Follow-Up Questions from Appropriation's 3/4/26 Sub-Committee Meeting

1. **Can DSS quantify current and necessary investments in order to better process GTI billing?**

DSS is in constant process improvement and efficiency planning with our fiscal intermediary (FI). We are currently scoping an improvement in our authorization system that will greatly improve payroll processing for the FI.

2. **Has DSS previously pulled back a state plan service and moved it to a waiver-only service?**

Yes, the state shifted coverage from state plan services to an 1115 waiver (i.e., Covered CT) pursuant to eligibility changes that impacted higher income adults under HUSKY A.

Historically, options like Community First Choice (CFC) have been exclusively waiver-based services that are in addition to state plan services. Only through the passage of the Affordable Care Act did it even become possible to offer these services as a state plan option. Connecticut took a unique approach a decade ago when Community First Choice was launched to remove a waiver service and make it a state plan service. That is not a typical practice but was done for the enhanced revenue match (6%). At the time, there were conservative projections on utilization and growth with the expectation that any additional costs would be largely offset by both the 6% enhanced reimbursement and the ability to provide self-directed PCA services at a much lower cost than agency-based home health services. Additionally, the evolution of the demands on the overall home and community-based service system has shown that many individuals needing services are unable to engage successfully in self-direction or have a lack of desire to self-direct and/or spenddown to meet the lower financial criteria for state plan services. Transitioning back to a waiver will allow the state to look at the home and community-based service system more holistically and reinvest Medicaid dollars in a more efficient and equitable manner for individuals in need across system rather than focusing on one service delivery mechanism.

3. **What is the average number of new CFC enrollees each month?**

The average number of new CFC enrollees is 68 per month.

4. **What additional services would be included under various waivers, including a new waiver, in order to transition CFC?**

   Nearly half of the CFC participants are already tied to a waiver and have access to a broad set of waiver services. For the individuals that are not currently on a waiver, DSS will review appropriateness for an existing waiver or establish a new waiver. The new waiver will be designed based on gaps in eligibility or service availability after an analysis of the individuals that need placement.

   Attached is an appendix titled HCBS Master List of Services that shows the array of services and supports offered under our different programs.

5. **Please provide the current wait list for each waiver.**

1915(c) Waiver	Waitlist Information
CT Home Care Program for Elders	Open for new participants
Personal Care Assistance	1,315 individuals, estimated 4-year wait
Acquired Brain Injury 1	Closed to new enrollment
Acquired Brain Injury 2	71 individuals, estimated 5-year wait
Mental Health Waiver	Short wait time, less than 3 months
Katie Beckett Waiver	329 individuals, estimated 3.5-year wait.
Autism Waiver	2,631 individuals, estimated 12-year wait
DDS Comp Waiver	Enrollment management by DDS
DDS IFS Waiver	Enrollment management by DDS
DDS EDS Waiver	Enrollment management by DDS

6. **Please provide the links to DSS's LTC projections.**

   Connecticut's Medicaid long-term care demand projections were updated April 2025 in an effort to account for the impacts of the public health emergency and updated census data. The report is in two parts: (1) analysis of 2025 data, which provides an explanation of findings and the process used by the actuaries in analyzing the data; and (2) appendices that contain detailed charts and graphs showing visuals of the data by town, population demographics, demand projections and bed availability of nursing homes and residential care home beds by town for review of availability of beds compared to the population data.

   In summary, the report indicates demand in both nursing home and home and community-based services are projected to increase.

- Home and Community-Based Service Projections (Prior Report is the last time the state conducted the survey in 2021):

Ages	HCBS Projections — Medicaid ABD					
	Prior Report			Current Report		
	2030	2035	2040	2030	2035	2040
0–64	15,323	15,628	15,926	13,787	13,613	13,458
65+	20,714	22,519	23,569	20,386	22,180	24,250
Total	**36,037**	**38,147**	**39,495**	**34,173**	**35,793**	**37,708**

- Nursing Home Projections (Prior Report is the last time the state conducted the survey in 2021):

Ages	NF Projections — Medicaid ABD					
	Prior Report			Current Report		
	2030	2035	2040	2030	2035	2040
0–64	832	629	478	937	806	695
65+	10,221	9,454	8,480	10,231	9,906	9,706
Total	**11,053**	**10,083**	**8,958**	**11,168**	**10,712**	**10,401**

Ages	NF Projections — All Payers					
	Prior Report			Current Report		
	2030	2035	2040	2030	2035	2040
Total	**N/A**			**15,691**	**15,054**	**14,620**

Link to Analysis of 2025 Data:
https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/medicaid-nursing-home-reimbursement/ct_ltc_demand_report_2025-04-07.pdf

Link to Appendices:
https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/medicaid-nursing-home-reimbursement/ct_ltc_demand_appendices_2025-04-07.pdf

7. Please provide TANF expenditure/claiming details.

Importantly, lapsing funds in the TFA account do not result in TANF block grant dollars being returned to the federal government. With the exception of funding that is directly appropriated to OEC to support the Care4Kids program, TANF block grant dollars are deposited to the resources of the General Fund. DSS then identifies what will be claimed against those dollars. See attached for the FFY 2025 TANF claiming, which includes a list of all state General Fund programs that are considered to be funded with TANF federal funds or are state funds designated for purposes of meeting TANF maintenance of effort (MOE) requirements. Because there are many other areas through which DSS can claim TANF-eligible expenditures and because such expenditures are not limited to DSS, the TANF block grant is fully utilized each year—regardless of lapses that may occur in accounts such as TFA—with no risk of funds being returned to the federal government.

As indicated previously, the Governor's proposed budget reflects adjustments to the TFA account based on current trends. The FY 2024/2025 biennial budget included three significant TFA program expansions: (1) raising the earned income disregard, (2) doubling the asset limit, and (3) increasing the time limit. Based on increases in the TFA caseload as a result of these expansions, the enacted budget assumed caseloads would continue to increase each year at an average of 5.5%. However, TFA caseloads began decreasing significantly in January 2025, which was after the estimates had been developed for the enacted budget. Between October 2024 and December 2025, caseloads dropped by nearly 19%. Given the sustained decline in caseloads and corresponding 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 and does not require any funding to be returned to the federal government.

8. Please provide TFA income and asset limits- current and max allowable.

Current Connecticut thresholds:

- Asset limit is $6,000.
- Income limit for new applications is 55% FPL (currently $15,026 for a family of 3).
- Income limit for active recipients, applicants for extensions or applications received within 4 months of closure is 100% FPL (currently $27,320 for a family of 3).
- If an active recipient's earned income exceeds 100% FPL, they are allowed to keep their TFA for up to 6 additional months as long as their earned income remains below 230% FPL (currently $62,836 for a family of 3).

For a comparison of CT TANF limits compared to other states, this federal data published in 2024 is helpful: Graphical Overview of State and Territory TANF Policies as of July 2022 (https://acf.gov/sites/default/files/documents/opre/OPRE-2022-WRD-Databook-January2024.pdf). While some things have changed since the report was published, this is generally an accurate state-to-state comparison.

The Urban Institute's Welfare Rules Database is the most comprehensive and detailed source of TANF data, including many state-by-state comparisons on specific points of program eligibility: The Welfare Rules Database - Urban Institute (https://wrd.urban.org/).

9. **How many TFA households lose eligibility due to exceeding income or asset limits? (Monthly average)**

On average, each month 53 households lose TFA eligibility due to exceeding the income limit and 3 households lose eligibility due to exceeding the asset limit.

10. **How many TFA applicants (households) are denied eligibility due to exceeding income/asset limits? (Monthly average)**

FFY 2026 Q1 data is as follows:

Month	Apps Denied – Over Income	Apps Denied – Over Assets		Total TFA App Denials
October 2025	409	22		1,220
November 2025	271	14		854
December 2025	369	22		1,146
App Denial Monthly Average	350	19		1,073

11. **Regarding TFA time limits, please identify the number of clients who are: (1) exempt, (2) no longer eligible after 36 months, and (3) no longer eligible after 48 months. (Monthly average)**

(1) exempt

Month	Total Exempt Recipients	Total Adult Recipients	Total Child Recipients	Total Cases (Households)
December 2025	6,460	1,611	4,849	3,218
January 2026	6,365	1,587	4,778	3,167
February 2026	6,369	1,584	4,785	3,139
Monthly average	6,398	1,594	4,804	3,174

(2) no longer eligible after 36 months

Households continue to be eligible for two 6-month extensions after reaching the 36-month time limit, assuming they continue to meet the program eligibility criteria. The table below shows February 2026 data on households who requested an extension.

TFA Extension Data						
	Approved	Not Approved	Became Exempt	Counter Rolled Back	Closed Prior to Review	Totals
Totals	32	1	319	0	0	352

(3) no longer eligible after 48 months

Time-limited TFA households rarely qualify for continued time-limited benefits after receiving 48 months of TFA benefits. Per the above table, many may continue to qualify with an exemption.

12. **Can you identify the average daily inpatient cost for behavioral health services? (to compare to med admin BH rates).**

The average behavioral health per diem inpatient rate for 2026 is $1,206.12.

Subsequent Questions Received

1. **How much Medicaid billing has occurred for services provided by Urgent Crisis Centers (UCCs) and what supplemental payments are being planned for FY 2027?**

   Payments under the Medicaid account

   - Medicaid billing for UCC services: A new Medicaid rate was established in October 2025 in coordination and collaboration with the UCCs. The average paid per visit is now $1,600, compared to the previous average of $325. Paid claims for the quarter ending December 2025 under the revised rate are currently unavailable as UCC claims are mixed with provider claims for enhanced care clinics. We expect to have clean data in the near future.
   - Medicaid supplemental payments to UCCs in SFY 2026: $4.4 million in total, or $1.46 million per UCC
     - The Department does not plan on issuing supplemental payments to UCCs in SFY 2027

   Payments under the Community Services account

   - Grant dollars appropriated for UCCs to help support non-Medicaid clients: $2.0 million in SFY 2026 and $1 million in SFY 2027: $3 million

2. **Is the state planning to submit an application for the CCBHC demonstration grant by the federal deadline of April 1, 2026?**

   No, DSS will not be applying for the demonstration grant this year. DSS has been working diligently with providers to finish the requirements for the planning grant but will not proceed with a Medicaid demonstration in this cohort. Instead, the state will look to identify any potential gaps in the system and consider opportunities to deploy elements of CCBHC, as appropriate, under the Rural Health Transformation program. The providers and the Department have mutually agreed to use the time this year as a planning year and three providers have been selected to participate in that process, CHR, The Village and BH Care. The Department will be working closely with these providers to identify appropriate outcomes, design treatment plans and other critical criteria, including an overall cost/benefit analysis.