Covered Connecticut (CoveredCT) 1115 Eligibility and Coverage Demonstration

Demonstration 11-W-00402/1

DY2 Q2 Monitoring Report

April 1, 2023 - June 30, 2023

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 demonstration or eligibility and coverage policy components of the broader demonstration

Overall section 1115 demonstration	
State	Connecticut
Demonstration name	Covered Connecticut
Approval period for section 1115 demonstration	12/15/2022 – 12/31/2027
Reporting Period	DY2Q2: 4/01/2023-6/30/2023
Marketplace-focused premium assistance program	
Marketplace-focused premium assistance program start date	7/1/2021
Implementation date if different from Marketplace-focused premium assistance program start date	12/15/2022

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**.**

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

Covered CT DY2 Q2 began on April 1, 2023 and coincided with the restart of Connecticut's redetermination process for Medicaid that was halted because of the Covid-19 Public Health Emergency. Monthly on a rolling, first-in first-out basis, Medicaid members will be redetermined for Medicaid eligibility and provided with options for and assistance with health insurance coverage should they no longer qualify for Medicaid. The Connecticut state health insurance exchange has estimated that between 10-15% of the Continuous Medicaid enrollment population and the new limited benefit population will qualify for Qualified Health Plan including the Covered CT program during the unwind period.

In October 2022, the Department of Social Services (DSS) became aware that contracts executed with the insurance carriers by the Office of Health Strategy (OHS), the state agency initially charged with administering the program, contained financial terms tied to program utilization. As part of the contract terms with the Carriers, a fee was negotiated and is paid as a percentage of all Covered CT premiums monthly in addition to the premium payment, to mitigate against risk from induced utilization with health insurance plans that have "0" cost share for members. The financial terms were impacting the program budget and there is limited data at present on Covered CT program utilization that details a full year of experience under the expanded eligibility implemented on July 1, 2022. DSS began discussions with the insurance carriers in May and requested a six-month extension of the contracts and an assignment of the extended contracts to DSS from the carriers for the period of July 1, 2023 through December 31, 2023. The request to extend and assign allows the state to fully manage all aspects of the program while also providing more time for discussions around new contract terms that will commence on January 1, 2024. Contract discussions for the amendments began with each carrier in May 2023 and DSS was able to secure a reduction in the program charge that is consistent with what the data supports and was implemented on July 1, 2023.

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 and in June 2023, the CGA extended this initiative for SFY 2024. The OHS Covered Connecticut outreach and engagement program kicked off in March 2023 and outreach, engagement and enrollment operations accelerated during quarter two with community-based organizations participating in over 124 events statewide. The OHS program reported 1,477 program encounters during quarter two and assisted with enrolling eligible residents in the Covered CT program during this period. In addition, DSS continued to conduct outreach efforts as part of the statewide PHE unwind campaign and also sought other ways to increase awareness including providing content to the State Department of Education for schools to include in their National School Lunch Program about the Covered CT.

3. Narrative information on implementation and operations

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

Connecticut has nothing to report for DY2 Q2.

Fiscal changes

Connecticut has nothing to report for DY2 Q2.

Related audit or investigation activity, including findings

Connecticut has nothing to report for Covered Connecticut for DY2 Q2.

Litigation activity

Connecticut has nothing to report for Covered Connecticut for DY2 Q2.

Appeals

Connecticut has nothing to report for Covered Connecticut for DY2 Q2.

Changes in key state personnel or organizational structure

Connecticut has nothing to report for Covered Connecticut for DY2 Q2.

Status and/or timely milestones for health plan contracts

The health plan contracts with the insurance carriers that supported the Covered CT program were owned and administered by the Connecticut Office of Health Strategy (OHS) until June 30, 2023 at which point the Department of Social Services (DSS) would need to have new contracts in place for July 1, 2023. DSS and the OHS requested of the Carriers a six-month extension of the contracts held with OHS and an assignment of the contracts to the DSS for the period of July 1, 2023 through December 31, 2023. The internal DSS team, in preparation for the contract amendment discussions, met bi-monthly to discuss and reach consensus on new contract terms, developed a detailed schedule for the end-to-end process and drafted an amendment to the master contract in preparation for Carrier review. Contract discussions with each Carrier began in May 2023 and the amendments, assignments and extensions were executed on-time for a July 1, 2023 start date. DSS also met with the Carriers in June to discuss the implementation of the amendments to

ensure a seamless transition from OHS to DSS including identifying and addressing any issues or barriers related to financial operations and reporting. DSS also began monthly oversight meetings with the Carriers June. DSS will meet with each Carrier monthly for the duration of the contract to ensure collaborative management of the program and to bring to resolution any issue raised by either party during the course of normal program operation.

DSS began preparing for the negotiation and execution of new contracts that will begin on January 1, 2024 including bi-monthly internal meetings to discuss and reach consensus on new contract terms, preparing a draft master contract for carrier review following negotiation discussions and developing a detailed schedule for the end-to-end process which will commence in July 2023.

Enrollment

Enrollment in Covered CT increased an average of 4% month over month during quarter two compared to quarter one of 2023 during which enrollment grew an average of 1% month over month.

Demonstration Year and Quarter	April	May	June
DY2 Q2	16,244	16,993	17,723

Connecticut Health Insurance Exchange, Access Health CT (AHCT)

As a result of the end of the PHE, AHCT resumed the existing verification processing in April, 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. Members with outstanding verification requests due prior to May 1, 2023, have had their due dates extended. 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 June 30, 2023, 408 Covered CT households failed the verification process and lost eligibility for Covered CT.

AHCT continued to support weekly reporting during DY2 Q2, 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 and Covered CT Executive Committee meetings, offering subject matter expertise and further strengthening the partnership through the continued engagement.

Dental

The dental benefit was implemented utilizing existing system infrastructure and there was no report of any member issues related to enrollment or services in DY2 Q2.

BeneCare continues to support a dashboard for the Covered CT dental program that provides reporting on utilization monthly. Utilization of the dental benefit was slow to build in the initial months of the benefit roll-out to Covered CT members but rose steadily in the last quarter of 2022 and has remained strong in the first two quarters of 2023. Utilization of dental services has been highest for exams, preventive care and restorative care.

Non-Emergency Medical Transportation (NEMT)

The NEMT benefit was implemented in July 2022 utilizing existing system infrastructure and is administered by MTM/VEYO. Utilization of the benefit for DY2 Q2 increased by 247% over the last quarter.

Reports of member issues accessing the benefit during DY2 Q2 has been low with only one reported incident. A member seeking transportation was told they were not enrolled in the benefit under Covered CT after receiving confirmation that they were enrolled in the program. After further investigation, it was determined the Medicaid member was only granted temporary eligibility (Active 1/30/23 to 2/8/23) for an emergency hospital stay due to undocumented immigration status. Since then, the individual has received Resident Alien status and was referred to a Qualified Health Plan.

Outreach and Engagement

The Connecticut Office of Health Strategy (OHS) as noted above, 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 and extended by the CGA in June 2023 for state fiscal year 2024. The OHS Covered Connecticut outreach and engagement program which kicked off in March 2023, provides ten community and consumer focused organizations that have deep connections in their respective communities, with funds to assist in outreach, education and enrollment in CoveredCT.

During DY2 Q2 outreach activities and events included:

- participating in community wellness events;
- participating in orientation events at colleges and universities;
- distributing flyers at food pantries;
- hosting tables at local festivals to provide information;
- participating in meet and greets at schools;
- participating in Chamber of Commerce events; and
- host tables at job fairs.

Through the enrollment assistance offered by the program 77 members were enrolled in Covered CT, 77 were enrolled in a QHP and 1714 were enrolled in HUSKY Health/Medicaid for the period of April 1, 2023 through June 30, 2023

Emergency situation/disaster

Connecticut has nothing to report for Covered Connecticut for DY2 Q2.

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 <u>all beneficiaries in the demonstration</u>, 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			
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, through SB 978, proposed expanding eligibility for CoveredCT up to 200% FPL beginning in SFY 2024 and would require the Commissioner of Social Services to (1) amend the Medicaid 1115 Covered Connecticut waiver to expand health care coverage to persons whose earnings do not exceed two hundred per cent of the federal poverty level, and (2) develop a second tier of such program to cover persons whose earnings are between two hundred per cent and three hundred per cent of the federal poverty level. The SFY 2024/2025 Appropriations Committee recommended budget also included funding to expand CoveredCT to 200% FPL with no cost sharing. The Connecticut General Assembly did not expand eligibility for Covered CT in June 2023.

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 State is anticipating future prior period adjustments associated with the reporting quarter. The current submission will be based on the original BN template provided by CMS in February 2023. The State would like to request an updated template reflecting the recent Technical Correction update completed in April 2023 with respect to the CAP target percentages once available.
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 a vendor to conduct the independent evaluation of the Covered Connecticut demonstration in January of 2023. The evaluation vendor provided a timeline that provided ample time for development and review prior to submission. The state continued to meet regularly during DY2 Q2 to discuss and provide input and feedback into the driver diagram and evaluation measures.
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 was submitted to CMS on June 23, 2023.
2.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Draft evaluation Design Plan Due: June 23, 2023

	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.	X	The first public forum for Covered Connecticut was held June 12, 2023. Participation was broad and included DSS, OHS, AHCT, the insurance carriers and members of the public. The agenda included a brief history and overview of the Covered CT program, operational updates and public comment. The state only received one public comment in the form of a question regarding applying for benefits Meeting minutes, public comment and responses to public comment were posted to the Covered CT Demonstration page on Ct.gov.

	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."

Limited proprietary coding is contained in the measure specifications and HEDIS VS for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications and HEDIS VS.

The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications and HEDIS VS.

The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure specifications and HEDIS VS. The UB Codes are included with the permission of the AHA. Anyone desiring to use the UB Codes in a commercial product to calculate measure results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.