Testimony before the Human Services Committee
Deputy Commissioner Shantelle Varrs
Department of Social Services
February 20, 2025

Good morning, Chairs Lesser and Gilchrest, Ranking Members Harding and Case; and distinguished members of the Human Services Committee. I am Shantelle Varrs, Deputy Commissioner at the Department of Social Services. I am pleased to offer remarks on several of the bills on today's agenda.

SENATE BILL 164: AN ACT ESTABLISHING A TASK FORCE TO STUDY EXPANDING SERVICES PROVIDED BY THE 2-1-1 INFOLINE PROGRAM OPERATED BY THE UNITED WAY OF CONNECTICUT.

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 of Social Services, 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 reasonable to include the Department as a member of such a task force and DSS looks forward to participating if the legislation were to pass.

SENATE BILL 1298: AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION STANDARDS.

The intent, purpose, and impact of this bill are not entirely clear to the Department.

The Department's best understanding of this legislation is that it would allow any individual operating a taxicab or livery vehicle, regardless of whether their application has been approved by the appropriate state agency for the appropriate licensure endorsement, to provide transportation services to Medicaid members who are utilizing non-emergency medical transportation (NEMT), for a period not to exceed ninety days.

However, it is not clear whether the taxi or livery company hiring such driver would be required to conduct a criminal history records check, a search of sexual offender registry databases, or a review of their driving history record. Based on the language as written, DSS is concerned that the bill may, in effect, exempt individuals from certain requirements under CGS 14-44 by being "deemed to have met such requirements."

The licensing currently required by CGS 14-44, generally known as the "f-endorsement," is approved by the Department of Motor Vehicles (DMV) and the Department of Transportation (DOT). However, these regulations are applicable only for a driver that is driving for a company that has a Taxi or Livery license plate. Based on current DOT regulations, drivers hired through Transportation Network Companies (TNC) are not required to hold the "f-endorsement" licensure.

The Department's contracted NEMT broker for the state's Medicaid program, currently MTM, Inc., requires independent drivers to undergo a variety of requirements before they are approved to provide trips for Medicaid members under the NEMT benefit. 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 DOT for the f-endorsement in an effort for MTM to adhere strictly to those requirements.

Additionally, TNC 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. Medicaid members who participate in the NEMT benefit are some of the most vulnerable individuals the Department serves and, as such, the Department is not comfortable supporting any changes that would add any risk to this invaluable service.

For the above reasons, DSS opposes this bill.

SENATE BILL 1300: 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. Allowing spouses to be paid under the state-funded home care program as proposed in this bill is of concern for DSS. The Department has held a long-standing position that there is

a conflict of interest when the spouse that participates in the healthcare decision-making has an opportunity for financial gain in providing that care. As such, DSS does not recommend extending payments to spouses, conservators or legally liable relatives.

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 beyond current levels due to this change. While spouses and other family caregivers have 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 $22 million in state funding when fully annualized.

Because these costs are not supported in the Governor's recommended budget, the Department must oppose these changes.

SENATE BILL 1301: AN ACT CONCERNING MEDICAID RATES FOR COMMUNITY HOSPITALS IN RURAL AREAS.

This bill defines "community hospital in a rural area" as: a nonfederal, acute care hospital designated by the Connecticut State Office of Rural Health as a rural hospital; open to the general public; and located in an area of the state that is not designated as a metropolitan area by the U.S. Office of Management and Budget and the Census Bureau.

The bill requires DSS to amend the Medicaid state plan to increase Medicaid reimbursement rates for any such hospital that meets the above definition, and for those rates to be increased to the same level as Medicare rates for the same services. This bill would increase Medicaid expenditures and require additional funding. Medicare pays hospitals in a variety of different ways depending on the hospital's federal designation. Hospitals designated critical access receive 101% of their allowed costs, and hospitals with the rural emergency designation then receive an additional 5% increase. In comparison, Connecticut's Medicaid program pays hospitals through both fee-for-service payments and supplemental payments which are in addition to the regular Medicaid payments.

Under the current supplemental payment structure, some of the supplemental payments, through the small hospital pool, *already* provide proportionally more funds to certain hospitals in more rural areas. Overall, Medicaid pays over $600 million combined in supplemental payments, Disproportionate Share Hospital (DSH) payments, and graduate medical education (GME) payments to hospitals in addition to the regular payments. The standard hospital Medicaid payment also receives a 2% increase annually in addition to the supplemental payments as required by the settlement agreement between the hospitals and the state. It is premature to contemplate any rate methodology changes until the end of the agreement in July 2026. Finally, this proposal would significantly increase state costs for payments to the relevant hospitals, which would involve a fiscal impact for which funding is not available in the Governor's proposed budget.

For the above reasons, DSS opposes this bill.

SENATE BILL 1299: AN ACT CONCERNING MEDICAID-COVERED DENTAL CARE.

This bill makes various changes to the Department's Medicaid coverage of dental services. Specifically, section 1 of the bill exempts prevention services such as oral exams and dental cleanings from the annual $1,000 payment cap for members receiving dental services. Section 2 expands coverage for adult dental services from one to two dental cleanings per year and adds periodontal therapy. Section 3 restricts DSS from requiring separate dental services and procedures be provided to a member in a single visit at a mobile dental clinic, school-based health center, or expanded school health site.

The Department has several concerns with this proposal. The exemption of oral exams and dental cleanings from the annual payment cap will have a fiscal impact to the Department. Were these two items to be excluded, DSS would anticipate members to exceed that $1,000 payment cap, with a significant anticipated cost to the state. These costs are not accounted for in the Governor's recommended budget.

The expansion in section 2 will also have a fiscal impact that is not accounted for in the Governor's budget. While DSS appreciates the goals of expanding the frequency in which dental cleanings occur, the additional coverage would require a corresponding appropriation to DSS.

DSS has additional concerns with section 3 and the restriction of requiring dental services to be provided in a single visit. The bill will allow Federally Qualified Health Centers (FQHCs) who operate mobile and school programs to be reimbursed for multiple encounters to complete routine preventive care that could be completed in one visit. As individuals with private health insurance know, if there is a need for multiple dental services, most facilities will seek to complete all necessary care in a single visit. Conducting all needed services in one visit eliminates the needless billing for multiple visits where the care can be provided at the same visit and reduces the burden on members DSS seeks to allow our members with the accommodation to schedule one visit for all services rather than the burden of having to go to multiple appointments. DSS allows for exceptions such as emergency services or for other medically necessary reasons if a member needs to return for multiple visits.

For the above reasons, DSS opposes this bill.

HOUSE BILL 6936: AN ACT CONCERNING FUNDING FOR INPATIENT ADDICTION TREATMENT PROVIDERS THAT COVERS ROOM AND BOARD COSTS FOR MEDICAID ENROLLEES

This bill would require state-funded medical assistance coverage, within available appropriations, for room and board costs for all persons enrolled in Medicaid who are receiving residential substance use disorder treatment.

Currently, the Department provides state funding only for room and board costs to substance use disorder (SUD) residential treatment programs under our current SUD Demonstration Waiver, which has been in effect since 2022. The Department's annual expenditures for state funded

room and board is approximately $15 million. Room and board expenditures are based on the Department's annual budget appropriation.

The bill also states that DSS may amend the SUD Demonstration Waiver or the Medicaid State Plan to the extent such coverage is consistent with federal Medicaid law. The Department state funds the room and board component of the residential stay because, per the Standard Terms and Conditions of our Demonstration Waiver with the Centers for Medicare and Medicaid Services (CMS), room and board costs are not a permissible cost under Medicaid. The Standard Terms and Conditions for the SUD Demonstration Waiver, specifically STC #20, reference unallowable expenditures under the SUD Expenditure Authority, include, but are not limited to "Room and board costs for residential treatment services providers unless they qualify as inpatient facilities under section 1905(a) of the Act." Residential treatment under these circumstances do not qualify under 1905(a) of the Social Security Act.

As such, DSS suggests that this bill is not needed, as DSS already covers such services.

HOUSE BILL 6935: AN ACT CONCERNING CHILDREN'S HOSPITAL MEDICAID RATE PARITY

This bill requires DSS to increase Medicaid reimbursement rates for the Connecticut Children's Medical Center. On or by October 1, 2025, DSS must increase rates to achieve parity with Medicaid reimbursement rates for the same services provided by hospitals that primarily serve adults.

Currently, hospitals are reimbursed for inpatient services through the APR-DRG methodology, which pays hospitals a base rate and increases the rate based on the severity of the patient's condition and treatment. The children's hospital in Connecticut receives the second highest APR-DRG base rate when compared to all other hospitals. The current methodology acknowledges the severity and acuity level of the patients and is updated annually through an adjustment factor to recognize changes in the index. The system also adjusts the rate further under a peer grouping for children's hospitals by applying a specific adjustment factor.

The children's hospital also receives many financial benefits from the state that are not generally available to other hospitals. The children's hospital receives a quarterly supplemental payment for physician services to support the care provided to children. Annually this payment is approximately $10 million. The children's hospital also receives a graduate medical education (GME) payment of approximately $1.1 million annually. Unlike all of the nongovernmental general hospitals, the children's hospital is exempt from the state's inpatient and outpatient hospital user fees (provider tax), which is a significant financial benefit to the children's hospital. When considering the full picture of all these elements, the children's hospital already receives significantly more favorable financial treatment from the state than other hospitals. Finally, this bill would significantly increase costs for rates paid to the children's hospital, which would require additional funds that are not included in the Governor's proposed budget.

For the above reasons, DSS opposes this bill.

HOUSE BILL 6934: AN ACT CONCERNING MEDICAID COVERAGE FOR LICENSED INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANTS.

This bill would require the Department of Social Services (DSS) to add lactation consultants to the list of practitioners for whom such services will be covered in the payment to physicians and other qualified licensed practitioners serving as the accountable provider under the maternity bundle payment program.

DSS implemented the maternity bundle payment program in January 2025. As part of the maternity bundle program specifications, access to lactation supports, through the accountable provider, was added as a core feature. The addition of lactation support requires the provision of breastfeeding education and support, screening for breastfeeding difficulties or other risk factors, *and* appropriate access to International Board-Certified Lactation Consultants (IBCLCs) for members at risk or presenting with clinical problems related to breastfeeding/lactation.

Consistent with the reimbursement methodology for the maternity bundle payment program, the accountable provider receives add-on funding for the provision of lactation support services. This program specification outlining the inclusion of lactation support services is published and can be accessed on the DSS maternity bundle website and the maternity bundle provider bulletin.

DSS values the provision of lactation support services and views this service as integral to addressing equity gaps for HUSKY Health birthing people. As a result, DSS has already included and remains committed to the inclusion of lactation support services in the maternity bundle payment program. For this reason, the Department suggests that this legislation is not needed.

HOUSE BILL 5579: AN ACT CONCERNING THE ESTABLISHMENT OF A HISPANIC AND COMMUNITIES OF COLOR NONPROFIT GROWTH AND STABILIZATION FUND.

The bill as written will direct funding, currently at $1 million, from the Human Resource Development - Hispanic Programs (HHD) account within DSS that has traditionally been used to provide direct services to our most vulnerable populations to a fund that would be used to build the service capacity of certain nonprofit organizations that meet the proposed definition of "eligible community-based organization."

Traditionally, HHD funds have been used to support services such as classes for English as a second language, addressing English language barriers, employment services, certified nurse's aide programs, client advocacy, literacy training, and service plan development to achieve goals such as permanent housing and treatment for substance use disorder. These are direct programs and services that assist clients in achieving self-sufficiency in the community. This bill would redirect those funds from the support of direct client programs and services to instead be used to improve operational efficiencies and adopt strategies for long-term fiscal sustainability of "eligible community-based organizations."

The Department supports and understands the value and importance of a strong and viable network of nonprofit providers. Without our nonprofit partners, we would not be able to support the various service needs of our communities. We do not, however, agree that the funds in the HHD account should be diverted from direct client services to support the economic development of a nonprofit provider. There are more appropriate resources within the state for the development and support of our nonprofit providers.

Additionally, the Department would like to note that it is currently in the procurement process for these identified resources and thus, any change would disrupt the existing service delivery system. For these reasons, the Department does not support this bill.

HOUSE BILL 6933:AN ACT CONCERNING MEDICAID BILLING FOR SUICIDE RISK ASSESSMENTS AT SCHOOL-BASED HEALTH CENTERS.

This bill will require DSS to provide Medicaid reimbursement for suicide risk assessment as a separate billable service.

Currently, the procedure code used to reimburse for suicide risk assessments is separately payable on the physician office and outpatient fee schedule, the medical clinic fee schedule (which is inclusive of school-based health centers that are enrolled as freestanding clinics), and the behavioral health clinic fee schedule. Additionally, suicide risk assessments performed and billed by a Federally Qualified Health Center (FQHC), including FQHCs that operate school-based health centers, are payable under the encounter rate.

Without additional context and details on this proposal, the Department is unable to speak to this issue in greater detail.

HOUSE BILL 6091:AN ACT CONCERNING AN EQUITABLE MEDICAID AUDIT, BILLING AND REIMBURSEMENT POLICY FOR PHARMACIES.

This bill prohibits DSS from denying Medicaid reimbursements to a pharmacy using extrapolation of data stemming from a clerical or technical error, requires DSS to provide a receipt confirmation process to pharmacies concerning any notices from DSS regarding pharmacy billing, and requires DSS to maintain a database of the Department's preferred drug list. Lastly, DSS is required to implement a grievance process for pharmacies to challenge reimbursement for dispensing a prescribed drug should it not cover the pharmacy's costs.

CGS 17b-99 outlines the details related to the audits of DSS providers. This section of Title 17b outlines the definitions of both a clerical error and extrapolation as it relates to the Department's audit process.

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 it is the Department's opinion that language specific to pharmacy providers should not be inserted.

A clerical error is defined within statute as an unintentional typographical, scrivener's or computer error. Subsection (d)(3) of CGS 17b-99 further addresses clerical errors, explicitly providing that: "Any clerical error discovered in a record or document produced for any such audit shall not of itself constitute a willful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established." The DSS audit division takes this language into account while conducting its audits.

The Department also objects to the language related to the exclusion of "minor technicalities" from the extrapolation process. This language is vague and could be interpreted in an inconsistent manner across audits performed by the Department.

Pursuant to subsection (d)(1)(B) of CGS 17b-99, extrapolation is defined as the means of the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn. For audits of medical providers, including pharmacies, it is determined if the results of the sample review will be extrapolated using the guidelines of CGS 17b-99.

Extrapolation is only utilized when the total net amount of extrapolated overpayment calculated from a statistically valid sampling and extrapolation methodology exceeds one and three-quarters percent of total claims paid to the provider for the audit period. This threshold of one and three-quarters percent for extrapolation is a mechanism that prevents singular or a few low dollar errors from being extrapolated over the entire universe of paid claims.

When comparing pharmacy audits to audits of other medical providers performed by the DSS audit division, the percentage of audits that are extrapolated is relatively low. For the 2024 and 2025 fiscal year to date, six out of the twenty-one audits were extrapolated. Over seventy percent of the pharmacy audits performed did not result in extrapolation.

Additionally, the audit process provides the provider time to respond and comment after the draft audit is issued, at an exit conference, and offers appeal rights if the provider is aggrieved by any decision made during the audit.

The proposed language in subsection (b)(1) is unclear and the Department is not sure of the intent or impact of that section. Currently, when submitting a claim, pharmacies receive an immediate response.

With regards to subsection (b)(2), DSS currently maintains a preferred drug list (PDL) and claims processed through Point of Service receive messages in real time. As such, DSS believes the language in subsection (b) is not needed.

Lastly, DSS also believes the requirement in subsection (c) is unnecessary. DSS follows the reimbursement methodologies accepted and approved by the Centers for Medicare & Medicaid Services (CMS) and provides a generous dispensing fee which far exceeds the commercial dispensing fee. Established reimbursement methodologies such as National Average Drug Acquisition Cost (NADAC) is routinely used when available to price medications appropriately. Developing a new grievance process would require additional staff to develop, implement, and

conduct such procedures, and would require appropriations to the Department that are not accounted for in the Governor's recommended budget.

For these reasons, the Department cannot support this bill.

HOUSE BILL 5730: AN ACT CONCERNING STAGGERED TERMS FOR MEMBERS OF THE TWO-GENERATIONAL ADVISORY BOARD.

This bill would make changes to the structure of the Two-Generational Advisory Board. Specifically, the bill clarifies that the members of the group who are representatives of nonprofit and philanthropic organizations shall be selected by the co-chairpersons.

Further, beginning July 1, 2025, the members of the board will be appointed, or reappointed, to a staggered three-year term. Not more than one-third of the board members' terms shall end on the same date.

As an active member of the Two-Gen initiative, the Department appreciates the Committee's interest in the structure of the board and the work that this important group undertakes. DSS believes that having a blend of experienced and new board members can be beneficial to advancing the work of the initiative. DSS supports this legislation.

HOUSE BILL 6080: AN ACT CONCERNING MEDICAID COVERAGE OF NONINVASIVE, CUSTOM BREAST PROSTHESES FOR MASTECTOMY PATIENTS

This bill would require Medicaid coverage of noninvasive, custom breast prostheses for mastectomy patients to enhance their comfort and reduce negative side effects.

Currently, Medicaid provides coverage of several breast prosthetic products, including custom breast prostheses post mastectomy. A custom breast prosthesis is a breast form that is made to fit a person's body shape and size and is designed to provide a more comfortable and natural looking fit for an individual after a mastectomy surgery. Custom breast prostheses are covered when medically necessary and does not require prior authorization. Any expansion of the current coverage would require a corresponding appropriation that is not included in the Governor's recommended budget. As such, DSS cannot support this bill.

HOUSE BILL 6087: AN ACT CONCERNING RECOGNIZING HEARING IMPAIRMENT AS A DISABILITY.

This bill would recognize hearing impairment as a disability to allow for certain accommodations and state medical assistance for individuals with a hearing impairment.

The language is unclear as to what type of state medical assistance would be provided, and whether this would include Medicaid coverage.

Were this bill to seek an expansion of Medicaid services to cover new or expanded services, there would be a corresponding fiscal impact to the Department, which would be dependent on

the details of such coverage, the number of individuals who would be included in the coverage, and other factors.

Such coverage expansion is not included in the Governor's recommended budget. As such, DSS cannot support this legislation.

HOUSE BILL 6088: AN ACT REQUIRING HEALTH CARE PROVIDERS WHO RECEIVE ANY STATE FUNDING TO ACCEPT CASH PAYMENT FOR SERVICES

The Department is not clear on the purpose and intent of this legislation. As such, DSS will withhold comment at this time.

HOUSE BILL 6101: AN ACT CONCERNING MEDICAID COVERAGE OF FOOD AS MEDICINE AND EXPANDING ACCESS TO THE CONNECTICUT FARMERS' MARKET/WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM

This bill requires DSS to submit an 1115 Medicaid waiver to provide Medicaid coverage for produce prescriptions for members with nutrition-related chronic diseases. Additionally, it requires DSS to address barriers to participation in the Connecticut Farmers' Market/Women, Infants and Children Nutrition Program (WIC FMNP) administered by the Department of Agriculture.

The Department appreciates the goals of this proposal and understands the importance and the positive impact that produce prescriptions, and WIC FMNP may have on Connecticut residents. However, the expansion considered by this legislation would have a corresponding fiscal impact to the Department, which would be dependent on the details of such coverage, the number of individuals who would be included in the coverage, and various other factors.

Moving forward with an 1115 waiver would require two sources of funding, neither of which is included in the Governor's budget. First, there is the administrative expense required to plan, apply for the waiver, and implement new services. In the two previous 1115 waivers that Connecticut has successfully applied for, DSS hired outside vendors to help; we anticipate a similar level of need here. Second, and more substantially, covering these additional services would require state resources. The Department appreciates the intent of this bill and recognizes that these interventions, if correctly targeted, have the potential to reduce state spending in the long term, however, as written, this bill will result in additional costs that are not in the Governor's budget.

It should be noted that WIC FMNP is associated with the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) administered by the Department of Public Health. WIC participants over 6 months of age are automatically eligible for, enrolled in, and issued WIC FMNP benefits in addition to their regular WIC benefits, typically between June and November of each year. WIC FMNP benefits can be used to buy eligible foods from farmers, farmers markets or roadside stands that have been approved by the state agency to accept these benefits.

DSS does not administer WIC, nor does it administer the WIC FMNP program. As such, the Department does not believe it is in a position to address any barriers to participation in these programs and it would be best left to the agencies that administer them.

For these reasons, DSS cannot support this bill.

SENATE BILL 981: AN ACT EXPANDING MEDICAID ELIGIBILITY FOR OLDER PERSONS AND PERSONS WITH DISABILITIES.

This bill will require DSS to provide Medicaid coverage for eligible persons who may have lost eligibility to Supplemental Security Income (SSI) due to a Social Security Title II cost-of-living adjustment (COLA) in accordance with Section 503 of Public Law 94-566, known as the Pickle Amendment.

Many states, known as "1634 states," have an agreement with the Social Security Administration (SSA) wherein individuals who receive SSI in those states receive Medicaid automatically and do not need to apply for Medicaid benefits separately. The agreements are only with states that use SSI criteria to determine Medicaid eligibility. If an individual in these states loses their eligibility for SSI, they also lose their eligibility for Medicaid. The Pickle Amendment requires that these individuals retain their eligibility for Medicaid if they were simultaneously receiving Social Security Old Age, Survivors or Disability Insurance (SSDI) and SSI and were deemed ineligible for SSI due to a COLA increase in their SSDI benefit.

Connecticut, however, is not a 1634 state and DSS does not automatically confer Medicaid eligibility based upon SSI eligibility. Rather, the Department determines eligibility based upon defined income and asset limits for all individuals 65 years of age or older, and/or who are blind or disabled. The income limits are adjusted each year to account for the annual SSA COLA. Therefore, once an individual is determined eligible for Medicaid, the receipt of an SSA COLA should not change a person's Medicaid eligibility from one year to another.

For this reason, the Department respectfully suggests this bill is unnecessary and may cause undue confusion if it were passed.

HOUSE BILL 5580: AN ACT CONCERNING MEDICAID COVERAGE FOR DIABETES PREVENTION, EDUCATION AND SELF-MANAGEMENT PROGRAMS AND MEDICAL NUTRITION THERAPY.

This bill seeks to require DSS to provide Medicaid coverage for diabetes prevention, education, and self-management and medical nutrition therapy.

The Department's medical administrative services organization, Community Health Network of Connecticut (CHNCT), currently offers an extensive array of services for Medicaid beneficiaries with diabetes. These services include:

- Intensive Care Management and Transitional Care Management for beneficiaries identified as 1) high risk with diabetes; 2) having gaps in care; or 3) having emergency department visits or inpatient stays related to diabetes.

- Direct contact with beneficiaries by nurses, pharmacists, social worker/behavioral health care coordinators, registered dietitians, community health workers, and non-clinical outreach staff to address diabetes care needs and provide ongoing coaching support.
- Wellness communications and automated reminders to ensure that beneficiaries with diabetes are getting the care they need to keep them healthy.
- Diabetes educational materials available through the HUSKY Health member website.

In addition, Public Act 23-94 requires DSS to cover nutritional counseling provided by a registered dietician-nutritionist for Medicaid and HUSKY B beneficiaries with severe obesity and beneficiaries with a body mass index of greater than 35. DSS is actively working to implement this coverage for Medicaid and HUSKY B beneficiaries.

If this bill seeks an expansion of Medicaid services to cover diabetes prevention, education and self-management programs, the addition of new Medicaid services would result in a corresponding fiscal impact to the Department, which would be dependent on the details of the coverage, the number of individuals who would be included in the coverage, and other various factors.

Such coverage expansion is not included in the Governor's recommended budget. As such, DSS cannot support this legislation.

SENATE BILL 803: AN ACT EXPANDING ACCESS TO OUTPATIENT SUBSTANCE ABUSE TREATMENT BY REDUCING REGULATORY BURDENS ON PROVIDERS.

This bill would prohibit requirements that substance use treatment providers provide on-site medical personnel 24 hours per day. Instead, such medical personnel would only be required on-site during business hours, with remote peer support and access to medical consultation after hours.

The Department believes, however, that the regulation in question (17b-262-819(f)), does not require in-person availability.

DSS looks forward to discussing the intent and goal of this proposal to better understand the change that is being sought.