Testimony before the Human Services Committee
Commissioner Andrea Barton Reeves
Department of Social Services
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Good morning, Senator Lesser, Representative Gilchrest, and distinguished members of the Human Services Committee. My name is Andrea Barton Reeves, and I am the Commissioner-Designate for the Department of Social Services (DSS).

I am pleased to appear before you today to offer remarks on several of the bills on today's agenda.

SB 10 AN ACT PROMOTING ACCESS TO AFFORDABLE PRESCRIPTION DRUGS, HEALTH CARE COVERAGE, TRANSPARENCY IN HEALTH CARE COSTS, HOME AND COMMUNITY-BASED SUPPORT FOR VULNERABLE PERSONS AND RIGHTS REGARDING GENDER IDENTITY AND EXPRESSION.

The Department of Social Services (Department) appreciates the intent of Sections 1-9 of the bill, which seek to lower prescription drug costs in Connecticut.

The Department recognizes the contributions of social workers to the health, well-being, and quality of life of older adults. The Department previously conducted an analysis for SB 946, where the Department estimated that adding up to two visits by licensed social workers for Connecticut Home Care Program for Elders (CHCPE) clients will increase the annual costs for the Medicaid waiver program by $1.446 million, with a state share cost of $723,000. The impact to the state-funded program is estimated to cost an additional $193,000, for a total state cost of $916,000 for this change. **Section 10** of this bill would mandate not less than two licensed clinical social worker visits to each individual enrolled in the CHCPE waiver or any other home and community-based services waiver administered by the Department and would therefore have a more significant fiscal impact that is not included in the Governor's budget.

Moreover, federal Medicaid policy and federal assurances require that any Medicaid service provided to a member, covered under the waiver, is based on an individual member's needs assessment. The Department is unable to pay for services that are not based on the outcome of the needs assessment. As a result, the proposed language is inconsistent with federal Medicaid policy. Furthermore, access agency staff who are typically educated as social workers perform the case management function, which is integral to every member's plan. Responsibilities include coordinating and providing services that are safe, timely, effective, efficient, equitable and person-centered; handling member assignments, assessment, development of service plans, review of member process and recommendations for case closures; and helping members achieve

wellness and autonomy. Therefore, in many cases, this requirement will be duplicative. For these reasons, the Department cannot support this section.

Sections 11 and 12 require the Commissioner of Social Services to design and implement a Community Health Worker (CHW) reimbursement program under Medicaid for services provided to HUSKY Health members. Additionally, the Department is required, in collaboration with the Office of Health Strategy, to identify opportunities to integrate CHWs into the HUSKY Health program.

CHWs are trusted frontline public health professionals who have a unique understanding of the socioeconomic needs of the communities and populations served. The Department recognizes the critical role that CHWs play in serving our members and, in recent years, the Department has incorporated CHWs into agency programs in various ways. For example, CHWs play an important role in our medical administrative service organization, Community Health Network of Connecticut (CHN CT) for over 11 years. Additionally, the Department is currently working with 9 Community Action Agencies to build or enhance a CHW program and, together with the Office of Early Childhood, the Department of Public Health, the Department of Children and Families, and the Office of Health Strategy, to launch the "Family Bridge" pilot program – an innovative perinatal pilot program that combines an evidence-based nurse home visiting model with CHWs in the Bridgeport area. The Department understands that CHWs help make a positive impact on the health and well-being of the people and communities served within Connecticut.

The Department has been allocated $500,000 in American Rescue Plan Act funds approved for evaluating the sustainability of CHWs in the "Family Bridge" pilot and to evaluate how to incorporate CHWs more broadly into the HUSKY Health program. The Department is currently preparing a request for proposal for a contractor to assist with this assessment and provide recommendations. Before moving forward with this language, the Department would respectfully request the opportunity to obtain these recommendations from this pilot to identify ways to integrate community health workers into HUSKY Health, with a focus on the utilization of value-based models that are presently undergoing evaluation by the Department.

The Department has concerns with **Sections 13 and 14**, which propose to expand the Covered CT health care insurance program to individuals with income up to 200% of the federal poverty level (FPL) and develop a plan for a second tier of the Covered CT program to provide state-assisted health care coverage to individuals whose income exceeds 200% FPL but does not exceed 300% FPL. While the Department supports the goal of reducing uninsured rates in the state and appreciates this Committee's support for, and interest in, expanding Covered CT, the Department has concerns with such an expansion for the reasons delineated below.

Background on the current Covered CT program

Covered CT was established during the 2021 legislative session through subsidies for Qualified Health Plans (QHPs) offered via the state-based marketplace (Access Health CT). This approach allows the state to maximize state dollars via an 1115 Medicaid waiver that would allow for federal financial participation of 50% of program costs.

The program was developed to provide no-cost health care coverage for individuals with income too high to qualify for HUSKY but not exceeding 175% FPL. Coverage is centered around silver-level qualified health plans that eligible residents can select on Access Health CT, with the addition of dental and non-emergency medical transportation benefits through the HUSKY provider network. The program pays for all premiums and cost-sharing that would otherwise be the responsibility of the eligible individual, so that eligible individuals will have no out-of-pocket costs.

The Department, in partnership with the Office of Health Strategy (OHS), the Connecticut Insurance Department, and Access Health CT, is still in the early stages of transferring administrative and budgetary authority from OHS per Public Act 22-118, § 252(b) while simultaneously operationalizing the program following eligibility expansion in July 2022 to include not only parents and needy caretaker relatives but also non-pregnant low-income adults that meet the age and income requirements of the Covered CT program. In addition, federal approval of the 1115 Medicaid waiver on December 15, 2022, will ensure federal funding is available to support the program.

To date, individuals have been able to retain their Medicaid coverage due to the numerous extensions of the federal public health emergency. With those extensions, the Department was required to suspend most discontinuances under Medicaid. Pursuant to the federal Consolidated Appropriations Act, 2023, that continuous enrollment requirement ends on March 31, 2023. Thus, individuals who are no longer eligible for Medicaid could begin coming off Medicaid following a redetermination starting in April 2023, which is when we expect enrollment in Covered CT to start to increase at a more accelerated pace. By June 2025, consistent with earlier projections, the Department anticipates that over 40,000 individuals will be enrolled in Covered CT.

Covered CT receives substantial federal financial support, both through enhanced subsidies for individuals purchasing qualified health plans through the state-based marketplace, as well as from Medicaid through the 1115 waiver. These federal enhanced subsidies are currently authorized at the federal level until December 31, 2025, and federal financial participation through the 1115 waiver is authorized until December 31, 2027. State costs for the current program are anticipated to be $20 million in SFY 2023 (based upon end of year enrollment of 19,700 enrollees), $29.9 million in SFY 2024 (based upon end of year enrollment of 36,800 enrollees), and $42.2 million in SFY 2025 (based upon end of year enrollment of 40,400 enrollees). Overall, approximately 50% of all funding for Covered CT comes from the federal government, with the remainder coming from the state. This percentage excludes the cost of the federal premium subsidies and reduced cost sharing currently available.

The projected level of federal funding for this program is important for the financial sustainability of the program at the current 175% FPL income eligibility threshold. This federal funding is contingent on both high levels of ongoing federal subsidies, as well as federal financial participation with the recent approval of the 1115 waiver.

Discussion of the proposed bill

Expanding eligibility as proposed in this bill would require a significant amount of funding for both services and administration. Moreover, this funding is not included in the Governor's

budget. Finally, the federal approval of the current program has only recently been secured and, with the expansion of eligible populations with income up to 175% FPL still being rolled out, anticipated enrollment is expected to take several years to reach targeted levels. For these reasons, the Department cannot support this expansion at this time.

Expanding Covered CT by the scope proposed in this bill will require the Department to request an amendment to the recently approved waiver. Application, review and approval of an amended waiver for Covered CT would likely take up to six-months and would include updates to supporting budget neutrality reports and revisions to the monitoring protocol and the evaluation design plan required of the state under the special terms and conditions of the waiver. The Department respectfully suggests that it would be prudent for the state to allow more time for program performance under the currently designed structure to assess utilization trends and costs as well as to allow time for the program to become fully operational under the administration of the Department before contemplating expansion to a significantly larger population. Moreover, it would be speculative to predict whether the federal government would approve federal Medicaid funding to support an expansion beyond the current threshold of 175% FPL.

The estimated cost of the expansion of Covered CT as proposed in the bill is also expected to be significant. Preliminary estimates of the incremental, annualized state share of the cost of expanding from 175% to 200% FPL could be in the range of $30 to 40 million. This assumes the approval of the expansion and the availability of federal funds under a revised 1115 waiver, as well as the continuation of the additional federal QHP cost sharing provisions. Increasing eligibility to 300% FPL, with some cost share above 200% FPL, would be a significant increase above that amount given the additional number of individuals that would be in the 200 to 300% FPL range. In addition to the programmatic and fiscal concerns (*i.e.*, the overall costs that are not included in the Governor's budget and the uncertainty of federal funding to help subsidize any expansion), the Department notes that it would require substantial ongoing administrative resources to support this change, as well as start-up resources to implement related system changes.

Finally, the Department notes that the volume of operational, system and administrative work being performed to conduct the "unwinding" of the Medicaid continuous enrollment provisions during the course of the pandemic, and the implementation of the significant new eligibility expansions over the past year, has stretched Department resources. In order to expand the Covered CT program at the scope contemplated under the proposed bill, the Department would be required to divert key resources from the unwinding process and the implementation of other eligibility expansions, thereby jeopardizing the success of that important work.

Section 15 of this bill directs Access Health CT to collaborate with the Department of Revenue Services to collect information from tax filers to enable Access Health CT to conduct outreach to tax filers who provide information indicating that they do not have health insurance coverage. The Department and Access Health CT share an integrated eligibility system and operational structure to support state residents seeking health insurance. The Department is the single state agency responsible for the administration of the Medicaid program and the majority of Medicaid enrollees have eligibility determined through Access Health CT's shared system and operations. To the extent that some of the uninsured population identified through the data-

sharing process proposed under this bill could be eligible for HUSKY coverage, the Department may need to be involved in the subsequent outreach as the state Medicaid agency.

Section 22 of the bill would require the Department to convene a working group for any planned policy changes to gender affirming care. While the Department appreciates the intent of this section, the Department has several concerns.

HUSKY Health has an extensive number of medical policies that are regularly reviewed and updated. The Department agrees with the underlying intent of this bill to ensure that policies are informed by clinical practice and engagement with health care practitioners and other stakeholders. For context, these policies help assist in making prior authorization and other similar decisions but, as required by section 17b-259b of the Connecticut General Statutes, each request is always based on an individualized determination of whether a service is medically necessary as defined in that statute. HUSKY Health medical policies are based on the most current recommendations and guidelines from medical societies, published, peer-reviewed medical literature, and state and national reimbursement policies and regulations.

As part of the Department's policy development process, our medical administrative services organization, Community Health Network of CT (CHNCT) receives input from the agency and may seek input from community-based practitioners and specialists. Policies are reviewed annually and updated based on new evidence, recommendations, or changes to state or national regulations. Policies are initially reviewed by CHNCT's medical reviewers at the monthly Policy Review Meeting and then presented at CHNCT's Clinical Quality Subcommittee, which meets quarterly, and includes input from community-based practitioners. Policies that are approved by CHNCT's Quality Committee of the Board are submitted to the Department for final approval, publication of a Provider Bulletin, and posting to the HUSKY Health provider website.

Pertaining to the HUSKY Health Gender Affirming Care policy, it is based on the most current recommendations from the World Professional Association for Transgender Health (WPATH), 8th edition. The policy is reviewed on an annual basis minimally, or more frequently if new guidelines are published. As part of the most recent policy review process, CHNCT met with and solicited recommendations and feedback from community-based practitioners with expertise in transgender healthcare.

Given the recent stakeholder input and updates to the gender affirming care policy, the Department does not believe the proposed changes are needed. Furthermore, the requirement to have a standing working group and a formal report submitted would not only place an unnecessary administrative burden on the policy making process, but it would likely hinder more frequent policy updates given each time a policy update is being considered the working group would have to be convened and a report developed and submitted. It would also require additional resources for the purposes of overseeing, running, and developing a working group and regular reporting. For these reasons, the Department must oppose this section of the bill.

As an alternative to codifying an administratively burdensome process in statute, the Department would be amenable to adding an additional gender affirming care review committee to the

CHNCT policy review process that would be comprised of medical professionals with an expertise in providing gender affirming care.

HB 5001 AN ACT CONCERNING RESOURCES AND SUPPORT SERVICES FOR PERSONS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY.

Section 3 of the bill requires the Commissioner of Social Services, in consultation with the Commissioner of Developmental Services and within available appropriations, to reduce the waiting lists for services in Medicaid waiver programs established under section 1915(c) of the Social Security Act and administered by the Department of Developmental Services (DDS).

The Department recognizes the importance home and community-based services (HCBS) play in the lives of those with developmental disabilities, as well as the contributions they make to their quality of life. DDS' HCBS assist members in maximizing their potential and increasing their independence while making valuable contributions in their communities. It is important to note that DDS does not maintain a waitlist for their HCBS waivers, but rather DDS maintains a waitlist of individuals that are determined to need residential services, including community living arrangements, or in need of more services due to a change in circumstances based on funding availability. While DSS is the single state Medicaid agency, DDS is the agency responsible for serving this population and, as such, they would be the appropriate agency to work on reducing the waiting lists and any reporting should this bill move forward.

Section 5 of the bill requires DSS, in consultation with the Secretary of the Office of Policy and Management and within available appropriations, to expand the Medicaid waiver program for persons with autism spectrum disorder (ASD) to allow not less than 600 persons on the waiting list to receive services under the program. It also requires DSS to file, by January 1, 2024, a report on the waiver program expansion with recommendations to further reduce the waiting list with the committees of cognizance.

The Department acknowledges the invaluable role the HCBS waiver plays in the lives of persons with autism spectrum disorder and their families. A total of 250 slots were added to the waiver in FYs 2022 and 2023. To date, the Department has worked with 110 of the 250 individuals from the waitlist bringing the total enrolled in the waiver to 219; these individuals are in various stages of service delivery for the waiver, including applying for Medicaid. Individuals with ASD who are under the age of 21 and eligible for HUSKY A, C or D, may also access autism services under the State Plan.

The Department knows how important these services are to those with ASD. An additional 600 slots under the waiver will have fiscal implications, including hiring and onboarding additional staff to support the additional members. Such an expansion cannot be done within available appropriations nor is funding included in the Governor's proposed budget.

Section 6 of this bill increases the asset limits used to determine eligibility for HUSKY C from $1,600 to $3,600 for a single person and from $2,400 to $5,400 for a married couple. This section also allows any person who has income above a HUSKY C income limit but who

otherwise qualifies for coverage to qualify for the program by spending down excess income in accordance with federal regulations.

Section 7 of this bill increases the HUSKY C "medically needy income limit" from the current level that is pegged to 143% of the temporary family assistance (TFA) program's benefit amount (equal to $700 for a single individual and $946 for a two-person household) to $1,465 per month. The current income eligibility level rises with changes in the cost of living, because the underlying TFA benefit is linked to the federal poverty level. The current income limits also provide higher income levels for larger household sizes. The proposed income limit would be a static amount applicable regardless of household size and is therefore a concern.

While the Department is generally supportive of the Committee's efforts to address the affordability of health care coverage and the overall goals of this bill, the changes in these two sections would result in substantial increases in expenditures as more people would qualify for the program and would qualify sooner. In addition to the substantial increase in program costs that would be required, the Department would also be required to hire additional staff to support the increased program enrollment that would result from these changes. These increases in costs are not accounted for in the Governor's budget and therefore DSS cannot support this proposal at this time. The Department also notes that there are challenges in making changes broadly to HUSKY C, which serves individuals who are aged, blind, or disabled. Each of the specific Medicaid coverage groups that fall under the HUSKY C umbrella have different eligibility rules. Should this bill move forward, the Department recommends that more specificity be used to identify the types of coverage intended to be amended by this bill in order to avoid inadvertent conflicts with other statutory provisions. For example, MED-Connect, which is coverage for the working disabled, falls under HUSKY C and already has higher asset limits than what is referenced in Section 6 of this bill.

Thank you for the opportunity to comment on HB 5001.