# Covered Connecticut (CoveredCT) 1115 Eligibility and Coverage Demonstration

**Demonstration 11-W-00402/1**

**DY2 Q3 Monitoring Report**

**Jul 1, 2023 - September 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** | |

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

DY2 Q3 began on July 1, 2023, during which time Connecticut's Public Health Emergency unwind and redetermination process for Medicaid, halted during the PHE, continued. Monthly on a rolling, first-in first-out basis, Connecticut Medicaid members are 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 a Qualified Health Plan including the Covered CT program during the unwind period. Enrollment in Covered CT increased an average of 5% month over month during quarter three.

During DY2 Q3, DSS focused on implementing carrier contract supports for the contract amendments assigned to DSS and extended until December 31, 2023. The state met with both carriers to discuss and implement processes for submission and payment of invoices, reporting requirements and processes for oversight and issue mitigation. The state will continue monthly oversight meetings with each carrier for the duration of the contract.

DSS also prepared for new contracts with the insurance carriers which will be implemented in 2024, meeting with both carriers to discuss terms and reach consensus. A decision was made in September that more time was needed to finalize the terms and DSS requested of each carrier an extension of the amendments that are currently in place until December 31, 2023 to February 29, 2024. The amendment extensions are in process and should be final and executed by the end of November.

DSS continued to meet with state partners monthly to provide updates on program progress, to ensure continued collaboration and to address and mitigate any decision, risk or issue related to Covered CT that state partners need to be aware of or included in with respect to solution/resolution.

## 3. Narrative information on implementation and operations

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

Connecticut has nothing to report for DY2 Q3.

**Fiscal changes**

Connecticut was able to secure a reduction in the program fee that is charged as a percentage of all Covered CT premiums; the reduced program charge became effective on July 1, 2023.

In June, health insurance carriers that provide coverage for Covered CT members, filed annual rate increase requests with the state of Connecticut. The Connecticut Department of Insurance approved increases in August that will take effect on January 21, 2024. Health insurance carriers that serve members of the Covered CT program received the following rate increases: Anthem Health Plans – 5.6%; Connecticare Benefits, Inc. - 10.3%; and ConnectiCare Insurance Company – 15.3%.

**Related audit or investigation activity, including findings**

Connecticut has nothing to report for Covered Connecticut for DY2 Q3.

**Litigation activity**

Connecticut has nothing to report for Covered Connecticut for DY2 Q3.

**Appeals**

Connecticut has nothing to report for Covered Connecticut for DY2 Q3.

**Changes in key state personnel or organizational structure**

Connecticut has nothing to report for Covered Connecticut for DY2 Q3.

**Status and/or timely milestones for health plan contracts**

The amendments to the health plan contracts with the insurance carriers that support the Covered CT program were implemented on July 1, 2023 for a period of six months. The internal DSS team, simultaneously, during quarter two, prepared for negotiations on new contract terms that were originally planned to be effective on January 1, 2024. DSS met several times during July and August to discuss and reach consensus on new contract terms, developed a detailed schedule for the end-to-end process and drafted a master contract in preparation for Carrier review. Contract discussions with each Carrier on the new contracts were delayed and meetings to discuss new terms were held in August and September. DSS, recognizing that there was impact to the schedule to execute the new contracts on time for a January 1, 2024 implementation, requested an extension on the amendments currently in place of an additional two-months; new contracts will be executed for a March 1, 2024 implementation. New contract terms are scheduled to be finalized in November and then routed through state processes for execution.

## Enrollment

Enrollment in Covered CT increased an average of 5% month over month during quarter three compared to quarter one of 2023 during which enrollment grew an average of 1% month over month and slightly higher than quarter two which saw an average of 4% growth month over month.

| Demonstration Year and Quarter | July | August | September |
|---|---|---|---|
| **DY2 Q3** | 18,193 | 19,948 | 20,321 |

## Connecticut Health Insurance Exchange, Access Health CT (AHCT)

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 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 (except for losing coverage because they failed to complete the manual Medicaid renewal) and newly eligible for Covered CT. This change will be performed for both online and batch flows. The auto-enrollment feature will be implemented in October of 2023.

AHCT continued to support weekly reporting during DY2 Q3, 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 Q3.

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 and has continued to increase steadily quarter over quarter. Utilization of dental services remains 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. Utilization of the benefit for DY2 Q3 increased by 247% over the last quarter. There was no report of any member issues related to enrollment or services in DY2 Q3.

**Outreach and Engagement**

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 state fiscal year 2024. The OHS Covered Connecticut outreach and engagement program kicked off in March 2023 and provides ten community and consumer focused organizations with deep connections in their respective communities, funds to assist in outreach, education and enrollment in CoveredCT.

During DY2 Q3 outreach activities and events included:

- Participated in local school meet and greets with parents and staff
- Presentation at public libraries on CoveredCT and enrollment
- Connected with congregants at local temples and churches in targeted communities
- Participated in Chamber of Commerce events
- Shared materials at food distributions sites in local communities

- Distributed materials to attendees at Alianza Hispana in New London
- Participated at the Hamden Pride Festival
- Shared information at Central Connecticut State University
- Provided flyers to participants of food pantries in Preston, Colchester, Norwich, Meriden and Griswold
- Offered information at food truck firework event in Waterbury
- Presented on Covered CT to Hispanic audience in Hartford
- Held a Facebook live on health insurance, enrollment and covered CT
- Tabled at the New London, Meriden and Waterbury libraries to provide information to attendees
- Shared flyers with participants of the Greenwich Farmer's Market
- Participated at the Community Fun and Fitness event in New Haven
- Connected with Stamford Health Department to share information with families scheduled for physicals
- Met with state agencies to strategize how to engage paraeducators
- Participated in National Night Out Event in Norwich, Stamford and Windsor
- Shared materials at Family Wellness Center Opening Activities in Hartford
- Offered materials to CNA uninsured staff at different nursing homes in Waterbury
- Tabled at Mount Aery Churches in Bridgeport to share material with attendees
- Offered information at the Human Services Department in Meriden
- Tabled at libraries in Torrington, Cheshire, Prospect, Waterbury and Bridgeport

Through the enrollment assistance offered by the program 148 members were enrolled in Covered CT during the quarter.

**Emergency situation/disaster**

Connecticut has nothing to report for Covered Connecticut for DY2 Q3.

## 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. | | | ConnectiCare has two separate corporate entities that are licensed in Connecticut and offering plans through the Connecticut Health Insurance Exchange dba Access Health CT (AHCT), ConnectiCare Benefits Inc. (CBI) and ConnectiCare Insurance Company Inc. (CICI). Both CBI and CICI offer Silver metal level plans through AHCT which are used by enrollees in the Covered CT program. During the DSS/Connecticare Covered CT monthly oversight meeting in August, Connecticare updated that they are modifying the current provider network for CICI plans from the FLEX network to a new Value network, and reclassifying Yale, Stamford and Greenwich health systems and others as out of network for PY 2024. The risk to the program is the potential for Covered CT members to use a provider that would be classified as out of network which would have the effect of increased program costs due to the increased out of pocket limit for out of network providers and increased cost-sharing for services with an out of network provider. The CICI Silver plan offerings for the 87% AV plan and the 94% AV plan that is offered to Covered CT members at time of enrollment have an annual out of pocket max for out of network providers that is $18,200 for an individual and $36,400 for a family compared to $950/$1900 for in network. The plan network for CBI plans is the CHOICE network for 2024, and this network includes the Yale, Stamford and Greenwich health systems. AHCT discussed solutions with ConnectiCare for PY 2024 autorenewals and a decision was made to allow all Covered CT members enrolled in the CICI Silver plans to be cross-walked to the CBI Silver plans during the Open Enrollment period at the end of this calendar year. Members will be noticed and will have the opportunity to update their preferred carrier if they so choose during the Open Enrollment period. The |

| Prompt | State has no trends/update to report (place an X) | Related metric(s) (if any) | State response |
|---|---|---|---|
| | | | Connecticut Insurance Department (CID) conducts an annual provider network adequacy review in April and if the CID finds the provider network is insufficient the carriers may be required to treat out of network providers as in network for member cost-sharing. |

| 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 be based on the revised BN template provided by CMS in October 2023. 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 a vendor to conduct the independent evaluation of the Covered Connecticut demonstration in January of 2023. The state continued to meet regularly during DY2 Q3 with our evaluation team to discuss and plan for inputs into 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. |
| 2.1.3 | List anticipated evaluation-related deliverables related to this demonstration and their due dates. | | State response to CMS comments on the Draft Evaluation Design Plan Due: January 14, 2024 |

| | 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:<br>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 | |

| | 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*

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