--MONTH COVERAGE FOR CONTRACEPTION AND HORMONE THERAPY.**

This bill would allow a 12-month supply of all FDA-approved prescription hormone medications and contraceptive drugs, devices, or products to be dispensed at one time.

Prescription hormone medications encompass a wide range of therapies, including sex hormones (estrogen, progesterone, testosterone), thyroid hormones (levothyroxine, liothyronine), corticosteroids (such as hydrocortisone, prednisone, and dexamethasone), growth hormone, insulin and insulin analogs, antidiuretic hormone analogs, parathyroid hormone analogs, and many others used to treat diverse endocrine conditions.

Many of these medications require ongoing clinical monitoring, including laboratory testing, dosage adjustments, and assessment for side effects or symptom changes. Dispensing a 12-month supply at once is not medically appropriate or evidence-based for many of these therapies and could compromise safe patient management.

There are also significant fiscal implications. Providing a full year of medication that may need to be changed at a subsequent visit leads to waste. Additionally, covering a year's supply when an individual may no longer be enrolled in Medicaid within that time frame is not fiscally responsible.

If the intent of this legislation is to allow for coverage of a narrower class of prescription hormone medications, such as sex hormones, the Department would be willing to review the clinical and fiscal impact of a revised proposal and work with the Committee to better understand the goals and available options moving forward.

Given the current language and broad scope of medications included in the bill along with the associated fiscal impact, the Department of Social Services cannot support this proposal as written.

## **HOUSE BILL 5483: AN ACT CONCERNING FERTILITY CARE UNDER THE MEDICAID PROGRAM.**

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, 2027, would result in increases of \$300,000 in SFY 2027, \$11.7 million in SFY 2028, and \$27.6 million in SFY 2029. 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 \$2.2 million in SFY 2027, \$29.4 million in SFY 2028, and \$47.4 million in SFY 2029. 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 cannot support this legislation.

### **HOUSE BILL 5484: AN ACT EXPANDING TRANSPORTATION OPTIONS FOR HOME CARE CLIENTS**

This bill seeks to increase reimbursement to certain home care providers who provide non-emergency medical transportation to and from medical appointments for Medicaid home care clients. Connecticut General Statutes (CGS) 17b-374, defines the provider types included in the home care worker registry, which are home health care agencies, home health aide agencies, and hospice agencies defined by CGS 19a-400, as well as homemaker-companion agencies as defined by CGS 20-670.

While the bill does not state the scope or amount of the potential fee increase, any expansion of services would require an appropriation. The services provided by these provider types already either include transportation as part of their rate, or prohibit transportation as part of the service, as Medicaid already provides non-emergency medical transportation as an available service.

Further, the definition of, and reimbursement for, companion services already include escorting an individual to necessary medical or dental or business appointments.

The definition of and reimbursement for personal care attendant services explicitly excludes transportation costs associated with the provision of personal care outside of the participant's home as this is billed separately and is not included in the scope of personal care.

The definition of homemaker does not allow any services to be rendered outside of the home; therefore, transportation cannot be provided.

Due to the costs anticipated by this service expansion, DSS cannot support the legislation.

### **HOUSE BILL 5486: AN ACT CONCERNING A DIAPER PARTNERSHIP GRANT PROGRAM.**

This bill would require the Department to develop and establish a grant program to fund the provision of diapers to eligible children via a partnership established between a hospital

association and a diaper distribution network with statewide reach. The Department would also be required to establish reporting requirements and, in turn, report to the legislature on the impact of such distribution.

In addition to the costs of the \$1 million grant, the proposed grant structure would require the Department to incur administrative costs for staff to develop and maintain the grant program.

While the Department appreciates and supports the goal of ensuring that families have sufficient access to diapers for their young children, the Department would incur new administrative costs as it establishes a competitive grant process, contracts, reports, and conducts required oversight. The Department cannot support legislation containing costs not included in the Governor's recommended budget.

**HOUSE BILL 5488: AN ACT ESTABLISHING A TASK FORCE TO STUDY EXPANDING THE 2-1-1 INFOLINE PROGRAM.**

This bill would establish a task force to study the expansion of services offered by the 2-1-1 Infoline program operated by the United Way. The Commissioner, or her designee, would be a member of this newly created task force. As a current funder of United Way 2-1-1 services, the Department believes it is sensible to include the Department as a member of such a task force and DSS would actively participate if the legislation were to pass. Additionally, the Department would suggest that this taskforce looks broadly at all potential strategies including, but not limited to existing 2-1-1 services, to address person-centered approaches that help meet gaps for families and individuals in need and explore options to holistically meet that need.