COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

CONNECTICUT

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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 13 CHCs operating 187 permanent clinical service delivery sites throughout the state of Connecticut. The Primary Care Association representing CHCs is the Community Health Center Association of Connecticut. [1] [2]
- Connecticut CHCs provided 1,606,600 visits to 329,009 patients in 2012. [3]
- The number of people served by CHCs grew an average of 5% annually from 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 42% of Connecticut's Medicaid population (US: 16%) and 9% of its overall population (US: 7%). Connecticut CHCs serve 30.5% of individuals with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 466,000, is projected to grow by an additional 200,000 people by 2022 (43% growth), with the uninsured rate projected to decrease from 11.5% to 6.1%. [4]

Policy & Reimbursement

- Connecticut spends about $7,600 per Medicaid enrollee annually – the 8th highest in the nation. [5]
- Connecticut reimburses CHCs in accordance with federal Prospective Payment System (PPS) requirements, including use of the Medicare Economic Index to adjust CHCs' per-visit rate annually. [6]
- Connecticut is a "single payer" of all CHC Medicaid claims, and does not use private Medicaid Managed Care companies. [7]
- Connecticut has implemented Medicaid expansion. [8] Beginning in 2014, the state has set eligibility limits at 138% FPL for childless adults, 201% FPL for parents, and 263% FPL for pregnant women and family incomes of up to 323% FPL for children. [9]
- Connecticut has a state-run Health Insurance Exchange, known as Access Health Connecticut. [10] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 79,192, surpassing a goal of 33,000. [11]
- Connecticut Medicaid enables a broad array of providers (including but not limited to: physicians, dentists, nurse practitioners, licensed social workers, physical therapists, dental hygienists) to bill Medicaid for face-to-face visits. [10]
- Connecticut is participating in several CMS Innovation Awards, including the "Prevention of Chronic Disease in Medicaid Demonstration," and was awarded State Innovation Model Grants. [12]

Connecticut CHCs Compared to CHCs Nationwide

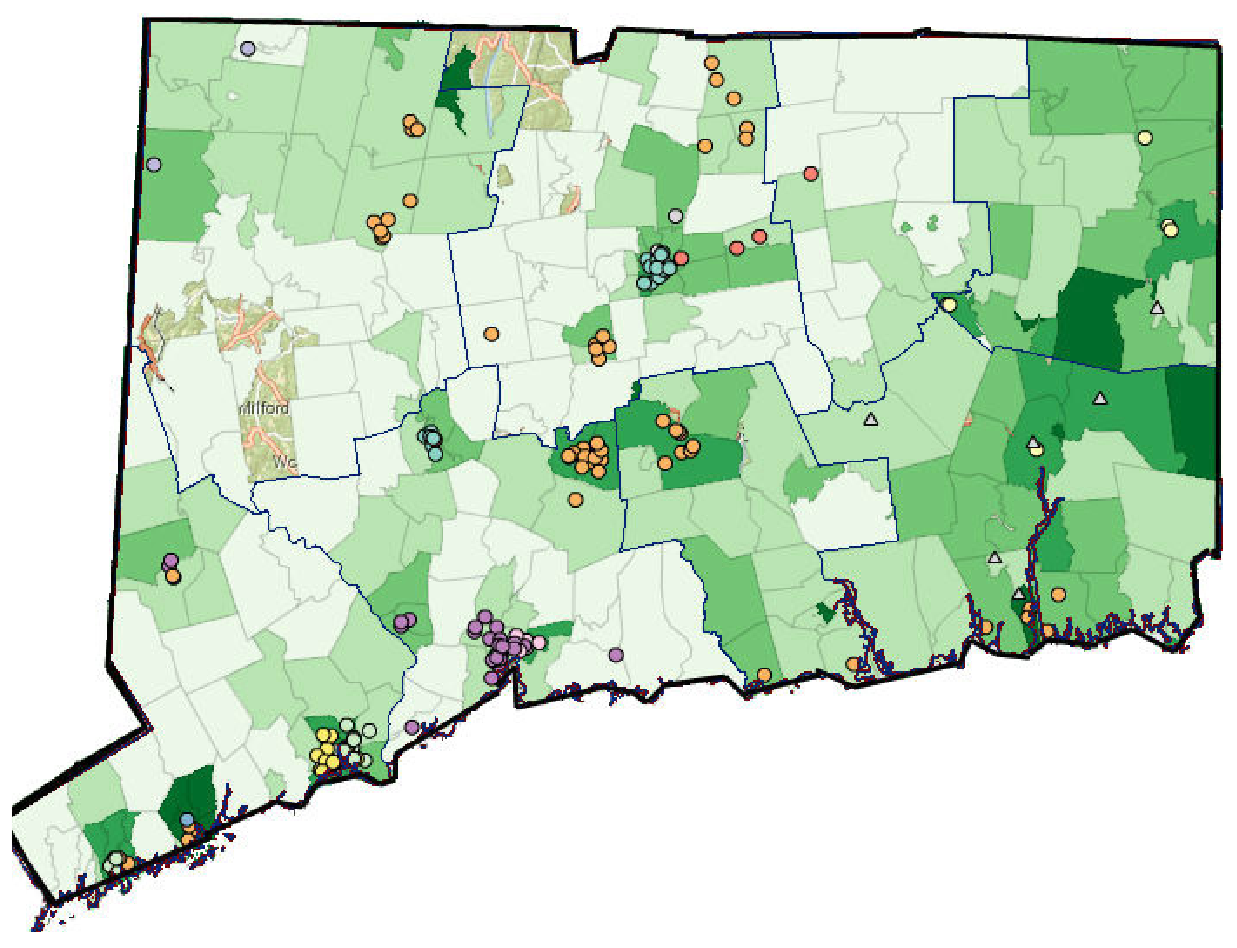
- Higher proportion of the total population served
- Nearly twice as many sites per CHC
- Substantially larger, providing nearly 80% more visits/organization
- Substantially higher proportion of Medicaid enrollees served
- More than twice as many mental health visits
- Higher than average annual growth rate

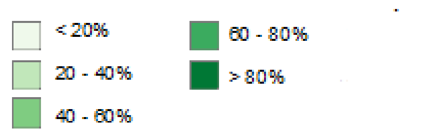
	CT	US
Population Served (2012)		
Total patients served by CHCs	329,009	21,102,391
% of population served by CHCs	9.4%	6.8%
% of under 200% FPL served by CHCs	30.5%	15.9%
% of Medicaid Enrollees Served	42.2%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	13	1284
Total CHC Service Delivery Sites (2014)	187	9509
Average Sites per CHC (2014)	14.4	7.4
Annual Visits (Total) (2012)	1,606,600	83,766,153
Annual Visits per CHC (2012)	123,585	69,922
Annual Visits Per Patient (2012)	4.88	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	62.8%	73.6%
Dental	15.7%	12.8%
Mental Health	17.0%	7.5%
Case Management/Enabling	4.5%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	5.0%	4.1%
Total Annual Visits	6.2%	4.3%
Medical	6.0%	3.5%
Dental	2.5%	7.6%
Mental Health	9.6%	9.6%
Case Management/Enabling	9.9%	1.6%

Note: All CHCs are Federally Qualifed Health Centers receiving Section 330 grants. Lookalikes not included.

Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Connecticut CHCs [13]



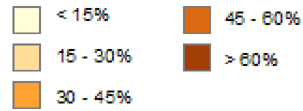


Colored circles represent CHC locations.
Unique color for each CHC network.

Source: UDS Mapper 2014

Connecticut Low Income Population [13]

% of Low-income (Pop below 200% FPL)



Colored circles represent CHC locations.
Unique color for each CHC network.

Source: UDS Mapper 2014

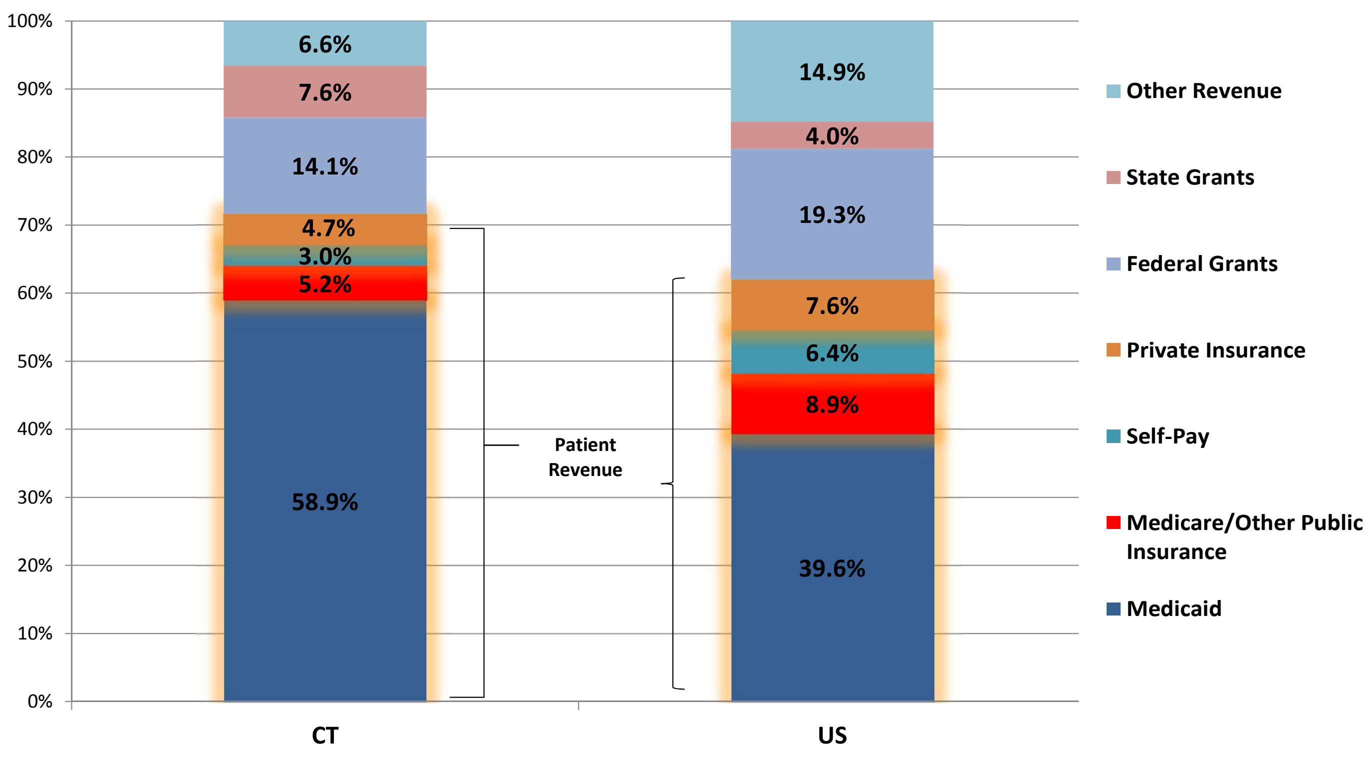
Connecticut CHCs Compared to CHCs Nationwide, 2012

- Higher proportion of revenue from patient services
- Substantially larger portion of patient revenue from Medicaid
- Lower reliance on federal grants

	CT	US
CHC Revenue Mix		
Patient Revenue	71.7%	62.9%
Medicaid	58.9%	39.6%
Medicare/Other Public Insurance	5.2%	8.9%
Self-Pay	3.0%	6.4%
Private Insurance	4.7%	7.6%
Federal Grants	14.1%	19.3%
State Grants	7.6%	4.0%
Other Revenue	6.6%	14.9%

Note: All CHCs are Federally Qualifed Health Centers receiving Section 330 grants. Lookalikes not included.

Source: UDS Summary Data 2010-2012, 2014



Source: UDS Summary Data 2012

Connecticut CHCs as a Group, 2009-2011

- Median Total Assets increased by 55%
- Unrestricted Net Assets grew by 77%
- Median Days Cash on Hand rose by 12%, from 39 to 44 days, above the benchmark

CT Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$6,930,850	$8,415,396	$10,728,694	55%	N/A
Total Revenues ($)	$12,820,595	$13,332,076	$15,935,425	24%	N/A
Profitability					
Total Margin (%)	2.8%	7.8%	2.8%	-1%	N/A
Unrestricted Net Assets ($)	$3,052,763	$4,540,293	$5,418,387	77%	N/A
Liquidity					
Days Cash on Hand	39	38	44	12%	>30 Days
Days in Accounts Receivable	24	21	19	-20%	<60 Days

Note: CHC 990s have limitations, and certain indicators could not be accurately analyzed as a result. For a more complete picture of CHC financials, audited financial statements should be consulted.

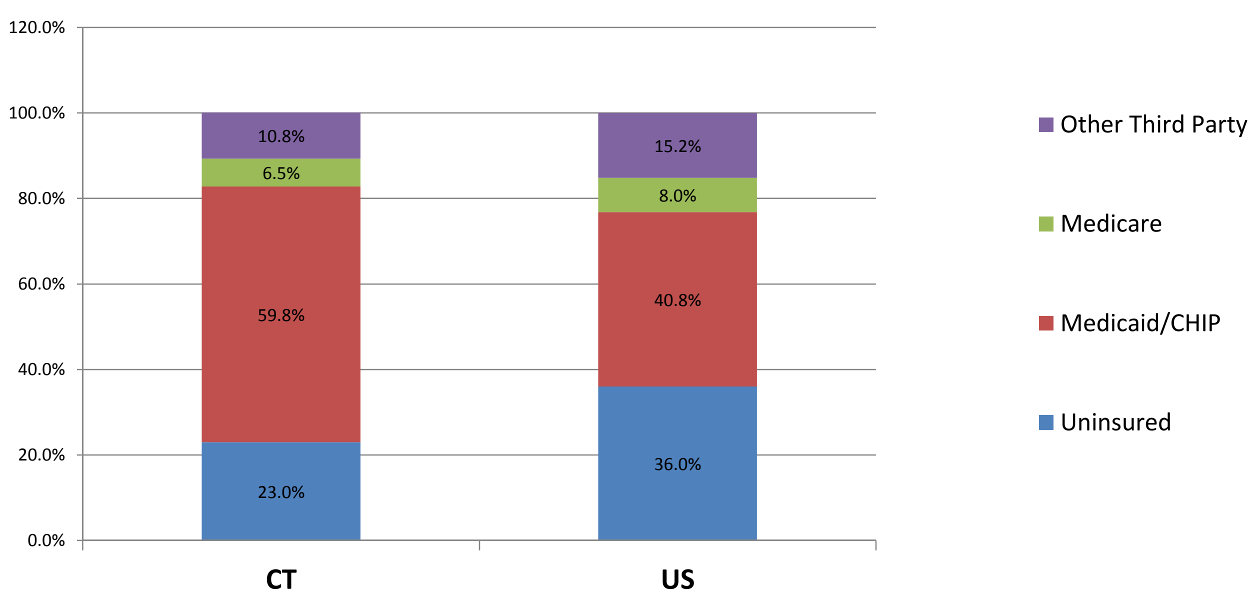
Sources: UDS Summary Data 2009-2011 and CHC Form 990s

Connecticut CHCs Visit Mix Compared to CHCs Nationwide [14]

- Proportion of patients living at or near poverty level is near national averages
- Substantially larger portion of patient visits are from those covered by Medicaid
- Fewer visits made by uninsured patients as compared to national averages

	CT	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	94.8%	92.6%
Patients at or below 100% poverty level	66.3%	71.9%
Coverage Status		
Uninsured	23.0%	36.0%
Medicaid/CHIP	59.8%	40.8%
Medicare	6.5%	8.0%
Other Third Party	10.8%	15.2%

Source: UDS Summary Data 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Significantly better than the national average on most primary care and prevention indicators
- Ranked #7 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Slightly lower proportion of the population is underserved for primary care
- Population underserved for dental near U.S. average

	CT	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	1.6%	5.3%
% low birthweights	8.0%	8.1%
% adults diagnosed with diabetes	7.0%	9.3%
Adult diabetes deaths per 100,000	15.4	20.8
Adult heart disease deaths per 100,000	155.7	179.1
Avoidable Hospitalizations per 1,000	60.4	66.6
America's Health Ranking (United Health Foundation)	7	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	316,448	35,057,608
% of total population	9.0%	11.3%
Estimated PCPs needed to achieve target PCP:Population	112	7067
Estimated underserved population for dental	334,549	31,707,007
% of total population	9.5%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	86	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [15]

- 77% of Connecticut CHCs sites have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- In January 2012, Connecticut introduced a person-centered medical home (PCMH) initiative with their redesigned HUSKY Health Program, but CHCs do not receive PCMH incentive payments.

Electronic Health Record Adoption [16]

- 85% of Connecticut CHC sites have adopted EHRs, compared to 88% nationally.
- Connecticut scores higher than the national average in 8 of the 12 EHR functionality categories.

Medicaid Policies – Highlights

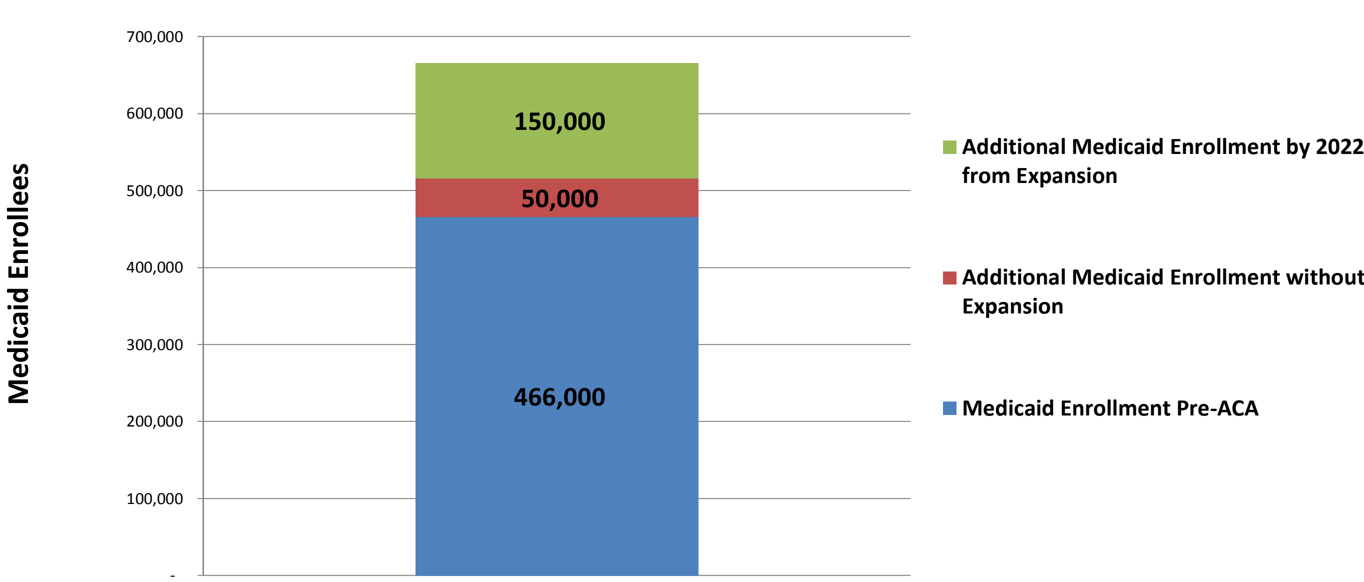
- Substantially higher per-enrollee Medicaid spending than national average
- Positive changes in Medicaid should increase access to care and expand enrollment

	CT	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$7,561	$5,563
Federal Medical Assistance Percentage (FMAP)	50.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	State	
Total Uninsured	405,000	53,277,000
% of Uninsured Individuals (all ages)	11.5%	17.2%
Medicaid Enrollment Pre-ACA	466,000	52,410,000
% of Total Population	13.3%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	50,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	200,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	42.9%	40.6%
Estimated Number Remaining Uninsured After ACA	224,000	27,930,000
Estimated % Uninsured After ACA (2020)	6.1%	8.7%

Source: Kaiser State Health Facts 2012, Urban Institute HIPSM 2012

Health Insurance & Medicaid Expansion – Highlights

- State is implementing Medicaid expansion and a State-run Health Insurance Exchange
- Lower than average uninsured rate
- State-supported Medicaid expansion will increase Medicaid enrollment by more than 40%
- Proportion of residents who are uninsured is expected to decrease by two-thirds from 11% to 6% over the next decade



Source: Kaiser State Health Facts 2012

Connecticut Medicaid Spending

Connecticut spends about $7,600 per Medicaid enrollee annually – the 8th highest in the nation for all health care services provided. [5]

According to the commissioner of the Department of Social Services (DSS), the department that administers HUSKY Health, Connecticut's public health coverage program, 4% of enrollees drive 49% of the costs (28,000 enrollees drive $2.3BN in annual spending). [11]

Medicaid Coverage & Administration

Connecticut has expanded its Medicaid program under the ACA. [6] In 2012, the state ended competing Medicaid Managed Care Organizations and instead awarded a single Administrative Services Organization (ASO) contract to managed its Medicaid program to Community Health Network of Connecticut, a not-for-profit organization that was started by several CHCs. [17] [18] [19]

While Connecticut does not make special payments for indigent care, it has historically had Medicaid eligibility limits well above those of most other states. With the Medicaid expansion, the state has set yet higher eligibility limits. Parents now have an upper eligibility limit of 201% FPL, while childless adults, who were previously only eligible if they were below 72% FPL (56% for the jobless) are now eligible up to 138% FPL. Even higher limits exist for pregnant women (263% FPL) and children (family income up to 323% FPL). [9]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	185%	250%	191%	70%
2014	323%	263%	201%	138%

*There is some variability in eligibility limits for children in 2013 under Medicaid based on age; however, the eligibility level chosen reflects the year's CHIP eligibility and/or highest eligibility level under Medicaid.

Source: Kaiser State Health Facts 2012

All behavioral health services for HUSKY Health are administered through the Connecticut Behavioral Health Partnership (BHP), which was designed to create an integrated behavioral health service system for Connecticut's Medicaid population, providing access to a more complete, coordinated, and effective system of community based behavioral health services and support. [20]

In FY 2012, the state passed the following Medicaid coordination initiatives:

- Benefit expansions: the state restored coverage for adult podiatry services, expanded coverage for tobacco cessation, but cut coverage for dental preventive care from 2 to 1 annual cleaning for adults, which is in-line with many Medicaid programs. [21]
- Simplification to HUSKY Health application/renewal: In response to a federal lawsuit, the state HUSKY Health administrator increased staff and modernized systems in an effort to reduce wait times for applicants. [21]

Connecticut CHC Reimbursement Policies [10]

Medicaid reimbursement for CHCs, is governed by the federal Prospective Payment System (PPS) requirements. Rates are adjusted (inflated) annually in accordance with the Medicare Economic Index (MEI).

The state lacks a scope of service definition, but will adjust rates to accommodate scope of service changes in practice. A CHC must request the rate change and submit an updated Medicaid cost report, which can take up to two years to process. According to the Connecticut PCA, recent Connecticut rate change efforts have typically involved adding dental services. Those CHCs that have applied for rate increases based on cost increases are generally still waiting for determinations.

In 2012, Connecticut changed its reimbursement methodology with the state becoming a single payer for CHC HUSKY Health payments. Therefore there are no capitation or wraparound payments. CHCs bill the state directly and are paid the whole rate every 2 weeks. [22]

Connecticut limits cost-sharing of medical and physician services with Medicaid populations to only select services and for only a nominal amount. [22] CHCs receive a separate fee-for-service Medicaid rate for medical, dental and mental health services rate based on a Medicaid cost report. The HUSKY Health program allows for up to one medical, one dental, and one behavioral CHC billable visit per patient in a given day. [23] There is no option for a CHC to obtain one all-inclusive Medicaid rate. [10]

More categories of providers are eligible to generate a reimbursable PPS encounter than is typical in other states. As shown in the table below, seven provider types can bill for face-to-face encounters.

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
CT	Yes	Yes	Yes	Yes	Physician Assistants; Allied Health Professionals, Chiropractors, Podiatrists

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
CT	Advanced Practice Nurses	Yes	No	Yes	No

Source: Update on the Status of the FQHC Medicaid Prospective Payment System in the States. NACHC, 2011

In January 2012, Connecticut introduced a person-centered medical home (PCMH) initiative with their redesigned HUSKY Health Program. To receive enhanced payments for medical home services, providers must be an active licensed physician, nurse practitioner or physician assistant with 60 percent of the practitioner's time focused on primary care. In January 2013, Connecticut amended the State Medicaid plan to eliminate incentive payments for CHCs. [21]

Collaboration with CMS [24]

Connecticut has collaborated with the Centers for Medicare and Medicaid Services (CMS) Innovation Center on a number of programs intended to develop and test service delivery models. The models typically provide incentive payments to participating providers, and include:

- **CHC Advanced Primary Care Demonstration** – Select CHC Grantees will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promotes better health, and lowers costs. One CHC is participating in the demonstration in Connecticut.
- **Medicaid Incentives for the Prevention of Chronic Disease** – which provides grants to states to utilize incentives to beneficiaries who participate in prevention programs that demonstrate changes in health risk and outcomes, including adoption of healthy behaviors.
- **State Innovation Model** – Connecticut was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan and has now applied for full funding.

Connecticut will collaborate with public and private stakeholders to design a transformed health care delivery system that incorporates promotion of integrated care models; use of the Health Insurance Exchange to inform and connect consumers to coverage; expanded supply of primary care physicians and other professionals; and increased engagement among regulators, providers and consumers. The resulting payment and delivery system model is intended to create greater alignment across multiple payers on contracting and payment strategies that promote value over volume, greater consistency in quality and other performance metrics, and expanded primary care.

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