DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 26, 2025

William Halsey
State Medicaid Director
Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Director Halsey:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Monitoring Protocol, submitted on June 23, 2025for Connecticut's section 1115 demonstration, "Covered Connecticut" (Project No: 11-W-00402/1).

The Monitoring Protocol may now be posted to the state's Medicaid website. The state may report the agreed upon measures under the 'State-Specific Metrics' tab of the Monitoring Report Workbook provided via email to the state on June 25, 2025.

We look forward to our continued partnership on the Covered Connecticut section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.06.26 05:36:18 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Maria DiMartino, State Monitoring Lead, Medicaid and CHIP Operations Group

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (AD) (Version 3.0)

State Connecticut

Demonstration Name Covered Connecticut

Table: Eliribility and Coverare Demonstration Planned Metrics - Anv Demonstration (AD)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic*	Data source	Calculation for	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data sources or state-specific definitions, policies, codes, target populations, etc.)**	State plans to phase in reporting (Y/N)	EasdC monitoring report in which metric will be phased in (Format DAQC-e.g., D1/Q3)	Explanation of any phases to phase in reporting over time
EXAMPLE: AD_33 (Do not delete or edit this row)	*EXAMPLE: Preventive care and office visit utilization*	*EXAMPLE: Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period.*	*EXAMPLE: 1.1.7 Access to care*	*EXAMPLE: Claims and encounters and other administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommendad*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Increase	Increase	Y		N		
AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status (i.e., enrolled, but not actively receiving benefits) for noncompliance with demonstration policies as of the last day of the measurement period.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if the state has a suspension policy	n.a.								
AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if the state has a non-eligibility period policy	n.a.								
AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and were not using a state-specific pathway back to coverage.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Increase	Increase	N	Connecticut can only report the MAGI population; the non-MAGI population is not a part of the demonstration.	N		
AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits).	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if the state has a defined re-enrollment or re-instatement pathway	n.a.								
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months, and are not using a state-specific pathway back to coverage.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	n.a.					Covered CT does not disenroll or suspend members from this program.			
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Total number of beneficiaries in the demonstration determined ineligible for Medicaid and disenrolled during the measurement period (separate reasons reported in other indicators), other than at renewal.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	n.a.								
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required if the state disenrolls beneficiaries for failure to provide timely change in circumstance information	Y	1/1/2023-12/31/2023	Decrease	Decrease	Y		N		
AD_9	Beneficiaries determined ineligible for Medicaid after state processes a beneficiary-reported change in circumstance	Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they were determined ineligible after the state processed a change in circumstance, such as income or family household.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	n.a.								
AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Consistent	Consistent	Y		N		
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
AD_12	Enrollment duration, 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment.	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
AD_13	Enrollment duration, 4-6 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment.	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
AD_14	Enrollment duration 7-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 7 or more months (up to 12 months) at the time of disenrollment.	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Increase	Increase	N	Connecticut will report the metric on an annual cadence.	N		
AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Decrease	Decrease	N	Connecticut will report the metric on an annual cadence and will replace the word "Medicaid" with "Demonstration" in metric description.	N		
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Consistent	Consistent	N	Connecticut will report the metric on an annual cadence and will replace the word "Medicaid" with "Demonstration" in metric description.	N		
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	n.a.								
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	n.a.					The Connecticut eligibility system auto-renews existing members during upon enrollment.			
AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	n.a.					All coverage ends on 12/31 of any year, if members have not renewed by 12/31 they will be disenrolled from CCT.			
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	1/1/2023-12/31/2023	Consistent	Consistent	N	Connecticut will report the metric on an annual cadence.	N		
AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
AD_23	Beneficiaries who reached 5% limit	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month.	1.1.5 Cost sharing limit	Administrative records	30 days	Month	Quarterly	Required if the state has cost-sharing or premiums	n.a.								
AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	n.a.								
AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y	1/1/2023-12/31/2023	Decrease	Decrease	Y		N		
AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y	1/1/2023-12/31/2023	Decrease	Decrease	Y		N		
AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period.	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y	1/1/2023-12/31/2023	Consistent with Network Adequacy Requirements	Consistent with Network Adequacy Requirements	Y		N		
AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period.	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	N						N		
AD_31	Specialist provider availability	Number of specialty physician and non-physician medical practitioners enrolled to deliver Medicaid services at the end of the measurement period.	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y	1/1/2023-12/31/2023	Consistent with Network Adequacy Requirements	Consistent with Network Adequacy Requirements	N	"Specialist" means a health care provider who (A) focuses on a specific area of physical, mental or behavioral health or a specific group of patients, and (B) has successfully completed required training and is recognized by	N		
AD_32	Specialist provider active participation	Number of specialty physician and non-physician medical practitioners enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period.	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	N						N		
AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters and other administrative records	90 days	Quarter	Quarterly	Recommended	N								
AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	N								
AD_35	Emergency department utilization, all use	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	Y	1/1/2023-12/31/2023	Consistent	Consistent	Y		N		
AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, than non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, than non-emergency visits should be defined as all visits not categorized as emergent using the method below.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended. Required if the state has copayments for non-emergency use	N								
AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	Y	1/1/2023-12/31/2023	Decrease	Decrease	Y		N		

#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation log	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data sources or state-specific definitions, policies, codes, target populations, etc.)[b]	State plans to phase in reporting (Y/N)	Easdf[c] monitoring report in which metric will be phased in (Format BYQ#: e.g., BY1Q3)	Explanation of any plans to phase in reporting over time
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	1.1.8 Quality of care and health outcomes	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	Y	1/1/2024-12/31/2024	Consistent	Consistent	N	Connecticut can report out in aggregate results for all members surveyed (as identified by CMS) in the Qualified Health Plan PPO population (Silver Plans). CMS creates the member file for the CAHPS survey that is sent to the Vendor, which contains those members CMS has selected for the survey. This information is blinded to Carriers, as such, Carriers are unable to drill-down into the Covered CT population alone.	N		
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N								
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 3488; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: 1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	1/1/2024-12/31/2024	Consistent	Consistent	Y		N		
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 3489; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace AD-39-2 with CMIT-265 (FUM). Baseline data for MY 2023 is not available for the HEDIS measures for this population; Connecticut requests an adjustment to baseline year reporting for HEDIS measures to 1/1/2024-12/31/2024.	N		
AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	1.1.8 Quality of care and health outcomes	Claims and encounters or EHR	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace CMS required metric AD-40 with QRS 0004: Initiation and engagement of SUD Treatment (IET). Baseline data for MY 2023 is not available for the HEDIS measures for this population; Connecticut requests an adjustment to baseline year reporting for HEDIS measures to 1/1/2024-12/31/2024. The age band that will be reported for this measure is 18-64 and 65+.	N		
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace CMS required metric AD-41 with QRS 0575: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following level during the measurement year: • Glycemic Status >9.0%.	N		
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace CMS required metric AD-42 with CMIT-40-AMR. The percentage of members 19 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Baseline data for MY 2023 is not available for the HEDIS measures for this population; Connecticut requests an adjustment to baseline year reporting for HEDIS	N		
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace CMS required metric AD-43 with CMIT- 167: Controlling High Blood Pressure (CBP-AD). Baseline data for MY 2023 is not available for the HEDIS measures for this population; Connecticut requests an adjustment to baseline year reporting for HEDIS measures to 1/1/2024-12/31/2024.	N		
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N	1/1/2024-12/31/2024			N	Detailed below in "State Specific Metrics." Connecticut requests to replace CMS required metrics AD-42 and AD-44 with CMIT-40-AMR. Baseline data for MY 2023 is not available for the HEDIS measures for this population; Connecticut requests an adjustment to baseline year reporting for HEDIS measures to 1/1/2024-12/31/2024.	N		
AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, healthy behavior incentives, premium assistance, and/or retroactive eligibility waivers.	1.1.9 Administrative cost	Administrative records	None	Demonstration year	Annually	Recommended	N				N				
State-specific metrics																	
		[Insert row(s) for any additional state-specific metrics by right-clicking on row 58 and selecting "Insert"]															
	Initiation and engagement of SUD Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.	Two rates are reported: • Initiation of SUD Treatment. The percentage of SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation visit	1.1.8 Quality of care and health outcomes	Administrative records	90 days							Consistent			N		
QRS-0004-NCQA						Calendar year	Annually		Y	1/1/2024-12/31/2024	Consistent						
QRS 0575-NCQA	Hemoglobin A1c [HbA1c] Control for Patient with Diabetes: HbA1c poor control (>9.0%)*	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following level during the measurement year: • Glycemic Status >9.0%.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days				Y	1/1/2024-12/31/2024	Decrease	Decrease			N		
						Calendar year	Annually										
CMIT_80/NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	The percentage of members 19 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	1.1.8 Quality of care and health outcomes	Administrative records	90 days				Y	1/1/2024-12/31/2024	Consistent	Consistent			N		
						Calendar year	Annually										
CMIT_167/NCQA	Controlling High Blood Pressure (CBP-AD)	The percentage of adult patients (aged 18-85) diagnosed with hypertension who have adequately controlled blood pressure (defined as less than 140/90 mmHg) during the measurement period,	1.1.8 Quality of care and health outcomes	Administrative, hybrid, or EHR	90 days				Y	1/1/2024-12/31/2024	Consistent	Consistent			N		
						Calendar year	Annually										
															N		
CMIT_265	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and healt	Administrative, hybrid	90 days	Calendar year	Annually		Y	1/1/2024-12/31/2024	Consistent	Consistent			N		

[a] The reporting topics correspond to the prompts for the any demonstration (AD) reporting topic in Section 4 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (PR) (Version 2.0)
State [Enter State Name]
Demonstration Name [Enter Demonstration Name]

Table: Eligibility and Coverage Demonstration Planned Metrics - Premiums and Account Payments (PR)

Standard information on CMS-provided metrics									Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporter ting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data sources or state-specific definitions, policies, codes, target populations, etc.)[b]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DYnQn; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: PR_21 (Do not delete or edit this row)	*EXAMPLE: Third-party premium payment*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.*	*EXAMPLE: PR.Med_1: Eligibility and payment amounts*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	n.a.								
PR_2	Beneficiaries who were exempt from premiums for that month	Among beneficiaries enrolled in the demonstration who were subject to the premium (or account contribution) policy on the basis of income or eligibility group, the count of those exempt from owing premiums or other monthly payments, and therefore not required to make payments. For example, demonstration policies may exempt beneficiaries who would otherwise be subject to premiums as incentives for healthy behaviors or other activities.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	n.a.								
PR_3	Beneficiaries who paid a premium during the month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid this month.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	n.a.								
PR_4	Beneficiaries who were subject to premium policy but decline hardship for that month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who were able to claim temporary hardship and were therefore not required to make a payment in the measurement period.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required if the state allows beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship	n.a.								
PR_5	Beneficiaries in short-term arrears (grace period)	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, the number of those who did not pay in the measurement period, but had not yet exceeded their grace period (i.e., allowable period of noncompliance).	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period	n.a.								
PR_6	Beneficiaries in long-term arrears	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who did not pay this month, and who remain enrolled even though they had exceeded the grace period, i.e., allowable period of noncompliance.	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period and allows continued enrollment for any income and eligibility groups otherwise subject to premiums once the grace period has been exceeded	n.a.								
PR_7	Beneficiaries with collectible debt	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), number of beneficiaries who had collectible debt.	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required	n.a.								
PR_8	Beneficiaries in enrollment duration tier 1	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 1 – the shortest enrollment duration, during which beneficiaries are subject to the first set of program rules and requirements. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	n.a.								
PR_9	Beneficiaries in enrollment duration tier 2	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 2 - the enrollment duration that follows tier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	n.a.								
PR_10	Beneficiaries in enrollment duration tiers 3+	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 3 – the enrollment duration that follows tier 2, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 2. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities. A state with more than three tiers of program rules should calculate additional metrics to report enrollment counts for current enrollees within each additional tier.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	n.a.								
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	Among beneficiaries enrolled in the demonstration who were not in their renewal month, number of beneficiaries for whom the state processed a change in household size or income during the measurement period and who remained enrolled in the demonstration.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_12	No premium change following mid-year processing of a change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments did not change.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_13	Premium increase following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments increased.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_14	Premium decrease following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments decreased.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of the measurement period for failure to pay premiums.	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of termination for failure to pay	n.a.								
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a non-eligibility period policy	n.a.								
PR_17	Beneficiaries whose benefits are suspended for failure to pay	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums.	PR.Med_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay	n.a.								
PR_18	No premium change	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who are redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with no change in premiums or other monthly payments.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_19	Premium increase	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with an increase in required premiums or other monthly payments.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_20	Premium decrease	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remained in income and eligibility groups subject to the demonstration, with a decrease in required premiums or other monthly payments.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	n.a.								
PR_21	Third-party premium payment	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.	PR.Med_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	n.a.								
State-specific metrics																	
[Insert rows(s) for any additional state-specific metrics by right-clicking on row 32 and selecting "Insert"]																	

[a] The reporting topics correspond to the premiums or account payments (PR) reporting topics in Section 3 of the monitoring report template.
[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.
[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (AD) (Version 3.0)

State: Connecticut

Demonstration Name: Covered Connecticut

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Any Demonstration (AD)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	AD_1 - AD_23, AD_33 - AD_44	CMS-provided	N				
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	CMS-provided	N				
Exempt groups	Eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income *EXAMPLE:* *Geographic exemptions, employer sponsored insurance exemptions, exemptions due to medical frailty*	Required for states that allow+K9:P9 beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	N				
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_44	State-specific	Y				

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 3.0)

State: Connecticut
Demonstration Name: Covered Connecticut

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the eligibility and coverage demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the eligibility and coverage demonstration reporting schedule table (Table 2). For each of the reporting categories listed in columns E and F, select Y or N in the "Deviation from standard reporting schedule (Y/N)" column to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category, the state should describe these deviations in the "Explanation for deviations" column and use the "Proposed deviations from standard reporting schedule" column to indicate the measurement periods with which it wishes to overwrite the standard schedule. All other columns are locked for editing and should not be altered by the state.

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates AD
Dates of first demonstration year	
Start date	12/15/2022
End date	12/31/2022
Dates of first quarter of the baseline period for CMS-constructed metrics	
Reporting period (EandC DY and Q) (Format DY#Q#; e.g. DY1Q1)	DY2Q1
Start date	1/1/2023
End date	3/31/2023
Broader section 1115 demonstration reporting period corresponding with the first EandC reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY#Q#; e.g. DY1Q3)	DY2Q1
First monitoring report due date (per STCs) (MM/DD/YYYY)	5/30/2023
First monitoring report in which the state plans to report calendar year (CY) metrics with a 90 day lag	
(Format CY#; e.g. CY2019)	CY2023
with monitoring report (Format DY#Q#; e.g.	DY6Q1
DY and Q start date (MM/DD/YYYY)	1/1/2026
DY and Q end date (MM/DD/YYYY)	3/31/2026
Dates of last reporting quarter:	
Start date	10/1/2027
End date	12/31/2027

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD
1/1/2023	3/31/2023	5/30/2023	DY2Q1	None	Narrative information	DY2Q1	N		
				30 days	Month	DY2Q1	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY2Q4
				None	Quarter	DY2Q1	N		
				90 days	Quarter		N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
4/1/2023	6/30/2023	8/29/2023	DY2Q2	None	Narrative information	DY2Q2	N		
				30 days	Month	DY2Q2	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY2Q4
				None	Quarter	DY2Q2	N		

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD
				90 days	Quarter	DY2Q1	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
7/1/2023	9/30/2023	11/29/2023	DY2Q3	None	Narrative information	DY2Q3	N		
				30 days	Month	DY2Q3	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY2Q4
				None	Quarter	DY2Q3	N		
				90 days	Quarter	DY2Q2	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
10/1/2023	12/31/2023	3/30/2024	DY2Q4	None	Narrative information	DY2Q4	N		
				30 days	Month	DY2Q4	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY2Q4
				None	Quarter	DY2Q4	N		
				90 days	Quarter	DY2Q3	N		
				90 days	Calendar year		N		
				None	Demonstration year	DY2	N		
1/1/2024	3/31/2024	5/30/2024	DY3Q1	None	Narrative information	DY3Q1	N		
				30 days	Month	DY3Q1	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY32Q4
				None	Quarter	DY3Q1	N		
				90 days	Quarter	DY2Q4	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
4/1/2024	6/30/2024	8/29/2024	DY3Q2	None	Narrative information	DY3Q2	N		
				30 days	Month	DY3Q2	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY32Q4
				None	Quarter	DY3Q2	N		
				90 days	Quarter	DY3Q1	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
7/1/2024	9/30/2024	11/29/2024	DY3Q3	None	Narrative information	DY3Q3	N		
				30 days	Month	DY3Q3	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY32Q4
				None	Quarter	DY3Q3	N		
				90 days	Quarter	DY3Q2	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
10/1/2024	12/31/2024	3/31/2025	DY3Q4	None	Narrative information	DY3Q4	N		
				30 days	Month	DY3Q4	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY32Q4
				None	Quarter	DY3Q4	N		
				90 days	Quarter	DY3Q3	N		

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD
				90 days	Calendar year		N		
				None	Demonstration year	DY3	N		
1/1/2025	3/31/2025	5/30/2025	DY4Q1	None	Narrative information	DY4Q1	N		
				30 days	Month	DY4Q1	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY4Q4
				None	Quarter	DY4Q1	N		
				90 days	Quarter	DY3Q4	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
4/1/2025	6/30/2025	8/29/2025	DY4Q2	None	Narrative information	DY4Q2	N		
				30 days	Month	DY4Q2	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY4Q4
				None	Quarter	DY4Q2	N		
				90 days	Quarter	DY4Q1	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
7/1/2025	9/30/2025	11/29/2025	DY4Q3	None	Narrative information	DY4Q3	N		
				30 days	Month	DY4Q3	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY4Q4
				None	Quarter	DY4Q3	N		
				90 days	Quarter	DY4Q2	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
10/1/2025	12/31/2025	3/31/2026	DY4Q4	None	Narrative information	DY4Q4	N		
				30 days	Month	DY4Q4	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY4Q4
				None	Quarter	DY4Q4	N		
				90 days	Quarter	DY4Q3	N		
				90 days	Calendar year		N		
				None	Demonstration year	DY4	N		

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD
1/1/2026	3/31/2026	5/30/2026	DY5Q1	None	Narrative information	DY5Q1	N		
				30 days	Month	DY5Q1	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY5Q4
				None	Quarter	DY5Q1	N		
				90 days	Quarter	DY4Q4	N		
				90 days	Calendar year	CY2023	N		
				None	Demonstration year		N		
4/1/2026	6/30/2026	8/29/2026	DY5Q2	None	Narrative information	DY5Q2	N		
				30 days	Month	DY5Q2	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY5Q4
				None	Quarter	DY5Q2	N		
				90 days	Quarter	DY5Q1	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
7/1/2026	9/30/2026	11/29/2026	DY5Q3	None	Narrative information	DY5Q3	N		
				30 days	Month	DY5Q3	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY5Q4
				None	Quarter	DY5Q3	N		
				90 days	Quarter	DY5Q2	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
10/1/2026	12/31/2026	3/31/2027	DY5Q4	None	Narrative information	DY5Q4	N		
				30 days	Month	DY5Q4	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY5Q4
				None	Quarter	DY5Q4	N		
				90 days	Quarter	DY5Q3	N		
				90 days	Calendar year		N		
				None	Demonstration year	DY5	N		

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD
1/1/2027	3/31/2027	5/30/2027	DY6Q1	None	Narrative information	DY6Q1	N		
				30 days	Month	DY6Q1	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY6Q4
				None	Quarter	DY6Q1	N		
				90 days	Quarter	DY5Q4	N		
				90 days	Calendar year	CY2024	N		
				None	Demonstration year		N		
4/1/2027	6/30/2027	8/29/2027	DY6Q2	None	Narrative information	DY6Q2	N		
				30 days	Month	DY6Q2	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY6Q4
				None	Quarter	DY6Q2	N		
				90 days	Quarter	DY6Q1	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
7/1/2027	9/30/2027	11/29/2027	DY6Q3	None	Narrative information	DY6Q3	N		
				30 days	Month	DY6Q3	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY6Q4
				None	Quarter	DY6Q3	N		
				90 days	Quarter	DY6Q2	N		
				90 days	Calendar year		N		
				None	Demonstration year		N		
10/1/2027	12/31/2027	3/30/2028	DY6Q4	None	Narrative information	DY6Q4	N		
				30 days	Month	DY6Q4	Y	For measure 15, 16, 17, and 21 CT renews annually; data only captured annually.	DY6Q4
				None	Quarter	DY6Q4	N		
				90 days	Quarter	DY6Q3	N		
				90 days	Calendar year		N		
				None	Demonstration year	DY6	N		
[Add rows for all additional demonstration reporting quarters]									

[a] **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. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "EandC reporting schedule tab" should align with the first day of a month. If a state's eligibility and coverage demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "EandC reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.