Covered Connecticut (CoveredCT) 1115 Eligibility and Coverage Demonstration

Demonstration 11-W-00402/1

DY2 Q4/Annual Monitoring Report

October 1, 2023 – December 31, 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	DY2Q4/Annual: 10/01/2023-12/31/2023
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 Q4 began on October 1, 2023, during which time Connecticut's Public Health Emergency unwind and redetermination process for Medicaid, halted during the PHE, continued. The Connecticut state health insurance exchange estimated that between 10-15% of the Continuous Medicaid enrollment population and the new limited benefit population would be eligible for a Qualified Health Plan including the Covered CT program during the unwind period. Covered CT enrollment increased an average of 8% month over month during DY2 Q4 and increased an average 25% over the prior quarter. From January to December, enrollment increased 64%.

During DY2, DSS focused on executing new contracts with the insurance carriers that support the covered CT program and on executing and implementing carrier supports for contract amendments assigned to DSS by the Office of Health Strategy. DSS executed amendments to the original OHS contracts on July 1, 2023; these expired on December 31, 2023. DSS, during DY2Q4 extended the amendments until February 29, 2024 to allow for additional time to reach consensus on terms for new contracts to be executed wholly by DSS. During DY2, the state met with both carriers regularly to discuss and implement processes for submission and payment of invoices, reporting requirements and processes for oversight and issue mitigation. The state initiated monthly oversight meetings during Q3 with each carrier and these continued through Q4.

DSS continued to meet with state partners monthly during DY2 at partner team meetings and executive committee meetings to provide updates on program progress, ensure continued collaboration and to address and mitigate any decision, risk or issue related to Covered CT. Collaboration with state partners also included updates to the CT eligibility system to support content and application flow changes to ensure clarity for the member during the eligibility and application process and to support an auto-enrollment feature for Covered CT during the application workflow; Phase I of the auto-enrollment feature was implemented in October 2024. DSS continued to collaborate and support outreach and engagement efforts led by OHS, meeting with OHS state partners monthly, participating in outreach and engagement efforts led by OHS and providing program information for outreach initiatives. During DY2 Q4 DSS met with OHS and Paraeducators to discuss the Covered CT program and answer questions related to eligibility and enrollment.

3. Narrative information on implementation and operations

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

Connecticut has nothing to report for DY2 Q4.

Fiscal changes

Connecticut has nothing to report for DY2 Q4.

Related audit or investigation activity, including findings

Connecticut has nothing to report for Covered Connecticut for DY2 Q4.

Litigation activity

Connecticut has nothing to report for Covered Connecticut for DY2 Q4.

Appeals

Connecticut has nothing to report for Covered Connecticut for DY2 Q4.

Changes in key state personnel or organizational structure

Connecticut has nothing to report for Covered Connecticut for DY2 Q4.

Status and/or timely milestones for health plan contracts

The contract amendments with the insurance carriers that support the Covered CT program, implemented on July 1, 2023 for a period of six months, were extended in October for an additional two-months with an end date of February 29, 2024. The extension allows for additional time to reach consensus for new contracts. Negotiations on new contract terms continued through December and are scheduled to be finalized in early 2024 and then routed through state processes for execution.

Enrollment

Commented [MJ1]: @Bjornberg, Jacob can you update for December and pull in the way CMS wants us to report as we did for the Legislative Report in December 😊 Thank You!!

Commented [BJ2R1]: Updated

Enrollment in Covered CT increased an average of 8% month over month during quarter four compared to quarter one of 2023 during which enrollment grew an average of 1% month over month and slightly higher than quarter two and three which saw an average of 4% growth month over month

Enrollment	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
PHE Unwind Enrollment				253	349	422	732	514	384	414	359	372
Non-Unwind Enrollment	15,519	15,766	15,906	15,991	16,644	17,610	18,181	19,334	19,937	20,989	20,943	25,170
Total Enrollment	**15,519**	**15,766**	**15,906**	**16,244**	**16,993**	**18,032**	**18,913**	**19,948**	**20,321**	**21,403**	**21,302**	**25,542**

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 is newly

eligible for Covered CT and opts-in to Covered CT auto-enrollment, they will be auto-enrolled into their pre-selected Covered CT plan if they are losing HUSKY coverage (unless they are losing coverage because they failed to complete the manual Medicaid renewal). This change will be performed for both online and batch flows. Phase I of the auto-enrollment feature was implemented in October 2023. Phase II of the auto-enrollment is targeted for February 2024 and will expand the auto-enrollment process to non-Medicaid individuals that are newly eligible for Covered CT.

As a result of the end of the PHE, AHCT resumed the existing verification processing which takes action for members on the exchange that have not provided supporting documentation needed to resolve inconsistencies in information required for their eligibility to receive APTCs and CSRs within the allotted timeframe. This includes verification of immigration status, income, identity or incarceration. A member will be required to submit supporting documentation if the information attested to by the member at the time of enrollment conflicts with or is unable to be verified by approved electronic sources. 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 November 30, 2023, 173 out of 21,302 Covered CT members failed the verification process and lost eligibility for Covered CT.

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

AHCT continued to support weekly reporting during the latter half of 2023, providing information on enrollment stratified by age, gender, zip code and income level. This information is shared with our state partners involved in outreach and engagement efforts, utilized for internal planning and utilized for reporting to the state legislature. Representatives from AHCT continued to participate in monthly Covered CT team meetings, Covered CT Executive Committee meetings and Covered CT reporting meetings, offering subject matter expertise and further strengthening the partnership through their continued engagement.

Dental

The dental benefit was instituted in July 2022 and is administered by BeneCare Dental Plans. BeneCare remains a great partner and strong supporter of the Covered CT program. BeneCare administers the dental benefit and manages the distribution of the member welcome packets for the dental and non-emergency medical transportation (NEMT) benefits for the Covered CT program for DSS. Prior to the roll-out of the dental benefit, BeneCare worked with the State of Connecticut and other state partners to ensure members were able to access services beginning July 1, 2022, when expanded benefits were implemented. BeneCare was able to produce and mail member "Welcome Packets," including member ID cards and program information for the Covered CT dental and NEMT programs. These packets are mailed to members upon enrollment. BeneCare has been responsive to requests made by DSS to update the member welcome packet to provide more detail on the transportation benefit following program expansion.

BeneCare continues to support a dashboard for the Covered CT dental program that details utilization monthly. Utilization of the dental benefit was slow to build in the initial months of the roll-out under Covered CT but rose steadily in the last quarter of 2022 and has remained strong throughout 2023. 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 the first seven months of DY2 increased steadily averaging a 76% increase month over month from January to July. Data for the latter half of 2023 is not available due to the recent transition in ownership of the NEMT vendor and the transition of analytics and reporting as a result; DSS will retrospectively report this information as soon as the data is available There was no report of any member issues related to enrollment or services in DY2 Q4.

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 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 Q4 outreach activities and events included: Distributing information at libraries, farmers markets, community health events, neighborhood health clinics, enrollment fairs, barbershops, and food pantries. Provided information at a Breast Cancer Awareness Event, Waterbury Public Schools Community Resource Fair, and distributed flyers at a Parent Teacher Conference in New Haven.

Through the enrollment assistance offered by the program 341 members were enrolled in Covered CT during the quarter and 545 members in total for 2023.

Emergency situation/disaster

Connecticut has nothing to report for Covered Connecticut for DY2 Q4.

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for <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.	X		Implemented auto-enrollment for members to opt-in to or decline Covered CT auto enrollment and Covered CT plan selections during the subsidized application flow. If the consumer is newly eligible for Covered CT and opts-in to Covered CT auto-enrollment, they will be auto-enrolled into their pre-selected Covered CT plan if they are losing HUSKY coverage (unless they are losing coverage because they failed to complete the manual Medicaid renewal).

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

5. Narrative information on other reporting topics

	Prompt	State has no update to report (place an X)	State response
1.	**Budget neutrality**		
1.1	**Current status and analysis**		
1.1.1	Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the eligibility and coverage policy component is part of a comprehensive demonstration, the state should provide an analysis of the eligibility and coverage policy related budget neutrality and an analysis of budget neutrality as a whole.		The State is working to run and submit budget neutrality reports this quarter. The State will keep CMS informed of its progress if the reports will miss the CMS deadlines. The current submission will include the most current Schedule C submission reflecting data through the quarter ending December 31, 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 Q4 with our evaluation team to address responses to CMS feedback and 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: 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 annual Public Forum has been scheduled for June 4, 2024.

	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:

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

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

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

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