



*Testimony before the Human Services Committee
Commissioner Andrea Barton Reeves
Department of Social Services
March 3rd, 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. We have submitted written comments, and I am pleased to offer remarks on several of the bills on today's agenda.

HOUSE BILL 5354: AN ACT CONCERNING MEDICAID PHARMACY AUDITS.

The Department of Social Services (DSS) urges against broad changes to the Department's auditing process. The revisions contained within this bill would result in a fiscal impact to the state in the form of reduced recoupment of Medicaid funds and restrict the Department's ability to monitor and safeguard state taxpayer dollars.

While this legislation seeks to specifically change the auditing process for only pharmacy providers, DSS cautions that the changes sought to the auditing statutes may ultimately result in collateral impacts on all other DSS medical providers, as other provider-types would likely seek similar revisions to audit processes in an effort to obtain 'consistency' in audit protocols. Comparing historical data on pharmacy audits to audits of other medical providers, pharmacy audits are generally less problematic. For example, looking at the audits conducted for state fiscal year 2025, pharmacy audits had recoupment amounts 38.3% lower than non-pharmacy audits. The Department urges against broad changes to the entire system in which we audit for a subset of providers that is historically less impacted than other providers.

Lastly, the language contained in CGS 17b-99 is general in nature and addresses audits of entities that participate as providers of services in a program operated or administered by the Department. The statute does not address specific provider types, and the Department recommends avoiding any language specific to pharmacy providers.

For the Committee's awareness, audit protocols are currently published on the DSS website ([Audit Protocols](#)), and the Department's Quality Assurance homepage outlines the overall audit process. The purpose of the protocols is to assist the medical provider community in developing programs to improve compliance with Medicaid requirements under state and federal law. Specific pharmacy audit protocols are also available ([PharmacyAuditProtocols.pdf](#)). The information contained on the Quality Assurance webpage, along with policy bulletins issued by

the Department, are meant as educational resources to the provider community with regards to the Department's auditing process and requirements of providers under state and federal law.

The Department's audit division is singularly focused on preventing abuse of the Medicaid system. While DSS understands the Committee's interest in protecting Medicaid providers, the changes sought in this legislation will limit the Department's ability to safeguard Medicaid dollars and hold providers accountable.

While the Department must oppose the bill as currently drafted, DSS appreciates the Committee's investment in the Medicaid system and our valuable providers and looks forward to future discussions on this matter.

HOUSE BILL 5355: AN ACT CONCERNING FUEL PRICING IN THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM.

This bill updates statute to remove reference to outdated language with regards to the Connecticut Energy Assistance Program fuel delivery model. Following the passage of Public Act 24-145, DSS convened a working group comprised of legislators, state agencies, stakeholders, and industry experts, to identify best practices for reimbursing fuel vendors while protecting maximum funding for benefit recipients. DSS was tasked with developing a new program delivery model based on the recommendations of the working group.

Through this collaborative effort, the working group identified new pricing standards no longer tied to county-based pricing, which is considered outdated, unnecessary upon implementation of a regional pricing standard, and not used by any other state. The Department, as approved by the legislature in the 2025 LIHEAP allocation plan, has now implemented *regional* pricing standards for deliverable fuel, as well as an option for vendors to use a "discount off retail" pricing standard. By removing the word "county" from statute, DSS seeks to align state law with the regional pricing practice developed through the working group, approved by the legislature in the agency's LIHEAP allocation plan, and integrated into the program's delivery model, which is based on regional pricing standards.

Additionally, this bill provides necessary clarification to the statutory language regarding the manner in which the state determines the daily price for fuel reimbursement under the "margin over rack" pricing option. This clarification ensures transparency for participating vendors and administrative accuracy for the Department. This clarification also reflects the longstanding practice in place in Connecticut and mirrors the approach taken by neighboring states who use a "margin over rack" reimbursement.

DSS urges passage of this legislation.

HOUSE BILL 5356: AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION.

The Department appreciates the Committee's interest in ensuring the highest safety measures are taken with non-emergency medical transportation (NEMT) drivers brokered through the Department's vendor, MTM, Inc.

For the Committee's awareness, MTM requires independent drivers to undergo a variety of safety requirements before they are approved to provide trips for Medicaid members under NEMT. Specifically, per the contract between DSS and MTM, said drivers must undergo criminal history records checks, motor vehicle driving record reviews, and a review of the sexual abuse registry. As part of the driver onboarding process, MTM conducts these background checks over the course of several days and weeks before an individual is able to drive for NEMT. The aforementioned background checks are modeled directly from the process used by the Department of Transportation (DOT) for the F-endorsement, which is required for operation of a taxi, livery vehicle, service bus, motor bus, or motor coach.

F-endorsement uses fingerprint-based background checks while MTM uses demographic-based background checks. This means that MTM begins a background check not just based on a name but based on numerous demographic data points such as birthdate, social security number, and address in order to "triangulate" the search to the correct person. While neither fingerprint-based nor demographic-based background checks are 100% foolproof, MTM has been successful with obtaining background checks for the correct person using the demographic-based method.

Additionally, the MTM in-house drivers are required to participate in various training programs, many of which are not required of drivers from taxi companies, Uber, and Lyft. These rigorous training programs include defensive driver training, CPR training, first aid training, and training on the Health Insurance Portability and Accountability Act (HIPAA), among other educational and professional development requirements. The majority of these training programs are not required by DOT when granting the F endorsement license and would not be required by a taxi driver under this new legislation.

The above noted requirements are in place as part of MTM's and DSS' commitment to ensuring member safety. DSS seeks to ensure that individuals who are providing NEMT services are adequately trained and have received appropriate vetting.

If the intent of this legislation is to allow drivers who require the F-endorsement to operate for up to 90 days while their F-endorsement is pending approval by DMV, DSS must oppose this bill. The Department has considerable concerns with inviting such risk into the process, especially because these rides are for our most vulnerable population. The Department currently does not have an access issue, or shortage of drivers, for our NEMT program. As such, any benefit that would be created by allowing a driver on the road without the approved F-endorsement does not outweigh the risk to the safety of our members.

Further, the Department understands this bill to require all drivers, even if they receive in-house background checks through MTM, to obtain the F-endorsement license. Adding an additional

requirement of these independent drivers is likely to cause drivers to drop out of the program, leaving a potential gap in the amount of services MTM can provide. Fewer independent drivers would result in a higher rate of drivers from other sources, which is likely to raise overall costs for the program.

With regard to the annual review of MTM rates, DSS would like to continue the conversation and get a better sense of the Committee's goals with the new language. There are various contracting and timing complexities that may challenge the Department's ability to comply with this language. DSS would appreciate further opportunity to discuss this bill in greater detail.

HOUSE BILL 5357: AN ACT CONCERNING RESIDENTIAL CARE HOMES.

The Department opposes this bill as written. This bill will be in direct conflict with current rate setting practices for Residential Care Homes (RCHs) and current Department regulations. For example, the current limit for an administrator's salary is \$63,407 for RCHs with 60 beds or less. This bill would increase that limit to \$75,000 for RCHs with 60 beds or less. This will increase cost to the state supplemental program by approximately \$1.0 million.

This bill also removes important inflationary adjustments that are intended to support RCHs. Removing the current inflation increases given to RCHs based on the Gross Domestic Product (GDP) deflator. This bill removes the Department's ability to recognize inflation using the nationally accepted GDP index and instead replaces it with an undefined index. RCHs would lose their ability to understand predictable GDP inflationary adjustments under this proposed language. Further, the proposed inflation language only gives RCHs nine months of an undetermined inflation adjustment while the current inflationary increase is based on a full twelve months.

The bill also provides for an inflationary adjustment of 3% in FY 2027, which will increase costs to the state supplemental program by approximately \$2.9 million.

The Department also has concerns regarding the proposed increase in the minimum allowable fair rent from \$3.10 to \$5.00 per day. As written, this language is not clear on its intent. The Department estimates this section will have a fiscal impact of approximately \$1.0 million to the state supplemental program. Fair rent is an important component of reimbursement, supporting capital improvements and the purchase cost of RCH buildings and, as such, the Department welcomes further discussion and modeling before it can commit to increasing the current limit of \$3.10. A more detailed analysis is needed to understand the fiscal impact and what the correct increase should be to cover costs. Any increase will, however, require additional funding that has not been budgeted

The Department also has concerns with the hold harmless provision that requires any rebasing of rates to include a stop loss such that no provider's rate is reduced as a result of the rebasing. This provision removes rebasing entirely, which is concerning since rebasing ensures that costs are correctly accounted for in reimbursement and then removed when the cost expires—it ensures costs are correctly reflected in the rate and that the state is not overpaying or underpaying. For example, if a facility purchased capital equipment, that equipment is only factored in the rate for

the useful life of the equipment. When costs end at their useful life, they are removed from the rate so the state does not overpay for an item. The opposite is true as well, when costs are incurred they should be factored into the rate for the period of the useful life only. Rebasing also provides predictability to the state budget, predictability to the RCH and aligns with recommendations from the Medicaid rate study.

Lastly, the new language on line 239 of the bill is duplicative, as that language is already contained in line 229 of the current statute. Having such duplicate language in statute may cause confusion and should be removed.

For the above reasons, and because funding for these changes is not included in the Governor's recommended budget, the Department cannot support this bill. DSS would appreciate an opportunity to discuss the proponents' goals in an effort to better understand the intent of this legislation.

HOUSE BILL 5358: AN ACT CONCERNING THE REBASING OF RATES OF REIMBURSEMENT FOR CERTAIN RESIDENTIAL FACILITIES.

The Department urges passage of this bill. This bill will codify a process for periodic review of Connecticut's Community Living Arrangements (CLAs) and Intermediate Care Facilities (ICFs) costs and state reimbursements, otherwise known as "rebasings." Unlike nursing homes, which have a predictable, statutory schedule for rebasing, CLAs and ICFs do not have a defined frequency for rebasing in state statute.

Specifically, this bill establishes a rebasing frequency that aligns the application of inflation adjustments with the methodology already successfully used by nursing homes and residential care homes. Beginning on July 1, 2026, costs for ICFs and CLAs are to be rebased every two years as determined by the Commissioner and when funds have been appropriated for such purpose.

Rebasing more frequently will keep state funding in line with costs, and ensure the state is not overpaying for costs that have been diminished or eliminated, such as mortgage costs or one-time costs. This process will also ensure that provider costs are accurately reflected to support important resident quality of care costs such as food, room and board, resident supports, and other costs that ensure resident quality of care. For context, the last rebasing of CLA rates was over ten years ago and the Department recognizes costs have changed since the last rebasing. A predictable rebasing schedule helps to not only control state costs, but ensure providers have cost changes recognized in the rate of reimbursement. Predictable rebasing also aligns with the findings of the Medicaid rate study to ensure support of member care and predictable rate setting that aligns with state expenditures.

Further, this bill will make technical updates to allow for inflationary adjustments based on the Gross Domestic Product (GDP) deflator when funding is appropriated. This also addresses "fair rent" additions based on actual useful life of assets, ensuring that the homes our clients live in can be properly maintained and updated.

DSS urges passage of this legislation.

HOUSE BILL 5040: AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HEALTH AND HUMAN SERVICES.

Section 1 of this bill standardizes the State Administered General Assistance (SAGA) benefit amount for all eligible recipients. SAGA serves adults who are either temporarily or permanently unable to work due to a documented medical condition and whose income and assets are below program limits. SAGA is only provided to individuals who don't qualify for any other cash assistance programs.

DSS determines if applicants are “unemployable” by meeting medical, non-medical, or “transitional” criteria. Upon approval, individuals that meet the medical or non-medical criteria are eligible for a benefit of \$262 per month. (Note: The \$269 benefit amount that is referenced in the bill reflects the benefit level that will be in place effective July 1, 2026, after the current \$262 benefit is increased to account for a cost-of-living adjustment.)

Those that are considered to be “transitional,” which means a doctor has determined they are unable to work for at least two months, would receive a benefit of either \$66 or \$262 depending on whether or not that individual reports a shelter expense. Additionally, the applicant's medical information is sent for an independent review to determine if the individual meets the definition of medically unemployable.

If the independent review determines that the individual is medically unemployable, the individual then becomes eligible to receive \$262 per month, retroactively and ongoing, for the duration that the medical review permits. DSS is also required to historically correct the prior \$66 monthly benefit issuances to ensure the SAGA participant receives \$262 per month for the entire eligible period.

This bill eliminates the temporary payment standard reduction for transitional persons, thus reducing the delay in providing benefits to beneficiaries in urgent need of support and reducing the agency's administrative burden.

Section 2 of this bill eliminates the restriction of not managing antiretroviral drug classes on the Medicaid Preferred Drug List (PDL).

There are currently over 140 therapeutic drug classes on the PDL. The PDL provides preferred options for a prescriber to use in a stepwise approach to treat various disease states. Should a preferred medication not be suitable in a specific case, the prescriber can easily submit a prior authorization request with documentation to substantiate the reason a preferred product is not appropriate. If the non-preferred product is deemed appropriate, a prior authorization is entered and the HUSKY member can receive the non-preferred medication.

Antiretrovirals belong to a class of medications that is currently not subject to our PDL. The Department supports this change to better manage outcomes for HUSKY members and provide

appropriate prescription coverage by ensuring alignment with clinical criteria and best practices. This change will also allow the state to receive supplemental rebates on these medications.

Section 3 of this bill maintains the income and asset requirements of the Medicaid for Employees with Disabilities program ("MED-Connect") that became effective April 1, 2025. PA 24-81 expanded MED-Connect income and asset eligibility, which provides Medicaid coverage to employees with disabilities. Specifically, section 64 required DSS to (1) increase the income limits from \$75,000 to \$85,000 and double the asset limit to \$20,000 for individuals and \$30,000 for couples, and (2) phase in the elimination of income and asset limits over four years beginning July 1, 2026, by annually increasing the income limit by \$10,000 and the asset limit by \$10,000 for individuals and \$15,000 for couples, with all income and asset limits to be lifted effective July 1, 2029. When fully annualized in FY 2030, this expansion in coverage was projected to result in state costs of over \$8.3 million (\$16.6 million after factoring in the federal share). Given these costs, the Governor's budget maintains the April 2025 levels going forward for savings of \$1.0 million in FY 2027 (\$2.1 million after factoring in the federal share). The Department observes that the current program income limit for individuals exceeds the state's median income and that, outside of a small number of states that have no income or asset limits, Connecticut has the highest income eligibility of any state.

Section 4 of this bill provides important Medicaid rate increases to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers. Increases to the Medicaid per diem will provide ICF/IID providers with additional funding supports necessary to improve resident care, support worker wages, and provide a direct benefit to Medicaid members receiving services in ICF/IID facilities. This language was included in Senate Bill 298, which recently passed and is awaiting the Governor's signature. It will allow ICF/IID providers to receive a Medicaid per diem rate increase of 5.8% starting July 1, 2026; a Medicaid per diem rate increase of 6.3% starting July 1, 2027; and a Medicaid per diem rate increase of 6.3% effective January 1, 2028. The Department supports these increases as they provide necessary funds to support care provided to Connecticut's most vulnerable residents.

Section 5 of this bill targets increases given to nursing home facility rates to support wage increases for licensed nurses engaged solely in direct patient care services. In 2025, the Governor made a significant investment of over \$110 million (gross) over the biennium with additional commitments in FY 2028 to the nursing home industry, Investments included direct support of worker wages and associated benefits that are targeted to staff that provide direct care services to nursing home residents. Direct care staff such as registered nurses, certified nurse aides, and support workers such as housekeeping, laundry and maintenance workers are to directly benefit from these investments and experience increases in their wages and benefits. This bill clarifies the intent of the funding to ensure that workers directly caring for and supporting nursing home residents will receive and directly benefit from the previously provided investments. The Department supports this clarifying language.

Section 6 of this bill allows the Commissioner of Social Services to review data on the effectiveness of certain high-cost medications. This analysis will better position the Department in rebate negotiations with manufacturers to drive down costs. As high dollar drugs continuously

enter the marketplace, it is important to understand if they provide better clinical outcomes resulting in overall less cost to the state compared to lower cost medication alternatives.

This information may be made public to increase transparency of drug spend while encouraging manufacturers to provide the best price possible in all circumstances.

The Department is in full support of the changes in this bill.

SENATE BILL 326: AN ACT CONCERNING HUSKY C ASSET LIMITS

This bill requires the Department of Social Services to phase out the asset limits for HUSKY C over a five-year period. HUSKY C provides health coverage to Connecticut residents who are 65 years of age or older, and/or who are blind or have a disability. The asset limits are currently \$1,600 for a single adult and \$2,400 for a married couple. The bill also requires DSS to report to the legislature on the number of individuals eligible for HUSKY C and the increased costs incurred as a result of this change.

While the Department appreciates the Committee’s objective, this expansion of Medicaid would require a significant amount of funding that is not contemplated in the Governor’s recommended budget. The Department estimates that this bill will cost the state approximately \$142 million in FY 2027, \$491 million in FY 2028, \$733 million in FY 2029, \$927 million in FY 2030 and \$1.070 billion in FY 2031. This estimate does not include administrative costs to support the increased volume in program enrollment that would result from these changes. Furthermore, elimination of asset limits would make Connecticut an outlier in terms of the maximum asset limits compared to other states – only California has no asset limits in their HUSKY C equivalent programs.

The Department cannot support the bill at this time.

SENATE BILL 327: AN ACT EXPANDING EMERGENCY MEDICAID COVERAGE

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

DSS appreciates the intent of this bill but has concerns about aspects of the proposal that do not align with federal laws that limit the state’s ability to obtain federal Medicaid reimbursement for services provided to this population. Federal regulations at 42 C.F.R. 440.255 provide that individuals who meet all Medicaid requirements except for immigration status will be eligible only for limited emergency medical services “required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

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

A wide range of conditions or diagnoses are already covered by emergency Medicaid because such coverage is based upon the emergent status of the event and not the specific diagnosis. As a result, the vast majority of emergency Medicaid services are provided through inpatient emergency admissions. Correspondingly, the state does not routinely cover outpatient services, except for dialysis and related services needed as a result of end stage renal disease, nor do we cover chronic condition “management” as an outpatient service because this would not be in line with the federal definition of emergency Medicaid. Any services provided that do not comply with the federal definition would not qualify for federal Medicaid reimbursement and would require the state to cover all such costs.

The bill also requires DSS to establish an administrative system for persons to apply in advance for emergency Medicaid coverage for conditions that could be treated in outpatient settings, rather than in hospital emergency departments. While DSS appreciates the intent to streamline the application process for beneficiaries, funding would be required to support both personnel and changes across multiple eligibility and claims payment systems for implementation. These additional costs were not included in the Governor’s recommended budget.

Finally, DSS observes that federal administrative policies related to the use and sharing of Medicaid data and information have recently changed, such that all Medicaid services and corresponding detailed personal information about individuals receiving such services are now subject to being shared with immigration enforcement officials and potentially other heretofore prohibited disclosures with federal government agencies outside of the U.S. Department of Health and Human Services. DSS believes that this change in federal policy may discourage state residents from pursuing ongoing medical coverage, and therefore this proposed financial investment in system and process changes may not result in increased access as previously envisioned.

While conceptually supportive of this legislation in the past, DSS strongly cautions against such changes at this time and thus cannot support this bill.

SENATE BILL 328: AN ACT REQUIRING NURSING HOMES TO SPEND EIGHTY PER CENT OF REVENUE ON DIRECT PATIENT CARE.

This bill requires nursing home facilities to spend at least 80% of Medicaid funding provided by the state on direct care. DSS supports the principle of aligning funding with direct care but, as written, believes the bill will have unintended, adverse consequences on total resident care.

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

As written, the bill would require 80% of Medicaid funding to be spent solely on the direct care component which is defined in the bill under subdivision (12) as “hands-on care provided to a facility resident by nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care.” This would leave only 20% remaining for the other vital nursing home services that support total resident need, such as: (i) dietary staff, food, housekeeping staff, laundry services, and resident supplies; (ii) capital costs such as moveable equipment needed for care; (iii) administrative and general costs such as facility maintenance and plant operation expenses; and (iv) property or fair rent to incentivize facility improvements and building upgrades.

Related, on July 1, 2026, the Department will transition nursing home reimbursement to an acuity-based Patient Driven Payment Model (PDPM) methodology which will align Medicaid spend with the nursing component of PDPM. PDPM is a federally-mandated system that focuses on the resident’s clinical characteristic rather than the current system that relies on the volume of services provided. PDPM will adjust the direct care component of the Medicaid rate to ensure funding increases to meet the resource need of the patient. PDPM will have the same effect as the intent of this bill by directing funding resources to direct care as nursing home resident needs and acuity increase. Further, the PDPM nursing component assesses patient acuity and resource utilization to determine reimbursement by focusing on clinical conditions, extensive services (e.g., vent/trach), specialized care, behavioral symptoms, cognitive performance, depression, and functional status using activities of daily living. PDPM will better direct reimbursement to resident care by focusing more on clinical conditions than the current system.

The Department respectfully suggests consideration of language that would support total resident care and not just one component of the Medicaid funding. For example, New Jersey legislation requires 90% of profits to be reinvested into direct care of nursing home residents. New York and Massachusetts require 70% and 75%, respectively, of total revenue – not just Medicaid spend – directed towards total resident care.

DSS would appreciate the opportunity to continue working with the Committee and stakeholders to improve transparency in the costs and spending in Connecticut nursing homes.

SENATE BILL 329: AN ACT EXPANDING MEDICAID ELIGIBILITY FOR OLDER ADULTS WITH DISABILITIES.

This bill requires DSS to disregard benefits received under Title II of the Social Security Act by a disabled adult child (DAC) who meets the criteria set forth at 42 USC 402(d)(1)(G) from being used in the determination of HUSKY C eligibility.

A DAC is an unmarried disabled individual age 18 or older whose disability began before age 22, is receiving SSI, and who is the child of an individual entitled to Social Security benefits. When the parent retires, becomes disabled, or dies, the DAC is entitled to receive a monthly Social Security benefit under Title II that ranges from 50% to 75% of the parent’s benefit.

Based on data from the Social Security Administration, in December 2023 there were approximately 13,000 DAC beneficiaries in Connecticut.¹ While DSS does not have data on the number of individuals specifically affected by the inclusion of these benefits in the HUSKY C eligibility determination, nor how many DACs are currently enrolled in HUSKY C, nor how many are currently subject to a spenddown, based on the eligibility conditions needed to qualify as a DAC, DSS believes that most DACs are likely already eligible for Medicaid, and are either already enrolled or can enroll subject to a spenddown.

The potential cost to the state would therefore be the difference between immediate Medicaid eligibility and when Medicaid would be activated under a spenddown. Based on prior analyses of individuals who meet spenddown requirements because they provide qualifying medical expenses, almost all who qualify do so immediately within the 6-month spenddown period because they have recurring medical expenses that are always available to meet the spenddown threshold. The Department therefore estimates that the cost to eliminate the spenddown for these individuals is likely relatively small compared to someone who is newly enrolling in HUSKY C.

Beyond the costs resulting from individuals no longer needing to meet a spenddown to qualify, this change has the potential to increase the number of individuals who are eligible for HUSKY C, which could in turn result in substantial additional costs under Medicaid. Finally, effectuating this policy change would require some system changes to identify this as a particular type of excludable income within DSS' eligibility system, with associated implementation costs.

As these costs were not contemplated in the Governor's recommended budget, the Department cannot support this bill at this time.

SENATE BILL 330: AN ACT COMPENSATING SPOUSES FOR STATE-FUNDED HOME CARE.

This bill requires DSS to allow the spouses of participants on the state-funded Connecticut Home Care Program for Elders (CHCPE) to be compensated as personal care assistants. State-funded CHCPE provides personal care assistant (PCA) services in several different ways; through agency-based PCA services, self-directed PCA services in which the participant is the employer, and through the agency-based Adult Family Living service. DSS currently prohibits spouses, conservators, and parents of minor children from being paid caregivers.

The changes proposed by this bill will result in significantly increased costs to DSS associated with members who would not otherwise access personal care services but will do so if provided by their spouse. Overall enrollment levels would also increase significantly due to this change. While spouses and other family caregivers inherently play a key role in ensuring that family members can live and participate in the community, the proposed expansion to *reimburse* spouses and other individuals providing personal care is expected to result in significant cost increases of at least \$31 million in state funding when fully annualized. This estimate does not factor in the additional costs for quality assurance due to the unique challenges to managing the

¹ https://www.ssa.gov/policy/docs/statcomps/di_asr/2023/di_asr23.pdf

fine line between informal, commonplace family supports and formal paid assistance from a spouse.

While DSS allows caregivers of many familial relationships to be paid support in all of our home and community-based services programs, DSS' long-standing position to disallow spouses from being paid is due to multiple factors. First, it would be difficult to distinguish between the informal role spouses play in caring for each other, from the specific activities of daily living (ADLs) and instrumental activities of daily living (IADLs) support that would be a requirement of a care plan. This would present a challenge for quality assurance within the program. Second, in Connecticut, a spouse is considered legally liable or legally responsible for their spouse. This means they are responsible for decision-making regarding care and are financially responsible for the individual. Allowing spouses to be paid results in an inherent conflict of interest when the spouse that participates in health care decision-making has an opportunity for financial gain in providing that care. These concerns are consistent with the Centers for Medicare & Medicaid Services' position that individuals in such relationships should not be paid as caregivers and, if they are, there are significant safeguards put in place and only in extraordinary situations.

For the foregoing reasons, DSS opposes this legislation.

SENATE BILL 331: AN ACT CONCERNING STEP THERAPY REQUIREMENTS FOR PRESCRIPTION DRUGS COVERED UNDER THE MEDICAID PROGRAM.

This bill will allow – in situations where manufacturer and FDA evidence-based guidelines exist – the use of step therapy beyond the current statutory 30-day limit.

Step therapy is a stepwise approach to the treatment of a medical condition, requiring a trial and subsequent failure of an alternative preferred medication before a non-preferred medication can be prescribed. Currently, Medicaid members may be required to try and fail one medication for a maximum of 30 days prior to a non-preferred drug being prescribed. However, at times, the manufacturer, or best practices, recommends more than one step, or a duration of treatment greater than 30 days to determine efficacy.

To address this, the bill allows for a duration of therapy to be based on manufacturer and clinical guidelines, which may be greater or less than 30 days, before a non-preferred medication can be prescribed. A common example where this proposed change would be impactful is treatment for autoimmune conditions, where some patients may notice initial improvement in symptoms after a few weeks on a prescribed therapy, but clinically meaningful improvement and full effect typically take longer than 30 days. Additional examples include medications to lower cholesterol or to lower blood sugar levels. Typically, the full effects of these medications will be seen within the first 3 months of use, but not necessarily within the first 30 days. Where therapies are statutorily required to end at 30 days, the true effectiveness of those prescriptions may not be fully understood. DSS is an outlier among other Medicaid fee-for-service states in that Connecticut law restricts the timeframe for use of certain medications. This proposal will align us with best practices used in other states and ensure our members are receiving care based on clinical guidelines.

By aligning statutory requirements with clinical guidelines and manufacturer recommendations, this proposal allows providers to exercise appropriate clinical judgment while maintaining the traditional step therapy process. To be clear, this proposal does not eliminate step therapy – rather, it modernizes the process and aligns with clinical best practices so step therapy functions as intended. This will encourage the use of clinically appropriate treatments without the rigid timelines that may work against patient outcomes, improve client outcomes, and ensure that beneficiaries receive safe, effective, and evidence-based care.

DSS urges passage of this legislation.