Covered Connecticut (Covered CT) 1115 Eligibility and Coverage Demonstration

Demonstration 11-W-00402/1

DY3 Q4/Annual Monitoring Report

October 1, 2024 – December 31, 2024

Medicaid Section 1115 Eligibility and Coverage Demonstrations
Monitoring Protocol Template

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Protocol Template (Part B) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STC). This state-specific Part B Template reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Medicaid Section 1115 Eligibility and Coverage Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here.

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. All approval periods should include a start date and an end date (MM/DD/YYYY - MM/DD/YYYY). The dates in this section should pertain to the current demonstration period. For a policy that the state implemented as part of a previous demonstration, the state should treat the approval period start date of the current demonstration as the implementation date unless the state has set a new date to implement a modified version of the policy.

For non-eligibility periods, the state should use the policy-specific rows to enter implementation dates for each applicable non-eligibility period. If the state has non-eligibility periods for premiums, it should only include a non-eligibility period implementation date for these policies if it differs from the implementation date for premiums. The state should include implementation dates for all other non-eligibility periods individually if the dates differ by policy. If the state has a non-eligibility period for a policy that is not listed in the table, the state should use the "other policy" row to specify the implementation date of that policy. In this row, the state should also replace "[enter here]" with the name of the policy to which the non-eligibility period implementation date applies.

Overall section 1115 demonstration	
State	Connecticut
Demonstration name	Covered Connecticut.
Approval period for section 1115 demonstration	12/15/2022 – 12/31/2027
Premiums or account payments	
Premiums or account payments start date	N/A
Implementation date if different from premiums or account payments start date	N/A
Healthy behavior incentives	
Healthy behavior incentives start date	N/A
Implementation date, if different from healthy behavior incentives start date	N/A
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	N/A
Implementation date, if different from retroactive eligibility waiver start date	N/A
Non-eligibility periods	

Non-eligibility periods start date	N/A
Implementation date for premiums and account payments non-eligibility periods, if different from non-eligibility periods start date	N/A
Implementation date for non-eligibility periods for failure to complete annual eligibility renewal process, if different from non-eligibility periods start date	N/A
Implementation date for non-eligibility periods for failure to report change in income or other change in circumstance, if different from non-eligibility periods start date	N/A
Implementation date for other non-eligibility periods, if different from non-eligibility periods start date. Policy: *[enter here]*	N/A

Notes:

1. **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start

date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

2. **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first eligibility and coverage demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first eligibility and coverage DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this

information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not complete renewal and were disenrolled from Medicaid (metric AD_19) over the course of the retrospective reporting period. This state may decide to highlight this change for CMS in Part B of its monitoring report by briefly summarizing the trend and explaining that during this period the state conducted additional outreach to beneficiaries about the renewal process.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

2. Executive Summary

During DY3 Connecticut's Public Health Emergency unwind and redetermination process for Medicaid, halted during the PHE, continued through Q1. Covered CT enrollment increased 1,582 members from the PHE redetermination process in Q1. Covered CT enrollment increased an average of 7% month over month during DY3Q4 and increased 68% over DY2.

In DY3 Q3 DSS began work on an amendment to the Covered CT 1115 waiver demonstration to support CT Public Act 24-138, enacted in June 2024, which eliminates subsidies for out-of-network providers and services except in cases in which the "No Surprises Act" would be applicable. DSS Plans to submit the amendment in Spring, 2025.

DSS, during Q1 and Q2 of DY3, focused on executing contracts with the health insurance carriers that provide policies to Covered CT members that would be wholly owned by the agency. DSS executed contracts with the health insurance carriers in April 2024 which were implemented for May 1, 2024, start. The new contracts had financial terms that expired on December 31, 2024. Amendments to the financial terms of the contracts were executed in December 2024, for a January 1, 2025, start. The amended contracts updated enrollment projections and extended the financial terms related to program utilization through December 31, 2025.

DSS continued to collaborate and support outreach and engagement efforts led by OHS, meeting with OHS state partners monthly, participating in outreach and engagement efforts led by OHS and providing program information for outreach initiatives. DSS and OHS partnered on scope and content for a marketing campaign for the Covered CT program designed to increase awareness of the program and target eligible residents.

DSS also began discussions with SimplifyCT, a community-based VITA organization that provides tax preparation services to partner on outreach and engagement with clients seeking tax preparation services. DSS and SimplifyCT discussed options to identify residents potentially eligible for Covered CT. DSS including further defining a scope of work that will add screener questions related to health insurance status and providing a warm hand-off to navigation services during the 2025 tax season as well as a targeted text campaign in 2025.

DSS continued to meet with state partners monthly during DY3 at partner team meetings, executive committee meetings and Carrier oversight meetings to provide updates on program progress, ensure continued collaboration and to address and mitigate any decision, risk or issue related to Covered CT.

3. Narrative information on implementation and operations

Changes to populations served, benefits, access, delivery systems, or eligibility

Connecticut General Assembly passed legislation to eliminate subsidies for out of-network providers and services for members of the Covered CT program. Implementation of the change across the program is pending the submission and approval of an amendment to the Covered CT 1115 waiver.

Fiscal changes

Connecticut has nothing to report for DY3 Q4.

Related audit or investigation activity, including findings

In February 2024, Connecticut state auditors of public accounts conducted a review of the operational and fiscal controls in place to manage the program with the goal of assessing risk with the management of the Covered CT program. State auditors reported findings and concluded that there was no need for a full audit.

Litigation activity

Connecticut has nothing to report for Covered Connecticut for DY3 Q4.

Appeals

Connecticut has nothing to report for Covered Connecticut for DY3 Q4.

Changes in key state personnel or organizational structure

Medicaid Director William "Gui" Woolston left state service on May 30, 2024. Acting Medicaid Director William Halsey was appointed Medicaid Director on August 28, 2024.

Status and/or timely milestones for health plan contracts

DSS executed contracts with the carriers on May 1, 2024, and amended the financial terms during Q4 for a January 1, 2025, start date.

Enrollment

Enrollment increased steadily during 2024. Covered CT saw consistent growth of 5% month-over-month during Q1, 3% month-over-month during Q2 and Q3 and an increase of 7% month-over-month for Q4. As of December 31, 2024, 42,305 individuals are enrolled in Covered CT.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
PHE Unwind Enrollment	573	377	632									
Non-Unwind Enrollment	27,967	29,470	30,643	32,054	32,961	33,866	33,551	34,645	35,696	37,016	38,532	42,305
Total Enrollment	**28,540**	**29,847**	**31,275**	**32,054**	**32,961**	**33,866**	**33,551**	**34,645**	**35,696**	**37,016**	**38,532**	**42,305**

Connecticut Health Insurance Exchange, Access Health CT (AHCT)

AHCT continued to support weekly reporting during 2024, providing information on enrollment stratified by age, gender, zip code and income level. This information is shared with our state partners involved in outreach and engagement efforts, utilized for internal planning and utilized for reporting to the state legislature. Representatives from AHCT continued to participate in monthly Covered CT team meetings, Covered CT Executive Committee meetings and Covered CT reporting meetings, offering subject matter expertise and further strengthening the partnership through their continued engagement.

AHCT worked in collaboration with DSS staff to develop requirements to implement auto-enrollment for members to opt-in to or decline Covered CT auto enrollment and Covered CT plan selections during the subsidized application flow. If the consumer is newly eligible for Covered CT and opts-in to Covered CT auto-enrollment, they will be auto-enrolled into their pre-selected Covered CT plan if they are losing HUSKY coverage (unless they are losing coverage because they failed to complete the manual Medicaid renewal). This change will be performed for both online and batch flows. Phase I of the auto-enrollment feature was implemented in October 2023. Phase II of the auto-enrollment was implemented in February 2024 and expanded the auto-enrollment process to non-Medicaid individuals that are newly eligible for Covered CT.

As a result of the end of the PHE, AHCT resumed the existing verification processing which takes action for members on the exchange that have not provided supporting documentation needed to resolve inconsistencies in information required for their eligibility to receive APTCs and CSRs within the allotted timeframe. This includes verification of immigration status, income, identity or incarceration. A member will be required to submit supporting documentation if the information attested to by the member at the time of enrollment conflicts with or is unable to be verified by approved electronic sources. A member with an open or active verification will have 90 days to provide the requested documentation to maintain their benefits. This impacts Covered CT members because program eligibility is dependent upon eligibility for and full application of APTCs and CSRs. As of December 31, 2024, 182 out of 42,305 Covered CT members failed the verification process and lost eligibility for Covered CT.

Dental

The dental benefit was instituted in July 2022 and is administered by BeneCare Dental Plans. In addition to administering the dental benefit, BeneCare also manages the distribution of the member welcome packets for the dental and non-emergency medical transportation (NEMT) benefits and continues to support reporting for the Covered CT program. During DY3, BeneCare continued support outreach and engagement efforts and a dashboard on dental program metrics for the Covered CT dental program. During DY3, utilization of the dental benefit remained strong throughout, increasing 87% over DY3. Utilization of dental services in DY3 was highest for exams, endodontics and restorative care. During 2024, 150 denials for services were issued and 5 were overturned through the appeals process. Denials and appeals included denial of coverage for mouth guards, replacement dentures, dentures deemed not medically necessary and crowns.

Non-Emergency Medical Transportation (NEMT)

The NEMT benefit was implemented in July 2022 and at which time Veyo was acquired by MTM and provider services transitioned to MTM from Veyo. Utilization of the benefit has historically been low within the Covered CT program and remained low in DY3 when compared to enrollment, fluctuating slightly month over month; utilization did increase however over DY2. The table below details utilization for Covered CT members who received services in the form of a public transit, sedan, wheelchair accessible vehicle and mileage reimbursement. Utilization of the benefit increased 107% over 2023.

NEMT Utilization January 1, 2024, through December 31, 2024

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
293	365	319	304	283	211	191	225	195	249	257	323

Outreach and Engagement

Access Health CT

During DY3, AHCT provided additional marketing support in the form of press releases, geo-targeted email campaigns and promoted Covered CT at enrollment fairs. In addition, AHCT collaborated with carriers and the UConn Health Provider Network on collateral for patient networks and to support outreach efforts; supported social media coverage and ensured the AHCT homepage content had current program information for consumers as well as a digital toolkit for community partners (AccessHealthCT.com/toolkit/).

During AHCT's Annual Open Enrollment Period, additional campaigns are conducted with targeted messaging to encourage consumers to take action to ensure they remain covered for the upcoming plan year. Individuals whose HUSKY coverage has ended and based on known information may be eligible for Covered CT are included in this activity.

Department of Social Services

DSS launched and continues to support and update a member facing website "Covered CT Program" (CT.gov) that provides information about the program, eligibility requirements, how to enroll, where to get help with enrolling and information about enrollment events. DSS also worked with OHS on various outreach efforts and held a public forum in June 2024 to receive feedback on the progress of the demonstration from stakeholders.

Office of Health Strategy

The Connecticut Office of Health Strategy (OHS) was mandated by the Connecticut General Assembly (CGA) in June 2021 to procure outreach, engagement and navigation services for the Covered Connecticut Demonstration for SFY 2023; this was extended by the Connecticut General Assembly in June 2023 for SFY 2024 and 2025. The OHS community-focused outreach and engagement initiative originally provided ten community and consumer-focused organizations that have deep connections in their respective communities with funds to assist in outreach, education and enrollment in Covered CT. An assessment of outcomes from the initiative has caused the OHS in partnership with DSS, to review the approach and develop a new strategy that combines outreach and engagement through a community-based organization and a targeted marketing campaign that includes messaging designed to reach likely eligible groups utilizing digital, video and traditional media, in multiple languages across varied platforms including social

media. Marketing campaign materials will include advertising and consumer engagement content as well as downloadable posters, flyers, enrollment guides, and other instructional content. At the close of 2024, a firm was engaged and scope with detailed requirements established.

During DY3 outreach activities and events included distributing information at libraries, farmers markets, community health events, neighborhood health clinics, enrollment fairs, barbershops, beauty salons, community events, food pantries and telephone and text campaigns. Through the enrollment assistance offered by the program 134 members were enrolled in Covered CT during 2024.

Other efforts included outreach to the CT Department of Revenue by OHS and DSS to discuss targeted outreach to Connecticut residents that may qualify based upon income reported on tax returns and outreach to representatives for CT Paraeducators to discuss the Covered CT program and eligibility and enrollment.

Emergency situation/disaster

Connecticut has nothing to report for Covered Connecticut for DY3 Q4.

4. Narrative information on implementation for any demonstration with eligibility and coverage policies

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for all beneficiaries in the demonstration, not only those subject to eligibility and coverage policies.)			
AD.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.	X	*AD_1-5*	
1.1.2 Discuss any data trends related to mid-year loss of demonstration eligibility. At a minimum, changes (+ or -) greater than two percent should be described.	X	*AD_6-10*	
1.1.3 Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.	X	*AD_11-13*	
1.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.	X	*AD_14-21*	
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.	X	*AD_22*	
1.1.6 Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.	X	*AD_23-27*	
1.1.7 Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.	X	*AD_28-36*	

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.8 Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.	X	*AD_37-43*	
1.1.9 Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	X	*AD_44*	
AD.Mod_1.2. Implementation update			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1 Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.			The Connecticut General Assembly passed legislation that reduced the FPL under the HUSKY A Medicaid program for parents and caretaker relatives to 133%. The number of members determined eligible for Covered CT on 10/1/2024 was approximately 8,438. DSS identified anyone over income as of October 1, 2024, for HUSKY A Parent/Caretaker relative and moved those eligible, to Transitional Medical Assistance (TMA). Approximately 8,100 members were eligible for TMA and the remainder were eligible for Covered CT or a QHP on the CT health insurance exchange, Access Health CT. At the end of DY3Q4 320 members transitioned to Covered CT. Once the TMA period ends, the members are expected to transition to Covered CT. The Connecticut General Assembly passed legislation to modify Covered CT program requirements and eliminate subsidies for out-of-network utilization (OON). DSS has drafted an 1115 waiver amendment request to support the change. Implementation of the state mandate will not occur until CMS decision regarding the amendment to the Covered CT 1115 waiver is received. The draft amendment was finalized at the end of DY3Q4 and was sent to state leads for review prior to the public comment period. Public comment is planned to commence at the end of April.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_2. State-specific metrics			
AD.Mod_2.1 Metric trends			
2.1.1 Discuss any data trends related to state-specific metrics. Discuss each state-specific metric trend in a separate row. Describe and explain changes (+ or -) greater than two percent.	X		

5. Narrative information on other reporting topics

	Prompt	State has no update to report (place an X)	State response
1.	**Budget neutrality**		
1.1	**Current status and analysis**		
1.1.1	Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the eligibility and coverage policy component is part of a comprehensive demonstration, the state should provide an analysis of the eligibility and coverage policy related budget neutrality and an analysis of budget neutrality as a whole.		The State is working to run and submit budget neutrality reports this quarter. The State will keep CMS informed of its progress if the reports will miss the CMS deadlines. The current submission will include the most current Schedule C submission reflecting data through the quarter ending December 31, 2024. The State observed that the template is including administrative expenses reported in the Schedule C in the Budget Neutrality Test but believes these costs should not be included in the BN test based on STC 39 (including Table 1: Master MEG Chart) and STC 50 (including Table 4: Hypothetical Budget Neutrality Test 1 Covered CT). The State would like to request an updated template with the C Report Grouper worksheet toggle changed to 'MAP Waivers Only' if CMS agrees.
1.2	**Implementation update**		
1.2.1	Describe any anticipated program changes that may impact financial/budget neutrality.	X	

Prompt		State has no update to report (place an X)	State response
2.	**Eligibility and coverage demonstration evaluation update**		
2.1	**Narrative information**		
2.1.1	Provide updates on eligibility and coverage policy evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.		The state contracted with Mercer Government Solutions to conduct the independent evaluation of the Covered Connecticut demonstration in January of 2023. The state continued to meet regularly during DY3 Q4 with the Mercer evaluation team to plan for implementation of the evaluation.
2.1.2	Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		The draft Evaluation Design Plan is complete and was submitted to CMS on June 23, 2023. Comments were received from CMS on November 7, 2023. Connecticut received approval of the Evaluation Design Plan on May 30, 2024.
2.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Monitoring Protocol Due: January 13, 2025 – Submitted; CMS response received. Draft Interim Evaluation Report Due: 31-Dec-2026

	Prompt	State has no update to report (place an X)	State response
3.	**Other eligibility and coverage demonstration reporting**		
3.1	**General reporting requirements**		
3.1.1	Describe whether the state foresees the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	.
3.1.2	Compared to the details outlined in the STCs and the monitoring protocol, describe whether the state has formally requested any changes or whether the state expects to formally request any changes to: 3.1.2.a The schedule for completing and submitting monitoring reports	X	
	3.1.2.b The content or completeness of submitted monitoring reports and or future monitoring reports	X	
3.1.3	Describe whether the state has identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	
3.1.4	Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR 431.428(a)5	X	

	Prompt	State has no update to report (place an X)	State response
3.2	**Post-award public forum**		
3.2.1	If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held indicating any resulting action items or issues. A summary of the post-award public forum should be included here for the period during which the forum was held and in the annual monitoring report.		The annual Public Forum was held on June 4, 2024; attendance included stakeholders from the Connecticut Health Insurance Exchange d.b.a. Access Health CT (AHCT), lead state agencies, insurance carriers, community-based organizations and other state stakeholders. Connecticut did not receive any public comment during the forum or following the meeting via email/mail and no issues or actions were captured during the meeting. The presentation included welcoming remarks from Commissioner Barton Reeves and interim Medicaid Director William Halsey. Program updates and a review of the evaluation design plan and process was the focus of the presentation.

	Prompt	State has no update to report (place an X)	State response
4.	**Notable state achievements and/or innovations**		
4.1	**Narrative information**		
4.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies (1) pursuant to the eligibility and coverage policy hypotheses (or if broader demonstration, then eligibility and coverage policy related) or (2) that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).	X	

*The state should remove all example text from the table prior to submission.

Note: States must prominently display the following notice on any display of measure rates based on NCQA technical specifications for 1115 eligibility and coverage demonstration monitoring metrics:

Measures MSC-AD, FUA-AD, FUM-AD, and IET_AD (metrics AD_38A, AD_39, and AD_40) are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has gr

anted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and

designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."

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