MAPOC Meeting

October 2023
Agenda

• Maternity Bundle
• Nursing Homes
• PHE Unwinding
• 1115 Waivers
Maternity Bundle
Nursing Homes
Nursing Homes 101

Overview

- 202 nursing homes in CT of which 195 participate in Medicaid; total licensed capacity 22,787 beds
- Range from 25 to 360 licensed beds

Two main state roles

1. Medicaid financing *(DSS primarily)*
   - 2020: 72.6% of CT nursing home residents paid by Medicaid; average daily rate (including applied income) = $280 (~$100k per year)
   - FY 2022: CT Medicaid spent a total of $1.12 billion (state + federal) on nursing home care *[state share = $490m]*

   - Medicaid also covers alternatives to nursing home care (“home and community-based services”). FY 2022: CT Medicaid spent $950 million on home and community-based alternatives to nursing home care *[state share = $390m]*

2. Regulating *(DPH primarily)*
   - DPH protects the health and safety of nursing home residents by inspecting and licensing
CT Medicaid Nursing Home Financing – process

CT Medicaid sets per-home per diem rates using a “cost-based” methodology
- Homes submit cost reports, categorizing their costs into 5 buckets
- When CT Medicaid rebases, a home’s reimbursement is based on its allowable costs in those 5 buckets, with bucket-specific ceilings
- Federally, nursing home reimbursement must recognize the "cost" of the setting. States can incorporate into the rate adjustments for goals of the Medicaid program such as quality or acuity through the state plan process.

High level overview

Regulatory language

- [Section 1903(a)(7) of the federal Social Security Act]: Requires Medicaid reimbursement to be “economic and efficient” and in accordance with patient care
- [C.G.S. 17b-340]: DSS Commissioner is authorized to use nursing facility cost reports to determine Medicaid rates

Highest level overview

1. Nursing homes incur costs
2. Nursing homes submit cost reports to DSS
3. When rebasing, DSS identifies “allowable” costs
4. DSS sets a per resident per day rate based on these reports using formula
Summary of payments

**Summary:**
- In 2019, 42 states adjusted payments based on resident acuity or case-mix (source). In 2022, CT joined that group.
- Acuity-based reimbursement uses federal Minimum Data Set (MDS) on nursing home residents’ care needs to calculate and update the direct care component of the rate quarterly.

**Status:** Live as of July 1, 2022. Phased roll-out

**Policy rationale:** 2 main rationales – see below

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**1. Gives homes financial incentives to serve our highest needs residents**

a. Enables CT to pay homes based on the complexity of their residents’ care needs

b. Ensures that homes that serve a disproportionately high share of high needs residents are compensated accordingly

c. Ensures that, as homes serve higher needs residents, their reimbursement rates quickly adjust to match their resident pool

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**2. Be a good fiscal steward**

a. Ensures that Medicaid dollars are flowing to homes based on the level of needs of Medicaid residents

b. Encourages nursing homes to further support rebalancing between institutional and home and community-based services by lowering payments to homes for lower acuity individuals
## Acuity: phase-in and next steps

<table>
<thead>
<tr>
<th>Selected Parameters</th>
<th>SFY 2023</th>
<th>SFY 2024</th>
<th>SFY 2025</th>
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</thead>
<tbody>
<tr>
<td>Cost report year</td>
<td>2019</td>
<td>2019</td>
<td>2019</td>
</tr>
<tr>
<td>Case mix neutrality limit</td>
<td>0.75%</td>
<td>1.51%</td>
<td>2.27%</td>
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<tr>
<td>Stop gain</td>
<td>$6.50</td>
<td>$20</td>
<td>None</td>
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<tr>
<td>Stop loss</td>
<td>$0</td>
<td>$5</td>
<td>None</td>
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</table>
# Summary of selected nursing-home related legislative activity, from last session

<table>
<thead>
<tr>
<th>Statutory Reference</th>
<th>Title of Report</th>
<th>Summary of Report</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1). PA 23-204 Sec. 275</td>
<td>Quality Metrics</td>
<td>Develop individualized reports annually to each nursing home facility showing the impact to the Medicaid rate for such home based on the quality metrics program. Reports to assist homes in evaluating impact of the quality metrics program facility’s rate. Final report to include information on the individualized reports and the anticipated impact on nursing home rates if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics</td>
<td>6/30/25</td>
<td>On Time / In Process</td>
</tr>
<tr>
<td>(2). PA 23-204 Sec. 298</td>
<td>Excess Licensed Bed Capacity</td>
<td>10-member work group to review and evaluate excess licensed bed capacity at skilled nursing facilities; Report to each individual nursing home the implications of the working group’s findings and recommendations on the nursing home’s Medicaid rate; and recommend Medicaid rate adjustments to address excess licensed bed capacity.</td>
<td>Interim: 12/31/23 Interim: 7/1/24 Final: 12/1/24</td>
<td>On Time / In Process</td>
</tr>
<tr>
<td>(3). PA 23-186 Sec. 1</td>
<td>Medicaid Rate Study</td>
<td>Two-part study of Medicaid rates of reimbursement beginning with (1) an examination of such rates for physician specialists, dentists and behavioral health providers followed by (2) a review of the reimbursement system for all other aspects of the Medicaid program.</td>
<td>Phase 1 : 2/1/24 Phase 2 : 1/1/25</td>
<td>On Time / In Process</td>
</tr>
<tr>
<td>(4). PA 22-57</td>
<td>Temporary Nursing Services Agencies Study</td>
<td>To evaluate the rates charged by temporary nursing services agencies and determine whether and what changes may be needed in the regulation of such rates</td>
<td>10/1/23</td>
<td>Complete</td>
</tr>
<tr>
<td>(5). PA 23-186 Sec. 6</td>
<td>Wait List</td>
<td>State Ombudsman, DPH, and DSS to convene a working group concerning any revisions necessary to nursing home waiting list requirements</td>
<td>1/1/24</td>
<td>On Time / In Process</td>
</tr>
<tr>
<td>(6). PA 23-48 Sec. 7 &amp; Sec. 10</td>
<td>Narrative Summaries Cost Reports</td>
<td>Nursing homes are required to submit narrative summaries which shall include profit and loss statements for the preceding three cost report years, total revenue, total expenditures, total assets, total liabilities, short-term debt, long-term debt and cash flows from investing, operating and financing activities. DSS to develop a guidebook including a plain language explanation of the terms and a description of the Medicaid nursing home rate setting process.</td>
<td>7/1/24</td>
<td>On Time / In Process</td>
</tr>
</tbody>
</table>
Introduction to quality payments

**Summary**: Adjust payments based on a home’s measured quality scores. Joining majority of states + Medicare who do this

**Status**: Phased rollout, pending final action by the legislature + CMS approval

**Policy rationale**: Improved patient care

- Gives homes financial incentives to improve patient care
  - Help “make the business case” for homes to invest in their residents and quality
  - Under previous – and current – systems, homes have no *direct* financial incentives to boost patient quality
Example: Pressure ulcers

Clinical context

Pressure ulcers (bed sores) impact an estimated 2+ million people per year... and can cause severe pain...

...and, if hospitalized, can cost tens of thousands of extra dollars (source) and death

How homes can help

Strong evidence, via randomized control trials, that homes can take steps to reduce pressure ulcer incidence rate

Table 1. Intervention Effect and Quality of Supporting Randomized Controlled Trials (RCTs)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description of Preventive Interventions</th>
<th>Participant Population</th>
<th>No. of RCTs/No. of Participants</th>
<th>Pressure Ulcers, RR (95% CI)</th>
<th>Randomization</th>
<th>Allocation Concealment</th>
<th>Blinding of Outcome Assessment</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pressure redistribution foam (e.g., cubed foams, visco-elastic foam, high-density foams vs standard hospital mattresses)</td>
<td>Medical, surgical, and rehabilitation patients</td>
<td>5/2016</td>
<td>0.40 (0.21-0.74)</td>
<td>4 RCTs</td>
<td>2 RCTs</td>
<td>None</td>
<td>McIntosh et al</td>
</tr>
<tr>
<td>2</td>
<td>Oral nutritional supplements (e.g., daily drinks of 257 mL, 2 kcal/mL vs standard hospital diet vs standard hospital diet)</td>
<td>Elderly hospital patients</td>
<td>4/124</td>
<td>0.85 (0.73-0.99)</td>
<td>4 RCTs</td>
<td>None</td>
<td>1 RCT</td>
<td>Stratton et al</td>
</tr>
<tr>
<td>3</td>
<td>A hypertaurine and regimen for skin dryness, applied twice per day to the sacrum, trochanters, and heels (Mepivaxt, Laboratories Bama-Geve SA, Barcelona, Spain) vs matched group placebo</td>
<td>Patients from home care and geriatric centers</td>
<td>1/380</td>
<td>0.42 (0.22-0.80)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Reddy et al</td>
</tr>
<tr>
<td>4</td>
<td>A foam cleanser combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Clinisan; Shlish Health Care, Waltham, England) vs soap and water for incontinence care</td>
<td>Residents of long-term care sites</td>
<td>1/93</td>
<td>0.32 (0.13-0.82)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Hodgkinson et al</td>
</tr>
</tbody>
</table>

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106015

From October 2022 MAPOC
Timeline as specified in PA 21-2 (as amended by PA 23-204), June Special Session

July 1, 2022: In accordance with section 17b-340d, phase in of case-mix reimbursement: Acuity (case mix) applied to the direct care component of the rate; a single facility rate for both CCNH and RHNS beds; vent and AIDS units/facilities will continue to receive a separate reimbursement rate.

July 1, 2023: DSS began to produce individualized reports to each nursing home showing quarterly quality measures, including raw quality scores, quality measure tiers and scores, and provider’s % of total statewide quality adjusted Medicaid days. First quarterly file is posted to the DSS webpage: Nursing Home Reimbursement Acuity Based Methodology (ct.gov)

Currently: Working with various stakeholders to "test and learn" and make adjustments to the model and its impact.

By June 30, 2025: The Department shall submit a final report with recommendations for implementation and impact on a rate withhold on nursing homes that fail to meet certain quality metrics.
Quality program overview

Stakeholder engagement

Residents:

- Late 2022 - early 2023: partnered Health Equity Solutions. Engaged nursing home residents. Focus groups with the E-Board of nursing home residents and the Statewide Family Council.
- Main themes: lack of staffing, inconsistent quality of care, poor communication, quality of food, patient-centered care, and lack of socialization

Provider workgroups: Assisted in determination of selected quality measures; workgroups will resume later this year and comprised of DPH, Ombudsman, DSS, Myers & Stauffer, industry representatives and resident councils

Overview of the program

7 quality measures (list next slide)

No dollars at risk during design phase (two-years)

Quality data is obtained from publicly available CMS quality and staffing data that is posted quarterly by CMS https://data.cms.gov/provider-data/

Exception is CoreQ consumer satisfaction survey data which will be captured annually

Underlying quality data will be updated quarterly and distributed to providers
Quality Program – Consumer Voice

Overview
CoreQ consumer satisfaction survey data which will be captured annually
• Use of the long-stay survey will best capture the Medicaid member experience
• CoreQ is a set of five measures for skilled nursing homes used to assess satisfaction among patients, residents, and their families
• Administered in Ohio, New Jersey, Tennessee and Georgia, and CMS is exploring use in Medicare

Stakeholder engagement
• Workgroups have taken place over the past year and will continue to ensure the consumer's voice is captured in the quality program
• Workgroups include the Ombudsman, UConn Center for Aging, Nursing Home Resident Councils, and Medical Policy unit
• Will be administered by neutral third party and not by the nursing home
Quality Measures

1. Adjusted total nurse staffing hours per resident day
2. Percentage of high risk long-stay residents with pressure ulcers (QM # 453)
3. Percentage of long-stay residents who lose too much weight (QM # 404)
4. Percentage of long-stay residents who received an antipsychotic medication (QM # 419)
5. Percentage of long-stay residents assessed and appropriately given the pneumococcal (QM # 415)
6. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine (QM # 454)
7. CoreQ – Consumer Satisfaction Survey – Stakeholdering with Ombudsman and resident councils
Quality Program Exclusion

Providers with the following characteristics will be ineligible for the payment under the Quality Payment Program: (CMS defined)

- **Special Focus Facility Status** - nursing homes that have a persistent record of poor care
- **Special Focus Facility Candidate Status** - nursing homes that have a history of serious quality issues or are included in the CMS program to stimulate improvements in their quality of care
- **Abuse Icon Present** - nursing home has been cited for an abuse violation in the past year or over each of the past two years, depending on the level of harm.

Eligibility will be determined on a quarterly basis from information posted on the public CMS use files (“Provider Information” File)

- **Source Data for Eligibility**: [https://data.cms.gov/provider-data/](https://data.cms.gov/provider-data/)
Additional Information

All information and materials are posted to the DSS webpage:

PHE Unwinding
1115 Demonstration Waivers
From April to August, an average of 77% of individuals maintained coverage at month end. Those who disenroll often re-enroll after the month end.
## Medicaid and CHIP Renewal Outcomes, by State (June 2023)

<table>
<thead>
<tr>
<th>State</th>
<th>Total Due for Renewal in June</th>
<th>Number Renewed in Medicaid/CHIP</th>
<th>Percent Renewed in Medicaid/CHIP*</th>
<th>Percent Renewed on an Ex Parte Basis* (i.e., based on available information)</th>
<th>Number Terminated from Medicaid/CHIP</th>
<th>Percent Terminated from Medicaid/CHIP</th>
<th>Percent Terminated for a Procedural Reason*</th>
<th>Number of Renewals Pending at the End of the Month</th>
<th>Percent Pending at the End of the Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>7,530</td>
<td>2,659</td>
<td>35.3%</td>
<td>24.8%</td>
<td>3,380</td>
<td>44.9%</td>
<td>28.0%</td>
<td>1,491</td>
<td>19.8%</td>
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<tr>
<td>AL</td>
<td>127,533</td>
<td>88,306</td>
<td>69.2%</td>
<td>36.2%</td>
<td>36,359</td>
<td>28.5%</td>
<td>23.5%</td>
<td>2,868</td>
<td>2.3%</td>
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<td>AR</td>
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<td>50,366</td>
<td>39.2%</td>
<td>26.3%</td>
<td>60,589</td>
<td>47.1%</td>
<td>35.3%</td>
<td>17,649</td>
<td>13.7%</td>
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<tr>
<td>AZ</td>
<td>230,082</td>
<td>154,324</td>
<td>67.1%</td>
<td>60.0%</td>
<td>66,657</td>
<td>29.0%</td>
<td>22.6%</td>
<td>9,101</td>
<td>4.0%</td>
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<td>CA</td>
<td>1,052,030</td>
<td>499,447</td>
<td>47.5%</td>
<td>26.7%</td>
<td>225,417</td>
<td>21.4%</td>
<td>19.0%</td>
<td>327,166</td>
<td>31.1%</td>
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<td>CO</td>
<td>127,475</td>
<td>61,273</td>
<td>48.1%</td>
<td>23.5%</td>
<td>62,539</td>
<td>49.1%</td>
<td>34.5%</td>
<td>3,663</td>
<td>2.9%</td>
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<td>CT</td>
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<td>58.0%</td>
<td>15,895</td>
<td>18.5%</td>
<td>13.6%</td>
<td>4,542</td>
<td>5.3%</td>
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<td>DC</td>
<td>21,620</td>
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<td>64.5%</td>
<td>53.9%</td>
<td>5,264</td>
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<td>22.8%</td>
<td>2,419</td>
<td>11.2%</td>
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<td>DE</td>
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<td>6.3%</td>
<td>11,857</td>
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<td>FL</td>
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<td>16.7%</td>
<td>75,327</td>
<td>18.6%</td>
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<td>79,520</td>
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<td>40.7%</td>
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<td>HI</td>
<td>39,818</td>
<td>21,649</td>
<td>54.4%</td>
<td>40.6%</td>
<td>10,612</td>
<td>26.7%</td>
<td>23.3%</td>
<td>7,557</td>
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<td>IA</td>
<td>84,961</td>
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<td>21.4%</td>
<td>8,064</td>
<td>9.5%</td>
<td>3.5%</td>
<td>44,626</td>
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<td>42.3%</td>
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<td>IN</td>
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<td>37.0%</td>
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<td>47,698</td>
<td>29.8%</td>
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<td>KS</td>
<td>68,374</td>
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<td>4.3%</td>
<td>1,780</td>
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<td>KY</td>
<td>89,275</td>
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<td>33.4%</td>
<td>37,494</td>
<td>42.0%</td>
<td>32.6%</td>
<td>12,007</td>
<td>13.5%</td>
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<td>LA</td>
<td>146,892</td>
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<td>47.3%</td>
<td>50,681</td>
<td>34.5%</td>
<td>25.7%</td>
<td>5,115</td>
<td>3.5%</td>
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<td>MA</td>
<td>82,084</td>
<td>57,176</td>
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<td>60.1%</td>
<td>30,970</td>
<td>37.7%</td>
<td>7.4%</td>
<td>Unable to report</td>
<td>Unable to report</td>
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<tr>
<td>MD</td>
<td>134,593</td>
<td>98,630</td>
<td>73.3%</td>
<td>52.8%</td>
<td>28,331</td>
<td>21.1%</td>
<td>12.7%</td>
<td>7,632</td>
<td>5.7%</td>
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<td>ME</td>
<td>31,957</td>
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<td>0.0%</td>
<td>1,747</td>
<td>5.5%</td>
<td>1.3%</td>
<td>22,321</td>
<td>69.9%</td>
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<tr>
<td>MI</td>
<td>215,712</td>
<td>103,540</td>
<td>48.0%</td>
<td>33.9%</td>
<td>12,011</td>
<td>5.6%</td>
<td>1.0%</td>
<td>100,161</td>
<td>46.4%</td>
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<tr>
<td>MN</td>
<td>97,220</td>
<td>47,175</td>
<td>48.5%</td>
<td>12.3%</td>
<td>6,867</td>
<td>7.1%</td>
<td>0.0%</td>
<td>43,178</td>
<td>44.4%</td>
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<td>MO</td>
<td>116,617</td>
<td>49,963</td>
<td>42.8%</td>
<td>32.3%</td>
<td>32,530</td>
<td>27.9%</td>
<td>20.0%</td>
<td>34,124</td>
<td>29.3%</td>
</tr>
<tr>
<td>MS</td>
<td>67,695</td>
<td>32,977</td>
<td>48.7%</td>
<td>17.3%</td>
<td>29,460</td>
<td>43.5%</td>
<td>34.8%</td>
<td>5,258</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

*Percentages calculated as a share of the total number of beneficiaries due for renewal in the reporting month.

AR, DC, DE, IA, IL, KS, KY, ME, MI, MN, MO, NJ, NY, OK, SC, WV, and WY held some procedural terminations for renewals due in June. MA reports the dispositions of renewals completed in the reporting period. Therefore, the state is unable to report the number of pending renewals to CMS, and MA’s data is excluded from the national totals. OR and TX did not complete renewals for a cohort due in June.

**Source:** State Medicaid and CHIP Renewal and Termination Data from the Unwinding Data Report as of August 16, 2023. Florida’s Medicaid and CHIP Renewal and Termination Data for the Unwinding Data Report as of July 31, 2023.
Medicaid and CHIP Renewal Outcomes, by State (June 2023)

<table>
<thead>
<tr>
<th>State</th>
<th>Total Due for Renewal in June</th>
<th>Number Renewed in Medicaid/CHIP</th>
<th>Percent Renewed in Medicaid/CHIP*</th>
<th>Percent Renewed on an Ex Parte Basis* (i.e., based on available information)</th>
<th>Number Terminated from Medicaid/CHIP</th>
<th>Percent Terminated from Medicaid and CHIP*</th>
<th>Percent Terminated for a Procedural Reason*</th>
<th>Number of Renewals Pending at the end of the Month</th>
<th>Percent Pending at the End of the Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td>42,712</td>
<td>14,559</td>
<td>34.1%</td>
<td>11.0%</td>
<td>17,335</td>
<td>40.6%</td>
<td>30.0%</td>
<td>10,818</td>
<td>25.3%</td>
</tr>
<tr>
<td>NC</td>
<td>185,093</td>
<td>137,896</td>
<td>74.5%</td>
<td>73.9%</td>
<td>35,099</td>
<td>19.0%</td>
<td>16.2%</td>
<td>12,098</td>
<td>6.5%</td>
</tr>
<tr>
<td>ND</td>
<td>12,900</td>
<td>5,283</td>
<td>41.0%</td>
<td>24.4%</td>
<td>6,874</td>
<td>53.3%</td>
<td>39.9%</td>
<td>743</td>
<td>5.8%</td>
</tr>
<tr>
<td>NE</td>
<td>29,598</td>
<td>15,524</td>
<td>52.5%</td>
<td>34.0%</td>
<td>4,386</td>
<td>14.8%</td>
<td>6.5%</td>
<td>9,688</td>
<td>32.7%</td>
</tr>
<tr>
<td>NH</td>
<td>16,154</td>
<td>7,586</td>
<td>47.0%</td>
<td>30.2%</td>
<td>8,355</td>
<td>51.7%</td>
<td>44.8%</td>
<td>213</td>
<td>1.3%</td>
</tr>
<tr>
<td>NJ</td>
<td>162,483</td>
<td>54,458</td>
<td>33.5%</td>
<td>11.6%</td>
<td>10,675</td>
<td>6.6%</td>
<td>2.3%</td>
<td>97,350</td>
<td>59.9%</td>
</tr>
<tr>
<td>NM</td>
<td>91,920</td>
<td>42,420</td>
<td>46.2%</td>
<td>38.1%</td>
<td>22,794</td>
<td>24.8%</td>
<td>22.8%</td>
<td>26,706</td>
<td>29.1%</td>
</tr>
<tr>
<td>NV</td>
<td>78,038</td>
<td>30,514</td>
<td>39.1%</td>
<td>33.6%</td>
<td>47,524</td>
<td>60.9%</td>
<td>57.2%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>NY</td>
<td>488,480</td>
<td>318,420</td>
<td>65.2%</td>
<td>24.1%</td>
<td>158,937</td>
<td>32.5%</td>
<td>17.2%</td>
<td>11,123</td>
<td>2.3%</td>
</tr>
<tr>
<td>OH</td>
<td>318,313</td>
<td>216,083</td>
<td>67.9%</td>
<td>36.4%</td>
<td>74,656</td>
<td>23.5%</td>
<td>17.5%</td>
<td>27,574</td>
<td>8.7%</td>
</tr>
<tr>
<td>OK</td>
<td>66,768</td>
<td>25,924</td>
<td>38.8%</td>
<td>11.0%</td>
<td>7,710</td>
<td>11.6%</td>
<td>0.0%</td>
<td>33,134</td>
<td>49.6%</td>
</tr>
<tr>
<td>PA</td>
<td>229,182</td>
<td>86,634</td>
<td>37.8%</td>
<td>4.6%</td>
<td>40,715</td>
<td>17.8%</td>
<td>7.5%</td>
<td>101,833</td>
<td>44.4%</td>
</tr>
<tr>
<td>RI</td>
<td>10,119</td>
<td>7,095</td>
<td>70.1%</td>
<td>64.3%</td>
<td>1,835</td>
<td>18.1%</td>
<td>12.8%</td>
<td>1,189</td>
<td>11.8%</td>
</tr>
<tr>
<td>SC</td>
<td>211,538</td>
<td>34,255</td>
<td>16.2%</td>
<td>10.2%</td>
<td>4,512</td>
<td>2.1%</td>
<td>0.0%</td>
<td>172,771</td>
<td>81.7%</td>
</tr>
<tr>
<td>SD</td>
<td>14,688</td>
<td>5,450</td>
<td>37.1%</td>
<td>9.0%</td>
<td>7,789</td>
<td>53.0%</td>
<td>28.4%</td>
<td>1,449</td>
<td>9.9%</td>
</tr>
<tr>
<td>TN</td>
<td>80,084</td>
<td>43,666</td>
<td>54.5%</td>
<td>31.0%</td>
<td>31,128</td>
<td>38.9%</td>
<td>29.7%</td>
<td>5,290</td>
<td>6.6%</td>
</tr>
<tr>
<td>UT</td>
<td>29,186</td>
<td>11,410</td>
<td>39.1%</td>
<td>24.0%</td>
<td>16,405</td>
<td>56.2%</td>
<td>54.4%</td>
<td>1,371</td>
<td>4.7%</td>
</tr>
<tr>
<td>VA</td>
<td>167,232</td>
<td>76,475</td>
<td>45.7%</td>
<td>28.4%</td>
<td>26,531</td>
<td>15.9%</td>
<td>13.3%</td>
<td>64,226</td>
<td>38.4%</td>
</tr>
<tr>
<td>VT</td>
<td>13,359</td>
<td>6,308</td>
<td>47.2%</td>
<td>29.0%</td>
<td>5,479</td>
<td>41.0%</td>
<td>28.7%</td>
<td>1,572</td>
<td>11.8%</td>
</tr>
<tr>
<td>WA</td>
<td>199,496</td>
<td>103,592</td>
<td>51.9%</td>
<td>45.2%</td>
<td>94,780</td>
<td>47.5%</td>
<td>42.9%</td>
<td>1,124</td>
<td>0.6%</td>
</tr>
<tr>
<td>WI</td>
<td>86,475</td>
<td>29,326</td>
<td>33.9%</td>
<td>6.9%</td>
<td>43,464</td>
<td>50.3%</td>
<td>24.2%</td>
<td>13,685</td>
<td>15.8%</td>
</tr>
<tr>
<td>WV</td>
<td>50,551</td>
<td>30,454</td>
<td>60.2%</td>
<td>11.3%</td>
<td>19,187</td>
<td>38.0%</td>
<td>28.3%</td>
<td>910</td>
<td>1.8%</td>
</tr>
<tr>
<td>WY</td>
<td>5,618</td>
<td>1,236</td>
<td>22.0%</td>
<td>0.4%</td>
<td>139</td>
<td>2.5%</td>
<td>0.0%</td>
<td>4,243</td>
<td>75.5%</td>
</tr>
</tbody>
</table>

Total 6,508,034   3,307,902  50.8%  29.4%  1,636,111  25.1%  18.5%  1,564,021  24.0%

*Percentages calculated as a share of the total number of beneficiaries due for renewal in the reporting month.

AR, DC, DE, IA, IL, KS, KY, ME, MI, MN, MO, NJ, NY, OK, SC, WV, and WY held some procedural terminations for renewals due in June. MA reports the dispositions of renewals completed in the reporting period. Therefore, the state is unable to report the number of pending renewals to CMS, and MA’s data is excluded from the national totals. OR and TX did not complete renewals for a cohort due in June.

Notes:

- Data captures renewal outcomes at individual level (not household). In August, 106,875 individuals went through the renewal process.
- 58% of individuals had coverage renewed without further information being requested from them. This is called an ex-parte or passive renewal.
- 16% of individuals could not be renewed passively (i.e., data sources show income over the program limit) and were sent a pre-filled form to complete their renewal.
- 5.5% of individuals were conditionally enrolled/renewal in process, but a final eligibility determination has not yet been made (pending receipt of outstanding verifications).
- Data is point-in-time at end of reporting month and does not include subsequent reenrollments.
Nearly 80,000 individuals renewed during August, with 58% renewing “passively”

**Notes:**

Medical Benefit Plans refer to the HUSKY Programs (A, B, C, and D) and the Medicare Savings Program (MSP)

- **HUSKY A** – Medicaid for children, parents, relative caregivers, and pregnant individuals
- **HUSKY B** – Children’s Health Insurance Program (CHIP)
- **HUSKY C** – Medicaid for older adults and individuals with disabilities
- **HUSKY D** – Medicaid for adults without dependent children
- **MSP** – provides premium and/or copayment assistance to Medicare beneficiaries
HUSKY Health Renewal Outcomes – August 2023

By Medical Benefit Plan

Notes:

Medical Benefit Plans refer to the HUSKY Programs (A, B, C, and D) and the Medicare Savings Program (MSP)

➢ HUSKY A – Medicaid for children, parents, relative caregivers, and pregnant individuals
➢ HUSKY B – Children’s Health Insurance Program (CHIP)
➢ HUSKY C – Medicaid for older adults and individuals with disabilities
➢ HUSKY D – Medicaid for adults without dependent children
➢ MSP – provides premium and/or copayment assistance to Medicare beneficiaries
41% of individuals who were disenrolled at renewal during the first 3 months of unwinding have regained coverage 30 to 90 days later, mostly by requalifying for HUSKY coverage. Most of the remaining households have stayed closed because they did not come in to renew coverage or be evaluated for other coverage options.

### RENEWAL POST-DISENROLLMENT STATUS

*Tracking Individuals after Disenrollment for 90 days*

<table>
<thead>
<tr>
<th>Renewal Disenrollment Tracking – 30/60/90 Days Later</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90-day mark</td>
<td>90-day mark</td>
<td>90-day mark</td>
<td>60-day mark</td>
<td>30-day mark</td>
</tr>
<tr>
<td>Total individuals disenrolled at renewal</td>
<td>24,508</td>
<td>25,342</td>
<td>15,569</td>
<td>32,643</td>
<td>22,298</td>
</tr>
<tr>
<td>Total individuals currently active in HUSKY</td>
<td>9,639</td>
<td>7,707</td>
<td>4,212</td>
<td>7,832</td>
<td>3,939</td>
</tr>
<tr>
<td>Total individuals currently active in QHP/APTC</td>
<td>851</td>
<td>1,493</td>
<td>1,145</td>
<td>2,372</td>
<td>1,278</td>
</tr>
<tr>
<td>Total individuals currently active in Covered CT</td>
<td>453</td>
<td>672</td>
<td>513</td>
<td>911</td>
<td>606</td>
</tr>
<tr>
<td>Total Individuals who transitioned to non-MAGI HUSKY</td>
<td>149</td>
<td>217</td>
<td>57</td>
<td>103</td>
<td>84</td>
</tr>
<tr>
<td>Total individuals who closed and are now active</td>
<td>11,092</td>
<td>10,089</td>
<td>5,927</td>
<td>11,218</td>
<td>5,907</td>
</tr>
<tr>
<td>Total individuals not enrolled in any state programs</td>
<td><strong>13,416</strong></td>
<td><strong>14,835</strong></td>
<td><strong>9,642</strong></td>
<td><strong>21,425</strong></td>
<td><strong>16,391</strong></td>
</tr>
</tbody>
</table>
In August 2023, CMS learned of eligibility system and operational issues affecting multiple states, resulting in eligible individuals being improperly disenrolled.

The issues pertain to ex-parte renewal functionality and processes (also known as auto-renewal or passive renewal). Ex-parte renewals allow people to remain enrolled without taking any action on their part when information from data sources support their eligibility.

States are required by federal regulation to use information already available to them through existing reliable data sources (e.g., state wage data, federal data services hub, etc.) to determine whether people are still eligible for Medicaid or CHIP.
EX-PARTE RENEWAL ISSUE AND CT MITIGATION EFFORTS - BACKGROUND

- CMS uncovered that eligibility systems in numerous states were conducting ex-parte renewals at the family/household level rather than at the individual level.

- Since each person in a family may have different eligibility requirements to qualify for Medicaid or CHIP, some people in the family were inadvertently being impacted by the eligibility determination results of others, including disenrollment.
  - For example, children often have higher eligibility thresholds than their parents, making them more likely to be eligible for Medicaid or CHIP coverage ongoing even if their parents no longer qualify. In some instances, if a parent failed to respond to a renewal request, although the children appear to remain eligible, they were also closing.

- CMS sent letters to all 50 states and territories requiring them to determine whether these type of issues exist and, if so, to swiftly correct the problems and reinstate coverage.

- CT undertook extensive analyses and determined that even though our ex-parte renewal process is very successful, making us one of the top states in the nation for ex-parte renewals, we were also inadvertently closing some individuals who should have remained enrolled.
Many states were not aware this was an issue, and some had even worked with CMS to certify their eligibility systems without specific reference to these requirements.

Unfortunately, the ex-parte method being used by states was not raised during the initial mitigation planning stages of the unwinding process when CMS entered into agreements with states on how they would do the work.

Noteworthy - the reason many states have been using a household-based approach is because Medicaid member advisory boards and other sources of Medicaid member feedback recommended that states streamline the number of applications, renewals, and notices sent to families while also promoting the alignment of eligibility dates across family members whenever possible.
Since the beginning of the PHE unwinding and the return to normal operations, DSS determined the following number of people were impacted between the months of April and August:

- 6,661 kids in HUSKY A
- 69 kids in HUSKY B
- 4,127 adults in HUSKY A
- 15,421 adults in HUSKY D
EX-PARTE RENEWAL ISSUE AND CT MITIGATION EFFORTS - OPTIONS

CMS asked states impacted by this issue to take one or more of the following steps to come into compliance:

1) Pause procedural disenrollments for those individuals impacted,

2) Reinstate coverage for all people impacted,

3) Implement one or more CMS-approved mitigation strategies to prevent further inappropriate disenrollments, and/or

4) Fix state systems and processes to ensure renewals are conducted in accordance with federal program requirements.
DSS opted to:

1. Prevent further inappropriate disenrollments for the individuals erroneously impacted in the months of September and October (completed). We will continue this exercise monthly until the permanent fix is completed.

2. Reinstate the approximately 26,000 individuals for the months of April through August 2023

3. The reinstatement process is anticipated to occur in November.

4. Affected individuals will be notified of their reinstatement and provided instructions for obtaining payments for unpaid medical bills and/or coverage for services through a special mailing.

5. Permanent fix to renewal rules – being scheduled

6. Anticipate adopting 1902(e)(14) waiver authority to use SNAP income data to confer Medicaid eligibility – imminent and retroactively
Preliminary analyses show impressive results:

**September:**

- 66% of HUSKY Health members were renewed on an ex-parte basis, up from 58% in August
- 89% of HUSKY Health members maintained coverage, up from 79% in August
- 6% procedural closures, down from 18% monthly average since the beginning of unwinding
Recent Actions by Other States to Address SDOH

**Context**

**What is an 1115 waiver?**
Section 1115 waivers are submitted to the Centers for Medicare & Medicaid Services (CMS) and give states additional flexibility to design and improve their Medicaid programs.

Throughout the fall of 2022, CMS has approved **four** new 1115 waivers supporting social determinants of health and has outlined a **new method** for waiver approval.

**What is ‘new’ here and what are the implications?**
The waivers submitted by Arizona, Arkansas, Massachusetts, and Oregon are focused on addressing Medicaid members **social determinants of health (SDOH)** – the economic and social conditions that influence individual and group differences in health status, also referred to as the **health-related social needs (HRSN)**.

**Example of services recently approved***

- **Housing supports** (covered in AR, AZ, MA, OR):
  - Pre-tenancy and tenancy sustaining services
  - One-time transition and moving costs
  - Housing deposits to secure housing (application and inspection fees)
  - Medically necessary home modifications

- **Nutrition supports** (covered in AR, MA, OR):
  - Nutrition counseling and education (only nutrition-related service covered in AR)
  - Medically tailored meals and food prescriptions
  - Necessary cooking supplies

- **Transportation services** to housing and nutrition services (covered in MA)

- **Case management, outreach, and education** including linkages to other state and federal benefit programs, benefit program assistance, and benefit program application fees (covered in AR, MA, OR)

*not inclusive of all services covered

**Technical changes to CMS definition of “budget neutrality”**

**What is “budget neutrality” and why do we care?**
Budget neutrality means that federal spending under a state’s 1115 demonstration cannot exceed projected costs in the absence of the demonstration. It limits the programs that can be covered under an 1115.

**Changes to CMS definition of budget neutrality and their implications:**

- Updated approach to calculating the “without waiver” (WOW) baseline (key part of budget neutrality calculation) → allows states to access more savings from prior approval periods

- CMS is treating HRSN expenditures as “hypothetical” → provides more flexibility to test innovative programs that CMS anticipates will result in overall lower Medicaid costs

- Applying a budget neutrality spending cap to HRSN service expenditures → ensures that the state maintains its investment in the state plan benefits to which enrollees are entitled while testing the benefit of the HRSN services

- Revising “mid-course” calculation that allows states to modify their baseline → provides flexibility and stability for the state

---

*not inclusive of all services covered
Section 1115 Waivers with provisions related to Social Determinants of Health (SDOH) as of 9/26/2023

Approved (12 States)  ▪  Approved and Pending (7 States)  ▪  Pending (5 States)

Oregon  California  Idaho  Utah  Arizona  Texas  Oklahoma  Kansas  Nebraska  South Dakota  North Dakota  Wisconsin  Indiana  Pennsylvania  Tennessee  Alabama  Georgia  South Carolina  W. Virginia

Note: Through Section 1115 Waiver authority, state can test approaches for addressing the SDOH of Medicaid enrollees, including the use of matching funds to test SDOH-related services and supports in ways that promote Medicaid program objectives. For more information on approved and pending SDOH provisions across states, see the SDOH table of the Kaiser Family Foundation waiver tracker.

SOURCE: KFF 1115 Waiver Tracker

CT Department of Social Services
Connecticut currently has two active 1115 waivers … with one under development

<table>
<thead>
<tr>
<th>Status</th>
<th>Substance Use Disorder (SUD)</th>
<th>Covered CT</th>
<th>Justice-Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Live</td>
<td>Live</td>
<td>Under development</td>
</tr>
<tr>
<td>Brief</td>
<td>Provide coverage of residential and inpatient SUD services under HUSKY Health that have previously been excluded due to long-standing federal policies</td>
<td>No-cost health insurance, including coverage of dental and non-emergency medical transportation services</td>
<td>(see details from <a href="#">September 2023 MAPOC</a>) Long-standing Medicaid prohibition: no Medicaid reimbursement for services provided to individuals incarcerated in a public institution, except inpatient hospitalization</td>
</tr>
<tr>
<td>description</td>
<td></td>
<td>Eligibility: up to 175% FPL…and not eligible for HUSKY Health</td>
<td></td>
</tr>
<tr>
<td>Timeline</td>
<td>7.5 months from CMS submission to approval after 3-4 years of development (including formal public process)</td>
<td>8 months from CMS submission to approval after 10-12 months of development (including formal public process)</td>
<td>Under development. Began development shortly after CMS first approved this type of waiver in January 2023.</td>
</tr>
</tbody>
</table>