Testimony in Support of S.B. 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

Ayesha R. Clarke, MSW, MPH, Interim Executive Director; Karen Siegel, MPH, Director of Policy; & Emily Bohmbach, MPH, Policy & Advocacy Specialist

Human Services Committee

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Dear Representative Gilchrest, Senator Lesser, Senator Seminara, Representative Case, and esteemed members of the Human Services Committee,

Thank you for accepting this testimony in **support of S.B. 10** on behalf of Health Equity Solutions (HES), a nonprofit organization with a statewide focus on advancing health equity through anti-racist policies and practices. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

Research, listening to Connecticut residents, and conversations with national experts, Centers for Medicare & Medicaid Services (CMS) staff, Community Health Workers (CHWs), CHW employers, and other stakeholders have all led HES to prioritize ***a robust CHW workforce with sustainable funding as one of the most crucial levers for advancing health equity***. This is a proven, cost-effective intervention to address the barriers to health that disproportionately impact Black, Latino/a, Indigenous, and other people of color in our state. ***We urge you to make Connecticut the 26th state to provide CHW services through Medicaid.*** We offer some small, recommended changes to the language below.

HES also strongly supports efforts to increase access to Covered CT (sections 13-14) and streamline enrollment in Access Health CT plans (section 15). We defer to our colleagues on other sections of this proposed bill and are broadly supportive of efforts to address affordability by ensuring fair contracting (section 9) and efforts to reinforce the right of all people to have their gender identity respected and receive gender-affirming health care (sections 16-22).

Sections 11-12: Medicaid Reimbursement for Community Health Workers

Who are Community Health Workers?

As defined in Section 20-195ttt, a community health worker is a public health outreach professional with an in-depth understanding of the experience, language, culture, and socioeconomic needs of the community. CHWs, go by many names: lay health workers, navigators, promotors, health educators, community health advocates, community health liaisons, and many other titles.

CHWs provide a range of services, including, but not limited to: outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health, and basic screenings and assessments of risks associated with social determinants of health. In other words, CHWs facilitate interactions between patients, the health care system, and social and economic services. For example, CHWs can help people: make appointments; understand their health insurance benefits; communicate effectively with doctors, pharmacists,

dentists, and other health care providers; adapt medical advice to their lived reality; access services like food and diaper banks; and more. Essentially, CHWs fill gaps in our health systems. While these may sound like small things, they are often the difference between being able to control asthma or diabetes and repeatedly ending up in the emergency room.

Community Health Workers Address Equity and Diversify and Strengthen the Health Care Workforce
Systemic racism and its consequences create many barriers to health for Black, Latino/a, Indigenous, and other people of color. While Medicaid eliminates cost barriers, other significant obstacles remain. From connecting clients to transportation services to helping clients adapt medical advice to their dietary preferences and lifestyles to helping clients navigate which benefits are available to them and how to best communicate with a doctor or pharmacist about their needs to encouraging people to get screened for breast cancer, CHWs can address these barriers. CHWs also alleviate pressure on other health care professionals both by providing health education and preventing urgent visits and by addressing non-clinical issues related to health that clinic-based health care professionals rarely can. For example, CHWs can assist with applications for food and housing assistance or conduct home visits to detect and help mitigate environmental factors related to asthma and other chronic conditions. ***With shortages of primary care doctors, social workers, and nurses already straining our health system, CHWs are needed now more than ever.***

A recent survey of certified CHWs in CT found that 27% identified as Black or African American and 44% identified as Hispanic or Latino, both overrepresented compared to the state population. CHWs foster trust in health systems because of their lived experience and ability to relate to their clients. At the same time, CHWs help health care professionals be more attuned to the communities they serve and to the cultures of those communities.

Medicaid Reimbursement

Currently, 25 states have implemented Medicaid reimbursement programs for CHWs. For example, Oregon's program centers the role of CHWs in providing "whole person" care and holding health care providers collectively accountable for health outcomes. Michigan's Medicaid program requires a ratio of at least 1 CHW for every 5,000 Medicaid enrollees. While Connecticut's Medicaid program has made very small steps towards including CHWs through care coordination efforts for severely ill members and to connect some members with primary care, the number of CHWs and scope of services are extremely limited, and Connecticut is not mentioned in the summary linked above or the Medicaid and CHIP Payment and Access Commission (MACPAC) summary of Medicaid CHW services likely for this reason.

HES supports efforts by the Office of Health Strategy to convene state agencies funding or working with CHW initiatives. Medicaid should not be the only payer for this important set of interventions AND it must engage in comprehensive CHW programming to meet the needs of its members. Connecticut's HUSKY Health (Medicaid and CHIP) enrollees are more likely to be Black, Latino/a, and other people of color than the state's population and all live in low-income households as required by eligibility limits. This means Medicaid enrollees have a higher need for CHW services because systemic racism and lower economic status lead to a higher need for social and economic supports, a higher likelihood of developing chronic diseases and many kinds of cancer, more difficulty navigating complex bureaucracies, and a higher likelihood of mistrusting health systems based on personal experiences of discrimination and historical mistreatment of Black and Indigenous people by our health systems. Without sustainable reimbursement, the CHW workforce is limited

in size and job stability is limited to the duration of a grant. This creates barriers for both the CHW workforce and the populations they serve. Sustainable reimbursement makes it possible for the workforce to grow, for CHWs to earn a reliable and livable income, and for CHWs' clients to be able to depend on someone they trust for the duration of an illness, while navigating a new diagnosis, or when experiencing a crisis. Medicaid has led the way in other states with robust, cross-payer CHW programs and it should in Connecticut, too. Federal officials have signaled an openness to CHW efforts of many kinds and approved a handful of sweeping reforms embedding CHWs, including in California and Massachusetts.

A High Impact Intervention with a High Return on Investment

Over the past 50 years, approximately 850 studies have demonstrated that CHW services are highly effective at reducing health inequities, improving health outcomes, and reducing costs across multiple settings and health conditions. Studies have demonstrated CHWs interventions resulted in: improved outcomes after hospitalization, increased primary care utilization, better communication between health providers, higher patient activation scores, decreases in reported preference for emergency or urgent care by 40%, improved relationships with primary care providers, an increased preference for use of primary care, a 69% decrease in hospital stays, and improved quality of care for Black adults with multiple chronic conditions living in high-poverty zip codes. These are just a few examples.

Further, CHW interventions consistently demonstrate a high return on investment. Researchers at the University of Massachusetts developed 4 CHW models based on Connecticut data and projected ROIs of $1.12, $1.86, $2, and $2.40 per dollar invested over 3 years. For example, improving asthma control for children in New Haven was projected to return $1.86 per $1 spent while connecting people in New London County with complex health needs to appropriate services was projected to result in an ROI of $2.40. More recently, an evaluation of COVID-19 CHW interventions deployed by 5 Connecticut health departments found that the number of averted cases likely offset the cost of the program while meeting the needs of community members reached by these interventions. In states with Medicaid CHW reimbursement programs, savings are significant: New Mexico saved $2 million in one year of reaching 448 Medicaid members and Arkansas' Medicaid CHW intervention showed a $3 return on investment amounting to $3.5 million in savings.

Policy Recommendations

A coalition of over 100 CHWs and allies convened by HES and the Community Health Worker Association of Connecticut (CHWACT) in 2022 agreed on a set of principles for Medicaid reimbursement to maximize the potential of this policy. These principles are largely reflected in the proposed language, with two small exceptions.

To fully reflect the coalition's input and ensure the feasibility of this proposal, we respectfully recommend: (1) Adding language stating, "the Department of Social Services may seek federal approval for a Medicaid waiver or a Medicaid state plan amendment to implement the provisions of this section." Any such action would be subject to public comment or, in the case of a waiver, legislative approval. This change simply clarifies that the agency has the authority to proceed. (2) Specifically requiring engagement of Medicaid enrollees in the program's design to increase the program's effectiveness.

Community Health Worker Coalition Principles

Overarching principles:

- Program design, implementation, and evaluation must include ***engagement of community health workers and HUSKY Health members*** and input should be documented;
- HUSKY Health should consult with other stakeholders, including physicians, health systems, community-based organizations, and CHW employers;
- OHS should continue to lead cross-agency collaboration on CHW efforts across the state; and
- The program must ***regularly evaluate equity in health outcomes***.

CHW services should include, at minimum:

- Navigation support for primary and secondary prevention (enrollment, making appointments, engaging in cancer screening and vaccination, etc.);
- Health coaching and health education for people with chronic or complex social and medical needs (including oral and behavioral health needs); and
- Pregnancy, birth, lactation, and postpartum support.

Funding:

- Reimbursement should not require physician referral, but MAY require diagnosis for chronic diseases;
- Reimbursement ***must include community-based CHWs;***
- Reimbursement must account for any "startup" costs associated with hiring, connecting to data systems, and paperwork;
- If the program leverages new or existing alternative payment models, these must include adequate funding for CHWs and incentivize collaboration with community-based organizations; and
- Payment models must ***center equity*** in any payment adjustment or incentive mechanism.

There was also broad agreement that HUSKY Health should have the flexibility to implement these policies through any combination of federal Medicaid authorities that will align with these goals including state plan amendments, waivers, leveraging contracting arrangements, and flexible funding for preventive health care.

History of CHWs in Connecticut

Health Equity Solutions submits this testimony after years of research and coalition building on this issue. Why? Community health workers (CHW) are a crucial, well-supported means for addressing inequities in health. Since its inception, our organization has worked alongside CHWs to advocate for and implement certification and served as inaugural cochair and staff for the CHW Advisory Board overseen by the Office of Health Strategy.

In 2021, with certification up and running, HES collaborated with the Community Health Workers Association of Connecticut (CHWACT) to conduct listening sessions with CHWs to learn more about their needs. Based on this input, HES and CHWACT co-convened a series of conversations with CHWs about how they could most productively interact with Medicaid throughout 2022, culminating in the shared vision for Medicaid reimbursement, which we have shared above.

The need for CHWs has never been more urgent. Our health and social systems grow increasingly more complex, even when the changes are positive. At the same time, accumulated health needs left

untreated during the pandemic-related social isolation increase the risk of preventable illness and death. Inequities remain a significant and consistent concern in Connecticut and community health workers offer effective, affordable solutions. This is truly a high reward policy both in terms of fiscal impact and improved health, health equity, and quality of life for Connecticut's people.

Sections 13-14: Increasing the Reach of Covered CT

Each year, HES conducts listening sessions to inform our policy agenda. Health care access, including affordability, is consistently a top priority for health equity identified by the Connecticut residents who participate. We support the state's efforts to create affordable health insurance options for more of Connecticut's residents and respectfully urge this committee to advance the proposal to ***expand the reach of our state's Covered CT program***. This proposal is poised to reduce inequities in health care coverage and cost experienced by Black, Indigenous, Latino/a, and other people of color in our state. Affordable health insurance options are particularly important now to avoid an increase in uninsurance rates as the pandemic-related requirement to keep people enrolled in Medicaid ends and hundreds of thousands of Connecticut residents currently enrolled in Medicaid risk losing coverage due to small increases in income or administrative errors.

While Connecticut has a relatively low rate of uninsurance and has made significant strides in expanding no-cost health insurance programs, over 165,000 households have health insurance plans they cannot afford. The state's Consumer Health Affordability Index found that 18% of Connecticut households with working adults had health insurance costs that exceed an affordability benchmark. A shocking 42% of families purchasing insurance on Access Health CT faced costs that exceeded the affordability benchmark in 2021. The racial wealth gap in Connecticut is vast and Black, Indigenous, Latino/a, and other people of color in our state are already at greater risk of avoiding care, accruing medical debt, and going uninsured.

Unfortunately, many Connecticut residents still lack options for insurance they can afford to both enroll in and use. Many people who earn over 175% of the federal poverty level (FPL)—the current eligibility limit for Covered CT—find subsidies on Access Health CT still leave them with high out-of-pocket costs. An adult working full-time and earning minimum wage today, before the minimum wage increases in June 2023, already exceeds eligibility for Covered CT for a household of one.

Increasing the eligibility limit for Covered CT will increase the likelihood of families staying insured when they lose HUSKY coverage and improve access to health care by removing cost burdens. While Medicaid redeterminations begin in the coming weeks, many children and parents will be offered an additional year of Medicaid coverage and be at risk of uninsurance again in 2024 and thousands of people cycle on and off of Medicaid each year due to small fluctuations in income. This proposal mitigates the impact of both immediate and long-term challenges to affording health insurance.

The impact of Covered CT will depend on both enrollment and utilization. **HES strongly urges the state to fund more community-based health navigators or community health workers (CHWs)** to ensure people can find their way through the increasingly complex health insurance options and access care. More targeted outreach through trusted, community- and faith-based organizations would build on

lessons learned from pandemic-related outreach. In addition, the dental and transportation benefits are key to the wellbeing of enrollees and navigators could play a vital role in ensuring Covered CT enrollees are aware of and know how to use these benefits.

Finally, ***we respectfully recommend deleting Sec. 14(b)(1) allowing benefits to be reduced*** for the highest tier of enrollees. It is likely an actuarial analysis will find minimal cost savings associated with the wraparound services provided by Covered CT and these will be important to the small number of people in this slightly higher income bracket who may need them. The same is true for other benefits that might seem extraneous to the average person, but are crucial to the small number of people who use them.

Section 15: Streamlining Access to Access Health CT Coverage

As noted above, inequities in insurance coverage rates remain pervasive in Connecticut. As the public health emergency ends and the maintenance of effort requirements for Medicaid expire, hundreds of thousands of state residents currently enrolled in Medicaid will likely be asked to document their income or be found ineligible for Medicaid. Estimates by the federal government note the high level of administrative coverage losses (meaning loss of Medicaid by eligible people) experienced by Latino/a, Black, Asian, and multiracial individuals.

These administrative losses are not unique to the pandemic. Churn—individuals moving on and off HUSKY due to changes in income or difficulty filing paperwork—has long been a concern. Further, tracking of HUSKY members who were affected by cuts to HUSKY A found that few enrolled in Access Health, suggesting transitions between Medicaid and Access Health lead to administrative losses of coverage. Similarly, MACPAC found poor rates of transition to private insurance and high rates of coverage gaps for people transitioning from Medicaid to the federal health insurance marketplace.

This proposal to allow Connecticut residents to opt into sharing their information with Access Health CT when filing their state taxes is commendable. It can help people understand and access their health insurance options. Clarifications based on Maine’s statute might increase the effectiveness of this proposal and ensure that the likelihood of eligibility for a tax-subsidized qualified health plan and for Medicaid are considered.

We urge the legislature to take this effort to advance “easy enrollment” a step further and look to California for an examples of how to simplify and facilitate the transition between Medicaid, Covered CT, and qualified health plans available on Access Health CT without any tax liability implications for enrollees. This brief lays out options for improving “account transfers” or data sharing between Medicaid and Access Health CT, which CT could adopt.

Concluding Remarks

As noted above, we respectfully urge the committee to consider our recommended changes to sections 11-15 of this proposed bill and move this important legislation forward.

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Thank you for the opportunity to submit this testimony in support of **S.B. 10.** We can be reached with any questions at aclarke@hesct.org, ksiegel@hesct.org, or 860-937-6611.