STATE OF CONNECTICUT

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OFFICE OF THE COMMISSIONER

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Re: Responses to Public Comments Regarding Connecticut's Waiver Pursuant to Section 1115 of the Social Security Act to Support the Covered Connecticut Program

Dear Commenter:

Thank you for submitting comments regarding Connecticut's waiver pursuant to section 1115 of the Social Security Act. The purpose of this waiver is to implement the Covered Connecticut ("Covered CT") program, established pursuant to state law in Public Act 21-2, June special session. The Department of Social Services ("DSS" or the "State"), Connecticut's single state Medicaid agency, appreciates your input and participation in this process. Below are summaries of the comments that DSS received during the public comment period (including written comments sent to DSS and also verbal comments made during the public hearings held on February 10, 2022, and February 16, 2022) and DSS's responses to the comments.

Program Design

1. What inspired the program? Do similar programs exist in other states?

   Response: Covered CT is a product of the 2021 legislative session of the Connecticut General Assembly. The program is intended to expand affordable health care coverage in part by leveraging federal subsidies for exchange-based coverage options. Massachusetts and Vermont have programs that are similar but not identical to Connecticut's program design.

2. How long has it taken to develop the program? What have the State's conversations with CMS been like?

   Response: DSS and its state partners (Office of Health Strategy, Access Health CT and the Connecticut Insurance Department) have been working to develop the program for many months. We have had multiple informal conversations with the U.S. Centers for Medicare & Medicaid Services (CMS) focused on the program concept. CMS has been a responsive and helpful partner and is committed to officially reviewing our application once it has been formally submitted and after the federal public comment period has closed.

Budget and Finance

3. Are Section 1115 waivers supposed to be budget neutral? If so, how does the State plan to offset the program costs?

Response: As required by federal law in section 1115 of the Social Security Act, section 1115 demonstration waivers must be budget neutral to the federal Medicaid budget. This means it will cost the federal Medicaid program no more with the waiver than without it. There is no need to plan to offset waiver program costs because the cost to the federal government is projected to be less with the waiver than with a comparable full expansion of Medicaid.

4. What is the State's contingency plan if the enhanced subsidies authorized under the federal American Rescue Plan (ARP) Act are not extended?

   Response: Should the enhanced subsidies under the ARP end on December 31, 2022, as currently authorized by federal law, or on any date prior to the expiration of the Demonstration, the State would need to revisit the Demonstration's financing and possibly make programmatic changes, such as, but not in any particular order: utilize state funding, reduce eligibility or benefits, cap enrollment, or terminate the Demonstration.

Eligibility

5. What is the State's communications strategy for the program? How will it educate the public and outreach to potentially eligible individuals?

   Response: As the Demonstration go-live date approaches, the State will launch an outreach campaign to promote enrollment in the program. It will use administrative data from the eligibility and enrollment system shared by Medicaid and Access Health CT to identify potentially eligible individuals for targeted outreach, including adults who are not enrolled in Medicaid but whose children are enrolled in Medicaid or CHIP.

   At go-live, individuals enrolled in a silver-level qualified health plan (QHP) will have their premium and cost-sharing amounts reduced to zero and eligible individuals enrolled in a bronze-level plan will be offered the opportunity to move to a free silver-level plan.

   More broadly, the State will launch a communications campaign to educate the general public on the availability of the program. It will leverage existing channels, such as member notices, mail, email, online member accounts, websites, social media, press releases, and provider bulletins. Additional methods, such as text messaging, robocalls, radio and television advertising, are being explored. To the extent that the Demonstration goes live during the public health emergency (PHE) winddown period, communications about reapplying for Medicaid will also include information about the availability of the Demonstration program.

6. What is the impact of a parent's enrollment in Covered CT on a child's enrollment in HUSKY Health?

Response: Children are eligible for HUSKY Health (*i.e.,* Medicaid or CHIP) regardless of QHP coverage for other family members. A parent's enrollment in Covered CT will not impact a child's enrollment in HUSKY Health.

7. Can you estimate the overlap between children eligible for Medicaid and CHIP and parents eligible for the Covered CT?

   Response: Currently, children are eligible for Medicaid or CHIP at income levels higher than parents. Covered CT will increase the income limit for parents to 175% of the federal poverty limit (FPL). Medicaid currently covers parents and caretaker relatives up to 160% FPL. DSS estimates that by the final year of the Demonstration, approximately 13,000 parents will enroll in QHP coverage through Covered CT because of its higher income limit.

8. When people are redetermined for Medicaid eligibility, how will they be notified about Covered CT?

   Response: The State has an integrated eligibility system for Medicaid, CHIP and QHP coverage. When a person's eligibility is redetermined for any of these programs, eligibility for all programs is considered. Enrollees will be notified of the eligibility decision through this integrated system, which includes both letters and electronic means of communication. If determined eligible for Medicaid, they will be automatically enrolled. If determined eligible for Covered CT, they will be notified and offered the opportunity to enroll in QHP coverage immediately.

9. Why do the enrollment projections assume very gradual growth rather than full uptake initially?

   Response: A key assumption behind these enrollment projections is that many people have had their Medicaid eligibility extended due to the continuous eligibility requirements of the federal COVID PHE. However, when the federal PHE expires, the State will gradually resume redeterminations of eligibility for Medicaid members, and members, who experienced an increase in income, will gradually transition from Medicaid to Covered CT eligibility. Enrollment into the program will be slower for parents than childless adults, because of the availability of Transitional Medical Assistance, which provides an additional year of Medicaid coverage for parents and caretaker relatives.

10. How will the State simplify Covered CT enrollment to reduce the loss of coverage, particularly as people move back and forth between assistance programs?

    Response: Eligibility and enrollment for Medicaid, CHIP and QHP coverage is already simplified and streamlined by the State's existing integrated eligibility system, which is a single point of entry for determination of eligibility for all three types of healthcare coverage. When a person is

determined eligible for Medicaid or CHIP, they are automatically enrolled. When determined eligible for Covered CT, they will be notified of the opportunity to enroll in silver-level QHP coverage offered through Access Health CT. At go-live, individuals enrolled in a silver-level QHP will automatically have their premium and cost-sharing amounts reduced to zero, and eligible individuals enrolled in a bronze-level plan will be offered the opportunity to move to a free silver-level plan.

Benefits

11. Will Covered CT put a strain on access to dental services given that it is projected to add coverage for up to 39,000 individuals?

    Response: DSS continues to evaluate demand for dental services by Covered CT enrollees and has proposed a rate increase for adult dental services through the Governor's proposed budget adjustments to help ensure access to dental care.

12. What is the ability of the non-emergency medical transportation (NEMT) system to serve more people?

    Response: DSS continues to evaluate demand for NEMT services by Covered CT enrollees and the capacity of the NEMT system to accommodate this additional population.

13. How can the program help enrollees navigate the complexities of the healthcare system? Can the program fund community-based health navigators or community health workers to help enrollees understand their benefits and how to use them?

    Response: Demonstration benefits are as specified in state law, with QHP coverage available through Access Health CT and dental care and NEMT benefits delivered through HUSKY Health. Enrollees will have access to resources to help understand QHP choices and how QHP coverage works, including online resources, enrollment specialists, community navigators and customer call centers to help eligible individuals choose a QHP that best meets their individual needs and locate network providers to access covered services.

Evaluation

14. Commenters posed several questions regarding evaluation of the program's impact, including:
    - What impact will the program have on access to care?
    - How will the program affect service utilization, such as preventive and primary care and emergency department visits?
    - Will parents' enrollment in the program impact the way their children use services in HUSKY Health?

- How will differences in covered services and provider networks impact continuity of care for adults who move between Medicaid and QHP enrollment?
- How will future increases in the state's minimum wage affect the affordability of healthcare coverage as the number of state residents who earn too much to qualify for the Covered CT program grows?
- How will health disparities and progress towards health equity be measured?
- How will the State engage enrollees to gather qualitative and quantitative data on enrollee experiences with the program?

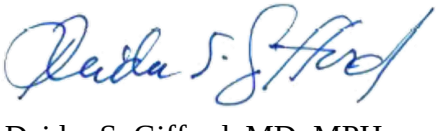
Response: The waiver application presents an overview of DSS's preliminary plan to evaluate the Demonstration. While it is subject to change and will be further defined as the program is implemented, it currently includes sample measures that may be used to test the Demonstration's hypotheses that providing free QHP coverage and dental care and NEMT services comparable to the benefits under Connecticut Medicaid will: improve the affordability of health insurance coverage; promote health insurance coverage (*i.e.*, increase the number of people who have health insurance coverage through a QHP); ensure stable coverage; reduce the statewide uninsured rate; improve oral health; enable access to medical appointments; and reduce health disparities and improve health equity.

DSS is considering the use of measures from the CMS Adult Core Healthcare Effectiveness Data and Information Set (HEDIS) to answer questions about the impact of the program on service utilization patterns, such as increased preventive and primary care use and decreased emergency department visits. National standards for assessing enrollee experiences, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, are also under consideration.

DSS recognizes the importance of understanding health disparities to inform State actions to improve health equity, and the preliminary evaluation plan contemplates the use of methods such as performance measure data stratified by race, ethnicity, and income to track the program's progress as required by state law.

Thank you again for your comments and for your interest in Covered CT.

Sincerely,



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