Community First Choice

1. What steps need to occur to implement the proposed policy change?

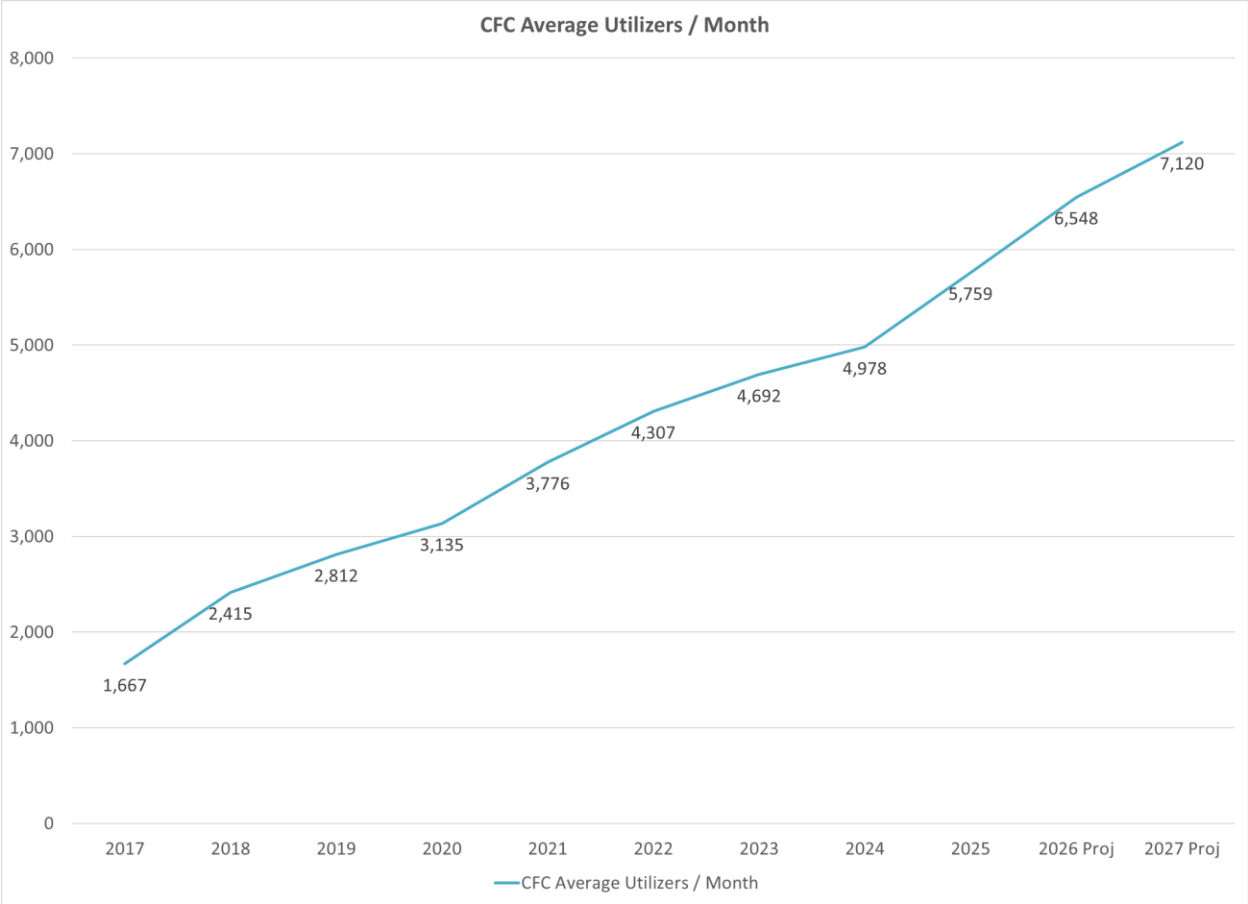
   The transition to move the self-directed PCA service from the 1915(k) authority into 1915(c) home and community-based services waivers will require internal coordination, and planful collaboration across CMS, our sister agencies, and SEIU 1199NE. Self-directed PCAs will remain available to all active participants during and post transition, and we will continue to onboard members into the program during the transition process. We will be securing a programmatic and fiscal consultant to help navigate the change in authority. CMS will guide us on the technical aspects and we intend to engage stakeholders and participants as we design the new waiver and scope of services. It is important to note that the state has a long history of this service being in the waivers and we will have a project plan developed to ensure smooth implementation.

2. Can you provide the average cost per person using agency based PCA services vs self-directed care, general background info, number of people served, demographics?

   The table below compares agency-based PCA costs vs. CFC costs for SFY 2025.

Program	Average Monthly Billing Participants	Total Cost	Care Management Cost	Fiscal Intermediary Cost	Per Member Per Month Cost
Agency-Based	8,132	$421,831,485	$1,236,077	n/a	$4,335
CFC	5,759	$371,039,455	n/a	$10,483,420	$5,521

   The graph below includes CFC utilizing members per month for SFY 2017 through SFY 2025 with projections for SFY 2026 and SFY 2027. CFC is entirely self-directed.



3. Please provide data showing historical trends for HCBS vs institutional settings (costs and number served, FY 16 to present).

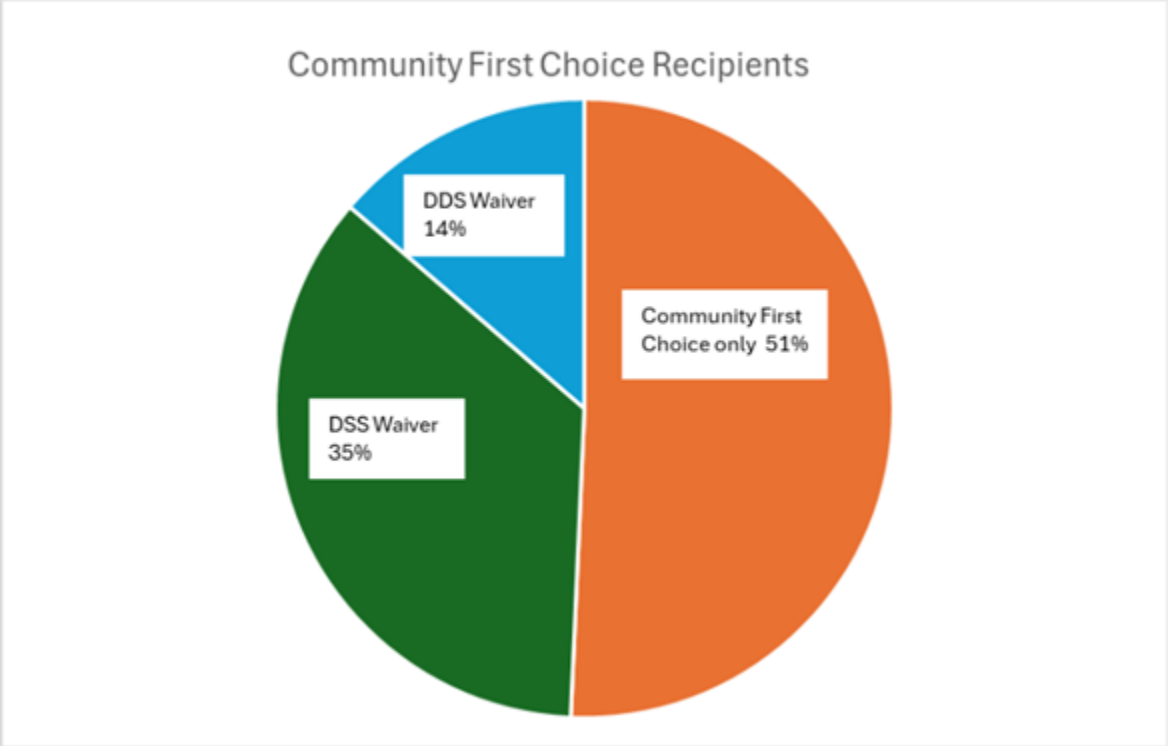
   Since SFY 2003, the proportion of Medicaid clients receiving care in the community has increased by 54%, from 46% in SFY 2003 to 71% in SFY 2025. During the same time, the proportion of Medicaid long-term care expenditures for home and community-based care has increased by 94%, from 31% in SFY 2003 to 60% in SFY 2025.

   By comparison, since SFY 2000, the proportion receiving care in the community has increased by 46%, from 41% in SFY 2000 to 60% in SFY 2016. Expenditure trends did not begin to be collected until SFY 2003. However, since SFY 2003, the proportion of Medicaid long-term care expenditures for community care has increased by 58%, from 31% in SFY 2003 to 49% in SFY 2016.

   To see complete year-over-year trends, see pages 1 and 2 of the 2025 Annual Rebalancing Report submitted to the legislature on December 30, 2025.

4. Is it possible to identify CFC client characteristics - disabled vs aging population?

Community First Choice (CFC) serves Medicaid members who meet nursing home level of care. This chart illustrates the overlap with other home and community-based services. As shown in the chart below, 49% of CFC participants are already in a waiver program.



CFC Population - Data pulled 2.25.2026 - Open/Active Cases				
Program/Waiver:	**Under 18**	**18 to 64**	**65+**	**Total**
Standalone CFC	255	3062	714	4031
DDS Waiver w/CFC	103	966	21	1090
Autism Waiver w/CFC	4	22	0	26
Katie Beckett w/CFC	47	50	0	97
Mental Health Waiver w/CFC	0	23	4	27
ABI 1 w/CFC	0	59	21	80
ABI 2 w/CFC	0	71	17	88
CHCPE Category 3 w/CFC	0	1	1750	1751
PCA Waiver w/CFC	0	750	10	760
Combined Total	**409**	**5004**	**2537**	**7950**

5. Does this policy change consider the inclusion of/increased support for day programs?

   Community First Choice provides personal care assistance to help individuals with hands on care, cueing and supervision with their daily care needs. For those not enrolled in a waiver, CFC does not have access to adult day programs. Individuals that are currently accessing CFC along with a waiver generally have access to an adult day center or a day program. This policy change does not change that access. For individuals that will be new to a waiver will now have access to adult day if that is a service they would like to offset for their PCA needs. Most individuals that require PCA will still need some level of support, but they could add in adult day to supplement some of that care and supervision if they move to a waiver that offers that service. We have yet to determine if the new waiver will offer additional services and support but will add that for consideration.

6. How many PCAs provide services under CFC?

   Community First Choice has an average of 16,000 active PCAs in a given month. On average, consumers have 4 PCAs assigned to their care plan as permanent or backup staff.

7. Will we lose the enhanced federal match of 6%?

   Yes, sunsetting CFC will result in the loss of the 6% enhanced federal match but moving participants to waivers, as proposed in the Governor's budget, will better position the state in the long run with net savings to the state beginning in FY 2028.

Patient Driven Payment Model

8. Please explain why this method significantly reduces Medicaid payments to nursing homes.

   To calculate quarterly acuity nursing home reimbursement adjustments under Medicaid, DSS currently uses a Resource Utilization Group (RUG) system for classifying nursing home residents based on their acuity and resource needs. Effective October 1, 2025, however, the Centers for Medicare & Medicaid Services (CMS) is implementing federal changes to nursing home resident assessments which will require states that rely on RUGs for resident assessments to transition to the new method of resident assessment called Patient Driven Payment Model (PDPM).

   PDPM is a resident assessment classification system that categorizes residents based on their clinical needs and characteristics. This is different than the RUGs assessment which looks at the volume of services provided to the resident.

   - PDPM is designed to ensure more accurate and appropriate payment for residents by focusing on the resident's individual care needs versus volume-driven payment.

- PDPM focuses payment based on the resident's individual comprehensive clinical care needs by using standardized ICD-10 diagnosis codes and individual resident characteristics as the basis for PDPM classification.

To transition to PDPM in alignment with the updated CMS data, the rate must be based on the most recent 2024 cost report data since payment will now reflect residents' characteristics rather than the volume of services measured under the old RUGs method. PDPM is designed to better measure individual care needs and, as such, it will allow for more accurate and appropriate payments.

9. Are you able to show the baseline impact of PDPM on rates by nursing home?

The Department is developing a model to show a home-by-home impact. The transition to PDPM and the associated rebasing will be phased in over three years. The phase-in will require additional state funding of $11.9 million in FY 2027 and $12.7 million in FY 2028. This rebase is expected to result in savings to the state of $22.4 million in FY 2027 and $24.4 million in FY 2028 while the industry will receive, in the aggregate, over $20 million in each of the three years of the phase-in.

- The three-year phase-in of the PDPM model will allow homes time to transition. Over the three years, the state will invest in a stop gain/loss to give homes time to understand the changes in reimbursement and to make the necessary operational adjustments. The phase-in, which will require additional state funding of $11.9 million in FY 2027, will provide not only predictability in nursing home reimbursement but will also support continuity of care for nursing home residents as homes adjust operations and develop best practices under PDPM.
- A new Medicaid utilization pool will reward homes that serve a higher proportion of Medicaid members and help to promote more choices for Medicaid members. Nursing homes with greater than 75% Medicaid utilization will be eligible to receive funding from a pool of $2.5 million in FY 2027 and $5.0 million beginning in FY 2028.
- A quality performance program will be funded beginning in FY 2029, when the system has fully transitioned to the new model. Eligible nursing homes may receive funding under a $10 million pool based on CMS' quality metrics and consumer satisfaction measures.

Phase-In	Year 1 FY 2027	Year 2 FY 2028	Year 3 FY 2029
Max Gain (Stop Gain)	$6.25	$10.00	None
Max Loss (Stop Loss)	($15.75)	($23.00)	None
Medicaid Utilization Pool (> 75%)	$2,500,0000	$5,000,000	$5,000,000
Quality Performance Pool	$0	$0	$10,000,000

10. How will the new $13.1 million in state funding be used to support homes?

    Reinvestments to the industry in FY 2027 will be targeted to support homes with the transition to PDPM and to reward those homes that serve a greater percentage of Medicaid members. This additional funding will help to stabilize the industry and allow for more choices for Medicaid members.

11. What is the net financial impact to the nursing home system?

    In terms of Medicaid, which on average represents over 70% of nursing home funding, the Governor's proposal will help to mitigate the impact of PDPM over the three-year phase-in period, as shown below.

	FY 2027	FY 2028	FY 2029
PDPM Implementation Savings	($44,800,000)	($48,800,000)	($48,800,000)
Cost to Phase-In PDPM	23,700,000	25,400,000	21,200,000
Medicaid Utilization Pool	2,500,000	5,000,000	5,000,000
Quality Performance Pool	0	0	10,000,000
Net Change	($18,600,000)	($18,400,000)	($12,600,000)
State Share Impact	($9,300,000)	($9,200,000)	($6,300,000)

PL 119-21

12. Please detail the policy changes impacting the FY 27 budget, including new state costs and anticipated savings.

    The Governor's budget reflects Medicaid savings of $22.5 million ($124.2 million after factoring in the federal share) based on the assumption that nearly 65,000 Medicaid enrollees will lose coverage by 6/30/27 due to work requirements and changes in non-citizen eligibility. While all HUSKY D enrollees will be subject to the new work requirements, which will be in effect beginning 1/1/27, DSS continues to evaluate how many enrollees the department may be able to automatically determine to be compliant or exempt, and how many may need to provide additional information to maintain eligibility. DSS' current working estimate is that between 78,000 and 128,000 individuals may be at risk of losing coverage due to the work requirements (9% -14% of total Medicaid enrollment) but, ultimately, the number losing coverage is expected to be lower. For the purposes of the Governor's budget, it is assumed that approximately 56,200 will lose coverage as result of the work requirements. The budget also assumes approximately 8,300 non-citizens will lose Medicaid coverage effective 10/1/26 due to new restrictions that remove eligibility for refugees/asylees/parolees, victims of trafficking, victims of domestic violence, and Afghan and Iraqi nationals with special immigrant visas. The Governor's

budget does not assume any savings associated with the increased frequency of Medicaid eligibility verifications or the Medicaid changes to retroactive eligibility, both of which are effective 1/1/27.

As a result of the eligibility changes under PL 119-21, the Governor's budget includes $3.27 million, excluding fringe costs, to support 50 new positions.

13. Please detail the proposed position increases.

Position Title	Number of Positions	SFY 2027 Salary Costs	Description
Social Services Assistant	10	$450,000	These positions will help address the anticipated increase in call volume to the DSS call center with questions about eligibility changes resulting from PL 119-21.
Social Services Program Assistance Specialist	1	$80,000	This position will act as liaison between assistant and supervisors. Assisting with difficult phone calls and evaluating quality of responses in phone calls.
Social Services Program Assistance Supervisor	1	$90,000	This position will be responsible for monitoring and evaluating performance of assigned staff, determining priorities and planning workflow.
Eligibility Services Worker	30	$1,960,000	These positions will provide capacity to meet the increase in demand for SNAP interviews, in person support, and call volume demand that is anticipated with the PL 119-21 changes. They will support client education to meet eligibility requirements and increase the potential for accurate determination of SNAP benefits reducing potential federal penalties.
Eligibility Services Specialist	4	$310,000	These positions will support the supervisors in assisting with training, answering staff questions, monitoring cases, and managing complex and specialized client needs.
Eligibility Services Supervisor	3	$260,000	The supervisor positions will schedule unit priorities and workflow, review the work of staff to ensure accuracy, assist with complex case and system resolution, and monitor staff performance through the evaluation process.
Social Services Program Manager	1	$120,000	This position will support business systems to ensure that system changes are implemented and maintained in accordance with the required federal changes.
Total	**50**	**$3,270,000**	

The table above outlines the position titles, number of positions, and the description of the positions that were included in the Governor's recommended budget. However, DSS is still refining the distribution of the 50 positions to maximize operational impact, using this investment to build capacity across the eligibility chain and support compliance, workload management, and service delivery demands.

14. Please detail policy impacts supported by SA 25-1, November Special Session, reserve funds.

The table below represents DSS' current projections, which are subject to change as more information becomes available.

Initiative	*Amount FY 2026*	*Amount FY 2027*	*Total*
Information system modifications to accommodate changes to eligibility and payment rules under Medicaid and SNAP	*$540,000*	*$0*	*$540,000*
Provide additional call center resources through Conduent	*$1,000,000*	*$0*	*$1,000,000*
Additional funding for 211 to support increased call volume	*$1,300,000*	*$1,300,000*	*$2,600,000*
Funding for statewide network of community food banks and pantries to increase capacity to serve residents impacted by SNAP eligibility changes	*$8,800,000*	*$15,750,000*	*$24,550,000*
Replace expiring enhanced premium tax credits for residents enrolled in Covered CT	*$11,300,000*	*$30,300,000*	*$41,600,000*
Adjust current assessment on total premiums to reimburse carriers for potentially higher utilization in Covered CT	*$5,900,000*	*$16,600,000*	*$22,500,000*
Coverage of the lost federal reimbursement for services provided by Planned Parenthood of Southern New England	*$8,500,000*	*$0*	*$8,500,000*
Provide Supplemental Payments to FQHCs to Support Loss of Exchange Subsidies for Certain Individuals < 100% FPL - covers through FY 2027	*$5,000,000*	*$0*	*$5,000,000*
Replace loss of enhanced healthcare subsidies for those not on Covered CT between 100% and 200% FPL - covers 2026 calendar year	*$1,300,000*	*$1,300,000*	*$2,600,000*
Replace 50% of the lost enhanced healthcare subsidies for those between 400% and 500% FPL - covers 2026 calendar year	*$24,080,000*	*$24,080,000*	*$48,160,000*
Funding for community health workers to help residents understand and navigate changes to SNAP and Medicaid eligibility	*$500,000*	*$1,500,000*	*$2,000,000*
Provide funding to Community Action Agencies to support community outreach and assistance for SNAP recipients in meeting new eligibility requirements	*$2,100,000*	*$0-*	*$2,100,000*
State Share of HR1 IAPD for system upgrades to ensure successful implementation of federal eligibility changes	*$11,400,000*		*$11,400,000*
	$81,720,000	*$90,830,000*	*$172,550,000*

Substance Use Disorder Waiver Reserve Line item

15. Please detail all changes made to the SUD Waiver Reserve line item, including a brief statement of purpose of funding transferred to each agency.

    Background: The substance use disorder (SUD) 1115 demonstration waiver allows the state to receive federal reimbursement for residential SUD treatment services. Without this waiver, most residential treatment services would not be reimbursable under Medicaid because of the long-standing Medicaid prohibition of payment for "institutions for mental diseases." This definition includes SUD services. This waiver brings in new federal dollars, and, from the very

beginning of the waiver, the state committed to reinvesting any surplus dollars from this revenue back into the system.

Proposal: Transfer a total of $17,975,000 out of the SUD Waiver Reserve account with transfers totaling $15,025,000 to DMHAS, DCF, and CSSD and $2,950,000 to DSS' Medicaid account. These transfers support the SUD waiver, which allows Medicaid members with opioid use disorder and other SUDs to receive medically necessary treatment services in the most appropriate setting.

- DMHAS: $10,750,000 includes adding beds and funding for recovery houses, Cornell Sott therapeutic shelter, grants for SUD services for non-Medicaid members, and other services
- DCF: $1,635,000 includes peer support specialists
- CSSD: $2,640,000 includes grants for SUD providers, justice-involved waiver costs, and recovery house
- DSS: $2,950,000 to fund Medicaid rate increases for SUD providers, and other SUD-related costs.

16. How does the Consolidated Appropriations Act of 2023 (CAA) impact the SUD waiver reserve account?

    Section 5121 of the Consolidated Appropriations Act of 2023 requires states to provide Targeted Case Management (TCM) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to all eligible juveniles under 21 years of age and former foster care individuals age 18 up to age 26 who are within 30 days of their scheduled date of release (or as soon as practicable after release from the public institution). This change, which is to be in place by July 1, 2026, will improve care coordination and physical and behavioral health outcomes for these youth prior to release from a carceral setting, including pre- adjudicated youth pending disposition.

    DSS is awaiting CMS' approval to amend the SUD waiver to expand Medicaid coverage to justice-involved individuals 90 days prior to their release; changes being sought include those required to comply with the CAA. Since the changes fall under the SUD waiver, the required program funding to comply with the CAA – estimated at $6.87 million – has been added to DSS' SUD Waiver Reserve account

MED-Connect

17. Please detail current enrollment, number of clients with subsidies, estimated # impacted by maintaining current eligibility requirements.

    There are approximately 3,600 individuals currently enrolled in the MED-Connect program, of which approximately 58% currently pay a premium. Given that the proposal would cap the income and asset requirements at the already enacted levels, we do not believe any current

recipients would be impacted by this change. The continued expansion of MED-Connect under PA 24-81 was projected to increase program enrollment by approximately 2,500 individuals at a gross cost of $16.6 million ($8.3 million state share) when fully annualized in SFY 2030. This assumes a monthly cost/case of $650, with a premium offset of $90, resulting in a per member per month cost of $560.

Intermediate Care Facilities (ICFs)

18. Has DSS reviewed the regulations that limit ICF payments due to allowable cost caps?

    In accordance with PA 25-168, the Department is required to amend the regulations of Connecticut state agencies to allow for the waiver of the separate inflation cost limitation on direct care costs when rebasing rates for intermediate care facilities for individuals with intellectual disabilities after the fiscal year ending June 30, 2027. The Department is in the process of reviewing and updating regulations to be in compliance with the public act.

19. Does DSS have proposed changes to such regs? What is the anticipated cost to modify?

    Proposed changes are not yet finalized. The cost to remove the direct care inflation cost caps, based on the most recent 2024 cost reports, is estimated at $2.4 million ($1.2 million state share).

Medicaid Provider Rates

20. Please detail how budgeted funds are anticipated to be distributed in FY 26 and FY 27.

    The table below represents DSS' anticipated rollout of the provider rate increases.

Provider/Service	FY 2026	FY 2027
Physician Fee Schedule (Primary Care, Specialists, and Optometry)	5,500,000	12,600,000
FQHC Rates	5,000,000	12,000,000
Adult Behavioral Health	2,000,000	5,000,000
Child Behavioral Health (TCB)	1,000,000	3,000,000
Therapy Services (PT, OT, Speech, Audiology) - Clinic and Independent	500,000	2,000,000
Adult Dental	170,000	1,000,000
Birth Center Facility Fees	80,000	480,000
Collaborative Care Model (Primary Care)	-	800,000
Collaborative Care Model (FQHC)	-	200,000

Chronic Disease / Chronic Disease Hospital (LTACH)	1,030,000	6,800,000
Obstetrics Pay-for-Performance	120,000	120,000
Family Planning	-	1,000,000
Total	**15,400,000**	**45,000,000**

21. What does the annual rate review process look like? Is there a schedule?

Rate study overview and results: Connecticut Department of Social Services Rate Study
DSS Rate Study Phase 1
DSS Rate Study Phase 2

The rate study recommended the development of a rational rate setting process based on successful strategies implemented in other state Medicaid programs. A rate evaluation process supports the Department's goal to:

- Develop appropriate rates and payment methods.
- Develop methodological assessments for member access across the program.
- Invest resources in enhancing coordination of care and prioritizing services that prevent or reduce disease burden instead of acute disease treatment. Please refer to Question 19 regarding providers that are being reviewed as part of the year one and the corresponding Medicaid rate increases.

The Medicaid rate evaluation process takes place over a five-year cycle and establishes a set schedule for regular rate review and adjustment of Medicaid rates paid to all Medicaid providers. It also formalizes a clear and transparent process for rate determination and ensures review of relevant state and national data to inform rate amounts and payment models, with emphasis on models that promote high value services, member access and explore value-based reimbursement when appropriate. See attached rate evaluation schedule.

22. Is there a rate analysis (similar to the rate study) for waiver rates? How does CT compare?

Yes. DSS and DDS waiver rates were reviewed as part of phase 2 of the larger Medicaid rate study. Please see the link below and reference the sections for home and community-based services (HCBS) for DSS and DDS. Overall findings showed that the average waiver costs are higher in Connecticut than in neighboring states and also that service utilization occurs predominantly in residential supports. (Total expenditures for residential supports across both agencies comprise more than 70% of total expenditures.)

DSS Rate Study Phase 2

Medication Administration

23. Please provide the total cost for med admin services at the (1) initial visit rate, (2) subsequent visit rate, and the associated utilization of each.

    Please see table below, which reflects dates of service in SFY 2025.

Procedure Code	Visit Type	Units of Service	Rate
T1502 – Administration of oral, intramuscular and/or subcutaneous medication by health care agency/ professional, per visit	Initial Visit	1,955,424	$54.12
T1502-TT – Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit	Subsequent Visit	231,810	$27.06
T1503 – Administration of medication, other than oral and/or injectable, by a health care agency/ professional, per visit	Initial Visit	1,798	$54.12
T1503-TT – Administration of medication, other than oral and/or injectable, by a health care agency/ professional, per visit	Subsequent Visit	-	$27.06

Community Health Workers

24. Please provide an update regarding Medicaid reimbursement for community health workers.

    DSS continues to look for opportunities to implement and cover community health workers or similar services. At this time, under Medicaid, community health workers (CHWs) are employed at federally qualified health centers to provide care coordination services under the PCMH+ program. CHN, the medical administrative services organization (ASO) also employs CHWs as part of their member engagement team. Additionally, DSS recently awarded funding to the Community Action Agencies to employ CHWs to do community-based outreach and education related to PL 119-21.

Current Services Updates

25. Please describe caseload/cost trends contributing to the proposed reductions to TFA and SAGA.

As described below, the Governor's proposed budget reflects adjustments based on current trends. It is important to note that no federal TANF block grant dollars lapse and no TANF funds are carried over or returned to the federal government, even with lower enrollment in TFA. (With the exception of funding to support OEC's Care4Kids program, TANF block grant funds are deposited directly into the resources of the General Fund.)

The FY 2024 / FY 2025 budget included three significant TFA program expansions: (1) raising the earned income disregard, (2) doubling the asset limit, and (3) increasing the time limit to 36 months. As a result of these expansions, TFA caseloads grew by approximately 5% in FY 2024. The current budget appropriation for TFA assumed that caseloads would continue to increase at an average of approximately 5.5% per year for FY 2025, FY 2026, and FY 2027. However, TFA caseloads began decreasing significantly in January 2025. Between December 2024, which the current budget appropriation levels were based on, and December 2025, when the re-estimate for the Governor's recommended budget for FY 2027 was completed, caseloads dropped by 16%. Despite the downward trend in caseloads and expenditures, the Governor's recommended budget assumes costs and caseloads will remain flat for the remainder of FY 2026 and increase by 3% in FY 2027. Given the sustained decline in caseloads and expenditures since October 2024, the recommended adjustment to remove $21.4 million from the FY 2027 TFA appropriation is warranted as it more closely aligns the funding level with actual caseloads and expenditures.

The FY 2024 / FY 2025 budget expanded the SAGA program by doubling the asset limit, resulting in a caseload increase in FY 2024 of approximately 5.7%. The current budget assumed caseloads would continue to grow at an average of approximately 3.9% annually in FY 2025, FY 2026, and FY 2027. A further complication in projecting the SAGA cost and caseload needs in the current budget was that the FY 2024 caseload data included a one-time domestic violence benefit administered through SAGA, which inflated costs and obscured the underlying SAGA trends. This benefit has since been removed from SAGA, with funding shifted to the DSS Domestic Violence Shelters account, allowing for a clear and accurate SAGA caseload trend to inform FY 2027 needs. Despite earlier growth assumptions, SAGA caseloads began declining sharply in December 2024. Between December 2024, the basis of the current appropriation, and December 2025, when the Governor's FY 2027 re-estimate was completed, caseloads fell by approximately 18%. Despite the downward trend in caseloads and expenditures, the Governor's recommended budget assumes costs and caseloads will remain flat for the remainder of FY 2026 and increase by 4% in FY 2027. Given the sustained declines in caseloads and expenditures since December 2024, the recommended $4 million reduction to the FY 2027 SAGA appropriation to better align funding with actual experience.

Connecticut Children's Medical Center (CCMC)

26. Please summarize payments made to CCMC (line item and Medicaid/DSH).

See table below for payments to CCMC in SFY 2025.

CCMC Payments In SFY 2025	
Hospital Inpatient	$87,407,085
Hospital Outpatient	$87,843,789
Graduate Medical Education (GME)	$1,178,499
Physician	$20,516,055
Physician Supplemental	$9,046,696
PCMH+ Shared Savings	$7,128,765
Disproportionate Share Hospital (DSH)	$11,138,737
Total	$224,259,626

27. Does DSS have concerns regarding including CCMC under the hospital tax/supplemental payment distribution?

    DSS agrees with the Governor's proposed budget adjustments that would keep CCMC exempt from the hospital provider tax and outside of the supplemental payment distribution. There are several reasons to keep CCMC exempt from this structure:

    - Minimizes changes to the hospital tax structure and preserves additional leeway for the federal statistical test that must be met ongoing to exempt providers from a provider tax
    - In order to preserve the overall upper payment limit (UPL) room for hospitals, which is an estimated Medicare payment level above which the state will not receive federal share on Medicaid for that provider category, any potential increased payments to CCMC should be in categories of payment not subject to the hospital UPL, such as disproportionate share hospital (DSH) payments, which CCMC already receives per the line item noted above.

Hospital Supplemental Payments

28. Please provide an overview of the hospital settlement timeline, current negotiations, and related funding.

    The hospital settlement agreement covers state fiscal years 2020 through 2026 and expires June 30, 2026. The administration has been in ongoing conversations with the Connecticut Hospital Association regarding the hospital tax and payment structure starting in SFY 2027. The Governor's proposed budget reduces the hospital tax in SFY 2027 from $375 million to $100 million and retains the $140 million increase in hospital supplemental payments that was included in the enacted budget. Compared to SFY 2026, the hospital tax is increased by $100 million while the hospital supplemental payments are increased by $140 million, resulting in a

net gain to the hospitals of $40 million (about $15 million of which would benefit Waterbury Hospital, which was recently acquired by a joint venture affiliated with UConn Health Center).

29. Please explain the different budget components of the current settlement: provider tax (revenue), Medicaid rate increases (appropriations), supplemental payments (appropriations), and match on gross appropriated supplemental payments (federal grants revenue).

    For SFY 2026, the current assessed hospital provider tax is $820 million (revenue). Medicaid rate increases since 2018 that are incorporated into the current rates for SFY 2026 amount to an estimated 45.6% increase for inpatient services and 20.5% for outpatient services, totaling roughly $635 million ($210 million state share and $425 million federal share). Payments to these hospitals under the Hospital Supplemental Payments account for SFY 2026 total $568.3 million; this account is gross appropriated with federal reimbursement of $381 million deposited to federal grants revenue, resulting in a net state share of $188 million for these supplemental payments.

    Note: Rate increases are funded under the Medicaid account, supplemental payments are funded under the Hospital Supplemental Payments account and, for the tax, the hospitals file their quarterly returns and remit the corresponding quarterly payment to DRS, who then deposits it into the Core-CT account under the General Fund.

Federal Budget

30. How is DSS impacted by the Consolidated Appropriations Act of 2026?

    - Disproportionate Share Hospital (DSH) Reductions – eliminates scheduled DSH payment cuts through September 30, 2027, and reduces the total DSH cut to $8 billion in FFY 2028.
    - Streamlined Out-of-State Provider Enrollment – requires states to create a simplified enrollment process for out-of-state providers in Medicaid and CHIP, requiring minimal screening.
    - Pharmacy Benefit Manager (PBM) Reforms – restricts spread pricing in Medicaid and mandates a GAO study on price-based PBM compensation models within the program.
    - Maternal Health – establishes new maternity care reporting requirements for rural hospitals, with dedicated federal funding to hospitals and states to comply with the reporting.
    - Block Grant Funding – provides level funding through FFY 2026 for LIHEAP, CSBG, and SSBG and through December 2026 for TANF.

GT Independence

31. Please summarize the purpose of the DSS contract with GTI.

    Collectively, DSS, DDS, and ADS contract with GTI to provide fiscal intermediary (FI) services. The fiscal intermediary supports participants in those agencies that have elected to self-direct their services; the participant is the employer of their personal care attendant(s) and other self-directed services if applicable. The FI is responsible for a variety of tasks, including managing individual budgets, timely processing of Medicaid claims, timely processing of payroll, onboarding self-directed employees, running criminal background checks, and verifying work eligibility requirements. The FI also provides training, customer service, and tax filings on behalf of the participants, as well as administrative support to the agencies for other services related to their programs.

32. Please summarize the recent issues DSS and clients have experienced with GTI.

    GTI has been the FI for DSS, DDS, and ADS since March 2024. For the last two years there have been some persistent problems with onboarding, customer service response times, communications with PCAs, and payroll non-payment issues.

33. Please summarize any steps DSS is taking to address these issues.

    DSS, as well as our sister agencies, are committed to continual improvement for our members and have heard the complaints over the last two years. In August of 2025, DSS placed GTI under formal "enhanced contract monitoring," which required intensive formal monitoring of key areas where the contractor was under-performing. This monitoring was re-evaluated in December 2025 and continued for another six months. GTI has made progress in improving their operations in Connecticut but is not yet performing at a level that meets our standards. We will continue to monitor their performance, hold them accountable to their Service Level Agreements, where applicable, and use corrective action when necessary. GTI has a significant fiduciary responsibility to the departments, the members they serve and the employees that rely on their services to be paid properly. We understand the seriousness of this and DSS is doing all it can to improve their performance and meet the expectations of the impacted members.