Table of Contents

State/Territory Name: Connecticut

State Plan Amendment (SPA) #: CT-23-0002-CHIP

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

April 20, 2026

Bill Halsey
Director, Division of Health Services
Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Director Halsey:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number CT-23-0002-CHIP, submitted on June 30, 2023, with additional information submitted on April 20, 2026, has been approved. Through this SPA, Connecticut eliminates its HUSKY Plus program. In addition, this SPA demonstrates compliance with the American Rescue Plan Act of 2021 (ARP). The effective date for the SPA is July 1, 2022.

This SPA eliminates the HUSKY Plus program as Connecticut is incorporating all services previously provided to a subset of children into the existing HUSKY B program and providing them to the entire CHIP population, with the exception of non-emergency medical transportation. Non-emergency medical transportation will continue to only be available to children with a health condition that requires them to be homebound. With this consolidation, the state can conduct a single screening and application process for children to receive the benefits offered through the HUSKY B program.

The "HUSKY B Member Handbook" includes references to annual and lifetime limits that are no longer permissible as specified at 42 CFR 457.480(a) of the CHIP regulations; however, CT-23-0002 was submitted prior to this regulatory change. The state has informed CMS that it will submit a SPA to comply with these requirements by the end of its current state fiscal year and update all related materials to reflect these policy changes. In addition, in July 2025, Connecticut provided notice to providers that the limits on eyeglasses and hearing aids in CHIP are no longer in effect and that HUSKY B members will no longer be responsible for any portion of these expenses.

Section 9821 of the ARP amended sections 2103(c)(11)(B) and 2103(e)(2) of the Act to mandate coverage of COVID-19 testing, treatment, and vaccines and their administration without cost-sharing or amount, duration, or scope limitations. Sections 2103(c)(11)(B) and 2103(e)(2) of the Act also require states to cover, without cost sharing, the treatment of conditions that may seriously complicate COVID-19 treatment, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19. The state provided the necessary assurances to

demonstrate compliance with the ARP in accordance with the requirements of sections 2103(c)(11)(B) and 2103(e)(2) of the Act. These changes were in effect through September 30, 2024, the last day of the ARP coverage period, as described in section 1135(g)(1)(B) of the Social Security Act (the Act).

Your title XXI project officer is Chanelle Parkar. She is available to answer questions concerning this amendment and other CHIP-related matters and can be reached at Chanelle.Parkar@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Jessica Stephens/

Jessica Stephens
Acting Director

6/30/2023

AMENDED CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: **Connecticut**
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))

Andrea Barton Reeves, JD, Commissioner, CT DSS, June 30, 2023
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: ~~William Woolston~~William Halsey~~, Ph.D~~ Position/Title: Director of Medicaid and Division of Health Services

Name: ~~Nicholas Venditto~~Brianna Mitchell Position/Title: CFO

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1.4 CT-23-0002 (Amendment #17) CHIP COVID-19 Coverage Updates: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP. This SPA also reflects a change in the state's supplemental program, HUSKY Plus to HUSKY B

Date Submitted: June 30, 2023
Date Approved:
Date Effective:
Proposed Effective Date: July 1, 2022 (COVID-19 Coverage); July 1, 2022 (HUSKY Plus to HUSKY B)

1.4-TC **Tribal Consultation.** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The state notified the two federally recognized tribes of this SPA by email on June 15, 2022. The state provided a further email to the two federally recognized tribes of this SPA on June 29, 2023 that the SPA is being submitted to CMS on June 30, 2023. There were no changes from the SPA that was sent on June 15, 2022 and the SPA that was sent on June 29, 2023.

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42 CFR 457.490(a))

The State will utilize the same delivery system and utilization controls as applicable to the rest of the CHIP population.

☐ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

As described in the State's Medicaid state plan amendment, under Part A of the HUSKY Plan, the State used Title XXI funds to expand Medicaid eligibility for children 14-18 with family income up to 185% of the FPL. The Title XXI- funded expansion of Medicaid was phased out effective 10/1/02. As of 10/1/02, Title XXI funds are used only for the stand-alone SCHIP program (HUSKY B).

As of 1/1/12, all medical services for Connecticut's Medicaid and CHIP population are coordinated by the statewide HUSKY Health medical Administrative Services Organization (ASO). The State eliminated the managed care organization (MCO) service delivery model on 12/31/11. Medical services for children with family income over 185% of the FPL under the HUSKY Plan, Part B are now obtained through providers in the fee-for-service Connecticut Medical Assistance Program (CMAP) network, the same network through which Connecticut's Medicaid recipients receive their benefits. Behavioral health services have been administered by a behavioral health ASO since 7/1/05 and a dental ASO has provided dental services since 9/1/08. Pharmacy services have been provided through CMAP network providers since 2/1/08.

The State selects ASOs through a competitive bidding process. The State issues a Request for Proposal (RFP) that establishes operational and financial requirements and requires bidders to provide evidence of their ability to meet the requirements. The requirements include but are not limited to: access to care, provider network, member services,

utilization management, claims processing, and quality assurance. The State awards the right to negotiate a contract based on a fair evaluation of all proposals submitted in response to the RFP. This method includes evaluation of the following factors: provider network for each service area, efficiency of operation, ability to provide the required services, quality management, and ability to perform the necessary administrative tasks, financial viability, and price. The ASO contracts do not include financial requirements because the ASOs are not capitated and bear no risk.

During the period 1/1/08 through 7/31/08, the state changed its contractual relationship with the existing at-risk MCOs to non-risk pre-paid inpatient health plans (PIHPs). The State returned to at-risk MCO contracts effective 8/1/08.

As of 12/31/11, the Department terminated its MCO contracts.

Following the end of the MCO contracts, the Department implemented a self-insured, managed fee-for-service approach for both Medicaid and CHIP. In support of achieving better heath and care experience outcomes for members, and engagement with providers, the Department has entered into contracts with ASOs for each of the three major service types – Medical, Behavioral Health, and Dental. The structure of each of the ASO contracts supports the Department's desired results. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures.

ASO arrangements have substantially improved engagement with both members and providers. Members now have streamlined toll-free and web-based access to clear information and support on how to access and to utilize their benefits. Providers now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid.

~~As of May 1, 2022, t~~The supplemental program known as HUSKY Plus ended on May 1, 2022, and ~~was eliminated. A~~all services and goods that were available through that program are now available to all members enrolled in HUSKY B with the exception of non-emergency medical transportation, which will be limited to those with a health condition that requires them to be homebound. All services will be provided without any additional screening or application. ~~ That is, the HUSKY Plus program has been effectively merged into the HUSKY B program. Members will not need to go through a separate screening and application process in order to receive the benefits.~~ The scope of benefits, including any limitations, will remain the same, and the ~~ The same~~ prior authorization requirements will continue to apply. Please note that the criteria for the provision of medical transportation services included in section 6.2.29.

~~of the state plan.~~

See attached documents that provide Husky B benefit descriptions attached hereto.

~~*In addition, the state, using Title XXI funds, has established a supplemental health insurance program, known as the HUSKY Plus Physical program, for those enrollees in the state subsidized portion of Part B whose medical needs cannot be accommodated within the basic benefit package offered by the Department under the HUSKY Plan, Part B. The HUSKY Plus Physical program supplements HUSKY Plan, Part B coverage for enrollees with intensive physical health needs. Effective 7/1/03, the physical health services are delivered through the Connecticut Children's Medical Center (CCMC)/ Title V network.*~~

~~*Effective 7/1/17, The Department is changing the HUSKY Plus contractor from Connecticut Children's Medical Center (CCMC) to the same administrative services organization (ASO) used for all HUSKY's Medicaid and CHIP programs. Also, providers are reimbursed for HPP services using the same MMIS as for all HUSKY Health programs. See Appendix 3.1 for additional information on the HUSKY Plus Physical program.*~~

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42 CFR 457.490(b))

The state includes a definition of medical necessity and utilization management requirements in the RFP and the contracts with its ASOs. The ASOs are required to have

written utilization management policies and procedures that include the medical necessity criteria for authorization and denial of payment and protocols for prior approval. The ASOs are also required to have mechanisms to ensure consistent application of the review criteria. In addition, the MCOs and ASOs must have utilization controls to ensure that only services described in the approved state plan are provided to HUSKY B members.

~~*As discussed in Appendix 3.1 (summarizing HUSKY Plus Physical), utilization is managed through prior authorization based on individual care plans and medical necessity guidelines.*~~

~~*During a national disaster, the State may make numerous changes to prior authorization requirements. These changes will apply to all CHIP enrollees. The changes may include the suspension of prior authorization for: in-state and border hospital admissions; inpatient hospice days beyond the fifth day; advanced radiology and imaging services; various home health services; and specific dental services. The state may also suspend registration and prior authorization requirements for numerous behavioral health outpatient services; wavie cost sharing requirements; delay processing renewals and extend renewal deadlines for families; and delay tribal consultation.*~~

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☐ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42 CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
See CT-14-0005, CS18, Non-Financial Eligibility - Citizenship.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

See 14-0001, CS7, Eligibility – Targeted Low-Income Children.

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

See 14-0001, CS7, Eligibility – Targeted Low-Income Children.

Individuals must be under 19 years of age.

4.1.2.1-PC ☒ Age:Conception through birth (SHO #02-004, issued November 12, 2002)

See CS-22-0001, CS9, Coverage from Conception through Birth.

4.1.3 ☒ Income of each separate eligibility group (if applicable):

See CT-14-0001, CS7, Eligibility – Targeted Low-Income Children

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through % of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☒ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

No asset/resource limit.

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

See CT-14-0005, CS 17 – Non-Financial Eligibility – Residency
To be eligible for the HUSKY Plan, Part B, a child must be a resident of Connecticut.

4.1.6 ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

~~*Measures of disability acuity will apply in HUSKY Plus Physical (See Appendix 3.1).*~~

Section 5. **Outreach and Coordination**

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42 CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

~~*Title V refers potential applicants who do not qualify for its program to HUSKY B and HUSKY Plus Physical. A Department representative monitors services provided by the Connecticut Children's Medical Center, the agent responsible for HUSKY B Children with Special Health Care Needs with Title V. (**See Appendix 3.1.**)*~~

The Department contracts with school-based health clinics.

HUSKY B~~Plus Physical~~ and the HUSKY Health medical ASO, in conjunction with the Department, also coordinate with the Birth to Three program, which provides services to children with special health care needs.

Section 6. **Coverage Requirements for Children's Health Insurance**

☐

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage.

Please note that the HUSKY B benefits combine the most generous benefits offered at the inception of the HUSKY, Part B plan under three state employee options available in 1998 (Blue Cross, MD Health Plan, and Kaiser Permanente), in addition to covered services mandated by the Federal CHIP regulations. ~~*In addition, HUSKY B benefits also include a limited supplemental program, HUSKY Plus (which is not available to state employees) for children whose medical needs cannot be fully met by the coverage available under the regular HUSKY B benefits. (See Revised Appendix 3.1)*~~ *The same benefit package (Secretary approved-benchmark plus) applies to unborn children like other children in CHIP.*

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other. (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services

covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☐ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.22. ☒ Case management services (Section 2110(a)(20))

Case management is available through the medical and behavioral ASOs, depending on the member's needs.

6.2.23. ☒ Care coordination services (Section 2110(a)(21))

Care coordination is available to members who are part of the Primary Care Medical

Home initiative .

6.2.24. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Short term and long term rehabilitation is covered under HUSKY B ~~and long-term coverage is available through HUSKY Plus. See Appendix 3.1 for additional information on HUSKY Plus Physical~~

6.2.25. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
Services of nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths will be covered.

6.2.28. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. ☒ Medical transportation (Section 2110(a)(26))

Transportation by ambulance will be covered for emergency matters. However, non-emergency transportation (NEMT) is limited and subject to the following:

- *Two round trip rides per year to any health care appointment by ambulance, chair-van or other licensed medical transportation service provided the child(ren) is/are identified to have a special health*

condition which usually has them housebound.

- *Transportation between two hospitals should the child(ren) need to be transferred.*
- *Ambulance travel requires documentation that it is the safest and most appropriate means of transporting the child(ren).*

~~*Transportation by ambulance will be covered but non-emergency transportation will not. Limited non-emergency transportation will be covered by HUSKY Plus Physical (See Appendix 3.1 for information on HUSKY Plus Physical).*~~

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))
Translation and outreach services will be available through the HUSKY ASOs. All printed materials must be in English and Spanish and any other languages if more than five percent of the ASO enrollees speak the alternative language.

6.2.31. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

~~*See Appendices 3.1 and 6.1: HUSKY Plus Benefits and HUSKY B Benefits*~~

6.2- UNBORN CHILDREN – The state provides the same scope of benefits to unborn children as it does to other Targeted Low-Income Children. This includes comprehensive prenatal care with no cost sharing. When comprehensive prenatal care is rendered by the same provider or provider group, the provider/group bills with a comprehensive bundle code that includes all routine prenatal, delivery and post-partum care and thus all the services are covered under the unborn children option. If a different provider or provider group renders the delivery, the delivery will be covered by Emergency Medicaid since the comprehensive bundle code cannot be billed.

Section 7. Quality and Appropriateness of Care

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42 CFR 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42 CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

The methods that are used to assure quality and appropriateness of care include contracting standards, licensing, reporting requirements, external reviews, and onsite reviews.

The HUSKY Health medical ASO contract includes specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations. The HUSKY Health medical ASO is required to arrange for immunizations and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the American Academy of Pediatrics. As described below, The HUSKY Health medical ASO is required to submit reports on well-baby care, childcare visits and immunizations. The Connecticut Department of Public Health has a statewide immunization registry (Connecticut Immunization Registry and Tracking System), to which providers report directly.

The behavioral health and dental ASO contracts will include specific standards for quality of care, including the provision of behavioral health and dental health intensive care management and service coordination. In addition, the behavioral health and dental ASOs will be required to submit to the Department periodic reports on utilization of dental health services and behavioral health services, including inpatient and outpatient services.

The HUSKY Health ASOs are required to meet all standards for quality of care as specified in their contracts with the State. The ASOs must be licensed by the Connecticut Insurance Department (CID) to operate as a utilization review company. CID continuously monitors quality through various mechanisms, including reporting, external reviews, and onsite reviews.

Reporting will include a report on each ASO's quality assurance plan (QAP), complaints, prior authorization denials, utilization review (UR) denials, and all data required for HEDIS (or equivalent data for non-NCQA accredited plans). In addition, the Department requires reports on compliance with the well-child periodicity schedule and on immunization. The State conducts periodic onsite reviews to determine ongoing compliance with contract requirements.

The unborn children covered under this coverage will be included in all current methods to assure quality and appropriateness of care.

7.1.1. ☒ Quality standards

7.1.2. ☐ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set

7.1.2 (b) ☒ Other

7.1.3. ☒ Information strategies

The HUSKY ASOs are required to educate enrollees about their benefits, rights and responsibilities under the HUSKY B. ~~including HUSKY Plus.~~ The HUSKY ASOs also educate enrollees about the importance of preventive services including medical and dental services, health promotion activities, and visiting their primary care provider instead of an emergency room. The unborn population will be included under these processes.

7.1.4. ☒ Quality improvement strategies

The State includes specific standards for quality of care in the contracts with its ASOs. These standards are monitored by the State through reporting requirements, onsite reviews, and external reviews.

In particular, the HUSKY ASOs are required to establish an internal QAP, which will be in writing and available to the public. The written description shall include detailed goals and annually developed objectives; address the quality of clinical care and non-clinical aspects of services for the entire range of care provided by each ASO; specify quality of care studies and related activities; provide for continuous performance of activities, including tracking of issues over time; and provide for review and feedback by physicians and other health professionals.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the

care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42 CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42 CFR 457.495(a))

The State requires the HUSKY Health medical ASO to submit reports on immunizations, and compliance with the well-child periodicity schedule.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42 CFR 457.495(b))

The State monitors access requirements through reporting and member satisfaction surveys. For medical, dental, pharmacy, and behavioral health services, the ASO will rely on the Connecticut Medical Assistance Program (CMAP) provider network to assure access to covered services. HUSKY Health ASO is required to monitor the CMAP provider network to ensure providers who fail to reenroll do so and also to recruit additional providers to make the network more robust.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42 CFR 457.495(c))

All HUSKY Health services (medical, behavioral health and dental) are provided through the CMAP network. HUSKY B members and members covered under the unborn coverage have access to all of the same providers as Medicaid recipients. The HUSKY Health medical, behavioral health and dental ASOs assist in managing the Department's network, but do not contract directly with network providers. All claims are processed by the Department's MMIS.

Pharmacy services are provided utilizing the Department's Preferred Drug List (PDL).

~~*For members enrolled in HUSKY Plus, the HUSKY Health medical ASO now administers that program. This allows for more streamlined and efficient coordination of services for*~~

~~*members eligible for HUSKY Plus, allowing members to receive supplemental services to the fullest extent possible in the least restrictive setting. (See Appendix 3.1).*~~

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Prior authorization of services covered in the HUSKY B benefit package shall be determined by the appropriate ASO based on the Department's individual care plans, medical necessity and in accordance with State law. However, the following services in the benefit package shall not require prior authorization:

(1) Preventive care, including:
- *(a) Periodic and well-child visits;*
- *(b) Immunizations; and*
- *(c) Prenatal care;*

(2) Preventive family planning services, including:
- *(a) Reproductive health exams;*
- *(b) Member counseling;*
- *(c) Member education;*
- *(d) Lab tests to detect the presence of conditions affecting reproductive health; and*
- *(e) Screening, testing and treatment of pre and post-test counseling for sexually transmitted diseases and HIV, and*

(3) Emergency ambulance services or emergency care.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums:

Effective July1, 2014, children with family income up to 249% of the FPL will not be required to pay a premium. Children with family income that exceeds 250% of the FPL but which does not exceed 318% of the FPL will be required to pay a premium of $30.00 per child per month, up to a maximum of $50.00 per family per month. Effective July 1, 2014, newborns with family income over 249% of the FPL will not be required to pay premiums for the first four months of coverage, provided they were born in a Connecticut hospital or designated border hospital. Effective August 1, 2015, pursuant to a change in state law, enrollment of children over 318% of the FPL will not be permitted. Private

organizations may subsidize premiums. For unborn children with family income up to 258% FPL, no premiums are required.

. .

8.2.2. ☐ Deductibles:
Not applicable.

None..

8.2.3. ☒ Coinsurance or copayments:

Coinsurance is only applicable for certain non-preventive dental services.

Copayments: For children in families with income over 196% of the FPL, the State has established a schedule of reasonable copayments for services other than the following: preventive care and services, inpatient physician and hospital, outpatient surgical, ambulance, skilled nursing, home health, hospice and short-term rehabilitation and physical therapy, occupational and speech therapies, lab and X-ray, preadmission testing, prosthetics, and durable medical equipment, and pregnancy related services, including medications prescribed during pregnancy. (See Appendix 6.1). Both targeted ~~low income~~low-income children and beneficiaries in the unborn child group will receive pregnancy-related services (including prescription medications) with no copayments. Due to the parity analysis under MHPAEA, the State will no longer charge copayments for outpatient behavioral health visits and outpatient substance abuse treatment. The State will implement that change as soon as practicable.

~~*There are no co-payment requirements for covered HUSKY Plus Physical services.*~~

Coinsurance for dental plans are required for specific procedures such as Crowns, Inlays, On lays, Prosthodontics, Recementing Bridges, Space Maintainers, Full or Partial Dentures, Repairs, Relining, Rebasing of Dentures, Root Canal Treatment, Connecticut – Child Health Plan - CHIP SPA – Amended 6/16/2023 70 Endodontic Surgery, Retreatment of Root Canal Therapy, Apicoectomy, Apexification, Miscellaneous Surgical Procedures, Surgical Extractions (including wisdom teeth), Periodontal Surgery, Non-surgical Extractions, Space Maintainers, General Anesthesia, Sedation in the office, Replacement Retainers, and other miscellaneous covered items.

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:
COVID-19 Vaccine:

** The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.*

COVID-19 Testing:

** The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.*

COVID-19 Treatment:

** The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.*

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

** The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.*

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The family share of premium payments, copayments and dental co-insurance payments were calculated to not exceed 5% of the lowest qualifying family income within each of the two income levels for subsidized benefits (e.g. 5% of 196% of FPL and 5% of 250% of the FPL) for the applicable household size. Cost sharing is tracked by the Department's Medicaid Management Information System (MMIS) as applicable and reported to the SPES. The SPES compiles the cost sharing amounts with premiums it has collected and reports back to the Department's MMIS vendor and the ASOs. When cost sharing maximums have been met, the ASOs will issue new member identification cards. If a family exceeds the maximum, the Department is required to reimburse the excess above the maximum amount to the family.

It is the responsibility of the SPES to review the member accounts at a minimum on a monthly basis to determine which families have reached their maximum annual cost sharing limit. The review must be completed no later than 15 days after the end of each review period. If, due to claims' time-lag, the family has paid more than the allowed limits for cost sharing, it is the responsibility of the Department to repay the overpayment to the family within three months of the SPES's determination that the maximum annual aggregate cost sharing limit for copayments had been met. The SPES is required to

establish and maintain a system to track the copayments incurred by each family in Income Levels 1 and 2 in order to adhere to the requirements of the maximum annual aggregate cost sharing. The ASOs and the Department also must require their providers and subcontractors to verify whether a family has reached the maximum annual aggregate cost sharing limit for copayments and co-insurance before charging a copayment or co-insurance amount.

When a family reaches the maximum annual aggregate cost sharing limit, the SPES will inform the Department. The ASOs will inform the providers, subcontractors and family that the limit has been met, that the providers and subcontractors cannot charge further cost sharing within the annual eligibility period.

If the family believes it has reached the maximum annual aggregate cost sharing limit, it may request, in writing, that the Department review the cost sharing amounts paid by the family. The Department will then review the cost sharing amounts paid by the family and respond to the family, in writing, within three weeks of the date of the family's written request. If the family disagrees with the determination, the family may request, in writing, a review by the Department. The ASOs are required to include a summary of this right and the appropriate procedures to request the review in their Member Handbooks.

~~*There are no cost sharing requirements for covered HUSKY Plus Physical services.*~~

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42 CFR 457.535)

Families of American Indian/Alaskan Native (AI/AN) children who are members of a federally organized tribe and who are in Income Level 1 or 2 are exempted from paying HUSKY B premiums or copayments. Income Level 1 represents those enrollees whose income falls between 196 percent and 249 percent of the federal poverty level. Income Level 2 represents those enrollees whose income falls between 250 percent and 318 percent of the federal poverty level.

The Department of Social Services staff informed representatives of the Mashantucket Pequots and the Mohegans, the two federally recognized tribes within the State of Connecticut, that federal requirements do not permit cost sharing for AI/AN children in the HUSKY B program. Staff also consulted with them about the best way to identify AI/AN children.

Based on recommendations made by both tribes, it was decided that applicants would be asked to verify their tribal membership at time of application. The HUSKY application was modified to ask if the child for whom application is made is a member of a federally

recognized tribe. If the answer is "yes", the applicant will need to provide the name of the tribe and verification of membership. HUSKY informational materials were also revised to include information about the cost sharing exemption for AI/AN children. The SPES, under contract with the Department to determine eligibility for HUSKY B applicants, will notify the ASOs when a new enrollee is qualified for exemption from cost-sharing due to AI/AN status. The ASOs will not charge the family for any partial premium payment and will issue the enrollee a membership card that specifies "no copayments"

~~*American Indian/Alaskan Native children enrolled in HUSKY Plus Physical will not be charged premiums or copayments as there are no cost sharing requirements.*~~

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

See CT14-0005, CS21, Non-Financial Eligibility – Substitution of Coverage). Enrollees are permitted up to 90 (days) to pay their initial premium and their premium for annual re-enrollment. Failure to do so will result preclude the enrollee from receiving initial coverage or having their coverage renewed, as applicable. Once the enrollee has coverage however, as of January 1, 2014, the Department no longer disenrolls enrollees for failure to pay the monthly premium.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42 CFR 457.710(b))

To increase the number of children in Connecticut with health insurance through the expansion of the HUSKY program.

To maximize participation in HUSKY B through outreach, a simplified application process

To promote the health of children through an improved health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.

~~*To assist those children enrolled in HUSKY B who have special physical health care needs, to receive appropriate care through a supplemental plan (HUSKY Plus Physical).*~~

~~*To maximize coordination between the HUSKY Health ASOs and HUSKY Plus Physical by integrating basic health care needs into the care provided for intensive health care needs, and, whenever possible, building upon existing therapeutic relationships with Title V providers.*~~

To promote the health of children covered under the unborn option by promoting optimal pregnancy outcomes.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42 CFR 457.710(c))

To increase the number of children covered by health insurance within Connecticut.

To maximize participation in HUSKY B.

- *Expand Medicaid (HUSKY Part A) enrollment of uninsured children 18 years old who are under 196% of the FPL.*

• Increase the number of insured children 18 or under who are between 196% and 318% of the federal poverty level.

To promote the health of children through a comprehensive health benefits package.

• Match or exceed the statewide average of the percentage of children in HUSKY B who receive immunizations by age two, meet or exceed state standards for well-child care, with a goal of at least 80% of children receiving all recommended well-child visits.

~~*To assist children with special physical health needs through HUSKY Plus.*~~

~~*• Ninety percent of referrals to HUSKY Plus will have eligibility determination made within 21 days.*~~

~~*• Track the percentage of referrals to HUSKY Plus accepted or denied.*~~

~~*To maximize coordination between HUSKY B and HUSKY Plus:*~~

~~*• The HUSKY Health ASO is now coordinating health care for HUSKY Plus members. The ASO is also pre-authorizing all HUSKY Plus covered services. Families now have a single entity to assist them and ensure that supplemental services are authorized when the child's medical needs surpass the regular HUSKY B package.*~~

~~*• 100% of HUSKY Plus children's needs will be assess and referred for Intensive Care Management.*~~

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Healthcare Effectiveness Data and Information Set~~Health Employer Data and Information Set~~) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

The Medical Assistance Oversight Council (MAPOC) and the Behavioral Health Partnership Oversight Council (BHPOC) serves in an advisory role to the Department for the behavioral health services as managed by the medical and behavioral health ASOs. The MAPOC and BHPOC are comprised of legislators, clients, advocacy groups, DSS, and other state agencies such as the Department of Children and Families and the Department of Mental Health and Addiction Services. The MAPOC and BHPOC meet once a month during which time the Department provides program updates. The MAPOC and BHPOC also have several subcommittees that provide a forum for important issues

to assure the viability of the medical and behavioral health service delivery system. The subcommittees include: Care Management, Complex Care, Quality and Access, Women & Children's Health, Adult Quality Access Policy and Child/Adolescent Quality, Access, and Operations. ~~Transition, Provider Advisory, Quality Management, Consumer Access, and the Department of Children and Families Subcommittee.~~