MAPOC Meeting

October 2023

CT Department of Social Services

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 <u>financing</u> *(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. <u>Regulating</u> *(DPH primarily)*
   - DPH protects the health and safety of nursing home residents by **inspecting and licensing**

From October 2022 MAPOC

CT Medicaid Nursing Home Financing – process

High level overview

- 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.

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

(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

(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

Selected Parameters	SFY 2023	SFY 2024	SFY 2025
Cost report year	2019	2019	2019
Case mix neutrality limit	0.75%	1.51%	2.27%
Stop gain	$6.50	$20	None
Stop loss	$0	$5	None

Summary of selected nursing-home related legislative activity, from last session

Statutory Reference	Title of Report	Summary of Report	Due Date	Status
(1). PA 23-204 Sec. 275	Quality Metrics	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 are 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	6/30/25	On Time / In Process Updates posted to DSS website *Today's focus*
(2). PA 23-204 Sec. 298	Excess Licensed Bed Capacity	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.	Interim: 12/31/23 Interim: 7/1/24 Final: 12/1/24	On Time / In Process
(3). PA 23-186 Sec. 1	Medicaid Rate Study	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.	Phase 1 : 2/1/24 Phase 2 : 1/1/25	On Time / In Process
(4). PA 22-57	Temporary Nursing Services Agencies Study	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	10/1/23	Complete
(5). PA 23-186 Sec. 6	Wait List	State Ombudsman, DPH, and DSS to convene a working group concerning any revisions necessary to nursing home waiting list requirements	1/1/24	On Time / In Process
(6). PA 23-48 Sec. 7 & Sec. 10	Narrative Summaries Cost Reports	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.	7/1/24	On Time / In Process

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

a. Help "make the business case" for homes to invest in their residents and quality
b. Under previous – and current – systems, homes have no *direct* financial incentives to boost patient quality

From October 2022 MAPOC

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

JAMA Internal Medicine

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

Strategy	Description of Preventive Interventions	Participant Population	No. of RCTs/ No. of Participants	Pressure Ulcers, RR (95% CI)[b]	Randomization[a]	Allocation Concealment[a]	Blinding of Outcome Assessment[a]	Source
1	Pressure redistribution foam (ie, cubed foams,[24,25] visco-elastic foam,[26] and high-density foams)[25-27] vs standard hospital mattresses	Medical, surgical, and rehabilitation patients	5/2016	0.40 (0.21-0.74)	4 RCTs	2 RCTs	None	McInnes et al[16]
2	Oral nutritional supplements (eg, daily drinks of 237 mL, 2 kcal/mL)[28] and standard hospital diet vs standard hospital diet	Elderly hospital patients	4/1224	0.85 (0.73-0.99)	4 RCTs	None	1 RCT	Stratton et al[17]
3	A hyperoxygenated fatty acid regimen for skin dryness, applied twice per day to the sacrum, trochanter, and heels (Mepentol; Laboratorios Bama-Geve SA, Barcelona, Spain) vs matched greasy placebo[22]	Patients from home care and/or geriatric centers	1/380	0.42 (0.22-0.80)	1 RCT	None	1 RCT	Reddy et al[12]
4	A foam cleanser combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Clinisan; Shiloh Health Care, Oldham, England) vs soap and water for incontinence care[23]	Residents of long-term care sites	1/93	0.32 (0.13-0.82)	1 RCT	None	1 RCT	Hodgkinson et al[18]

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

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 with 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/

Additional Information

All information and materials are posted to the DSS webpage:

https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Acuity-Based-Methodology

PHE Unwinding

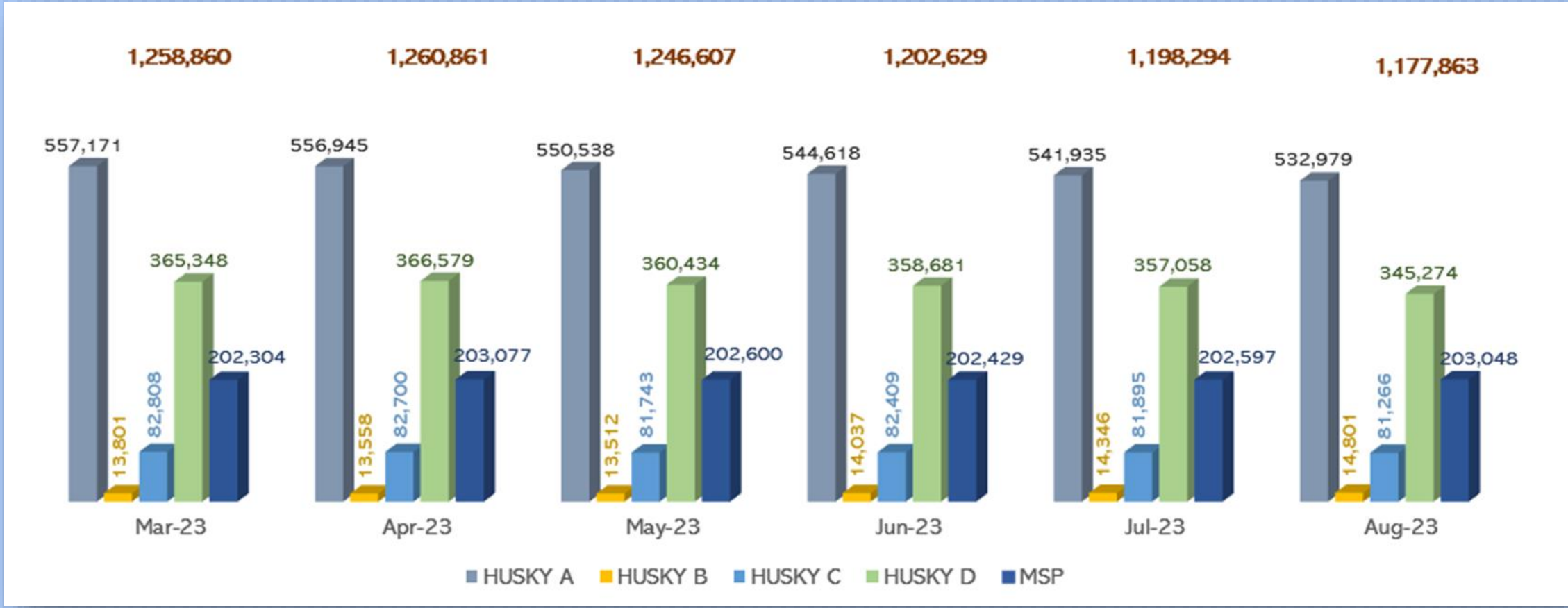
1115 Demonstration Waivers

PUBLIC HEALTH EMERGENCY (PHE) UNWINDING DATA DASHBOARD

APRIL – AUGUST 2023

HUSKY RENEWAL ACTIVITY AND OUTCOMES

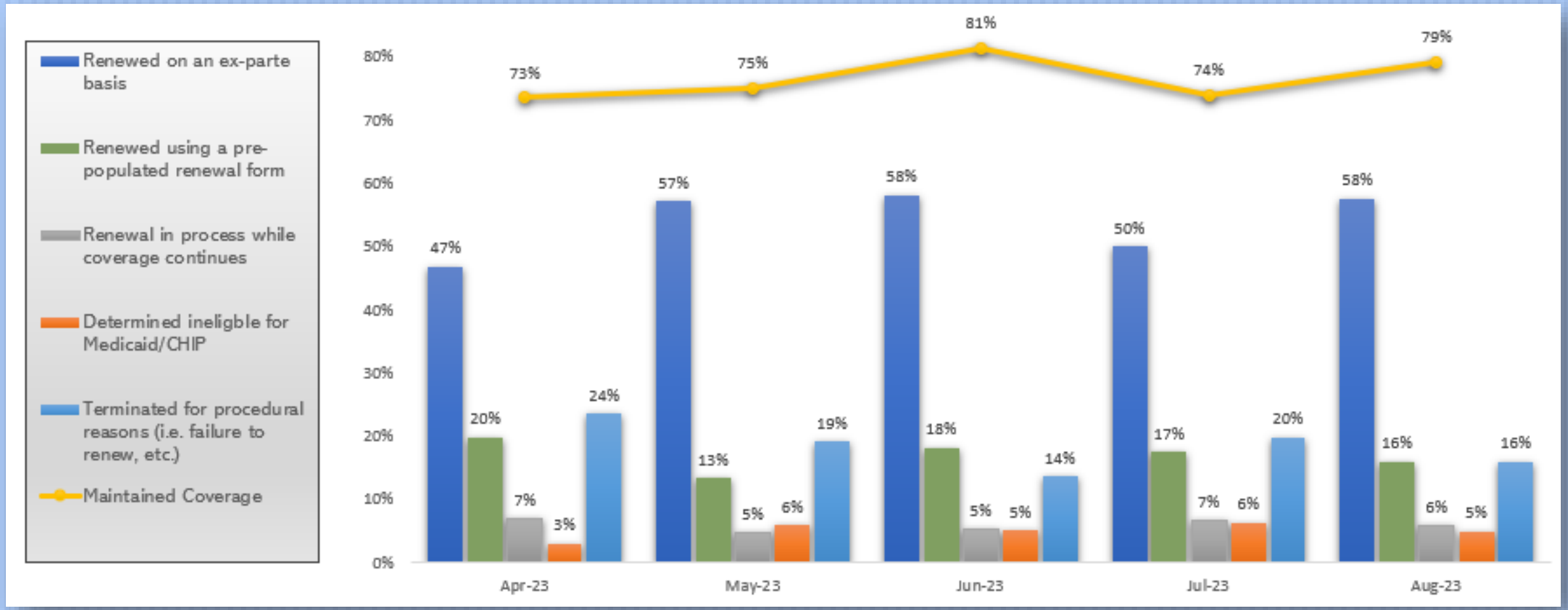
HUSKY ENROLLMENT DURING UNWINDING



Connecticut Department of Social Services

HUSKY Health Renewal Outcomes – April to August 2023

As reported by DSS to CMS at end of each month



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)

State	Total Due for Renewal in June	Among the Total Number of Medicaid/CHIP Beneficiaries Due for Renewal in June 2023:							
		Number Renewed in Medicaid/CHIP	Percent Renewed in Medicaid/CHIP*	Percent Renewed on an *Ex Parte* Basis* (i.e., based on available information)	Number Terminated from Medicaid/CHIP	Percent Terminated from Medicaid/CHIP*	Percent Terminated for a Procedural Reason*	Number of Renewals Pending at the End of the Month	Percent Pending at the End of the Month
AK	7,530	2,659	35.3%	24.8%	3,380	44.9%	28.0%	1,491	19.8%
AL	127,533	88,306	69.2%	36.2%	36,359	28.5%	23.5%	2,868	2.3%
AR	128,604	50,366	39.2%	26.3%	60,589	47.1%	35.3%	17,649	13.7%
AZ	230,082	154,324	67.1%	60.0%	66,657	29.0%	22.6%	9,101	4.0%
CA	1,052,030	499,447	47.5%	26.7%	225,417	21.4%	19.0%	327,166	31.1%
CO	127,475	61,273	48.1%	23.5%	62,539	49.1%	34.5%	3,663	2.9%
CT	85,764	65,327	76.2%	58.0%	15,895	18.5%	13.6%	4,542	5.3%
DC	21,620	13,937	64.5%	53.9%	5,264	24.4%	22.8%	2,419	11.2%
DE	23,759	7,287	30.7%	17.1%	4,615	19.4%	6.3%	11,857	49.9%
FL	404,036	249,189	61.7%	16.7%	75,327	18.6%	10.9%	79,520	19.7%
GA	219,359	64,423	29.4%	23.1%	95,578	43.6%	40.7%	59,358	27.1%
HI	39,818	21,649	54.4%	40.6%	10,612	26.7%	23.3%	7,557	19.0%
IA	84,961	32,271	38.0%	21.4%	8,064	9.5%	3.5%	44,626	52.5%
ID	37,946	10,085	26.6%	11.8%	27,861	73.4%	66.8%	0	0.0%
IL	199,040	128,370	64.5%	42.3%	15,149	7.6%	2.0%	55,521	27.9%
IN	160,155	76,862	48.0%	37.0%	35,595	22.2%	19.2%	47,698	29.8%
KS	68,374	6,515	9.5%	4.3%	1,780	2.6%	0.0%	60,079	87.9%
KY	89,275	39,774	44.6%	33.4%	37,494	42.0%	32.6%	12,007	13.5%
LA	146,892	91,096	62.0%	47.3%	50,681	34.5%	25.7%	5,115	3.5%
MA	82,084	57,176	69.7%	60.1%	30,970	37.7%	7.4%	Unable to report	Unable to report
MD	134,593	98,630	73.3%	52.8%	28,331	21.1%	12.7%	7,632	5.7%
ME	31,957	7,889	24.7%	0.0%	1,747	5.5%	1.3%	22,321	69.9%
MI	215,712	103,540	48.0%	33.9%	12,011	5.6%	1.0%	100,161	46.4%
MN	97,220	47,175	48.5%	12.3%	6,867	7.1%	0.0%	43,178	44.4%
MO	116,617	49,963	42.8%	32.3%	32,530	27.9%	20.0%	34,124	29.3%
MS	67,695	32,977	48.7%	17.3%	29,460	43.5%	34.8%	5,258	7.8%

*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)

State	Total Due for Renewal in June	Among the Total Number of Medicaid/CHIP Beneficiaries Due for Renewal in June 2023:							
		Number Renewed in Medicaid/CHIP	Percent Renewed in Medicaid/CHIP*	Percent Renewed on an *Ex Parte* Basis* (i.e., based on available information)	Number Terminated from Medicaid/CHIP	Percent Terminated from Medicaid and CHIP*	Percent Terminated for a Procedural Reason*	Number of Renewals Pending at the end of the Month	Percent Pending at the End of the Month
MT	42,712	14,559	34.1%	11.0%	17,335	40.6%	30.0%	10,818	25.3%
NC	185,093	137,896	74.5%	73.9%	35,099	19.0%	16.2%	12,098	6.5%
ND	12,900	5,283	41.0%	24.4%	6,874	53.3%	39.9%	743	5.8%
NE	29,598	15,524	52.5%	34.0%	4,386	14.8%	6.5%	9,688	32.7%
NH	16,154	7,586	47.0%	30.2%	8,355	51.7%	44.8%	213	1.3%
NJ	162,483	54,458	33.5%	11.6%	10,675	6.6%	2.3%	97,350	59.9%
NM	91,920	42,420	46.2%	38.1%	22,794	24.8%	22.8%	26,706	29.1%
NV	78,038	30,514	39.1%	33.6%	47,524	60.9%	57.2%	0	0.0%
NY	488,480	318,420	65.2%	24.1%	158,937	32.5%	17.2%	11,123	2.3%
OH	318,313	216,083	67.9%	36.4%	74,656	23.5%	17.5%	27,574	8.7%
OK	66,768	25,924	38.8%	11.0%	7,710	11.6%	0.0%	33,134	49.6%
PA	229,182	86,634	37.8%	4.6%	40,715	17.8%	7.5%	101,833	44.4%
RI	10,119	7,095	70.1%	64.3%	1,835	18.1%	12.8%	1,189	11.8%
SC	211,538	34,255	16.2%	10.2%	4,512	2.1%	0.0%	172,771	81.7%
SD	14,688	5,450	37.1%	9.0%	7,789	53.0%	28.4%	1,449	9.9%
TN	80,084	43,666	54.5%	31.0%	31,128	38.9%	29.7%	5,290	6.6%
UT	29,186	11,410	39.1%	24.0%	16,405	56.2%	54.4%	1,371	4.7%
VA	167,232	76,475	45.7%	28.4%	26,531	15.9%	13.3%	64,226	38.4%
VT	13,359	6,308	47.2%	29.0%	5,479	41.0%	28.7%	1,572	11.8%
WA	199,496	103,592	51.9%	45.2%	94,780	47.5%	42.9%	1,124	0.6%
WI	86,475	29,326	33.9%	6.9%	43,464	50.3%	24.2%	13,685	15.8%
WV	50,551	30,454	60.2%	11.3%	19,187	38.0%	28.3%	910	1.8%
WY	5,618	1,236	22.0%	0.4%	139	2.5%	0.0%	4,243	75.5%
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.

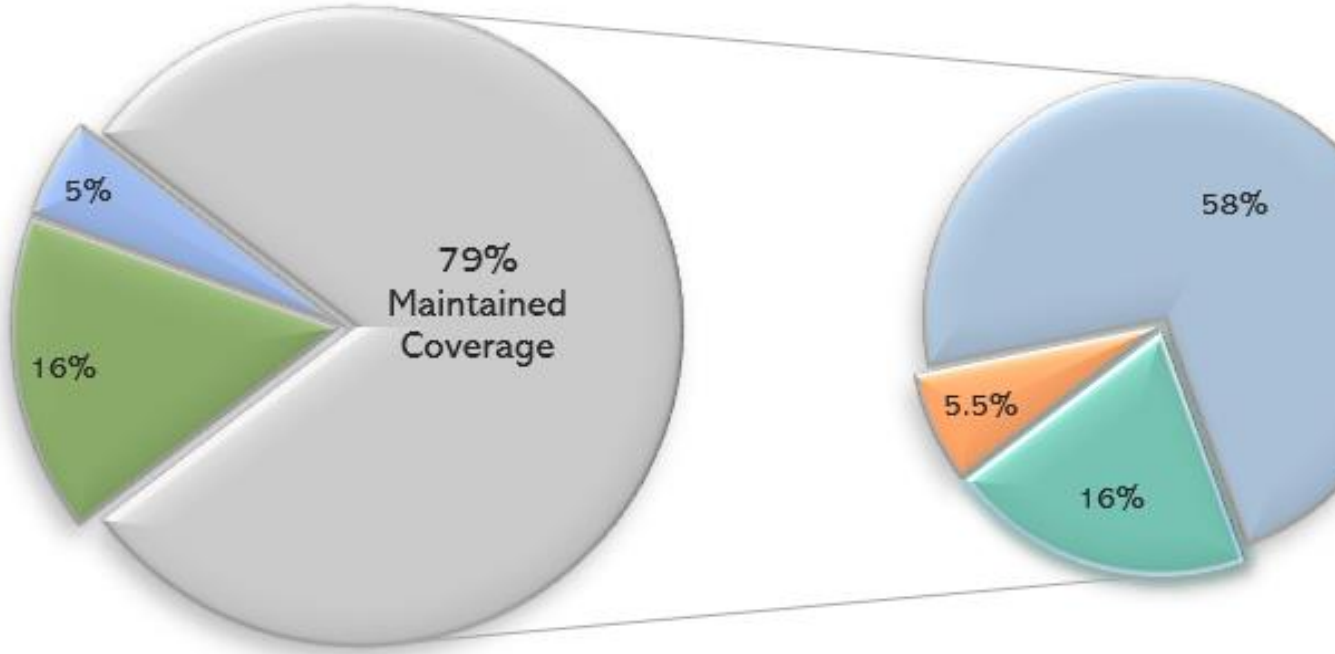
AR, DC, DE, IA, IL, KS, KY, ME, MI, MN, MO, NJ, NY, OK, SC, WV, and WY held some procedural terminations for renewals due in June. MA reports the dispositions of renewals completed in the reporting period. Therefore, the state is unable to report the number of pending renewals to CMS, and MA's data is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

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.

HUSKY RENEWAL OUTCOMES – LATEST STATUS

HUSKY Health Renewal Outcomes – August 2023

As reported by DSS to CMS at end of each month

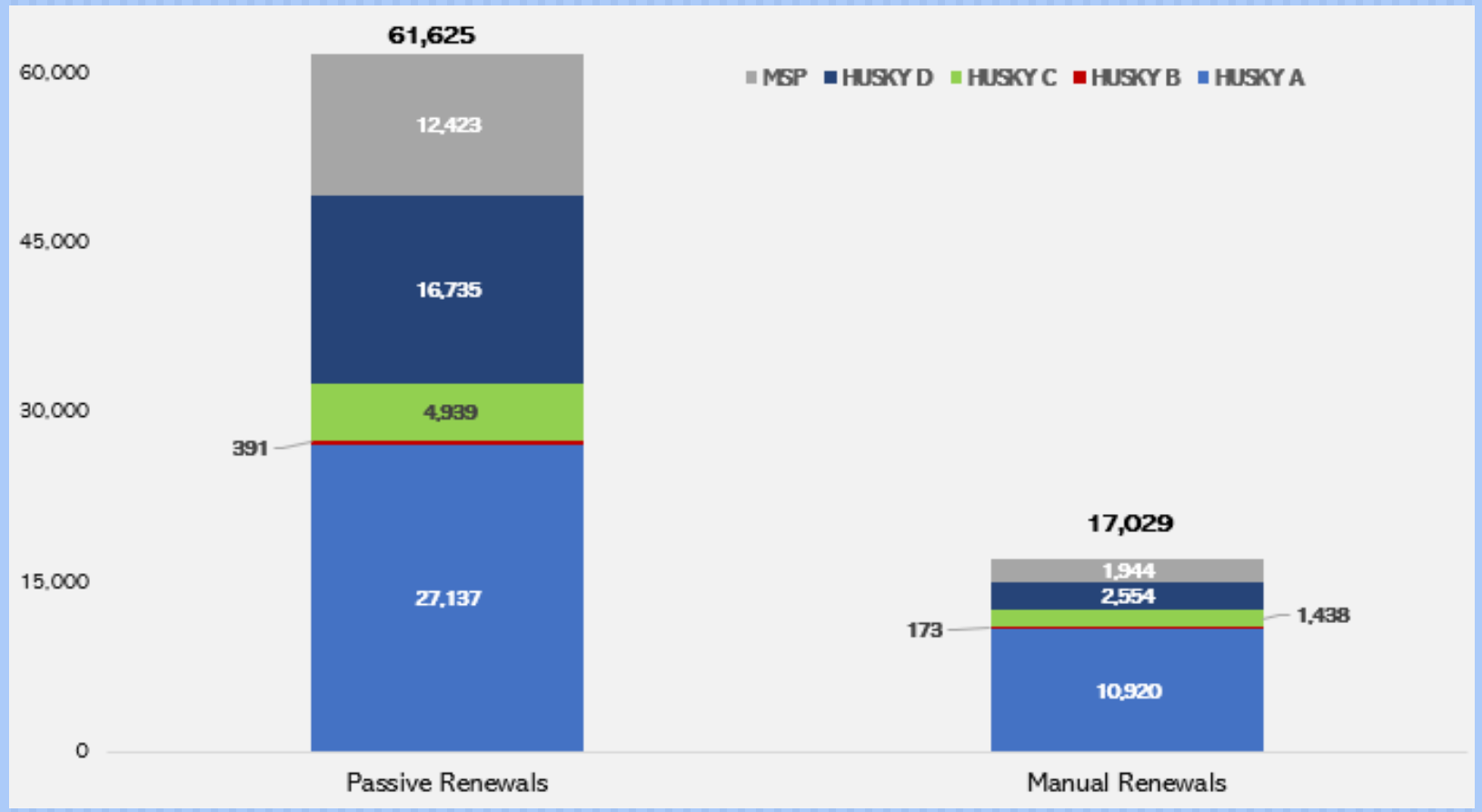


Notes:

- 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.

HUSKY HEALTH RENEWAL OUTCOMES – AUGUST 2023
PASSIVE VS. MANUAL RENEWALS BY MEDICAL BENEFIT PLAN

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

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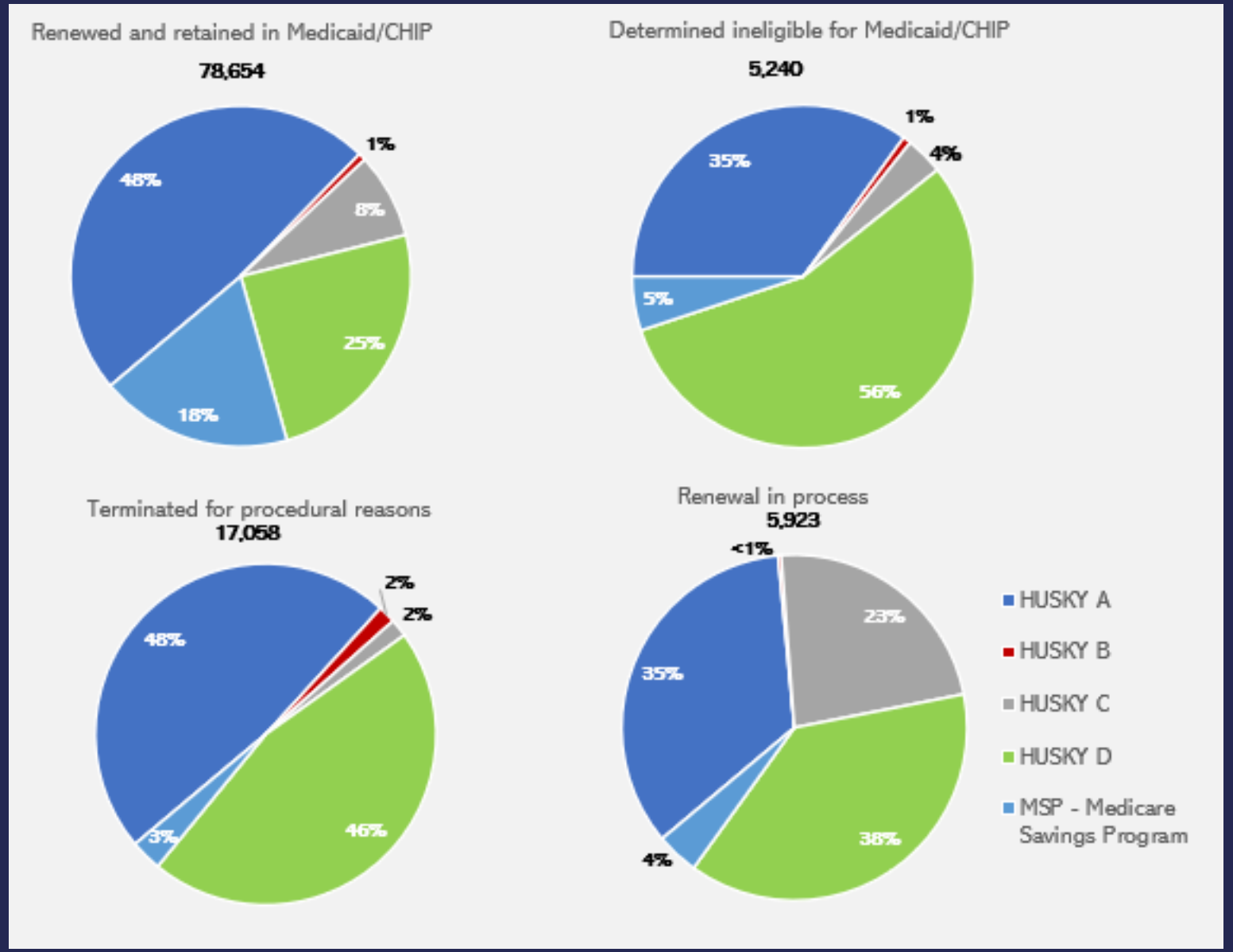
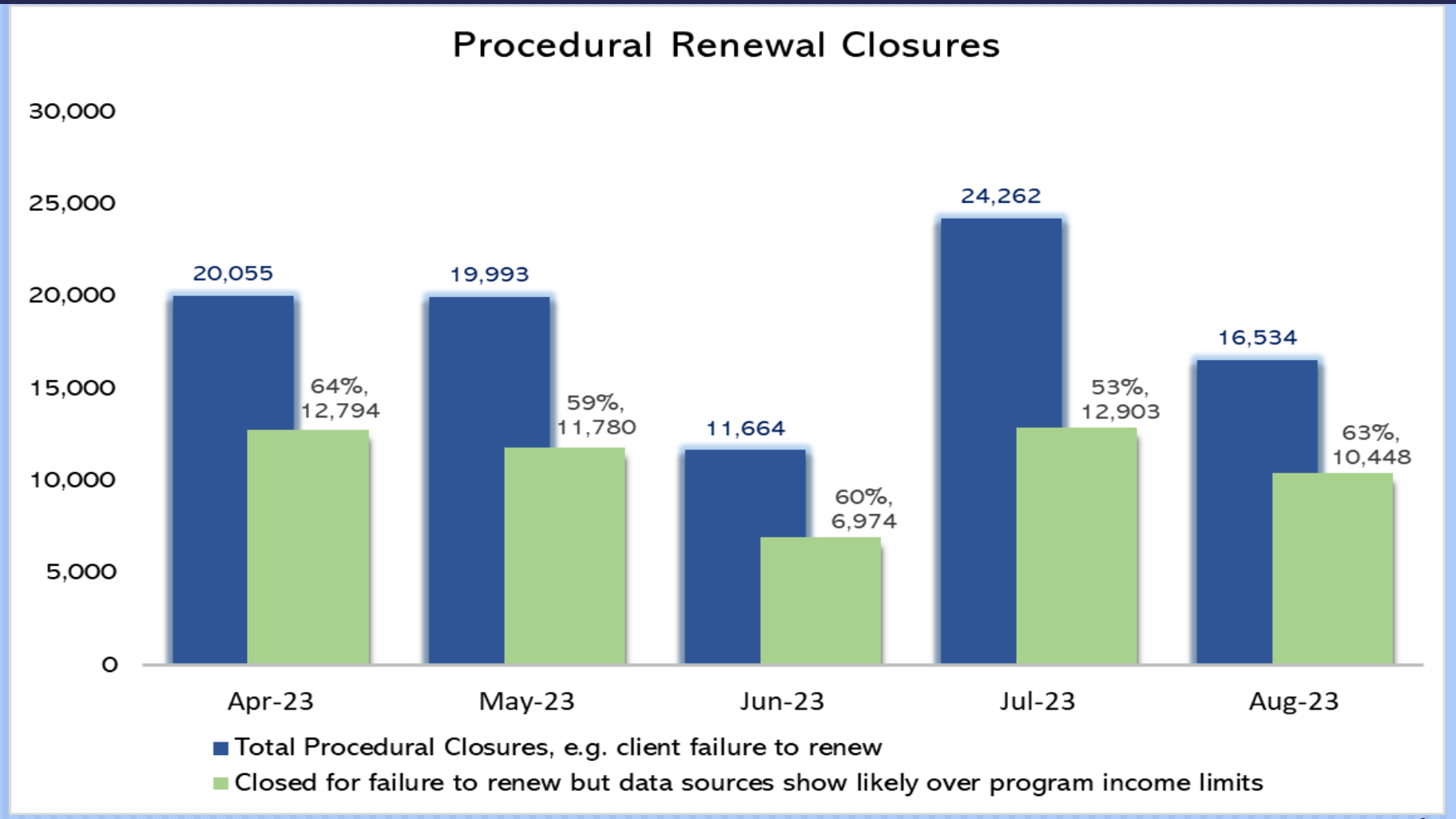


HUSKY HEALTH RENEWAL OUTCOMES



RENEWAL POST-DISENROLLMENT STATUS

Tracking Individuals after Disenrollment for 90 days

Renewal Disenrollment Tracking – 30/60/90 Days Later	April	May	June	July	August
	90-day mark	90-day mark	90-day mark	60-day mark	30-day mark
Total individuals disenrolled at renewal	24,508	25,342	15,569	32,643	22,298
Total individuals currently active in HUSKY	9,639	7,707	4,212	7,832	3,939
Total individuals currently active in QHP/APTC	851	1,493	1,145	2,372	1,278
Total individuals currently active in Covered CT	453	672	513	911	606
Total Individuals who transitioned to non-MAGI HUSKY	149	217	57	103	84
Total individuals who closed and are now active	11,092	10,089	5,927	11,218	5,907
Total individuals not enrolled in any state programs	13,416	14,835	9,642	21,425	16,391

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.

EX-PARTE RENEWAL ISSUE - BACKGROUND

- 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.

EX-PARTE RENEWAL ISSUE AND CT MITIGATION EFFORTS - BACKGROUND

- 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.

EX-PARTE RENEWAL ISSUE AND CT MITIGATION EFFORTS - IMPACT

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.

EX-PARTE RENEWAL ISSUE AND CT MITIGATION PLAN

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

PREVIEW OF EX-PARTE MITIGATION IMPACT

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

From Nov 2022 MAPOC

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?

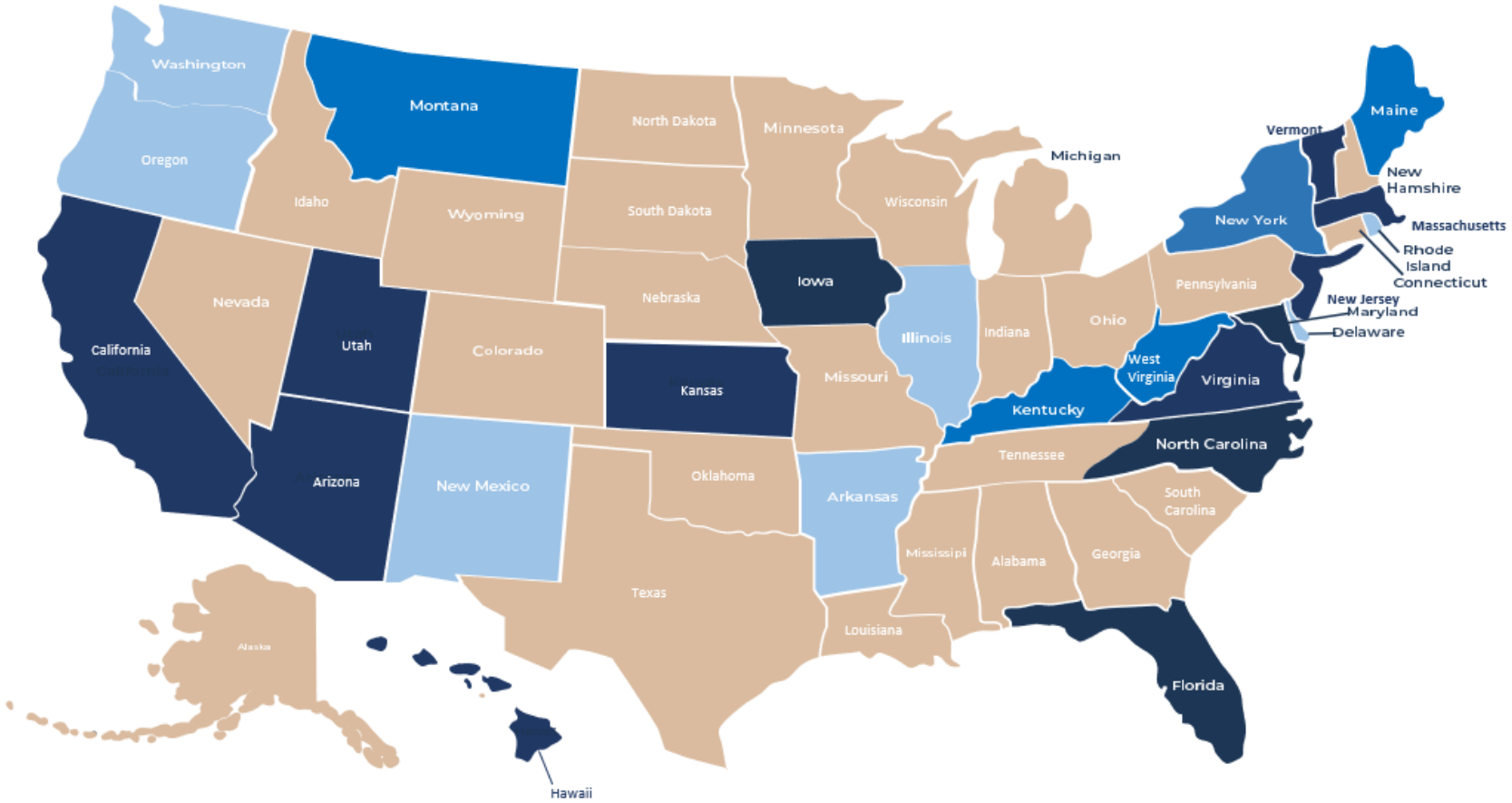
Budget neutrality means that federal spending under a state's 1115 demonstration cannot exceed projected costs in the absence of the demonstration. It limits the programs that can be covered under an 1115.

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*

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)**



Original map: **link**

Update list: **here**

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

Connecticut currently has two active 1115 waivers … with one under development

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