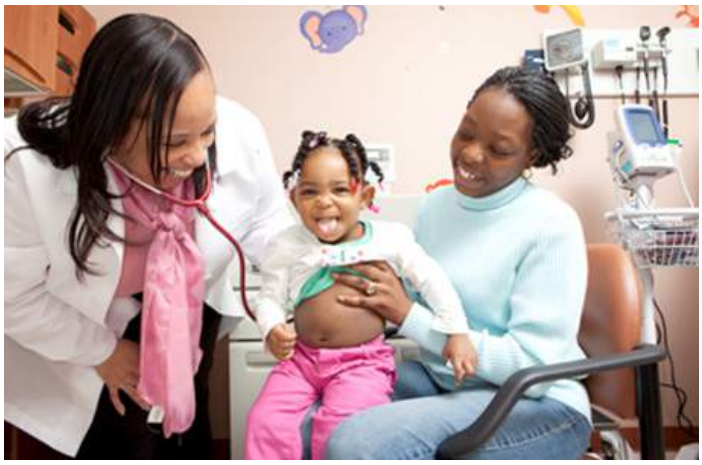

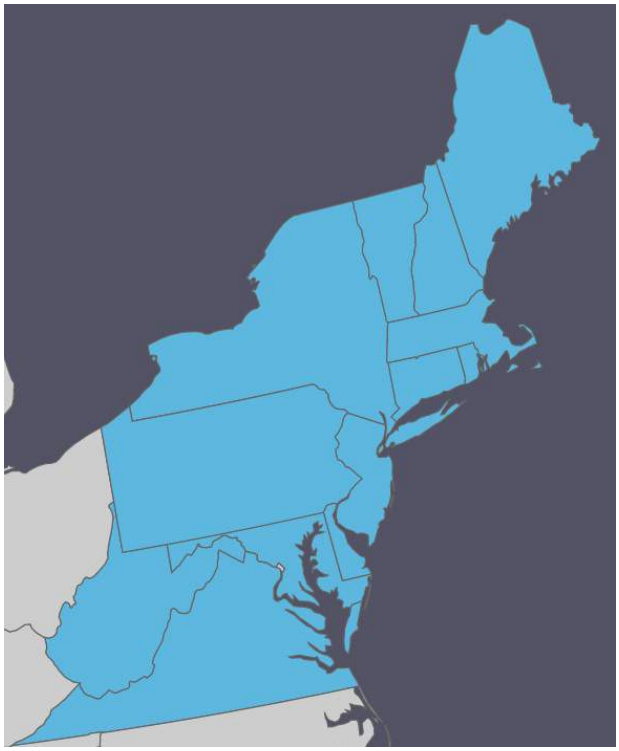

COMMUNITY HEALTH CENTER GROWTH & SUSTAINABILITY: *STATE PROFILES FROM THE NORTHEASTERN AND MID-ATLANTIC UNITED STATES*

December 2014

PRIMARY CARE DEVELOPMENT CORPORATION

Supported by the RCHN Community Health Foundation

Partner Support

The Primary Care Development Corporation wishes to thank the RCHN Community Health Foundation (RCHN CHF), and particularly Feygele Jacobs, President and Chief Executive Officer, for providing the funding and guidance to make CHC State Profiles possible.

PCDC and RCHN CHF hope that CHC State Profiles will help to enrich local, state and national discussions about primary care access, the importance of safety net providers like Community Health Centers in making available access to essential high quality health care and enabling services, and the role Community Health Centers play in improving the health of our nation's most vulnerable residents, notably low-income and uninsured children and adults.

Report Preparation

Community Health Center Growth & Sustainability: State Profiles from the Northeastern United States (CHC State Profiles) was produced with the help of numerous people. It was produced by Dan Lowenstein, Nancy Lager and Tom Manning, with significant contributions by Julia Busch, Morgana Davids, Bill O'Brien, Ronda Kotelchuck, Jeremy Mand, Kimberly Mirabella, Alex Purdie, and our intern Rizpah Bellard. We are grateful to our two Fellows, Grahme Deasy and Julian Fraga, who collected, organized and analyzed most of the data presented in the Profiles, as well as to Peter Epp and Aparna Mekala of CohnReznick, LLP for financial performance methodology and analytic assistance.

We would also like to express our appreciation to the National Association of Community Health Centers, Capital Link, and the State Primary Care Associations and industry experts who reviewed and contributed to these profiles.

PRIMARY CARE DEVELOPMENT CORPORATION

Mission and Vision

PCDC (the Primary Care Development Corporation) is a nonprofit organization dedicated to transforming and expanding primary care in underserved communities to improve health outcomes, reduce healthcare costs, and lessen disparities. Since 1993, PCDC has worked with hundreds of community health centers and other healthcare providers to strengthen and expand access to high quality primary care in underserved communities. (www.pcdc.org)

Programs

Investing in Primary Care: As a certified Community Development Financial Institution (CDFI) with two decades of market experience, PCDC provides the capital and know-how to build, renovate and expand community-based health care, so providers can serve more patients.

Strengthening Primary Care Capacity: Using proven strategies, PCDC provides expert consulting, training and coaching to help practices deliver patient-centered care that improves patient access, meaningful use of health IT, care coordination and patient experience.

Shaping Public Policy: PCDC supports and leads initiatives with policymakers and stakeholders that create favorable policies and greater resources to expand access to high quality primary care.

Impact

- **$515 million** invested and leveraged in low-income communities
- **1 million square feet** improved
- **900 healthcare organizations** strengthened
- **765,000 patients** with improved primary care access
- **7,000 healthcare workers** trained
- **Successful advocacy** that advances policies and public funding for primary care

RCHN COMMUNITY HEALTH FOUNDATION

The RCHN Community Health Foundation is a not-for-profit operating foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. (www.rchnfoundation.org)

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INTRODUCTION

An estimated 60 million Americans lack sufficient access to a primary care provider. As more patients become insured through Medicaid or private insurance and demand for primary care grows, community health centers (CHCs), which served some 21.7 million patients in 2013, are expected to play a critical role in meeting this demand.

As with any sector, health center growth – as well as initiatives to modernize and replace existing capacity – relies heavily on the ability to secure affordable capital. Those who provide capital to CHCs (community development financial institutions, commercial lenders, government and foundations) make investment decisions based on their analysis of a series of factors. Whereas many of these factors are specific to an individual CHC, the environment in which it operates can play a critical role in growth and sustainability, which are important considerations in the evaluation by an investor.

To help investors and other stakeholders better understand factors relevant to the operating environment of CHCs, the Primary Care Development Corporation (PCDC), a Community Development Financial Institution (CDFI) with extensive experience financing and supporting CHCs, prepared ***Community Health Center Growth and Sustainability: State Profiles from the Northeastern and Mid-Atlantic United States*** with support from the RCHN Community Health Foundation (RCHN CHF).

CHC State Profiles compiles key publicly available health and economic data, as well as aggregated health center financial data and relevant Medicaid policy information, from 13 Northeastern and Mid-Atlantic states (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia and West Virginia) and the District of Columbia (referred to collectively as the "Profiled States"). Where relevant or available, ***CHC State Profiles*** compares state-specific data to national data and/or recognized benchmarks. [1]

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1 In referring to CHCs or health centers, in these Profiles, we are specifically and in all instances referring to "comprehensive" Federally Qualified Health Centers (FQHCs) that receive a federal operating grant. These are the CHCs that are often referred to as "Grantees." Due to limitations of data availability, the Profiles do not include "Look-Alike" health centers (which represent less than 10% of CHCs in the Profiled States as of April 2014). Similarly, the Profiles do not include data from "Special Population" FQHCs serving only public housing, migrant farmworkers and homeless populations.

CRITICAL FACTORS AND OBSERVATIONS REGARDING CHC GROWTH AND SUSTAINABILITY

The factors analyzed for ***CHC State Profiles*** fall into five categories:

1. Health Center Scale
2. Health Center Financial Status
3. Primary Care Need
4. Primary Care Transformation
5. Medicaid and Health Insurance Landscape, including CHC Medicaid reimbursement policies

The factors included were selected from among hundreds based on their relevance to CHC growth and sustainability. In deciding which factors and indicators to include, PCDC consulted a number of experts and drew on more than 20 years of experience providing financing, technical assistance and advocacy to the community health center sector. *For more information please see Methodology and Sources.*

1. HEALTH CENTER SCALE

Scale is an important factor because it can indicate CHC impact on the state's underserved population. This is essentially the "market" in which CHCs operate. Their share of that market, and the extent to which that share is growing, can indicate current impact and future growth opportunities. Among the questions this information can help answer are: What is the footprint of health centers in the state? What proportion of the population do they serve? What are the demographics and composition of the population served? How much growth have the health centers achieved over the years analyzed?

Observations

- In the profiled states, there were 285 CHC organizations as of 2014
- CHCs collectively served over 5.3 million people in 2012
- From 2010 to 2012, median annual growth in patients served was approximately 4.2%, similar to the 4.1% growth by CHCs nationally.
- In Profiled States with a higher than average number of CHC visits/patient, CHCs tend to have a lower proportion of medical visits and a higher proportion of non-medical visits than CHCs nationwide.

The CHC sector is an essential provider to low-income populations:

- CHCs typically served 1 in 5 Medicaid enrollees across the Profiled States in 2012 and 1 in 6 low-income persons (those living in a household earning below 200% of the federal poverty level).
- In 5 of the Profiles States, CHCs served more than 1 in 4 Medicaid enrollees,
- In 3 of the Profiled states, CHCs served over 40% of the low-income population.

Factors Analyzed

Population Served by CHCs, in terms of size and demographics of population served, and the comparable data for the sector in each state, as well as the volume of services they provide.

- **Total Population Served by CHCs** and **Percentage of Population Served by CHCs** indicate the size of the population served and CHCs' market share.
- **Percentage of Population Under 200% of the Federal Poverty Level (FPL)**

  Served by CHCs. 200% of the FPL is a generally accepted measure of "low-income", which is the subset of the population that CHCs predominantly serve. This consists primarily of people who are uninsured or insured through public programs like Medicaid. In the US overall, 40% of the population is deemed low-income, ranging from a low of 25% in one state to a high of 47% in six states. [2]

  Where CHCs serve a higher percentage of people living below 200% of FPL they play a more vital safety net role. Lower percentages may indicate market opportunities for CHC growth within a state, though further analysis would be needed to determine how and where low-income residents currently receive care.

- **Percentage of State's Medicaid Enrollees Served by CHCs**

  Medicaid usually pays CHCs at a rate more commensurate with the cost of delivering services than do other payers. Higher percentages of Medicaid patients in a state suggest a greater number of patients will generate a more robust revenue stream. As above, lower percentages suggest that low-income residents are receiving care elsewhere or not at all and may indicate an opportunity for CHC growth. States that have expanded Medicaid offer greater opportunities for patient growth than states that have not.

CHC Characteristics & Volume

- **Number of CHCs, Total CHC Service Delivery Sites, and Annual Visits (Total)** measure the size of the CHC sector.
- **Average Sites per CHC**

  This can be an indicator of both market share and organizational strength. With regard to market share, a higher average number of sites would likely provide individual CHCs with greater access to their target population of low-income residents. Also, a higher ratio of sites per organization better positions CHCs to realize economies of scale.

  One caveat, for which data is not readily available, is the size of these sites. Organizations with many small sites may be less able to reap the same market share or financial benefits experienced by their counterparts who operate larger, and possibly fewer, sites.

- **Annual Visits per CHC**

  This tends to be an indicator of organizational strength since: (i) more volume generally generates more revenue through fee-for-service reimbursement structure); (ii) more volume provides the opportunity for CHCs to achieve greater economies of scale; and (iii) stronger CHCs are better positioned to attract and retain personnel at all organizational levels.

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2 Kaiser State Health Facts 2013: http://kff.org/other/state-indicator/population-up-to-200-fpl/

- **Annual Visits per Patient**

  This can be an indicator of service diversity and organizational strength since organizations that have a higher number of total patient visits typically offer a broader array of services, such as dental and/or mental health services, in addition to medical services (See Visit Mix below).

- **Visit Mix (Medical, Dental, Mental Health)**

  Higher percentages of dental and mental health visits point to more developed CHC clinical programs that offer a more comprehensive and coordinated set of services. As suggested above, higher percentages of dental and mental health visits do appear related to a larger number of visits per patient.

  Greater visit mix diversity also may indicate state primary care and Medicaid eligibility and reimbursement policies that enable CHCs to offer a greater array of services.

- **Compound Annual Visit Growth Rate (Total, Medical, Dental, Mental Health)**

  Higher than average annual growth rates point to CHCs that have more aggressively expanded during an overall period of strong national growth and may indicate supportive state policies in terms of Medicaid eligibility, changes to support expanded services, availability of grant funding and other factors.

2. HEALTH CENTER FINANCIAL STATUS

Understanding CHCs' revenue mix and how CHCs perform on key financial indicators is critical to modeling financial growth and sustainability projections necessary for the analysis to support sound investment. While the financial status of CHCs within a state can vary widely, their aggregated financial status can provide context for analysis of individual CHCs including how they compare to state and national averages or benchmarks. [3]

Observations

Based on a review of data from 2009-2011, the health centers presents across a range of financial circumstances:

- In 8 states, CHC median days cash – an important indicator of operating liquidity – exceeded the 30-day benchmark in 2011. In 4 states, the median was below 20 days. Median days cash grew by more than 20% in 3 states from 2009-2011, but decreased by more than 20% in 5 states.
- Assets typically grew substantially from 2009-2011, with the median growing by 10% or more per year in 11 states.
- Changes in financial strength were mixed, as measured by growth of unrestricted net assets (UNA) relative to growth of assets. Median UNA grew relative to assets in 6 states and was essentially unchanged in 3 more. In the other 5 states, median UNA grew at approximately half the rate of assets or less.
- Median total margin exceeded 4% in 6 states in 2011, and exceeded 2% in 5 more states.

3 The majority of CHC financial data was collected from publicly available IRS Form 990s, which all nonprofits must file. Information in 990s have limitations and data can differ from audited financial statements. Certain indicators could not be accurately analyzed as a result. For a more complete picture of CHC financials, audited financial statements should be consulted. Additionally, *Capital Link* (www.caplink.org), an organization that regularly tracks and analyzes CHC financial data, produces numerous valuable CHC sector reports that investors should consult.

Factors Analyzed

Revenue by Source

- **Proportion of Revenue from Patient Care vs. Grants**

  Though revenue diversity is optimal, CHCs with a higher proportion of total revenue deriving from patient revenue, as opposed to grant revenue, generally have a more sustainable business model. Federal and state grants, whose continuation depends on government budget actions, are less reliable revenue sources with greater potential for CHC destabilization. Over-dependence on grants from private sources can be similarly risky.

Revenue by Payer

- **Proportion of Revenue from Medicaid, Medicare & Other Public Insurance, Private Insurance, and Self-Pay Patients**

  Payment rates differ widely by payer. Public insurance (Medicaid, Medicare and other state-specific government programs) tend to offer routine cost of living increases and therefore pay more, , than private (aka commercial) insurance. Medicaid is typically the highest payer, with a federal mandate to pay CHCs based on reasonable cost, and so higher percentages of Medicaid revenue can point to a more sustainable business model. However, CHCs with greater proportions of commercial insurance in their payer mix may be better positioned to attract and retain increasing numbers of patients enrolled though state health insurance exchanges.

- **Visits by Payer**

  Higher proportions of uninsured patients correlate with greater reliance on government grants, notably federal Sect. 330 operating grant funding and possibly state-specific indigent care funding, which do not always fill the funding gap.

Financial Performance

Six indicators provide a good snapshot of growth, profitability, and liquidity. These are predicated on CHCs' financial audits as reported in the IRS Form 990, the tax form required of all non-profit tax-exempt organizations.

Growth

Increases in Total Assets and in Total Revenues over a three-year period and consistent trends are signs of sectoral strength.

1. **Total Assets**, according to the International Accounting Standards Board, include all "resources controlled by the entity as a result of past events and from which future economic benefits are expected to flow to the entity." For CHCs, these primarily include: Current Assets (e.g., cash and receivables); Long-Term Investments; and Fixed Assets (e.g., property, plant and equipment). Growth, relative to national trends, can indicate the relative strength of the sector.
2. **Unrestricted Net Assets (UNA)** is the portion of an organization's assets that is in excess of liabilities and can be used for any mission-appropriate purpose without restriction.

Profitability

3. **Total Revenues** include revenues from all sources, both operating and non-operating revenue sources, net of allowances (i.e., contractual or other "discounts"). Increases over the period analyzed and consistent trends are signs of strength.
4. **Total Margin**, defined as Total Net Income or Surplus / Total Revenue, is an indicator of overall financial health. Figures consistently higher than national averages suggest a sector better positioned to weather short-term environmental fluctuations and also better positioned for future growth. *For a more accurate picture, unrestricted net operating income or surplus/unrestricted operating revenue should be analyzed. This information is available on audited financial reports, but not on Form 990s.*

Liquidity

5. **Days Cash on Hand**, defined as Cash / Total Expenses / 365 (Excluding Bad Debt and Donated services), is a measure of liquidity, specifically how long, in the absence of new cash, the organization can cover its expenses before running out of cash and having to use reserves/investments. The industry benchmark is >30 days. [4] Higher than average cash on hand may indicate that CHCs have capital available to invest in future facility and/or operating expansion.
6. **Days in Accounts Receivable**, defined as Total Accounts Receivable / (Total Revenue / 365 Days), is a measure of how effective CHCs are managing billing and collections. The industry benchmark is <60 days. [5] A lower figure is desirable, and indicates that CHC billing is timely and complete and that payers' remittances are also timely. Higher than average Days in Accounts Receivable could indicate inadequate cash management or poor billing practices by CHCs or payer delays or other payment issues that affect the sector or state. ***Days in Accounts Payable*** are not included because of the limitations of the Form 990 data. Accounts payable information is best determined from audited financial statements.

3. PRIMARY CARE NEED

How a state performs on key health indicators related to primary care access (e.g., prenatal care, diabetes, heart disease, avoidable hospitalizations) sheds light on the state's commitment to public health, healthcare workforce and primary care infrastructure. Information about what portion of the state's population lacks access to primary medical and dental care, and how many providers are needed to meet this need, can help us better understand the need for primary care expansion, as well as the challenges in attracting and retaining a primary care workforce.

Observations

- In 6 of the Profiled States, 5% or more of the population lacks access to a primary care provider.
- In 8 states, 5% or more of the population lacks access to a dental provider.
- 9 states rank in the top 25, with 5 states in the top 10, in America's Health Rankings.

4 Capital Link, Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011, July 2013, pg. 28.

5 Capital Link, Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011, July 2013, pg. 30.

Factors Analyzed

Primary Care & Prevention Clinical Indicators

These measures are standard public health indicators, with higher rates indicative of insufficient investment in public health infrastructure and pronounced disparities in primary care access.

- **% Births to Women with Late/No Prenatal Care**
- **% Low Birthweight Births**
- **% Adults Diagnosed with Diabetes**
- **Adult Diabetes Deaths per 100,000 Population**
- **Adult Heart Disease Deaths per 100,000 Population**
- **Avoidable Hospitalizations** (number of Avoidable Medicare Hospitalizations per 1,000 Medicare Enrollees.)

Avoidable Hospitalizations are inpatient stays for Ambulatory Care Sensitive (ACS) conditions (e.g., asthma, hypertension, diabetes and bacterial pneumonia) that might have been prevented if primary and preventive care services were more readily accessible. The Agency for Health Care Research and Quality (AHRQ) defines Ambulatory Care Sensitive Conditions are conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease." [6] Avoidable hospitalization rates tend to be higher where residents lack adequate access to primary and preventive care, and studies link reductions in avoidable hospital use to insurance and primary/preventive care availability. Medicare enrollees are the only patients nationwide for whom ACS admissions are currently tracked.

America's Health Rankings, prepared annually by United Health Foundation, tracks "the state of our nation's health by studying numerous health measures to compile a comprehensive perspective on our nation's health issues, state by state." [7] The measures include, but are not limited to, rates of smoking, diabetes, asthma and preventable hospitalizations. The higher the ranking, the comparatively healthier a state's population is.

Primary Care Shortage & Workforce Indicators

In states with significant primary care shortages, residents likely encounter more difficulties in accessing care, and low-income residents tend to be even more adversely affected. Though CHCs in states with significant workforce shortages often experience challenges recruiting and retaining clinical staff for expansion, they have some salary and recruitment advantages relative to other providers serving low-income residents, such as the availability of federal and state programs to repay portions of student loan debt. This provides a potentially better vehicle for primary care expansion in underserved areas.

In many states, CHCs have increased their staffing ratio of nurse practitioners and physician assistants to physicians and established a more "team based" means of providing care. This approach allows all practitioners to work at the maximum scope of their training and licensure and has been shown to improve provider satisfaction and patient outcomes.

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6 Agency for Health Care Research and Quality, Prevention Quality Indicators Overview http://www.qualityindicators.ahrq.gov/. Updated 2003.

7 America's Health Rankings http://www.americashealthrankings.org/

- **Estimated Underserved Population for Primary Care**

  This estimate was generated by multiplying the number of primary care physicians in the Federal Health Professional Shortage Area (HPSA) by a target population-to-practitioner ratio of 2,000:1, and subtracting this figure from the total HPSA population. This is an indicator of the size of the potential market of new CHC users and relative to total population, a broad indicator of expansion opportunities, with higher numbers and percentages suggesting larger markets for CHC growth. HPSAs are designations of critical geographic areas, population groups, medical facilities, and other public facilities with shortages of health care professionals. [8]

  Important note: Aggregating HPSA data to a statewide level may mask significant primary care shortage areas in particular regions of some states. This is especially the case in states that have large urban and rural areas, as well as states with large areas with a diversity of socioeconomic regions. This report did not analyze regional variations within states.

- **Estimated Number of Primary Care Providers (PCPs) Needed to Achieve the Target PCP : Population Ratio**
- **Estimated Number of Dental Providers Needed to Achieve the Target Dental Provider: Population Ratio**

  Estimates were derived by computing the number of primary care or dental practitioners that would be needed to achieve a population to full-time-equivalent practitioner ratio of 3,500:1 (or 3,000:1 in high-need areas). This ratio should be understood in the context of how primary care delivery is changing. The responsibility for managing patient health and the cost of care is increasingly becoming a responsibility of the primary care provider, which would argue for smaller panels of patients. However, conventional wisdom is that team-based care enables physicians to manage larger panels with a skilled team of professionals.

4. PRIMARY CARE TRANSFORMATION

Health care is going through a period of significant change and disruption that will provide both challenges and opportunities for health centers.

- Reforms to provider reimbursement, focusing on the outcomes rather than the volume of care provided, will put pressure on health centers' primary payment mechanism – the Medicaid Prospective Payment System (PPS).
- As funding becomes available to support more robust primary care models, health centers stand to benefit, but could also face competition as new entrants see business opportunities in the primary care sector.
- New technologies and consumer access to data are making patients more informed "shoppers" and may reduce reliance on the traditional office visit.

CHCs that understand the impact these forces may have and that embrace adaptability will be in a much better position to stay ahead of the change and to grow and sustain their organizations over time. The level of adoption of electronic health records (EHR), Patient-Centered Medical Homes (PCMH), and federally-funded initiatives that support delivery system change and payment reform indicates their preparedness in a rapidly changing healthcare environment.

8 http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

Observations

The data show the Profiled States to be typically among the leaders nationally:

- 10 states have more widespread adoption of EHR than the national average among CHCs, and the other 4 states are very close to the national average. It should be noted, nonetheless, that not all states report advanced use of their EHRs to manage their patients' conditions.
- 11 states have a higher percentage of their CHCs recognized as a PCMH by the National Committee on Quality Assurance (NCQA) or other accrediting body as of 12/31/13, including 8 states with 50% or more CHCs recognized.
- CHCs in all states are participating in some level of federally-funded transformation, with some in more advanced stages.

Factors Analyzed

Electronic Health Record (EHR) Adoption

EHR adoption has become a foundational tool for improving primary care delivery and care management of individuals and populations. The self-reported status of EHR adoption among CHCs in each state is described, looking at as a whole at the number of sites/providers using EHR and the use of 12 functional categories (defined below) plus ability to report Uniform Data Systems (UDS) data electronically (see footnote 12). EHR adoption is indicative of CHCs' positioning for future health system delivery change.

EHR Functional Categories

- Patient history and demographic information
- Clinical notes
- Computerized provider order entry (CPOE) for lab tests
- CPOE for radiology tests
- Electronic entry of prescriptions
- Reminders for guideline-based interventions or screening tests
- Capability to exchange key clinical information among providers
- Notifiable diseases notification sent electronically
- Reporting to immunization registries done electronically
- Ability to provide patients with a copy of their health information on request
- Capacity to provide clinical summaries for patients for each office visit
- Protection of electronic health information
- Use an EHR to report clinical UDS data

Patient-Centered Medical Home (PCMH) Initiatives

PCMH is a coordinated, team-based delivery model that emphasizes patient participation and practice engagement where a patient receives care in a regular, continuous, and patient-centered manner. Studies show that patients with a medical care home experience fewer non-urgent emergency room visits and lower rates of avoidable hospitalizations. [9] The measures indicate how many CHCs have become recognized as a PCMH by NCQA or another national accrediting organization. The capacity of CHCs to adopt PCMH principles is essential to their participation in a transformed, integrated delivery system with a greater focus on improving health outcomes while lowering health care costs.

Federally-Funded Transformation Initiatives

The Affordable Care Act authorized federal health agencies to launch state-based innovation initiatives to help transform how health care is delivered and paid for. The Center of Medicare and Medicaid Services (CMS) is the primary sponsor of these initiatives, which include the Comprehensive Primary Care Initiative, FQHC Advanced Primary Care Practice Demonstration, Prevention of Chronic Disease in Medicaid Demonstration and State Innovation Models.

9 (1) Starfield B. "Primary Care: Balancing Health Needs, Services, and Technology" New York: Oxford University Press, 1998; (2) Starfield B. "Primary Care and Health: A Cross-National Comparison," JAMA 266(16):2268-71 October 1991; (3) Starfield B. "Is Primary Care Essential?" 344(8930):1129-33 October 1994; (4) Sox C. et al "Insurance or Regular Physician: Which is the Most Powerful Predictor of Health Care?" March 1998 American Journal of Public Health 88(3):364-370.

5. MEDICAID AND HEALTH INSURANCE LANDSCAPE

To describe how the payment environment for CHCs may change and provide opportunities for CHC growth, we present information on policies affecting CHCs' two largest payer segments: the uninsured and those enrolled in Medicaid. This includes the states' responses to a key aspect of the Affordable Care Act (ACA), namely Medicaid expansion.

CHCs with a larger proportion of patient revenue from Medicaid and private health insurance have a more predictable revenue source and are less susceptible to negative public policy changes at the state and federal level. States that have expanded Medicaid and operate state-run health insurance exchanges are generally considered more favorable financial environments for CHCs. This is particularly true for Medicaid expansion, as Medicaid is usually a more favorable payer to health centers than private insurance (see State CHC Medicaid Reimbursement Policies below)

Important note: Many communities will have market conditions or health center capacity that are favorable to health center expansion, even if the state itself does not have a particularly favorable policy environment.

Observations

The Profiled States are more likely to support Medicaid as a strategy to provide health care to low-income populations than states in other regions, which is significant as Medicaid is typically the best revenue source for CHCs.

- Each of the Profiled States spends more per Medicaid enrollee than the national average, based on 2010 figures. On average, the Profiled States spent 27% more than the national per-enrollee average.
- 11 of the 14 Profiled States (79%) have chosen to expand Medicaid eligibility in accordance with the Affordable Care Act (ACA), as compared to 16 of the remaining 37 states (43%, as of April 2014).
- Medicaid expansion is an active issue in the remaining three Profiled States, with one pursuing an alternative expansion strategy and the other two others not participating at time of publication.
- 10 of the Profiled States (71%) have adopted state-run exchanges, or partnered with the federal government, as compared to 13 of the remaining 37 states (35%).

Factors Analyzed

Medicaid Payments per Enrollee

This is defined as total Medicaid dollars spent by each state in a given year, for all Medicaid services provided, divided by the total number of Medicaid enrollees in that year. A higher-than-average number suggests more generous state Medicaid policies, and might also suggest opportunities for primary care expansion – especially through CHCs, which are notable for being cost-effective primary care providers – as a means of reducing per-enrollee spending.

Federal Medical Assistance Percentage (FMAP)

This is the federal share of a State's Medicaid program. FMAP rates have a statutory minimum of 50%,with higher percentages for states with lower state income. [10] Higher federal contributions indicate that a state likely has fewer public resources to invest in primary care. This may be seen as a proxy for a state's ability to provide public resources for CHC expansion.

10 http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

State Medicaid & Health Insurance Expansion

- **Supports Medicaid Expansion– Yes or No?**

  This indicates whether the state is/is not expanding per the ACA, as of the date of this publication. Medicaid expansion may be the single most important factor in CHC expansion viability, since Medicaid is the major source of revenue for most health centers. "Expansion" states provide major growth opportunities for CHCs. In non-expansion states, those in poverty will still use health centers, but without new financial resources, CHC expansion will be more challenging.

- **Type of Health Insurance Exchange**

  This indicates whether the state is implementing its own health insurance exchange or partnering with the federal government on the implementation, or deferring entirely to the federal government on implementation. Greater levels of state control tend to correlate with greater levels of policy support at the state level for the ACA. It is likely that, over time, this will lead to greater reductions in the uninsured population, potentially leading to more insured patients at CHCs, and hence, improved revenue streams.

- **Uninsured Non-Elderly Adults**

  This segment is the key target for new Medicaid and health insurance exchange enrollment. These newly insured individuals are a possible "new market" for CHCs (it has been well-documented that insured individuals seek care more than do uninsured individuals) and a newly-paying market that will bring new financial resources to CHCs.

- **Additional Medicaid Enrollment from Medicaid Expansion/Additional Medicaid Enrollment without Medicaid Expansion**

  These are estimates developed by the Urban Institute, and reported by the Kaiser Family Foundation, of the likely expansion to a state's Medicaid rolls expected, by 2022, (i) to result from a state formally expanding its Medicaid program in accordance with eligibility formulas in the ACA, or (ii) from enrollment growth in previously eligible categories. The percentage growth in the Medicaid rolls is generally higher for states with historically lower Medicaid eligibility thresholds.

- **Estimated Remaining Uninsured & Uninsured Rate after ACA (2022)**

  These are estimates developed by the Urban Institute, and reported by the Kaiser Family Foundation, of the number of state residents who will likely remain uninsured after ACA implementation due to ineligibility, most likely because they are undocumented immigrants. Health centers will continue to serve this population. If Massachusetts' health insurance reform experience is a guide, the number of uninsured patients served by CHCs held roughly steady, even as the statewide number of uninsured plunged, suggesting that the remaining residents without insurance increasingly turned to CHCs. As a policy matter, this suggests that CHCs will need to retain existing levels of resources – or increase resources – to cover the costs of caring for the uninsured.

CHC Medicaid Reimbursement Policies

CHCs receive Medicaid reimbursement (and Medicare as of October 2014) through a Prospective Payment System (PPS) rate based on a per-visit baseline payment rate set in 2000 equal to 100 percent of the center's average costs per visit. *Since 2001, states have been required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate increased each year by a standard medical inflation factor, known as the Medicare Economic Index ("MEI"), and adjusted "to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year." Under PPS, State Medicaid agencies are required to pay centers their PPS per-visit rate (or an alternative payment methodology, or "APM") for each face-to-face encounter between a Medicaid beneficiary and one of the center's billable providers for a medically necessary (and covered) service, regardless of the actual cost to the FQHC of providing that visit or the number of services performed at the visit.* [11]

CHC Medicaid reimbursement policy is the arena in which states usually have the greatest direct impact on CHC finances. There is considerable variance across the Profiled States, including:

- Which states use PPS versus an Alternative Payment Methodology;
- The number of visits per day, type of visits and providers that trigger a reimbursement vary across the Profile States;
- The scope of services criteria that triggers a rate adjustment; and
- Timeliness of payments for Medicaid claims.

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11 NACHC State Policy Report #38: Emerging Issues in the FQHC Prospective Payment System, 2011

METHODOLOGY AND SOURCES

CHC State Profiles was produced from a vast array of quantitative and qualitative data, highlighting key factors to provide a profile of the CHC sector in 13 Northeastern and Mid-Atlantic states and the District of Columbia and the environment in which CHCs operate. The specific factors, and their relevance, are detailed below.

Overall Methodology

To carry out this assessment, PCDC collected quantitative and qualitative data pertaining to 13 Eastern states and the District of Columbia (referred to herein collectively as "Profiled States"). We sought out quantitative data from secondary sources to provide a snapshot for each state of:

- The scale and market penetration of the Federally Qualified Health Centers (CHCs) in each state, drawing primarily on the HRSA Uniform Data System (UDS) [12] and information compiled by the Kaiser Family Foundation and other aggregators of health data;
- The financial status of CHCs, working with CohnReznick to analyze key financial performance indicators extracted from the IRS Form 990 filed by each CHC; and
- Primary care need, analyzing such variables as: population living in health shortage areas (e.g., health professional shortage areas (HPSAs); prevalence of preventable chronic disease; maternal health indicators; and avoidable hospitalizations.

To present each state's perspective on primary care generally and CHCs specifically, we gathered qualitative data on Medicaid policies and the reimbursement and regulatory environment, and supplemented this with information provided by leaders and staff from Primary Care Associations and individual health centers.

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12 HRSA Uniform Data Systems (UDS) is a core set of information appropriate for reviewing the operation and performance of health centers. The UDS tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. At time of analysis, 2012 UDS data was the latest available. 2013 data is now available at http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

Methodology for Analyzing Financial Performance Indicators

The financial indicators chosen for this analysis use data from the IRS Form 990, specifically in the Statement of Revenue, Statement of Functional Expenses, and Balance Sheet sections. The 990s provide uniform, publically-accessible data. The table below lists the indicators and the methodology for collecting the data from IRS Form 990:

Financial Indicator	Methodology	Source
Profitability		
Total Revenues	Total Revenue from all Sources	Form 990 Statement of Revenue
Total Margin	Total Net Income / Net Revenue	Form 990 Part I Summary
Growth		
Total Assets	Total Assets	Form 990 Balance Sheet
Unrestricted Net Assets	Unrestricted Net Assets	Form 990 Balance Sheet
Liquidity		
Total Days Cash-on-Hand	Cash /(Total Expenses / 365 Days) Excludes Bad Debt & Donated Services	Form 990 Statement of Revenue and Statement of Functional Expenses
Total Days in Accounts Receivable	Total Accounts Receivable / (Total Revenue / 365 Days)	Form 990 Balance Sheet and Statement of Revenue

Given the level of detail in the IRS 990, certain other financial ratios, such as the Current Ratio, Working Capital and Debt to Equity, could not be calculated.

For each indicator selected, State medians were compared to the optimal benchmark/range, where one exists, and to the US median for all CHCs. Since the "averages" include outliers which may skew the data, the median seemed to be a more accurate measure.

Benchmarks for these financial indicators are based on Federal expectations of CHCs. For Total Margin, Total Assets and Unrestricted Net Assets, where there is no industry benchmark, trends over time and comparison to the US median for all CHCs are more meaningful.

Data Issues and Caveats

Once the raw data was collected for each of the CHC grantees, we reviewed the information and determined a few limitations, outliers and inconsistencies with the way information was recorded on the IRS Form 990s across these health centers. The following is a list of issues as related to data collection and that determined whether the CHC was included in the analysis:

1. To ensure that the CHC program comprises a significant portion or is the only line of business, we evaluated the distribution of program services
2. Form 990s were available for all three years across all health centers with some exceptions
3. A few health centers did not record Cash and were noted in the dataset. For those health centers, the "Days on Cash" indicator may be lower than expected.
4. 990s can give a great deal of information about CHCs, but for more accurate information, audited financial statements should be consulted. For example, 990's do not provide the level of detail provided in an audit, such as the differentiation between unrestricted and restricted revenue and expenses
5. Other additional issues for consideration that impacts the quality of the data:

   Accounts Receivables – typically in analyzing collection experience, a review of the days outstanding in patient accounts receivable is analyzed. Since the 990s do not segregate patient accounts receivable from other receivables (e.g. government grants and contracts), days outstanding in "total" accounts receivable was analyzed since we were unable to exclude non-patient items.

   Accounts Payable were not included because the way this factor is reported 990s differs considerably from how it is reported on audited financial statements.

   Total Margin – when analyzing a health center's margin, the operating margin, excluding one-time, non-operating items, is typically compared to the operating revenue base. As non-operating items are not identified in the 990, we were unable to exclude non-operating items from the ratio.

   340-B Program Revenue – The 340B program is a U.S. government drug discount program that allows eligible health care organizations to purchase pharmaceuticals at discounted prices as compared to retail. 340B programs are an additional source of revenue for participating CHCs.

   Cost Report Settlements – In certain states, the Medicaid agency evaluates the health center's cost report filing and issues an adjusted PPS rate or Medicaid managed care "wraparound" rate, retroactively. In addition, adjustments in PPS rates for changes in scope of services may occur with sizable retroactive payments. It is not uncommon for states to take a lengthy period of time in settling these claims, resulting in sizable accounts receivable balances. These additional funds were transferred to Accounts Receivable to capture the full receivable and could create receivables that exceed the industry norm.

   Other Assets & Other Liabilities were analyzed to exclude, to the extent possible, all non-capital portions for these two categories. However, there is limited information in the supporting schedules to determine if all or any portion of the amount reported was related to capital.

Financial Indicator	Interpretation	Expectation
Profitability		
Total Revenues		Expectation is that there is a consistent upward trend, indicating CHC growth.
Total Margin	Measures the control of expenses relative to revenues	Expectation is that the margin is positive and constant or increasing over time. Note: this can be skewed by one-time non-operating items. Ideally it is best to analyze net unrestricted operating margin or surplus (from the audited financial statements)
Growth		
Total Assets		Expectation is that there is a consistent upward trend, indicating CHC growth.
Unrestricted Net Assets		Expectation is that there is a consistent upward trend, indicating CHC growth.
Liquidity		
Total Days Cash-on-Hand	Measures the number of days that a CHC could operate if no additional cash was obtained.	An increasing trend indicates that the CHC's cash position is strengthening. HRSA expects days cash-on-hand to be >30 days.
Total Days in Accounts Receivable	Measures the number of day, on average, that it takes a CHC to collect its receivables from third party payers, government grants/ contracts and other sources.	An increasing trend indicates that receivables are being paid more slowly and aging, and that deteriorating cash flow could hamper the CHC's ability to operate. The benchmark is <60 Days.

SOURCES

Links are clickable

The sources below were used in each of the State Profiles. Additionally, state-specific sources were used to better understand the environment in which CHCs operate. See individual state profile endnotes for sources used.

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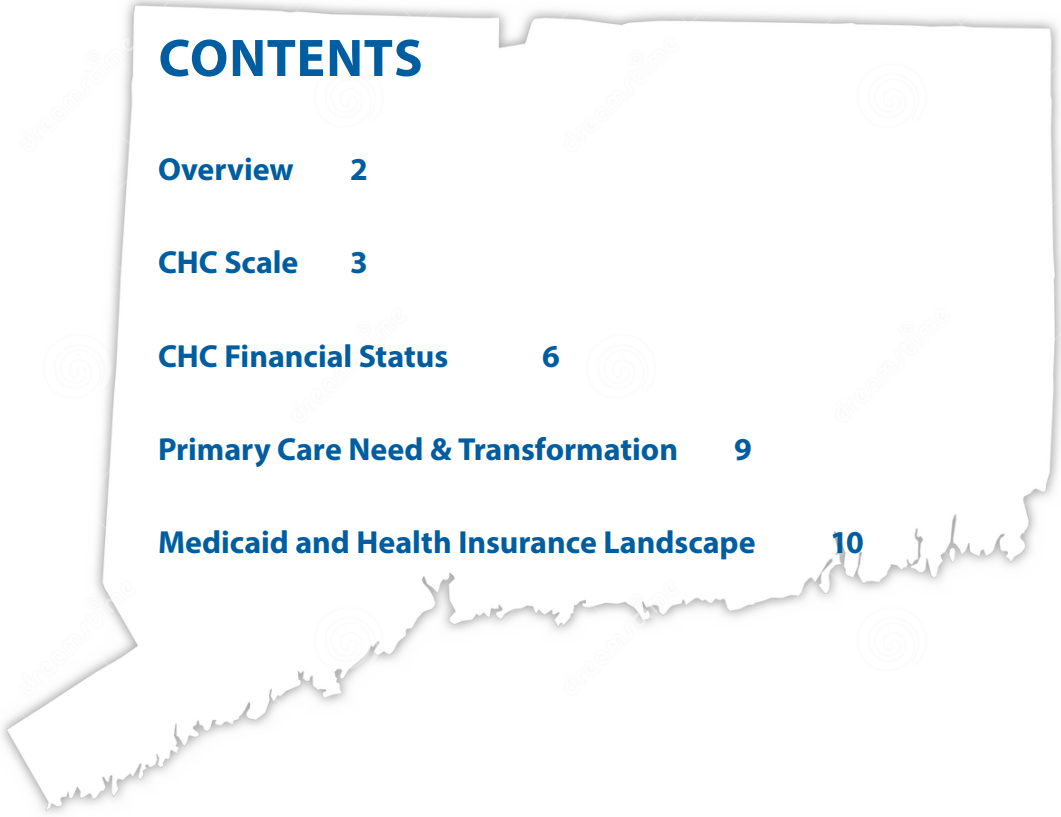
PRIMARY CARE DEVELOPMENT CORPORATION

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]

CHC SCALE

Connecticut CHCs Compared to CHCs Nationwide

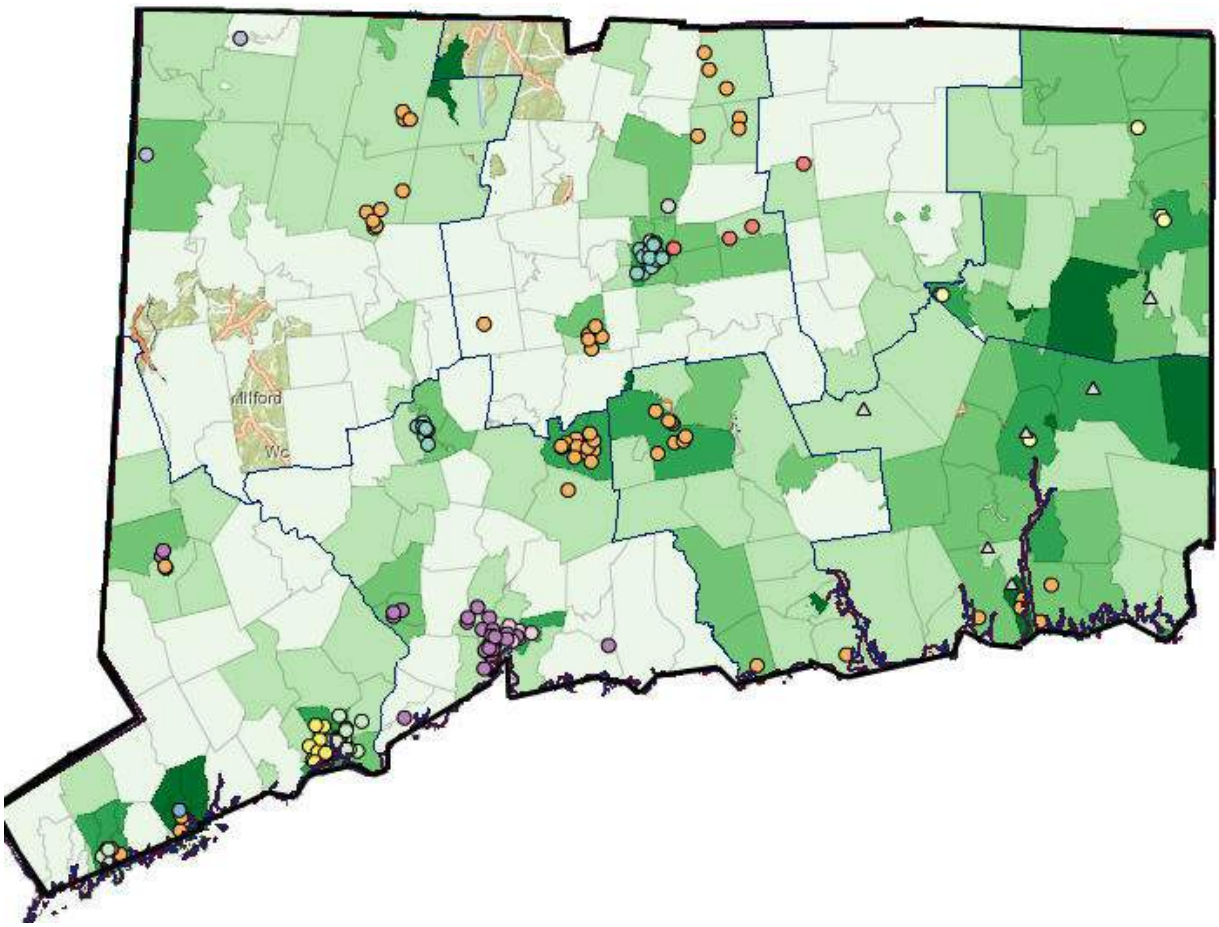
- Higher proportion of the total population served
- Nearly twice as many sites per CHC
- Substantially larger, providing nearly 80% more visits/organization
- Substantially higher proportion of Medicaid enrollees served
- More than twice as many mental health visits
- Higher than average annual growth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

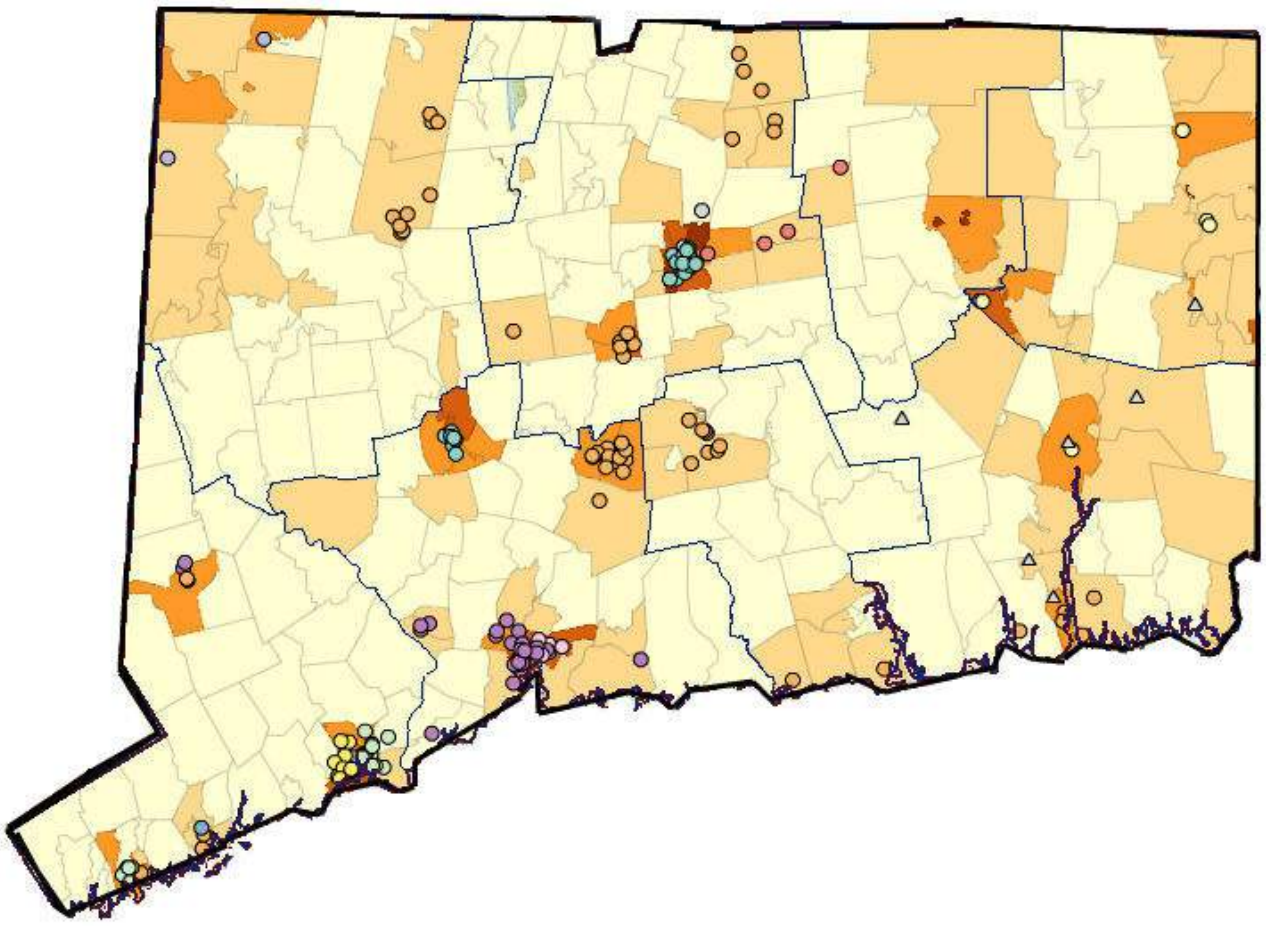
Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Connecticut CHCs [13]



Source: UDS Mapper 2014

Connecticut Low Income Population [13]



Source: UDS Mapper 2014

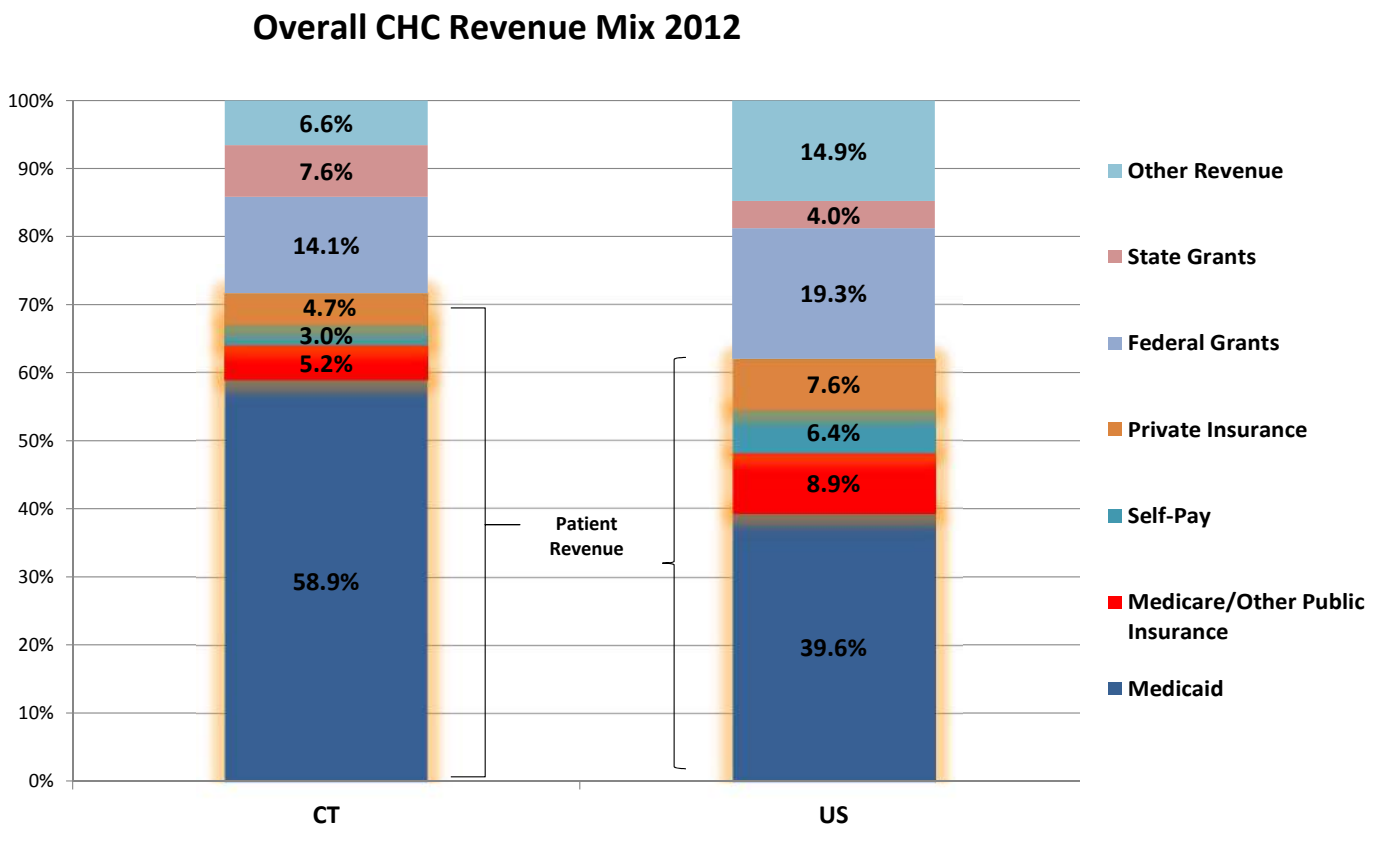
Connecticut CHCs Compared to CHCs Nationwide, 2012

- 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.

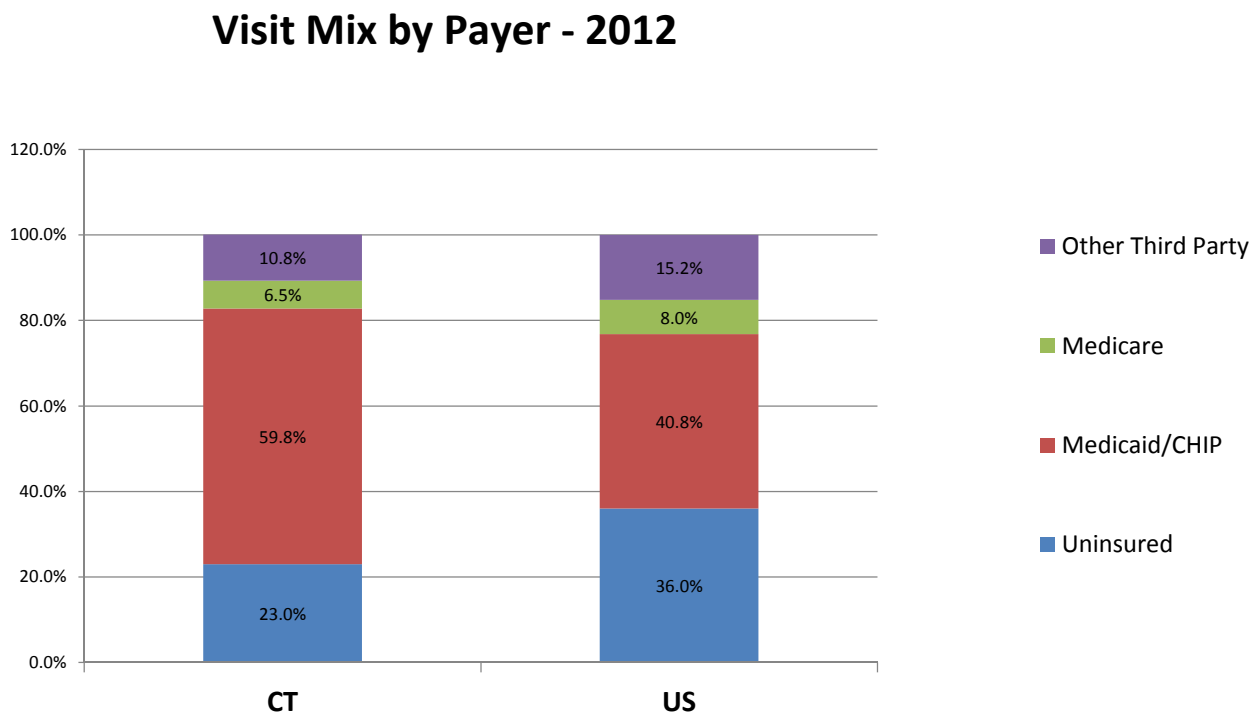
Sources: UDS Summary Data 2009-2011 and CHC Form 990s

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

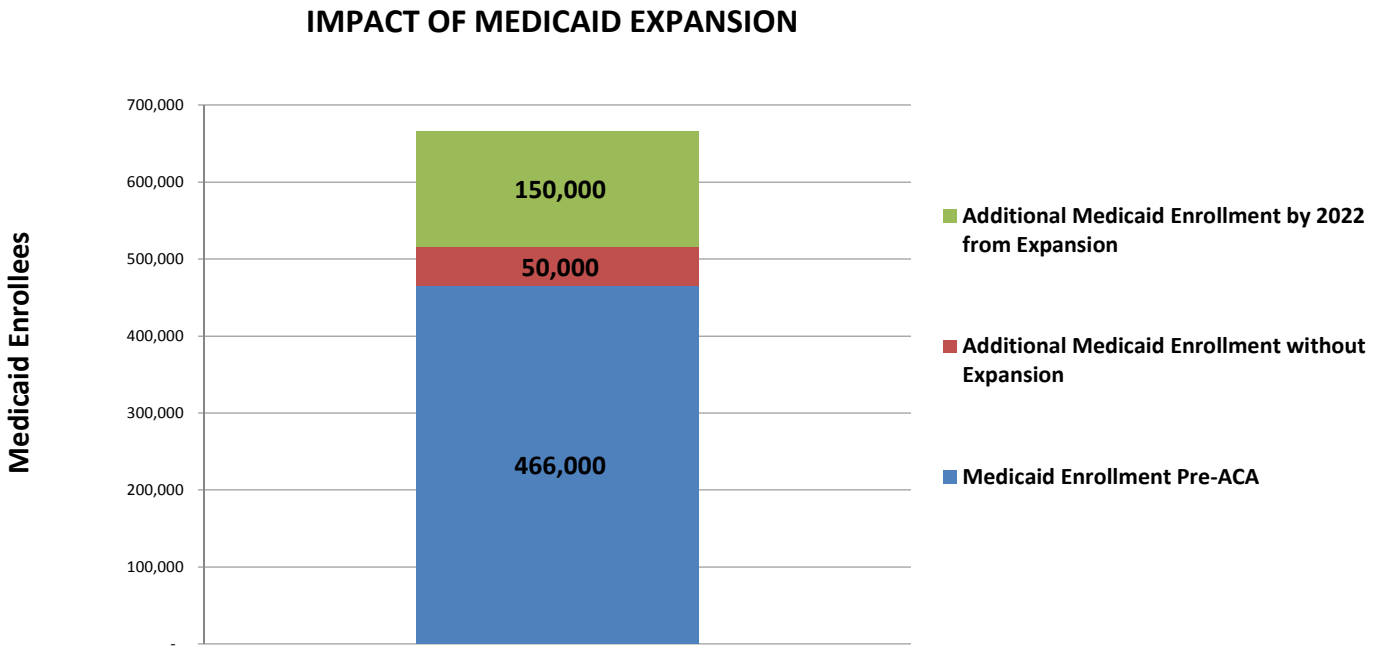
- Substantially higher per-enrollee Medicaid spending than national average
- Positive changes in Medicaid should increase access to care and expand enrollment

	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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PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

DELAWARE

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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 3 CHCs operating 12 permanent clinical service delivery sites throughout the state of Delaware. The Primary Care Association representing CHCs is the Mid-Atlantic Association of Community Health Centers, which also represents Maryland CHCs. [1] [2]
- Delaware CHCs provided 144,854 visits to 39,401 patients in 2012. [3]
- The number of people served by CHCs grew by an average of 9.1% annually from 2010-2012, compared to 4.3% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 9.4% of Delaware Medicaid population (US: 16%) and 4.4% of its overall population (US: 7%). Delaware CHCs serve 10.9% of patients with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 171,000, is projected to grow by an additional 37,000 people by 2022 (22% growth) per the Urban Institute; with the uninsured rate projected to decrease from 13.3% to 7.6%. [4]

Policy & Reimbursement

- Delaware spends about $5,800 per Medicaid enrollee annually– the 28th highest in the nation. [5]
- Delaware has implemented Medicaid expansion under the ACA.
- As of January 1st, 2014 the state has conformed with the Federal Medicaid expansion and set higher eligibility limit for childless adults and parents (138% FPL), with even higher limits for pregnant women (214% FPL) and children (family income up to 217% FPL). [6] [7]
- Delaware's Medicaid managed care program, Diamond State Health Plan, covers approximately 80% of Medicaid enrollees. [8]
- Medicaid reimbursement for Delaware's CHCs is governed by the federal Prospective Payment System (PPS) requirements, including use of the Medicare Economic Index to adjust CHCs' per visit rate annually. Rates can also be adjusted for additions and/or deletions of services. [9]
- Delaware Medicaid enables a broad array of providers (including physicians, nurse practitioners, licensed social workers and psychologists) to bill Medicaid for face-to-face visits. [10]
- Delaware has several FQHCs participating in the "FQHC Advanced Primary Care Demonstration" program, a program funded by the CMS Innovation Center; in addition Delaware was awarded State Innovation Model "Design Award." [11]
- Delaware has a state/federal partnership for its health insurance exchange, which is known as Choose Health Delaware. [12] [13] [14] Through the first enrollment period, individuals who selected health plans through the exchange reached a total of 14,087, against a goal of 8,000. [15]

Delaware CHCs Compared to CHCs Nationwide

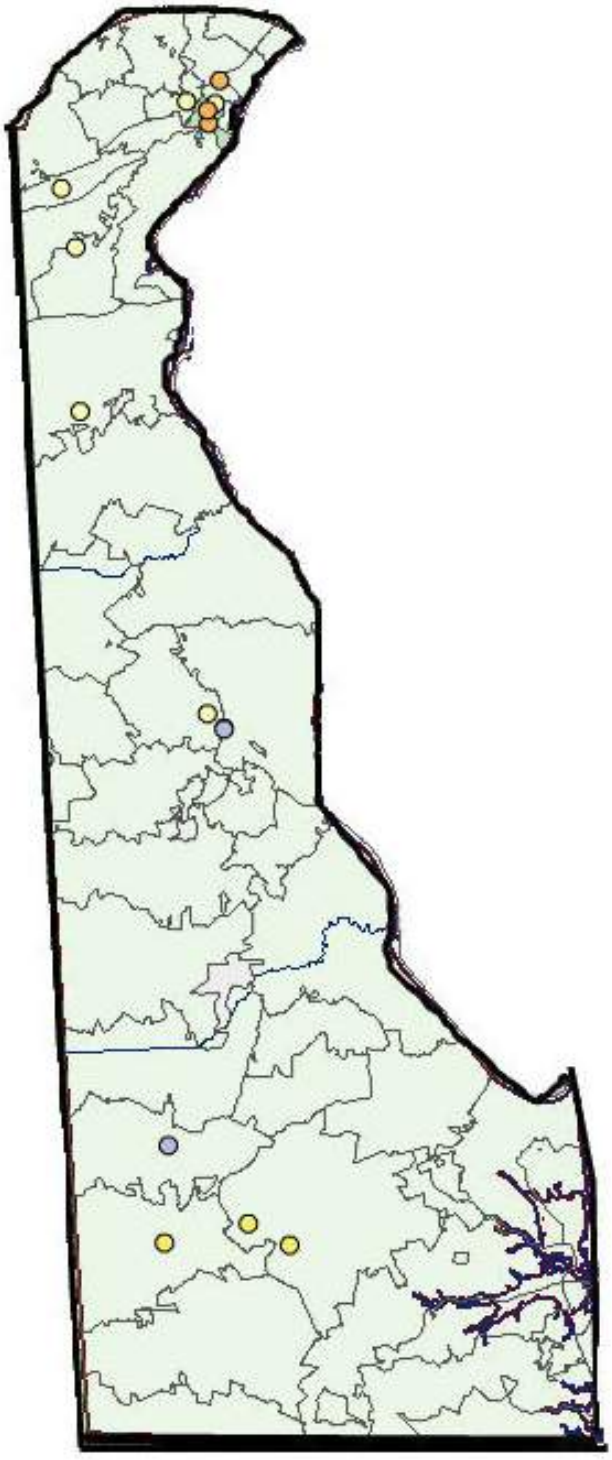
- Proportion of the total population served is 35% lower than CHCs nationally
- Lower proportion of Medicaid and low-income population served
- Delaware has 3 CHC organizations, one of which has about 2/3 of the state's CHC patients, with the other 2 organizations splitting the remaining 1/3.
- Mental health portion of visit mix is less than half the national average
- More than double the compound growth rate (2010-12), as measured by Total Annual Visits, with greatest growth in non-clinical Case Management/Enabling Services, and least in dental care.

	DE	US
Population Served (2012)		
Total patients served by CHCs	39,401	21,102,391
% of population served by CHCs	4.4%	6.8%
% of under 200% FPL served by CHCs	10.9%	15.9%
% of Medicaid Enrollees Served	9.4%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	3	1284
Total CHC Service Delivery Sites (2014)	12	9509
Average Sites per CHC (2014)	4.0	7.4
Annual Visits (Total) (2012)	144,854	83,766,153
Annual Visits per CHC (2012)	48,285	69,922
Annual Visits Per Patient (2012)	3.68	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	79.6%	73.6%
Dental	10.8%	12.8%
Mental Health	3.1%	7.5%
Case Management/Enabling	6.4%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	9.1%	4.1%
Total Annual Visits	9.4%	4.3%
Medical	7.4%	3.5%
Dental	5.3%	7.6%
Mental Health	6.7%	9.6%
Case Management/Enabling	79.3%	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 Delaware CHCs [16]



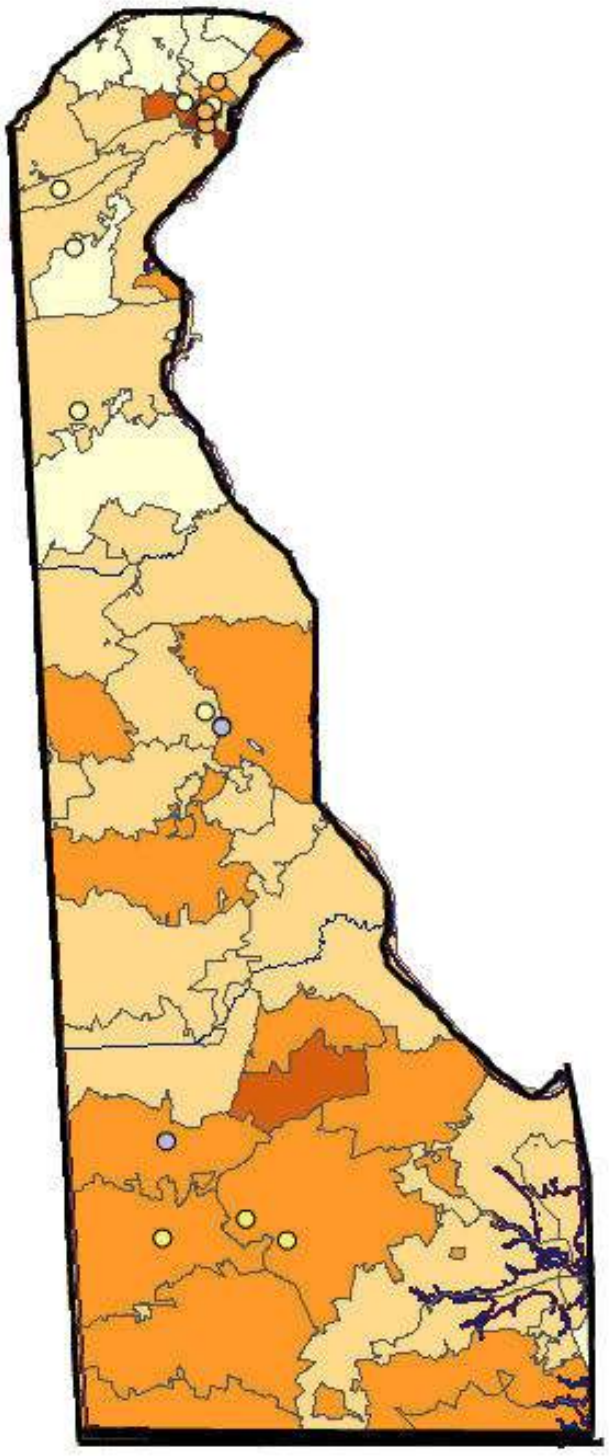
% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Source: UDS Mapper 2014

Delaware Low Income Population [16]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

Source: UDS Mapper 2014

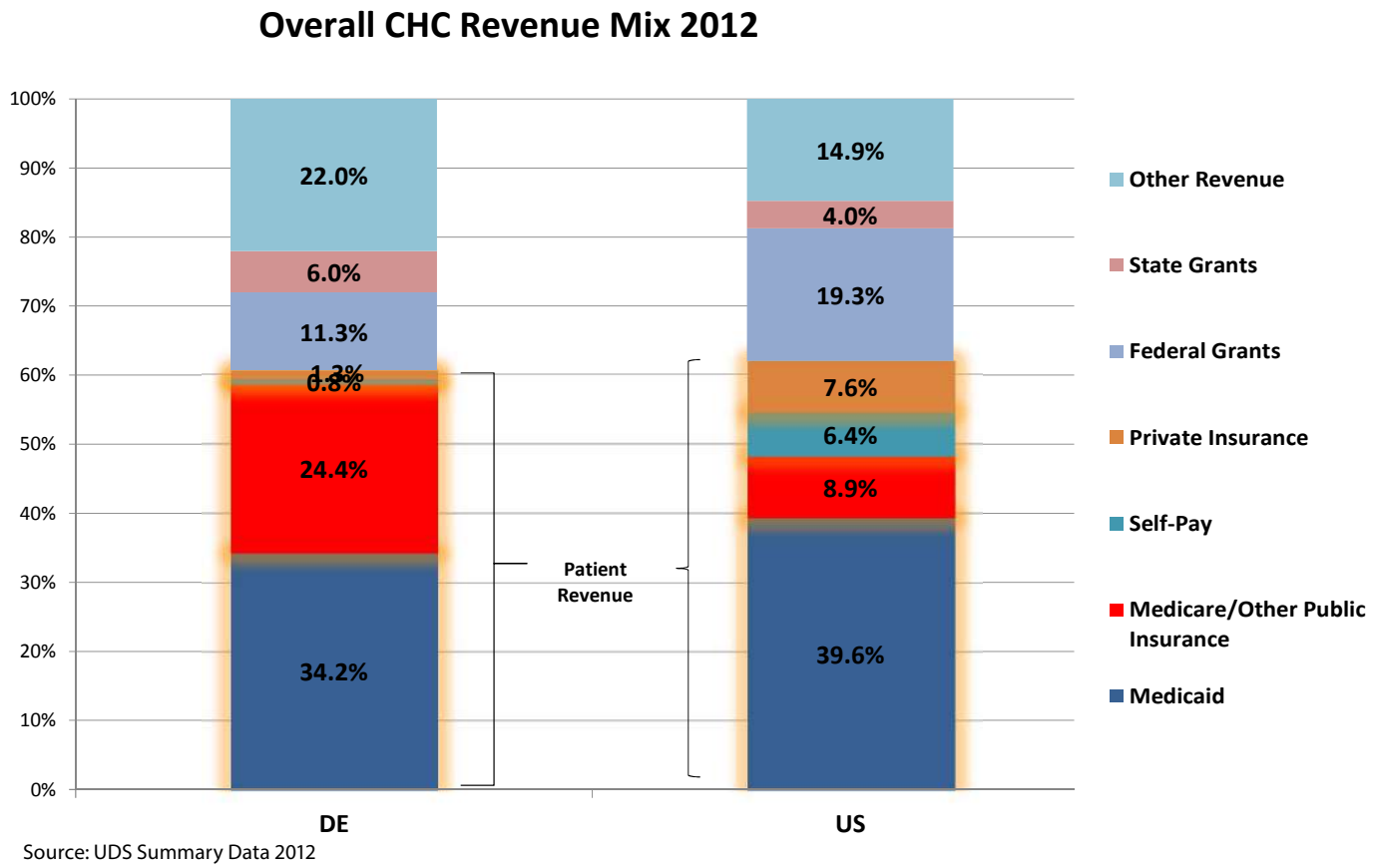
Delaware CHCs Compared to CHCs Nationwide, 2012

- Lower proportion of revenue from patient services
- Lower proportion of patient revenues from Medicaid
- Nearly triple the revenue from Medicare and other public insurance
- Virtually no self-pay revenue
- Much lower reliance on federal grants

	DE	US
CHC Revenue Mix		
Patient Revenue	60.7%	62.9%
Medicaid	34.2%	39.6%
Medicare/Other Public Insurance	24.4%	8.9%
Self-Pay	0.8%	6.4%
Private Insurance	1.3%	7.6%
Federal Grants	11.3%	19.3%
State Grants	6.0%	4.0%
Other Revenue	22.0%	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

Delaware CHCs as a Group, 2009-2011

- Median Total Assets increased by 83%
- Unrestricted Net Assets grew by 4%
- Median Days Cash on Hand rose by 25%, from 74 to 92 days, well above the benchmark range

DE Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$2,712,384	$3,630,987	$4,956,196	83%	N/A
Total Revenues ($)	$4,168,844	$5,154,966	$4,522,784	8%	N/A
Profitability					
Total Margin (%)	7.6%	12.6%	4.5%	-41%	N/A
Unrestricted Net Assets ($)	$1,877,955	$1,932,711	$1,954,613	4%	N/A
Liquidity					
Days Cash on Hand	71	110	60	-16%	>30 Days
Days in Accounts Receivable	25	21	23	-11%	<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.

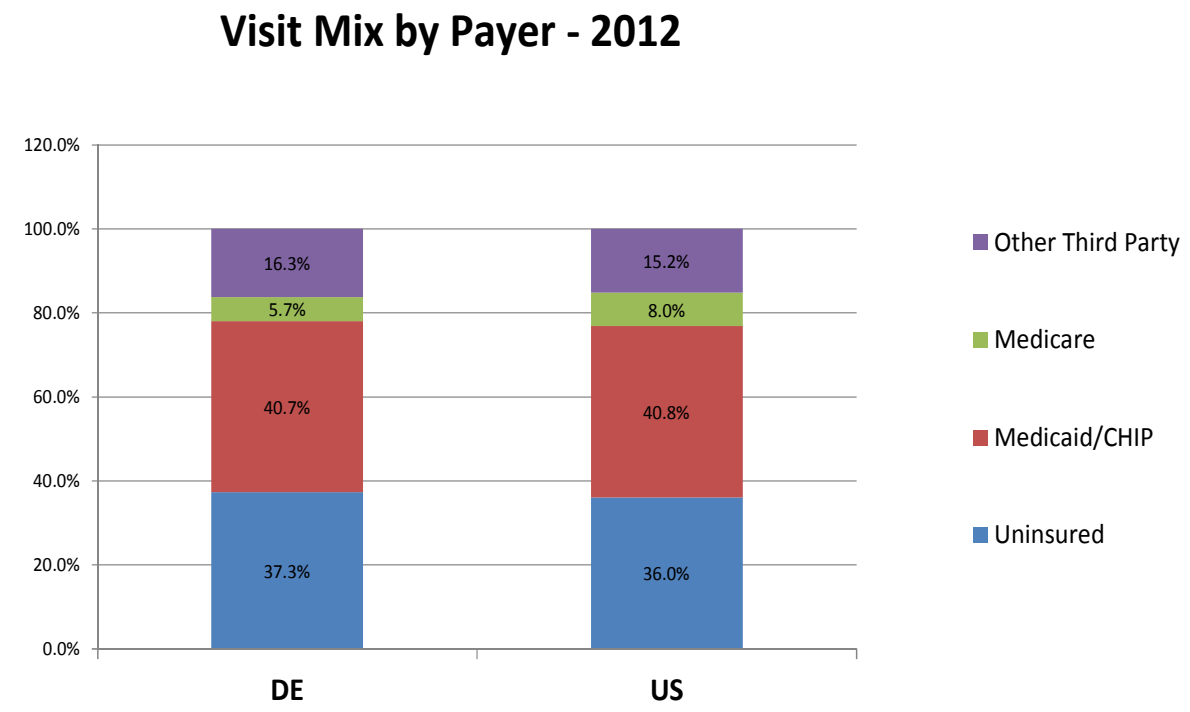
Sources: UDS Summary Data 2009-2011 and CHC Form 990s

Delaware CHCs Visit Mix Compared to CHCs Nationwide [17]

- Patient profile generally similar to national patient profile
- Overall percent of low-income patients, at 96%, slightly higher than national average, with patients below poverty line somewhat lower than national average
- Percent of patients covered by Medicaid and uninsured very close to national averages

	DE	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	96.0%	92.6%
Patients at or below 100% poverty level	61.5%	71.9%
Coverage Status		
Uninsured	37.3%	36.0%
Medicaid/CHIP	40.7%	40.8%
Medicare	5.7%	8.0%
Other Third Party	16.3%	15.2%

Source: UDS Summary Data 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near the national average on most primary care & prevention indicators
- Ranked #31 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Significantly lower proportion of population underserved for primary care
- Underserved population for dental well above national average

	DE	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	8.6%	5.3%
% low birthweights	8.9%	8.1%
% adults diagnosed with diabetes	8.3%	9.3%
Adult diabetes deaths per 100,000	19.2	20.8
Adult heart disease deaths per 100,000	175.7	179.1
Avoidable Hospitalizations per 1,000	58.6	66.6
America's Health Ranking (United Health Foundation)	31	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	12,755	35,057,608
% of total population	1.4%	11.3%
Estimated PCPs needed to achieve target PCP:Population	7	7067
Estimated underserved population for dental	141,424	31,707,007
% of total population	15.7%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	31	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [18]

- 100% of Delaware CHCs (3 of 3) have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- Delaware has no specific Medicaid-related PCMH initiatives.
- Delaware has set an overall goal to become the healthiest state in the nation by 2020 through a variety of initiatives, including the introduction of a statewide ACO.
- Under a State Innovation Plan, Delaware envisions at least 80% of the population to receive care under new payment models. [14]

Electronic Health Record Adoption [19]

- Well ahead of the national average EHR availability at state CHC sites (100 % in Delaware compared to 88% in the U.S.)
- Scores higher than the national average in 11 of the 12 EHR functionality categories, including perfect scores in 10 areas

Medicaid Policies – Highlights

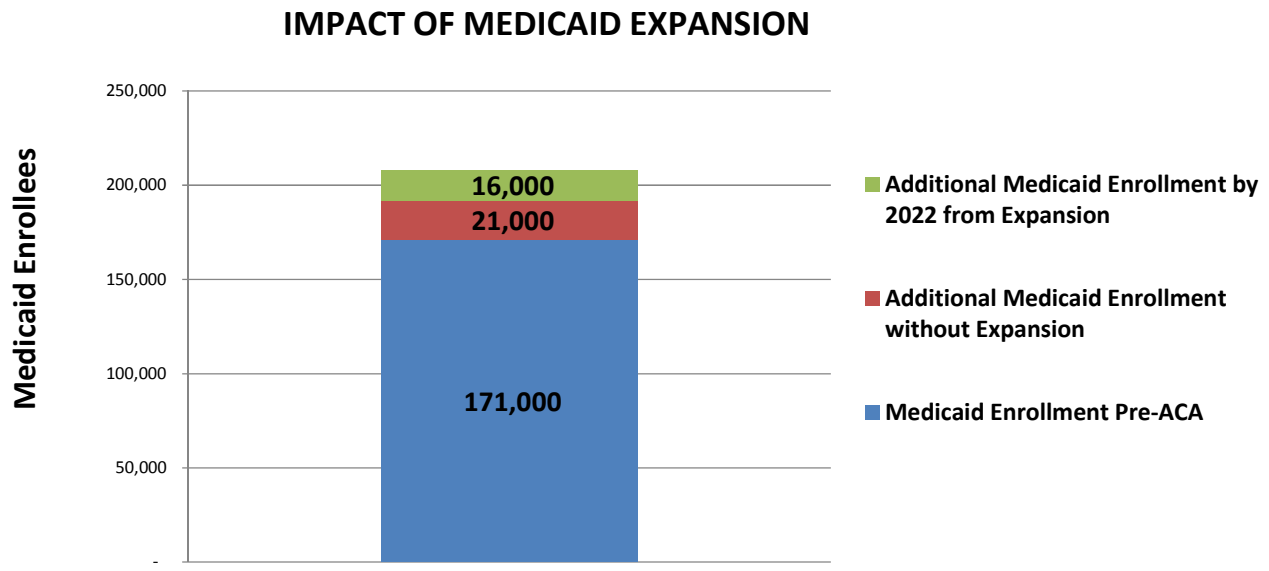
- Slightly higher per-enrollee Medicaid spending than the national average.
- Even prior to the ACA, non-disabled low-income adults have been eligible for Medicaid coverage. Accordingly, Delaware's historical figures show a higher rate of Medicaid enrollment as a percentage of population, and a lower rate of uninsurance.
- Delaware is expanding Medicaid eligibility per the ACA, primarily by raising income limits, and is partnering with the federal government in administering Delaware's insurance exchange.

	DE	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$5,826	$5,563
Federal Medical Assistance Percentage (FMAP)	55.7%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	Partnership	
Total Uninsured	120,000	53,277,000
% of Uninsured Individuals (all ages)	13.3%	17.2%
Medicaid Enrollment Pre-ACA	171,000	52,410,000
% of Total Population	19.0%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	21,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	37,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	21.6%	40.6%
Estimated Number Remaining Uninsured After ACA	73,000	27,930,000
Estimated % Uninsured After ACA (2020)	7.6%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Significantly lower proportion of uninsured than U.S. average
- With Medicaid expansion, enrollment is projected to increase by 34%
- Proportion of residents who are uninsured is projected to decrease from 13.3% to 7.6% by 2022



Source: Kaiser State Health Facts 2012

Delaware Medicaid Spending

Delaware spends about $5,800 per Medicaid enrollee annually – the 28th highest in the nation for all health care services provided. [5]

Between contributions from the state and Federal Government, nearly $1.5 billion was spent on the Medicaid program in 2012, comprising 44% of the state budget. [20] [21]

Medicaid enrollment increased 27%, from about 152,000 to over 190,000 between 2008 and 2011. [22]

Medicaid Coverage & Administration

Delaware's Medicaid program has operated under an 1115 Demonstration Waiver, the Diamond State Health Plan, since 1996. The Demonstration Waiver authorized a statewide, mandatory Medicaid managed care program, and expanded the state plan coverage to uninsured single adults earning up to 100% of the federal poverty level. [7] As of 2011, 80% of the state's Medicaid Population was enrolled within one of the MCO's operating in the state, either Delaware Physician Care (Aetna) or United. [23]

The Delaware Medical Assistance Program (DMAP), Delaware's traditional Medicaid program, applies today to only a small percentage of Medicaid enrollees in Delaware. [24]

Prior to the passage of the ACA, the state's minimum eligibility level for jobless parents was 100% FPL and 119% FPL for working parents. Children were covered up to 200% FPL through the CHIP program and pregnant woman were also covered up to 200% FPL. [25] [26] [27]

With the Medicaid expansion the state has set a higher eligibility limit for both groups. All parents now have an upper eligibility limit of 138% FPL, while childless adults, who were previously only eligible if they were at least below 110% FPL (100% for the jobless) will now be eligible up to 138% FPL as well. Even higher limits exist for pregnant women (214% FPL) and children (family income up to 217% FPL). [28]

In addition to the standard categories above, Delaware also has better coverage for cancer screening and treatment, covering Delawareans up to 600% FPL. [7]

Health Insurance Exchange

Choose Health Delaware is the state's health insurance marketplace, which is operated in partnership with the federal government. Delaware is exploring a regional partnership, whereby the state would partner with one or more other states. A regional partnership would spread administrative cost over a wider population and increase the size of the risk pool. [29]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	200%	200%	120%	110%
2014	217%	214%	138%	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

New Jersey CHC Reimbursement Policies

Delaware Medicaid reimbursement for CHCs, is governed by the federal Prospective Payment System (PPS) requirements (not an alternative payment methodology.)

Rates can be adjusted based on additions or deletions of services provided at a particular CHC. The net effect of all qualifying changes in scope of service must demonstrate to DMAP the likelihood of at least a 2.5% annual difference in Medicaid allowable costs compared to the costs used to compute the last approved PPS rate. If a 2.5% or more cost differential occurs between consecutive years, Delaware regulations call for an adjustment to the PPS rate. [10]

The only cost sharing in Delaware Medicaid is for pharmacy. All clients, other than those specifically excluded, are liable for sharing the cost of Medicaid covered prescription drugs as well as over-the-counter drugs prescribed by a practitioner. The co-payment is imposed for each drug that is prescribed and dispensed and is subject to a monthly cumulative cap. [30]

A visit is a face-to-face encounter between a center patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. [10]

CHC billable providers include: physician; nurse practitioner; physician assistant; nurse midwife services; clinical psychologist and clinical social worker services. [10]

Delaware only makes a very marginal payments to CHCs for indigent care (only $37,000 was paid to CHCs in 2012), but it has supported coverage beyond federal requirements. [31]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
DE	Yes	No	Yes	Yes	Midwives, PAs

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
DE	No	Yes	No	No	No

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

Collaboration with CMS

Delaware has set an overall goal to become the healthiest state in the nation by 2020 through a variety of initiatives, including the introduction of a statewide ACO. The state's health innovation plan received a $2.5 million Model Design Award from CMS in February 2013.

Choose Health Delaware, the state organization which is also administering the state-run aspects of the health insurance exchange, is considering using the Medicare Shared Savings program as a model for state accountable care policies. The group is also calling for more emphasis on team-based care, through community-based support and care coordination among care managers at providers and payers. [32] [33]

Delaware envisions Medicaid will offer providers two types of total cost of care arrangements – an upside only option, plus an option that includes downside risk sharing – and hopes to offer payment models consistent with these prototypes when the new contract period begins in 2015. [8]

Delaware's plan is intended to enable at least 80% of the population to receive care under new payment models. Delaware Medicaid will introduce the models described earlier in this section and Delaware will invite Medicare to introduce similar models. [8]

Notes

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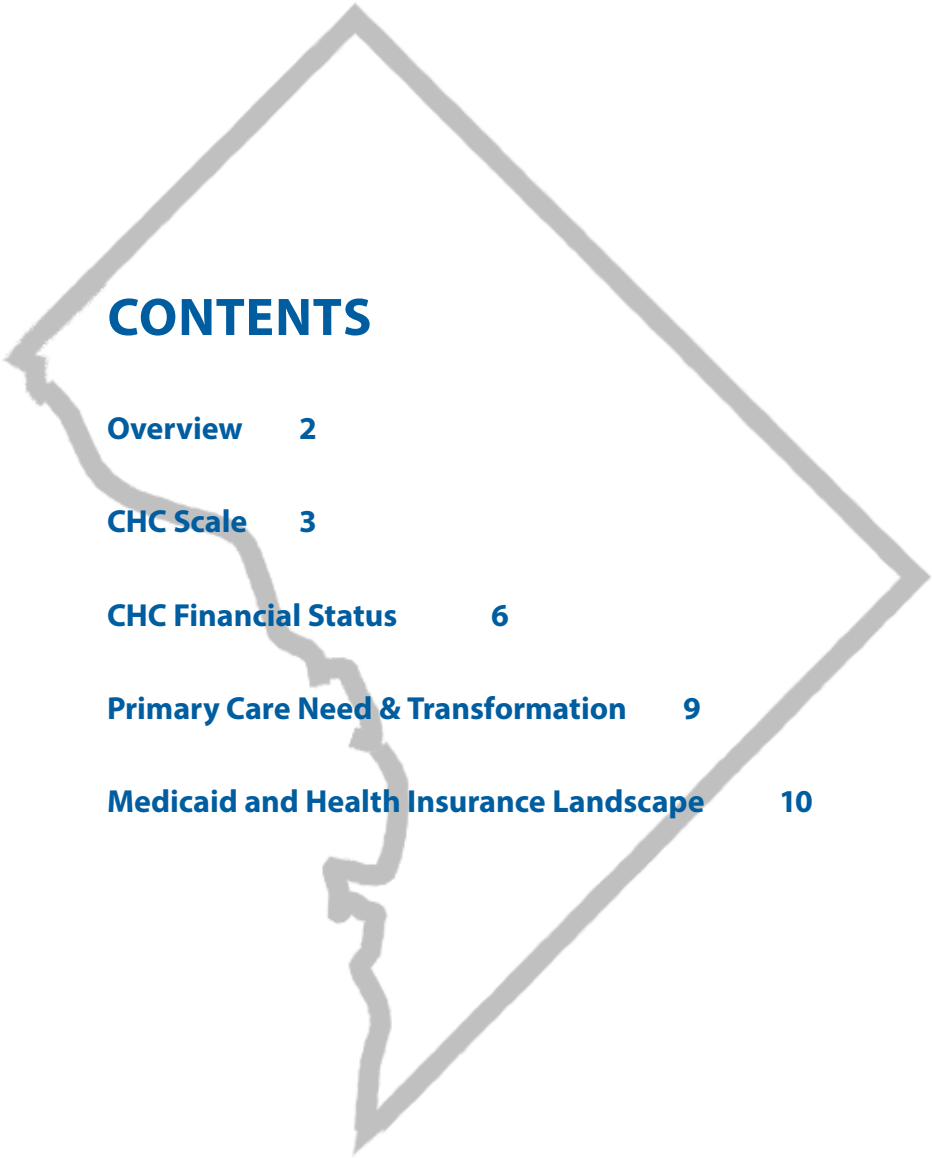
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

WASHINGTON D.C.



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 7 CHCs operating 40 permanent clinical service delivery sites throughout Washington D.C. CHCs are represented by the District of Columbia Primary Care Association. [1] [2]
- Washington D.C. CHCs provided 761,169 visits to 141,877 patients in 2012. [3]
- The number of people served by CHCs has grown by an average of 13.8% annually from 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 53.4% of the Washington D.C. Medicaid population (US: 16%) and 22.7% of its overall population (US: 7%). CHCs in Washington D.C. serve 56% of the population with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 153,000, is projected to grow by an additional 31,000 people by 2022 (20% growth); with the uninsured rate projected to decrease slightly from 11.2% to 9.5% by 2020. [4]

Policy & Reimbursement

- Washington D.C. spends about $11,000 per Medicaid enrollee annually – the highest in the nation. [5]
- Medicaid reimbursement for Washington D.C. CHCs is governed by the federal Prospective Payment System (PPS) requirements, including use of the Medicare Economic Index to adjust CHCs' per-visit rate annually. D.C. permits rate adjustments based on any increases or decreases in the scope of services furnished by the CHC during the fiscal year. [6]
- Washington D.C. was one of the first governments to implement a Medicaid expansion under the ACA, doing so in May, 2010, shortly after the law was passed. [7]
- Washington D.C. has set eligibility limits well above those in the ACA, with childless adults eligible up to 215% FPL; parents of dependent children up to 221% FPL; and pregnant women and children eligible up to family incomes of 324% FPL. [8]
- Washington D.C. Medicaid promotes the use of Managed Care Organizations (MCOs) which are administered and overseen by the Office of Managed Care. There are four different Managed Care Plans in the District. Over 65% of the Medicaid population is enrolled in a MCO. [9]
- Washington D.C. has a locally-administered Health Insurance Exchange, run by the Health Benefit Exchange Authority and available to the public through the Washington D.C. Health Link. [10] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 10,714, against a goal of 43,000. [11]
- Washington D.C. has one CHC with six sites participating in the "FQHC Advanced Primary Care Demonstration" program, funded by the CMS Innovation Center. [12]

Washington D.C. CHCs Compared to CHCs Nationwide

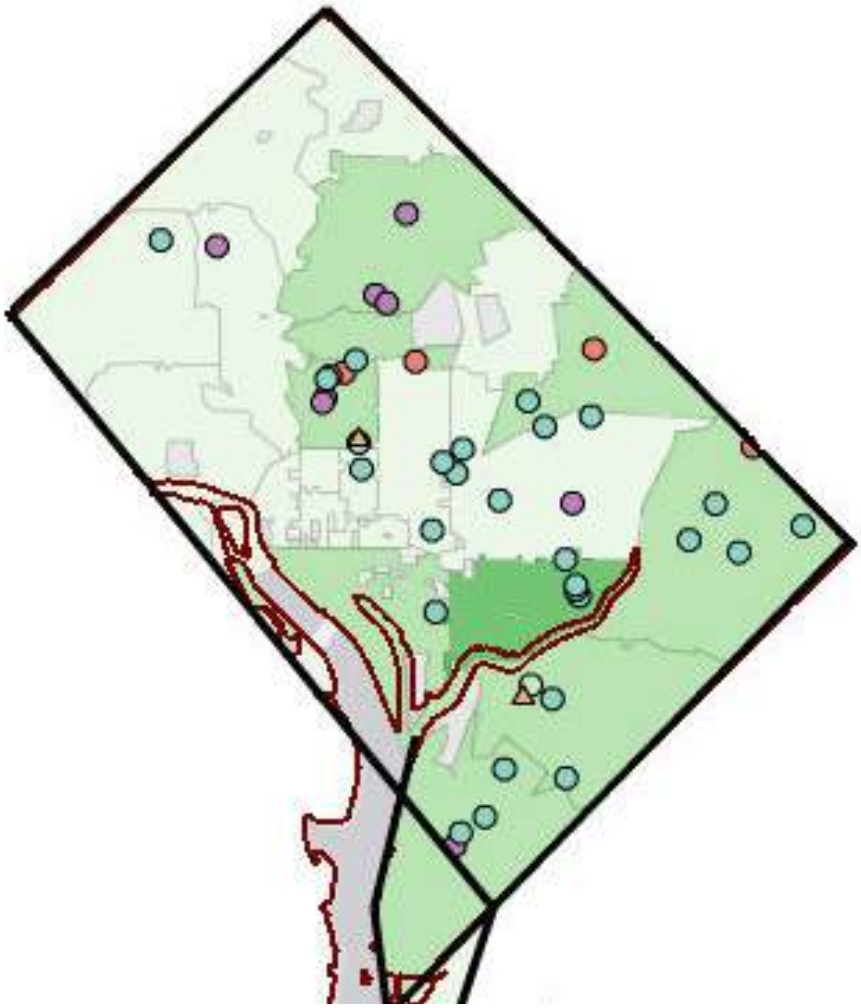
- Higher proportion of total population served
- Higher proportion of Medicaid enrollees served
- Twice the number of visits per CHC
- More than three times the growth rate in total patients and double the growth rate in visit volume, with greatest growth in mental health, and least in dental

	DC	US
Population Served (2012)		
Total patients served by CHCs	141,877	21,102,391
% of population served by CHCs	22.7%	6.8%
% of under 200% FPL served by CHCs	56.0%	15.9%
% of Medicaid Enrollees Served	53.4%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	7	1284
Total CHC Service Delivery Sites (2014)	40	9509
Average Sites per CHC (2014)	5.7	7.4
Annual Visits (Total) (2012)	761,169	83,766,153
Annual Visits per CHC (2012)	152,234	69,922
Annual Visits Per Patient (2012)	5.36	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	72.2%	73.6%
Dental	7.5%	12.8%
Mental Health	11.0%	7.5%
Case Management/Enabling	9.2%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	13.8%	4.1%
Total Annual Visits	9.8%	4.3%
Medical	9.1%	3.5%
Dental	6.1%	7.6%
Mental Health	22.8%	9.6%
Case Management/Enabling	6.1%	1.6%

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

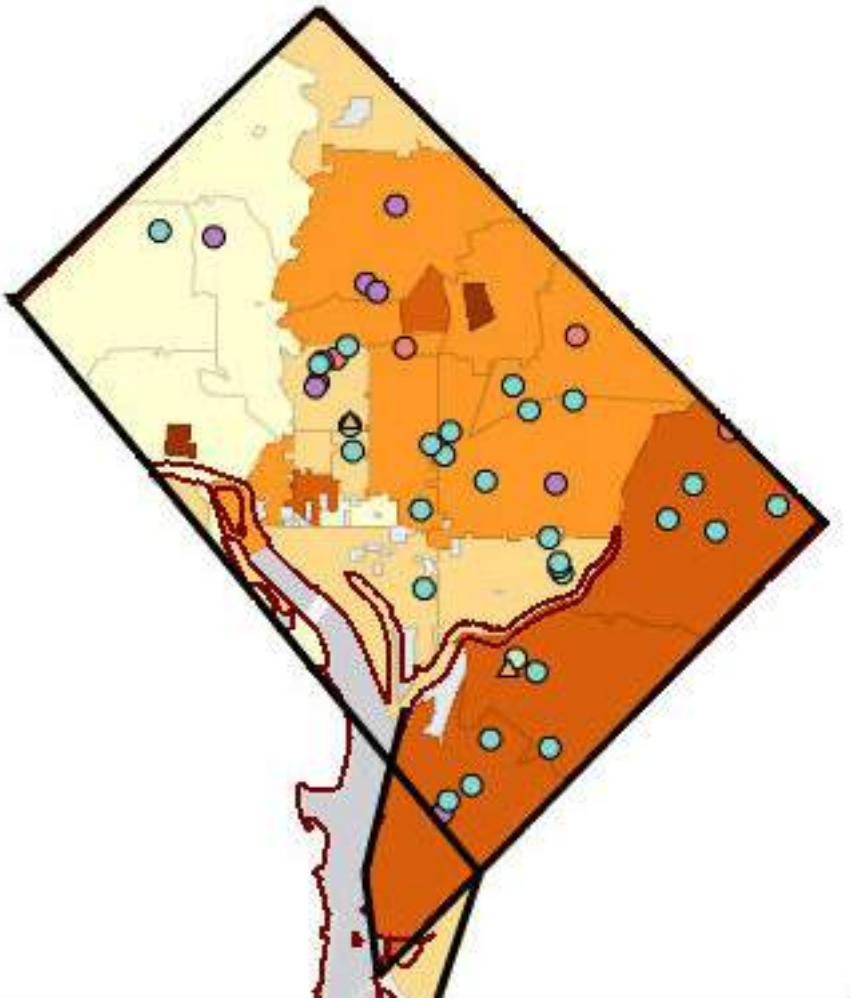
Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Washington D.C. CHCs [13]



Source: UDS Mapper 2014

Washington D.C. Low Income Population [14]



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

- < 15%
- 15 - 30%
- 30 - 45%
- 45 - 60%
- > 60%

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

Source: UDS Mapper 2014

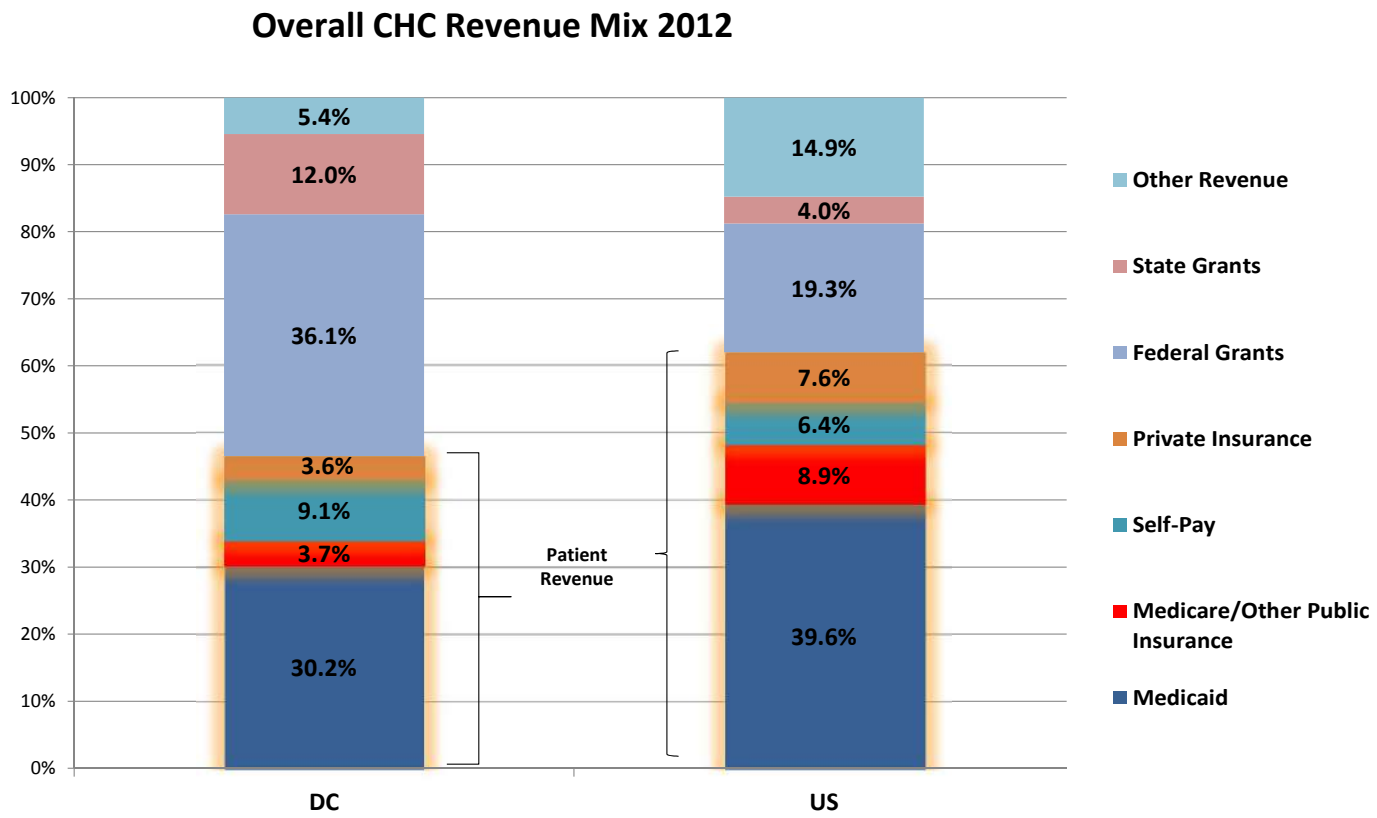
Washington D.C. CHCs Compared to CHCs Nationwide, 2012

- Slightly lower proportion of revenue from patient services
- Much greater revenue from other public insurance
- Significantly lower proportion of revenue from federal grants

	DC	US
CHC Revenue Mix		
Patient Revenue	46.6%	62.9%
Medicaid	30.2%	39.6%
Medicare/Other Public Insurance	3.7%	8.9%
Self-Pay	9.1%	6.4%
Private Insurance	3.6%	7.6%
Federal Grants	36.1%	19.3%
State Grants	12.0%	4.0%
Other Revenue	5.4%	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

Washington D.C. CHCs as a Group, 2009-2011

- Median Total Assets increased by 98%
- Median Days Cash on Hand rose by 84%, from 10 to 19 days, still well below the 30-day benchmark

DC Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$14,619,632	$21,459,225	$29,012,236	98%	N/A
Total Revenues ($)	$13,982,512	$19,128,367	$34,507,870	147%	N/A
Profitability					
Total Margin (%)	2.1%	1.8%	12.7%	503%	N/A
Unrestricted Net Assets ($)	$3,364,451	$3,532,223	$4,408,576	31%	N/A
Liquidity					
Days Cash on Hand	10	26	19	84%	>30 Days
Days in Accounts Receivable	40	30	36	-11%	<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.

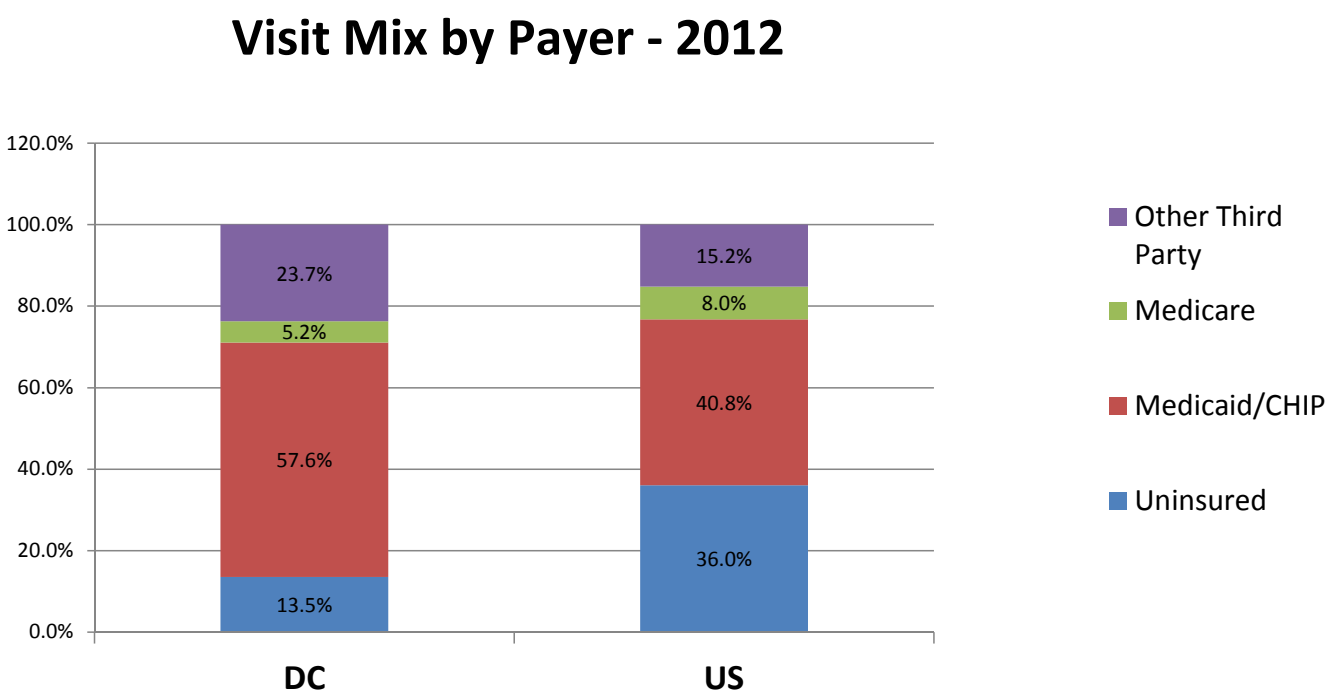
Sources: UDS Summary Data 2009-2011 and CHC Form 990s

Washington D.C. CHCs Visit Mix Compared to CHCs Nationwide [14]

- Slightly higher proportion visits from patients living at or near poverty
- Greater proportion of patient visits from Medicaid and/or CHIP
- Fewer patient visits from uninsured/self-pay

	DC	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	94.7%	92.6%
Patients at or below 100% poverty level	75.0%	71.9%
Coverage Status		
Uninsured	13.5%	36.0%
Medicaid/CHIP	57.6%	40.8%
Medicare	5.2%	8.0%
Other Third Party	23.7%	15.2%

Source: UDS Summary Data 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Somewhat worse than the national average on most primary care & prevention indicators
- Higher rates of death from diabetes and heart disease
- Higher proportion of children born below normal birth weights

Statewide Primary Care Shortage & Workforce Indicators

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

	DC	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	N/A	5.3%
% low birthweights	10.2%	8.1%
% adults diagnosed with diabetes	8.7%	9.3%
Adult diabetes deaths per 100,000	24.9	20.8
Adult heart disease deaths per 100,000	222.4	179.1
Avoidable Hospitalizations per 1,000	N/A	66.6
America's Health Ranking (United Health Foundation)	N/A	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	97,530	35,057,608
% of total population	15.6%	11.3%
Estimated PCPs needed to achieve target PCP:Population	43	7067
Estimated underserved population for dental	65,654	31,707,007
% of total population	10.5%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	17	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [15]

- 100% of Washington D.C. CHCs have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- Washington D.C. has received a planning grant from the Centers for Medicare & Medicaid Services (CMS) to establish health homes for Medicaid enrollees with chronic conditions.

Electronic Health Record Adoption [16]

- 100% of Washington D.C. CHC sites have EHR availability (compared to 88% in the U.S.)
- Higher than the national average in 11 of the 12 EHR functionality categories

Medicaid Policies – Highlights

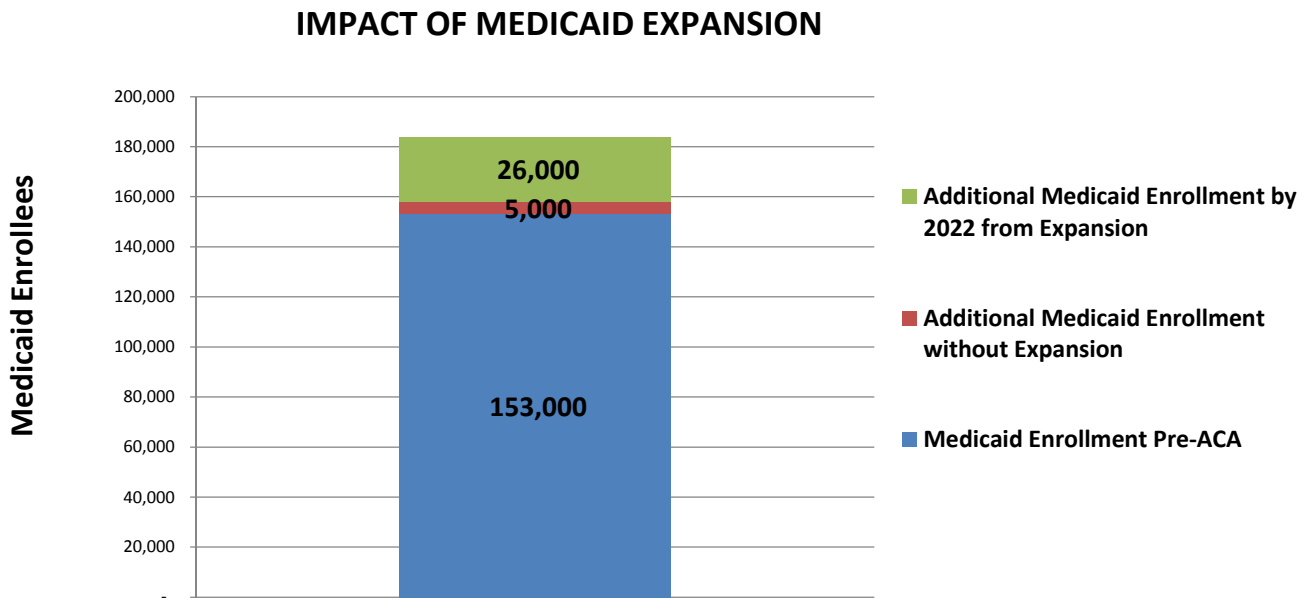
- One of the earliest jurisdictions to institute Medicaid expansion - 2 months after the passage of the ACA
- Substantially higher per-enrollee Medicaid spending than national average

	DC	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$8,029	$5,563
Federal Medical Assistance Percentage (FMAP)	70.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	State	
Total Uninsured	70,000	53,277,000
% of Uninsured Individuals (all ages)	11.2%	17.2%
Medicaid Enrollment Pre-ACA	153,000	52,410,000
% of Total Population	24.5%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	5,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	31,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	20.3%	40.6%
Estimated Number Remaining Uninsured After ACA	45,000	27,930,000
Estimated % Uninsured After ACA (2020)	9.4%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Implementing Medicaid expansion and a locally-run Health Insurance Exchange
- Medicaid expansion expected to increase Medicaid enrollment by >20%
- Proportion of residents who are uninsured is expected to decrease slightly from 11.2% to 9.5% over the next decade



Source: Kaiser State Health Facts 2012

Washington D.C. Medicaid Spending

Washington D.C. Medicaid spending per capita is the highest in the nation at $11,157. This is because D.C. has a very high proportion of their population on Medicaid while also being having the second smallest population in the United States. [17]

While children account for nearly half of total Medicaid enrollees and healthy adults an additional 24%, those populations account for only 1/4 of the total cost of the D.C Medicaid program. The Elderly and Disabled account for more than 75% of all spending, both costing slightly below $25,000 per person. [18]

Nearly 47% of all Medicaid spending is directed towards institutional care, lower than most states', indicating that a great deal of coverage is directed outside nursing home and long-term care facilities. [18]

Medicaid Coverage & Administration

Washington D.C. Medicaid is administered through the Department of Health Care Finance.

Enrollment in Washington D.C.'s Medicaid program saw minimal growth during the mid-2000s, but has since seen a dramatic expansion. [19] The recent growth in the Medicaid program is the result of both the implementation of the Medicaid expansion, as well as higher levels of unemployment since 2008. [19]

Prior to Medicaid expansion, healthy low-income adults were covered under the D.C. Health Alliance program which was funded from tax revenue from city residents. With the expansion of Medicaid eligibility, 30,000 residents enrolled in the Alliance program were moved into Medicaid.

Two-thirds of Medicaid enrollees in D.C. are signed up for one of three managed care plans offered, [19] [20] with one-third in traditional fee-for-service.

Washington D.C. has opted to go beyond minimum eligibility requirements required under federal law, and the District has worked in recent years to expand the scope of who can be served by its Medicaid program, including opting for early implementation of some Medicaid provisions of the federal Affordable Care Act. [20]

Following Medicaid expansion, the state now provides increased eligibility levels for all potential enrollees:

- Washington D.C. provides generous coverage for infants and children up to the age of 19, as well as pregnant woman (324% FPL.)
- Parents of dependent children are eligible up to 221% FPL.
- Childless adults are eligible up to 215% FPL under the expanded Medicaid program. [21]

Medicaid and CHIP Income Eligibility Limits as % of FPL

State	Separate CHIP Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	300%	300%	206%	211%
2014	324%	324%	221%	215%

*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

Prior to the implementation of the Medicaid expansion, the D.C. Health Alliance did not provide coverage for Behavioral Health Services. Since the expansion, there has been a 25% growth in behavioral health services provided, primarily due to the increased scope of coverage. [22]

The District's Medicaid program does not require participants to pay any co-payments for Medicaid services. [19]

Washington D.C. CHC Reimbursement Policies

Medicaid reimbursement, the primary revenue source for CHCs, is governed by the federal Prospective Payment System (PPS) requirements (i.e., not an alternative payment methodology though this is permitted under federal regulations.) [23]

Each year, the PPS is escalated by a cost inflation factor. Washington D.C. uses the Medicare Economic Index (MEI) to adjust the per visit rate annually. Further adjustments may be made to take into account any increase or decrease in scope of services, including the starting date of the change. [23]

The following categories of providers are eligible to generate a reimbursable PPS encounter: MD, DMD, and NPs can generate a PPS encounter for a face-to-face visit. [23]

Other provider organizations including but not limited to Alcohol and Substance Abuse Clinics, Mental Health Clinics, and Family Planning clinics can all be reimbursed for services provided. [23]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
DC	Yes	Yes	Yes	No	N/A

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
DC	No	Yes	No	No	No

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

Collaboration with CMS [24]

One Washington D.C. Community Health Center, at 6 sites, is participating in the **FQHC Advanced Primary Care Demonstration** funded by the Centers for Medicare and Medicaid Services (CMS) Innovation Center. Under the demonstration, selected FQHC Grantees receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promotes better health, and lowers costs.

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PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

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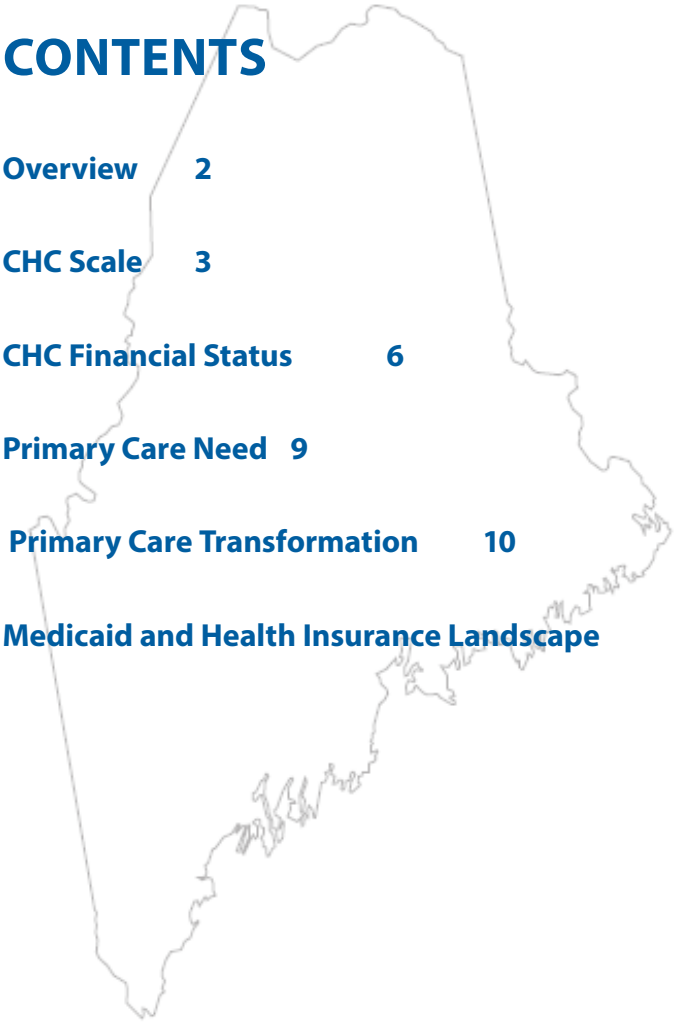

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OVERVIEW

Market Share & Growth

- As of 2014, there were 19 CHCs operating 134 permanent clinical service delivery sites throughout the state of Maine. The primary care association representing CHCs is the Maine Primary Care Association. [1] [2]
- Maine CHCs provided 843,390 visits to 181,467 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 1.8% annually between 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 18.1% of Maine's Medicaid population (US: 16%) and 13.7% of its overall population (US: 7%). Maine CHCs serve 28.5% of individuals with incomes <200%, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 300,000, is projected to grow by 10,000 (3.3%) by 2022 in the absence of a Medicaid expansion. Should Maine adopt the expansion, enrollment would be projected to grow by an additional 45,000 individuals (15%), with the uninsured rate projected to decrease from 11% to 5.1% by 2022. [4]

Policy & Reimbursement

- Maine spends slightly less than $6,600 per Medicaid enrollee annually – 26th highest in the nation. [5]
- Medicaid reimbursement for Maine CHCs is governed by "Cost Reimbursement" principles, [6] though the PCA indicates cost of services exceeds reimbursement.
- Maine is not implementing a Medicaid expansion under the ACA. The state's legislature has passed bills to expand Medicaid in accordance with the ACA five times, with each bill vetoed by the Governor. The most recent veto was April 9, 2014. [7]
- Medicaid eligibility for parents is up to 105% FPL; for pregnant women, 214% FPL; and for children, it is family income up to 213% FPL. [8]
- The health insurance exchange is federally run. In the first enrollment period, individuals who have selected health plans through the exchange reached a total of 44,258, surpassing a goal of 23,000. [9] [10]
- Maine is participating in several CMS Innovation Awards, including the "Multi-Payer Advanced Primary Care Program," and was awarded a State Innovation Model Grant awards. [11]

Main CHCs Compared to CHCs Nationwide

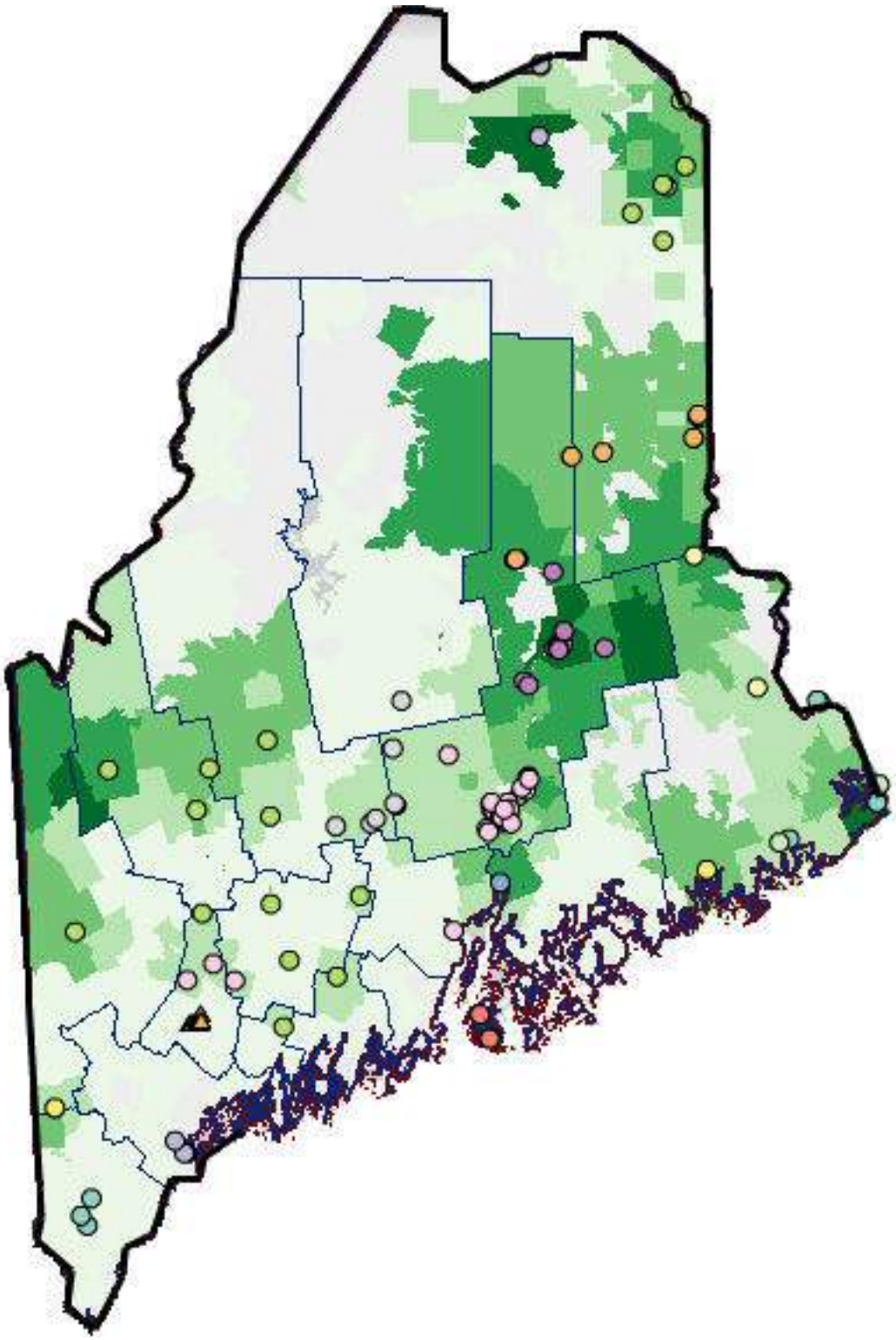
- Double the national average in percentage of population served
- Slightly higher proportion of Medicaid enrollees served
- Considerably higher proportion of mental health visits
- Visit volume growth rate near national average, but patient volume growth rate less than half the national average

	ME	US
Population Served (2012)		
Total patients served by CHCs	181,467	21,102,391
% of population served by CHCs	13.7%	6.8%
% of under 200% FPL served by CHCs	28.5%	15.9%
% of Medicaid Enrollees Served	18.1%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	19	1284
Total CHC Service Delivery Sites (2014)	65	9509
Average Sites per CHC (2014)	3.4	7.4
Annual Visits (Total) (2012)	843,390	83,766,153
Annual Visits per CHC (2012)	46,855	69,922
Annual Visits Per Patient (2012)	4.65	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	74.6%	73.6%
Dental	11.2%	12.8%
Mental Health	11.7%	7.5%
Case Management/Enabling	2.5%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	1.8%	4.1%
Total Annual Visits	4.2%	4.3%
Medical	1.5%	3.5%
Dental	8.6%	7.6%
Mental Health	13.8%	9.6%
Case Management/Enabling	3.9%	1.6%

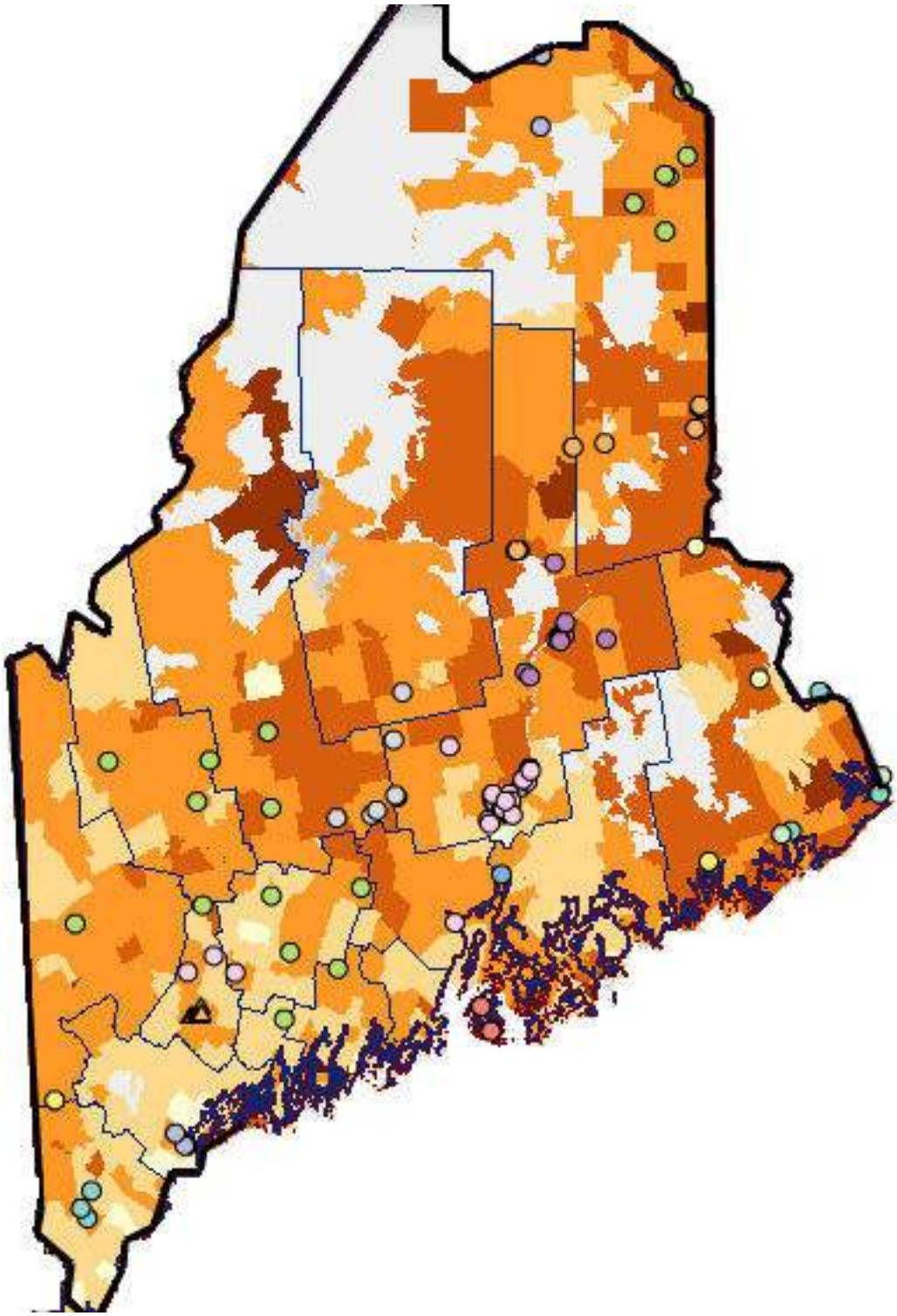
Note: All CHCs are Federally Qualifed Health Centers receiving Section 330 grants. Lookalikes not included.

Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Maine CHCs [12]



Maine Low Income Population [12]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

Maine CHCs Compared to CHCs Nationwide, 2012

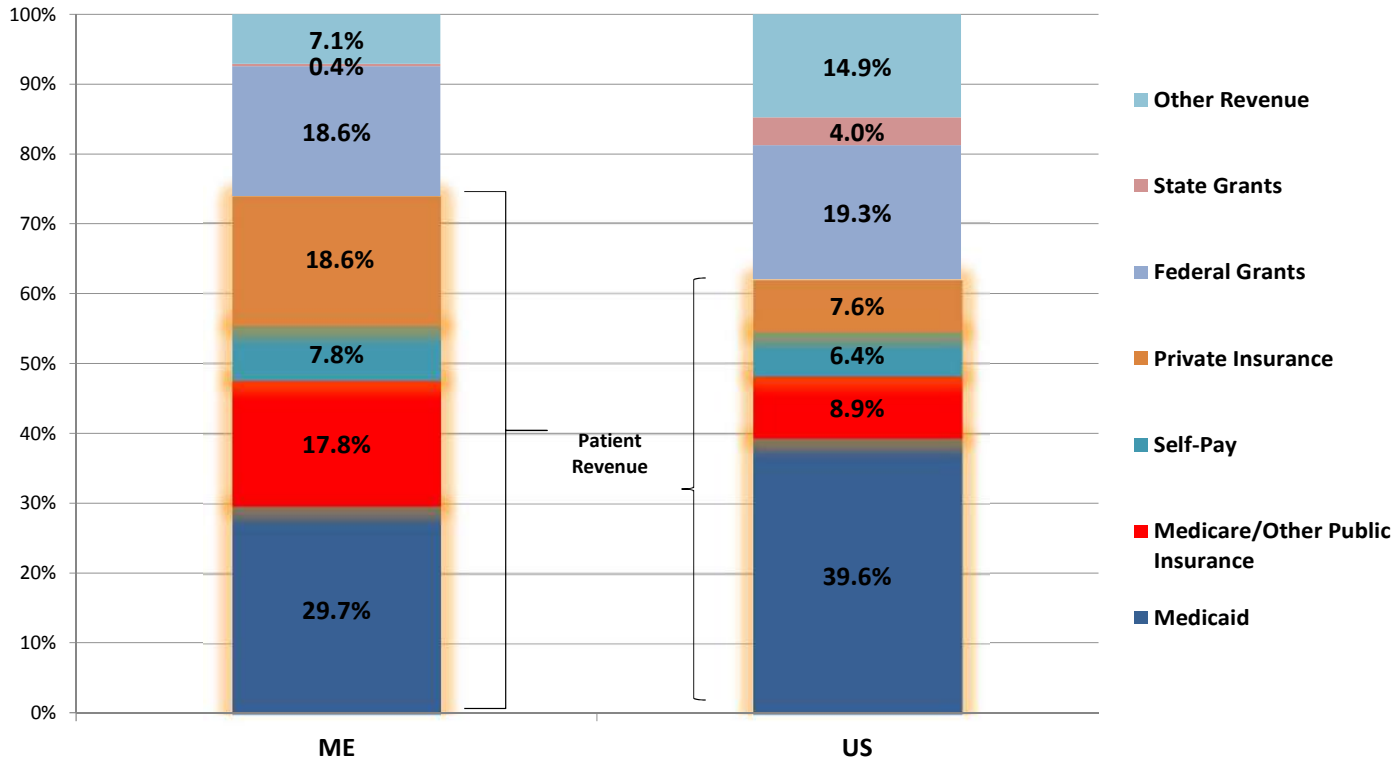
- Greater proportion of revenue from patient services
- Follow a rural CHC profile, with lower proportion of patient revenue from Medicaid, and higher proportions of revenue from private insurance and Medicare, reflecting the fact that Maine has one of the oldest populations in the country
- Very little state grant revenue

	ME	US
CHC Revenue Mix		
Patient Revenue	74.0%	62.9%
Medicaid	29.7%	39.6%
Medicare/Other Public Insurance	17.8%	8.9%
Self-Pay	7.8%	6.4%
Private Insurance	18.6%	7.6%
Federal Grants	18.6%	19.3%
State Grants	0.4%	4.0%
Other Revenue	7.1%	14.9%

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

Source: UDS Summary Data 2010-2012, 2014

Overall CHC Revenue Mix 2012



Source: UDS Summary Data 2012

CHC FINANCIAL STATUS

Maine CHCs as a Group, 2009-2011

- Median Total Assets increased by 8%
- Unrestricted Net Assets grew by 62%
- Median Days Cash on Hand decreased by 52%, from 23 to 11 days, well below the 30-day benchmark

ME Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$3,012,840	$3,432,225	$3,243,300	8%	N/A
Total Revenues ($)	$4,164,647	$4,799,768	$4,591,200	10%	N/A
Profitability					
Total Margin (%)	1.1%	6.3%	5.2%	360%	N/A
Unrestricted Net Assets ($)	$969,750	$1,281,211	$1,566,704	62%	N/A
Liquidity					
Days Cash on Hand	23	26	11	-52%	>30 Days
Days in Accounts Receivable	29	27	31	5%	<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.

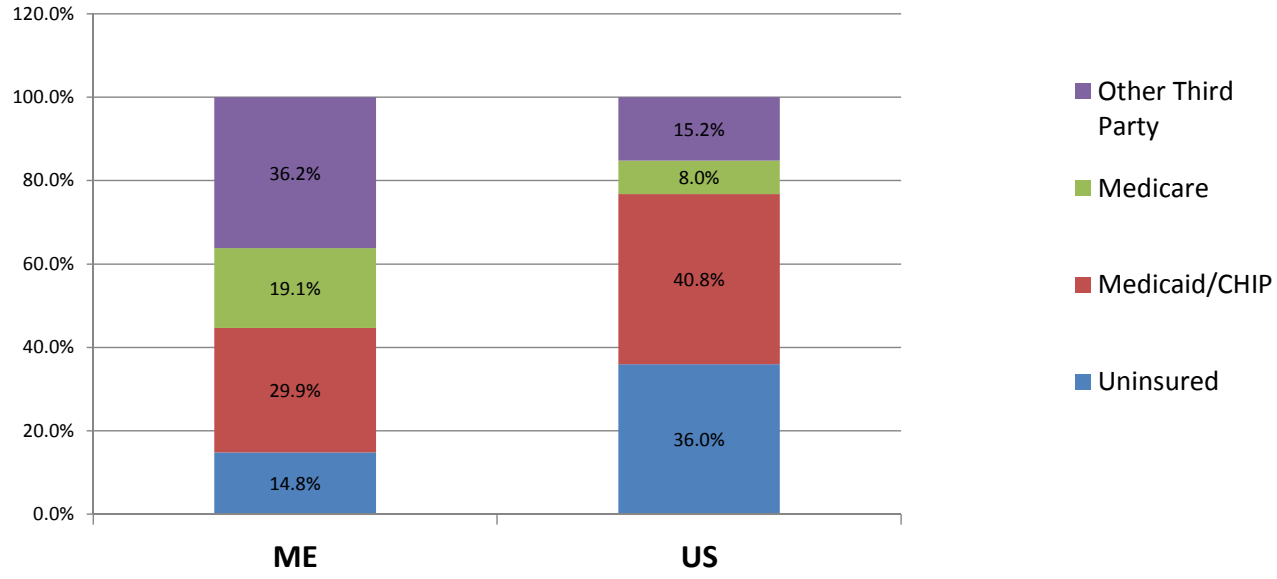
Maine CHCs Visit Mix Compared to CHCs Nationwide [13]

- Significantly lower proportion of patients living at or near poverty level, though there is considerable variability among CHCs
- Much lower proportion of patients are uninsured
- Significantly higher proportion of revenue from Medicare and other third party payer

CHC Visit Mix - 2012	ME	US
Income Status		
Patients at or below 200% poverty level	73.2%	92.6%
Patients at or below 100% poverty level	44.3%	71.9%
Coverage Status		
Uninsured	14.8%	36.0%
Medicaid/CHIP	29.9%	40.8%
Medicare	19.1%	8.0%
Other Third Party	36.2%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Better than national average on many primary care & prevention indicators
- Ranked #16 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Significantly lower proportion of population is underserved for primary care, though the PCA considers this an anomaly and shows considerable more need than data indicate.
- Underserved population for dental slightly above national average.

	ME	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	1.5%	5.3%
% low birthweights	6.3%	8.1%
% adults diagnosed with diabetes	8.5%	9.3%
Adult diabetes deaths per 100,000	21.8	20.8
Adult heart disease deaths per 100,000	151.1	179.1
Avoidable Hospitalizations per 1,000	59.3	66.6
America's Health Ranking (United Health Foundation)	16	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	32,236	35,057,608
% of total population	2.4%	11.3%
Estimated PCPs needed to achieve target PCP:Population Ratio	7	7067
Estimated underserved population for dental	177,854	31,707,007
% of total population	13.4%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	44	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [14]

- 58% of Maine CHC sites have achieved PCMH recognition or certification as of 12/31/13, compared to 44% nationally.
- Since 2010, 22 adult practices and 4 pediatric practices, serving 68,000 patients, have each received enhanced payments through a $500,000 Medicaid PCMH Pilot. The practices also receive transformation supports including a learning collaborative, practice coaching, and consultations with key experts.
- In 2012, pilot leaders launched 8 community care teams (CCTs) to support primary care providers in operating medical homes. In 2013, the Pilot program was expanded to include an additional 50 adult practices.
- In January 2013 CMS approved a health home State Plan Amendment for Medicaid enrollees with chronic conditions that is closely tied to the state's PCMH Pilot.
- Maine is one of 6 states selected in February 2013 to receive a State Innovation Model Testing Award; CMS awarded $33 million to Maine to advance patient centered medical homes.

Electronic Health Record Adoption [15]

- At 83%, Maine is close to national average (79%) in CHCs with her availability.
- Maine is near or above national average in 8 of the 12 EHR functionality categories. 12 CHCs are involved in a Health Center Controlled Network (HCCN) managed by the PCA.

Medicaid Policies – Highlights

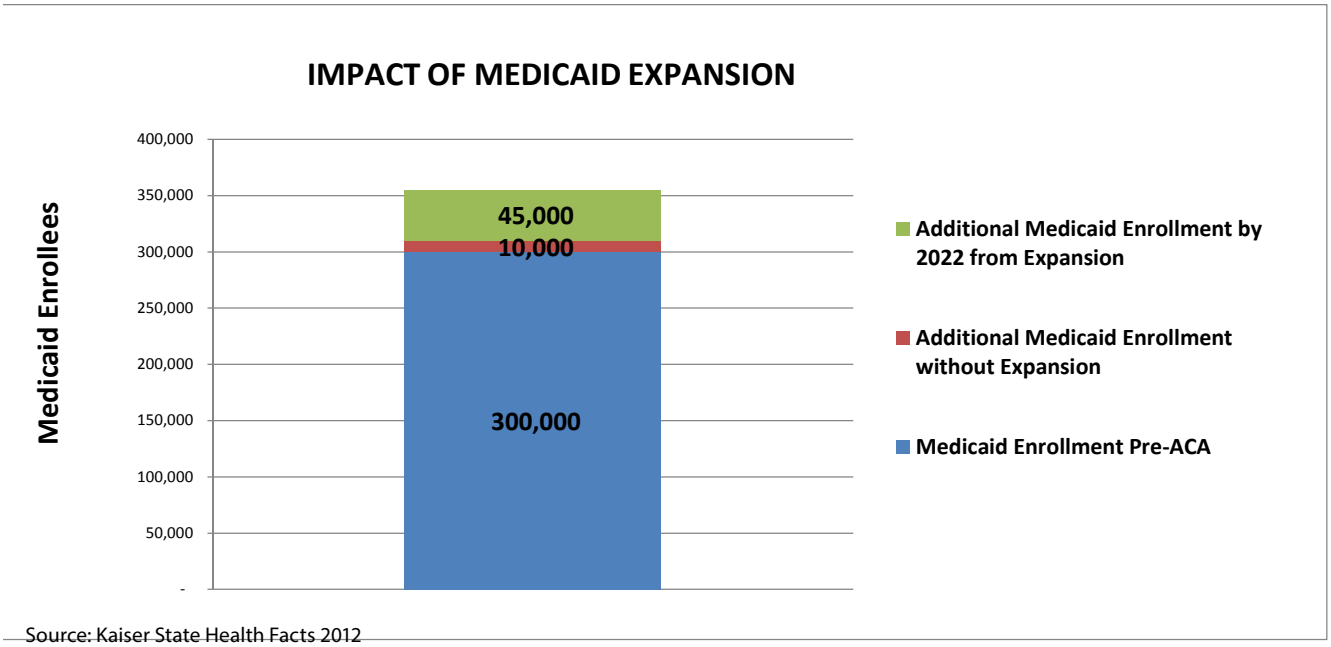
- Slightly higher per-enrollee Medicaid spending than the national average
- Under current policies, with no expansion, Medicaid enrollment is expected to grow 3.3% over the next 10 years; if the state adopts Medicaid expansion, growth will be substantially higher, at nearly 20%

	ME	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$5,968	$5,563
Federal Medical Assistance Percentage (FMAP)	62.6%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Not Expanding	
Health Insurance Exchange	Federal	
Total Uninsured	146,000	53,277,000
% of Uninsured Individuals (all ages)	11.0%	17.2%
Medicaid Enrollment Pre-ACA	300,000	52,410,000
% of Total Population	22.6%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	10,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	55,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	18.3%	40.6%
Estimated Number Remaining Uninsured After ACA	72,000	27,930,000
Estimated % Uninsured After ACA (2020)	5.1%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Has not expanded Medicaid and is not participating in creating a state-run exchange
- Residents are eligible for ACA subsidies through the federally-run healthcare.gov
- Lower proportion of uninsured than U.S. average, but significant numbers of individuals unable to access coverage because state did not expand Medicaid
- Proportion of residents who are uninsured is projected to decrease from 11.0% to 7.2% over the next decade without Medicaid expansion, and could decrease to 5.1% with Medicaid expansion



Source: Kaiser State Health Facts 2012

Maine Medicaid Spending

Maine spends just under $6,000 per Medicaid enrollee annually, the lowest in New England and the 26th highest in the nation for all health care services provided. [5]

For SFY 2013, Maine ranks 3rd in the nation in Medicaid expenditures as a percentage of the state's total budget. [16]

Medicaid Coverage & Administration

Maine has to date not chosen to expand its Medicaid program under the ACA[6], with the legislature supporting expansion and the Governor vetoing expansion legislation.

MaineCare is Maine's Medicaid program that has historically provided coverage for residents living below 100% FPL, as well as others with low-income. [17]

Most MaineCare beneficiaries receive their care through a Primary Care Management model of managed care. [18]

Current eligibility levels are shown below. Prior to 2014, Maine provided coverage to childless adults up to 100% FPL, and to parents of dependent children up to 200% FPL. [18] However, to reduce the budget, the state submitted an amendment to reduce coverage for parents, and failed to renew its waiver for coverage of childless adults in December 2013. [19] [20] Approximately 25,000 MaineCare patients were dropped from eligibility, many of which are CHC patients. [21]

There are no enrollment fees for participation in the Medicaid program; however, premiums are required for certain individuals based on their income level. Nominal co-payments are also required for certain services in selected settings. [22]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	185%	200%	200%	100%
2014	213%	214%	105%	0%

*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

Maine CHC Reimbursement Policies

Maine reimburses CHCs in accordance with the federal PPS methodology. Maine law additionally provides that the State "shall reimburse a federally qualified health center no less than 100% of reasonable costs, reduced by the total copayments for which members are responsible, for services furnished by the center within the scope of service approved by the federal Health Resources and Services Administration or the commissioner." [6] Maine does not provide funding to CHCs for indigent care. [23]

According to the Maine PCA, the PPS rate has not kept pace with inflation and reimbursements under MaineCare's PPS do not cover the full cost to care required under federal law, including enabling services like transportation, interpretation and case management.

A CHC can request a rate adjustment due to a substantial change in the type of service provided. The CHC will be required to submit documentation showing that the federal Health Resources Services Administration (HRSA) had approved its change in scope of services and a cost report reflecting at least six months of financial data supporting the claim. [24]

Services eligible to generate a reimbursable PPS encounter include those provided by MDs, DMDs, NPs, LSCWs, RNs, psychologists and dental hygienists.

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
ME	Yes	Yes	Yes	Yes	

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
ME	Yes	Yes		Yes	

Source: Kaiser State Health Facts 2012

MEDICAID AND HEALTH INSURANCE LANDSCAPE

Collaboration with CMS [25]

Maine is collaborating 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:

- **FQHC Advanced Primary Care Demonstration** – Select FQHC Grantees will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promote better health and lower costs. There are 6 grantees and 14 total health centers participating in the demonstration in Maine.
- **Multi-Payer Advanced Primary Care Practice Initiative (MAPCP)** – a Medicare program promoting Advanced Primary Care (APC) practices.
- **State Innovation Model** -- Maine is the recipient of a $33 million "Model Testing Award" to implement a State Health Care Innovation Plan.

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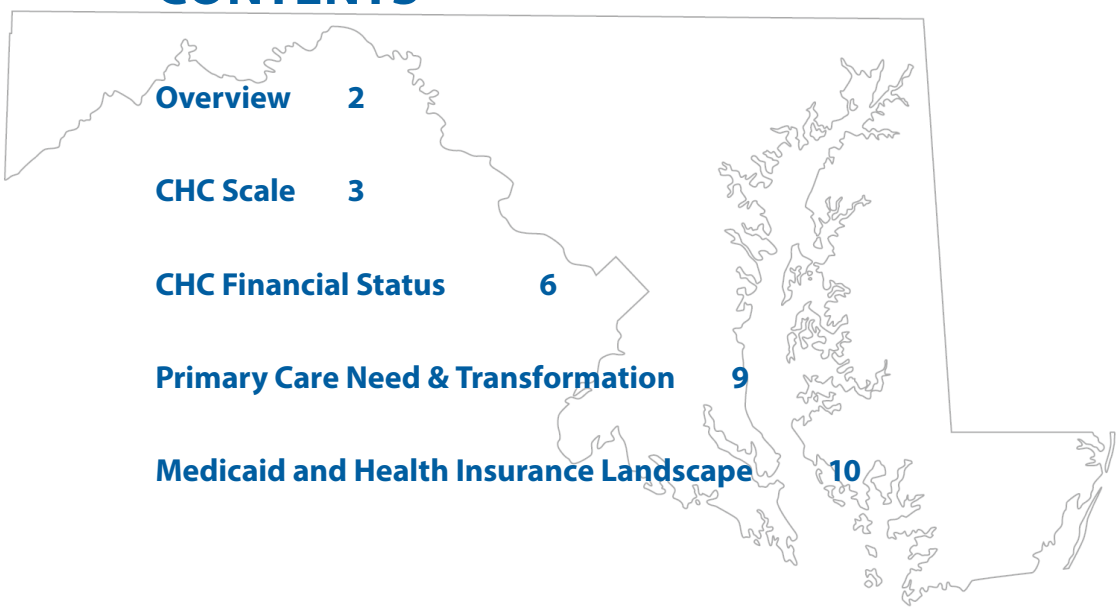
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY STATE PROFILES

MARYLAND

CONTENTS



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014 there were 15 CHCs operating 113 permanent clinical service delivery sites throughout the state of Maryland. CHCs in Maryland are represented by the Mid-Atlantic Association of Community Health Centers, which also represents Delaware CHCs. [1] [2]
- Maryland CHCs provided 1,368,938 visits to 291,579 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 4.7% from 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 17% of Maryland's Medicaid population (US: 16%) and 5% of its overall population (US: 7%). Maryland CHCs serve 15.1% of individuals with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 761,000, is projected with Medicaid expansion to grow by an additional 209,000 people by 2022 (27% growth), with the uninsured rate projected to decrease from 13.4% to 7% by 2020. [4]

Policy & Reimbursement

- Maryland spends slightly more than $7,000 per Medicaid enrollee annually – the 11th highest in the nation. [5]
- Maryland is implementing Medicaid expansion under the ACA, setting higher eligibility limits for parents and childless adults (138% FPL), pregnant women (264% FPL) and children (family income up to 322% FPL). [6]
- Medicaid managed care is run through the HealthChoice program. About 80% of Medicaid beneficiaries receive services through the program. [7]
- Medicaid reimbursement for Maryland's CHCs is governed by the PPS system. [8]
- Maryland Medicaid enables an array of providers) to bill Medicaid for face-to-face visits, including MDs, NPs, PAs, RNs, psychologists, LSWs and certified midwives. [9]
- Maryland has several FQHCs participating in the "FQHC Advanced Primary Care Demonstration" program, a program funded by the CMS Innovation Center; additionally, Maryland has been awarded State Innovation Model "Design Award." [10]
- Maryland has state-run Health Insurance Exchange known as the Maryland Health Benefit Exchange. [11] [12] The Maryland exchange encountered considerable technical difficulties, and had 67,757 individuals who selected a health plan in the first open enrollment period (thru 3/31/14) against a goal 150,000. [13]

Maryland CHCs Compared to CHCs Nationwide

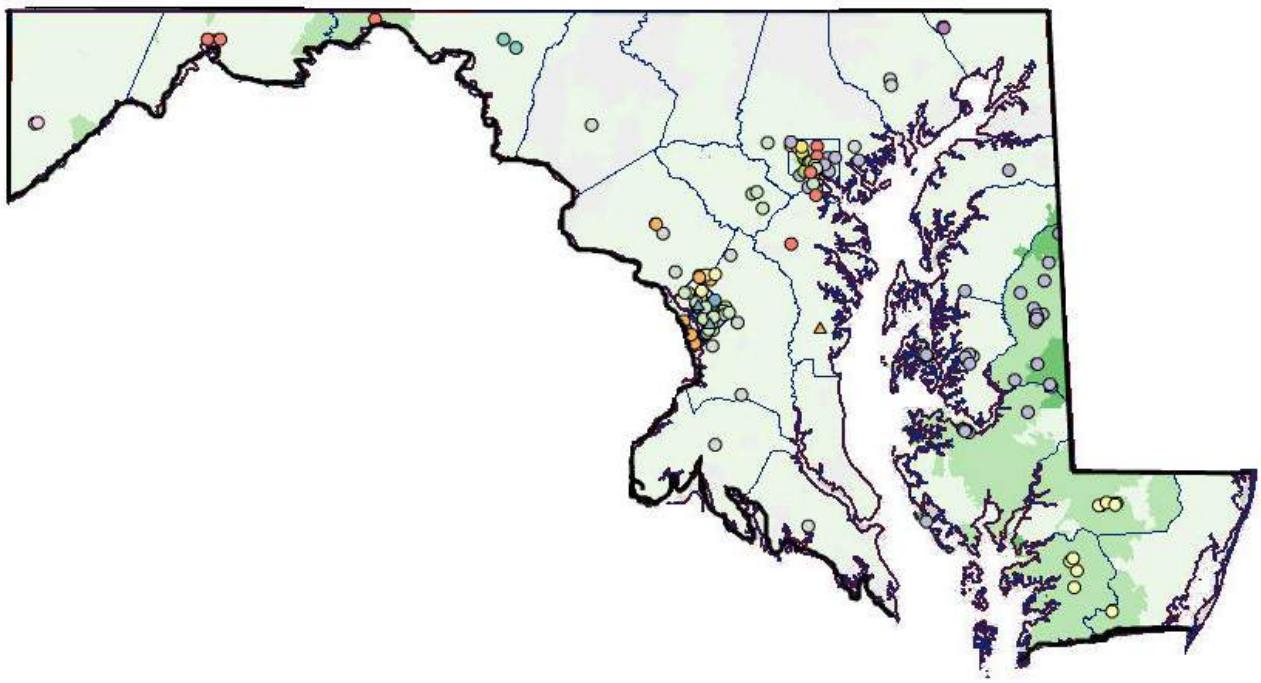
- Lower proportion of total population served at CHCs
- Proportion of Medicaid population served at CHCs near national average
- Visits per CHC is 22% higher than national average
- Significantly higher proportion of visits for Case Management/Enabling Services
- Growth rate (2010-12) in visits about 65% above national average, including very substantial growth in dental care

	MD	US
Population Served (2012)		
Total patients served by CHCs	291,579	21,102,391
% of population served by CHCs	5.0%	6.8%
% of under 200% FPL served by CHCs	15.1%	15.9%
% of Medicaid Enrollees Served	17.4%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	15	1284
Total CHC Service Delivery Sites (2014)	113	9509
Average Sites per CHC (2014)	7.5	7.4
Annual Visits (Total) (2012)	1,368,938	83,766,153
Annual Visits per CHC (2012)	85,559	69,922
Annual Visits Per Patient (2012)	4.69	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	70.6%	73.6%
Dental	7.7%	12.8%
Mental Health	11.6%	7.5%
Case Management/Enabling	10.2%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	4.7%	4.1%
Total Annual Visits	7.1%	4.3%
Medical	5.7%	3.5%
Dental	17.9%	7.6%
Mental Health	10.4%	9.6%
Case Management/Enabling	6.3%	1.6%

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

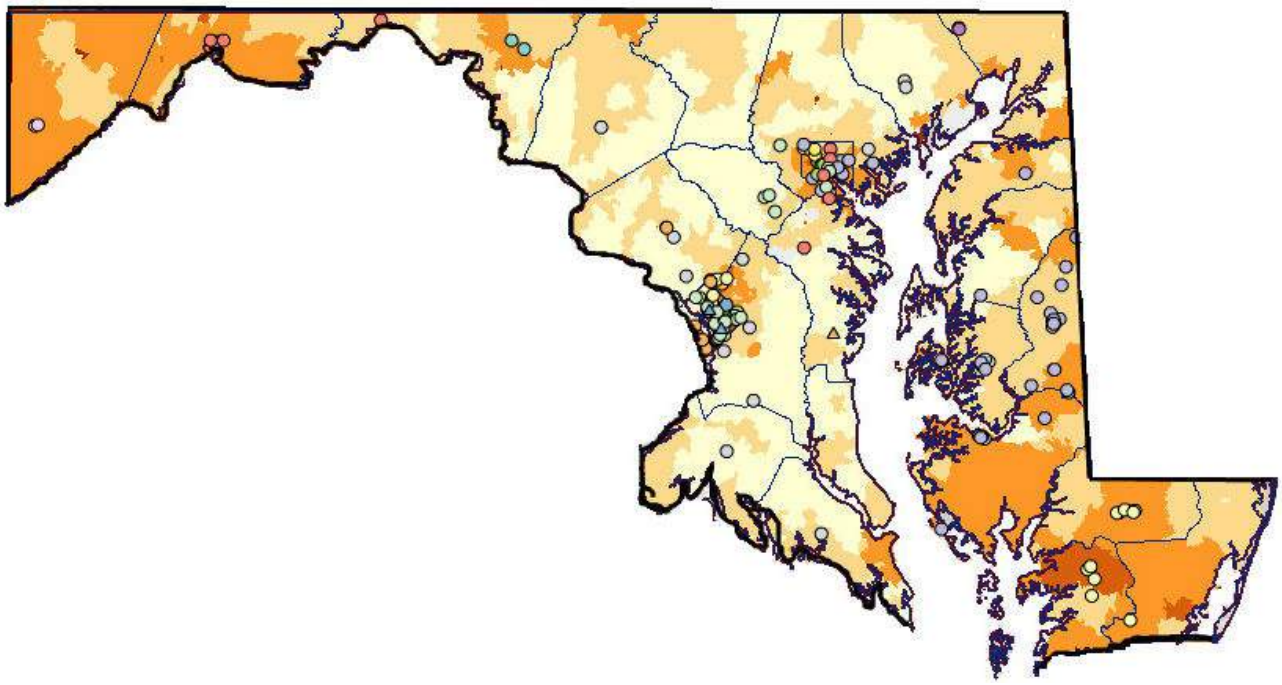
Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Maryland CHCs [14]



Source: UDS Mapper 2014

Maryland Low Income Population [14]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

Source: UDS Mapper 2014

Maryland CHCs Compared to CHCs Nationwide, 2012

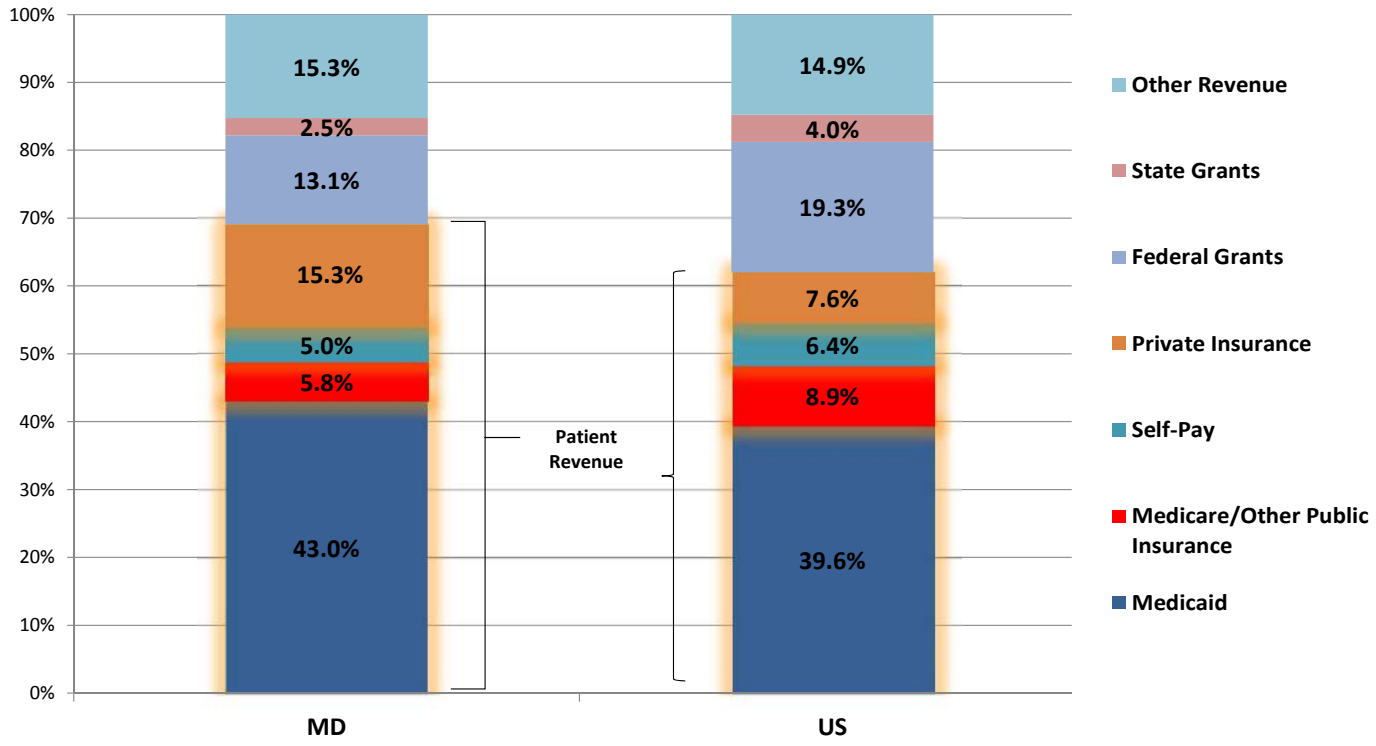
- Higher proportion of revenue from patient services
- Slightly higher portion of patient revenues from Medicaid
- Twice the proportion of revenue from private insurance
- Lower reliance on federal grants

	MD	US
CHC Revenue Mix		
Patient Revenue	69.2%	62.9%
Medicaid	43.0%	39.6%
Medicare/Other Public Insurance	5.8%	8.9%
Self-Pay	5.0%	6.4%
Private Insurance	15.3%	7.6%
Federal Grants	13.1%	19.3%
State Grants	2.5%	4.0%
Other Revenue	15.3%	14.9%

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

Source: UDS Summary Data 2010-2012, 2014

Overall CHC Revenue and Payer Mix 2012



Source: UDS Summary Data 2012

Maryland CHCs as a Group, 2009-2011

- Median Total Assets increased by 139%
- Unrestricted Net Assets grew by 32%
- Median Days Cash on Hand increased by 40%, from 39 to 54 days, well above 30-day benchmark

MD Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$4,384,400	$5,881,237	$10,487,327	139%	N/A
Total Revenues ($)	$10,046,949	$11,652,282	$12,662,731	26%	N/A
Profitability					
Total Margin (%)	5.1%	6.6%	1.8%	-65%	N/A
Unrestricted Net Assets ($)	$4,520,670	$5,457,258	$5,963,292	32%	N/A
Liquidity					
Days Cash on Hand	39	47	54	40%	>30 Days
Days in Accounts Receivable	26	23	30	11%	<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

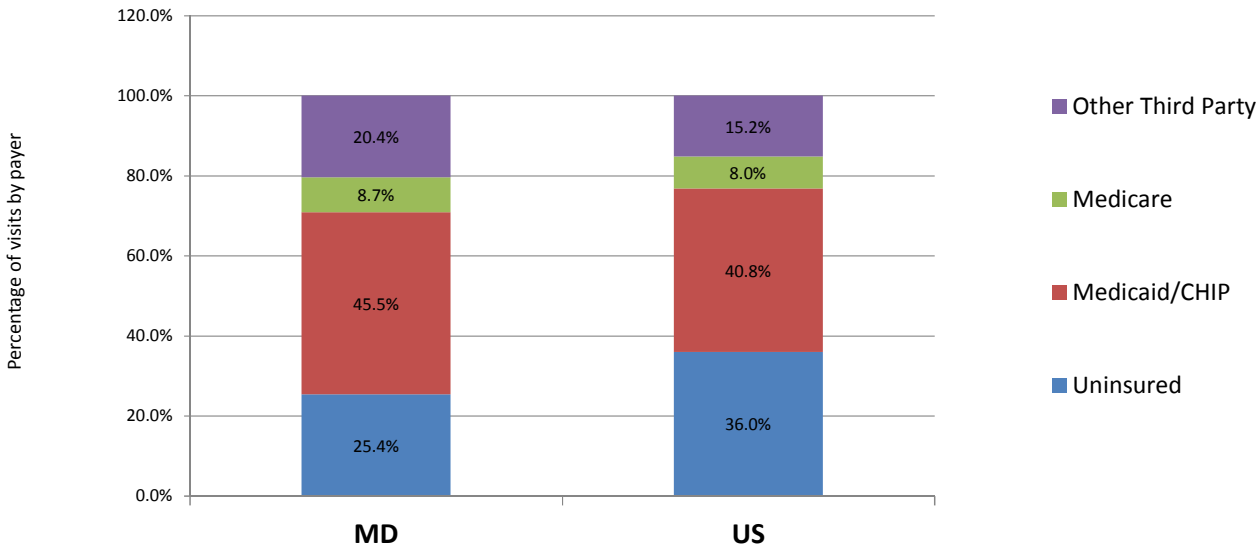
Maryland CHCs Visit Mix Compared to CHCs Nationwide [15]

- Slightly lower proportion of patients live at or below poverty level
- Higher percentage of patients have Medicare and Medicaid
- Lower percentage of uninsured patients

	MD	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	90.3%	92.6%
Patients at or below 100% poverty level	64.6%	71.9%
Coverage Status		
Uninsured	25.4%	36.0%
Medicaid/CHIP	45.5%	40.8%
Medicare	8.7%	8.0%
Other Third Party	20.4%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near national average on most primary care & prevention indicators
- Ranked #24 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Lower proportion of population is underserved for primary care
- Underserved population for dental also significantly below national average

	MD	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	6.2%	5.3%
% low birthweights	8.8%	8.1%
% adults diagnosed with diabetes	9.0%	9.3%
Adult diabetes deaths per 100,000	19.9	20.8
Adult heart disease deaths per 100,000	182.2	179.1
Avoidable Hospitalizations per 1,000	62.7	66.6
America's Health Ranking (United Health Foundation)	24	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	294,417	35,057,608
% of total population	5.0%	11.3%
Estimated PCPs needed to achieve target PCP:Population	163	7067
Estimated underserved population for dental	185,412	31,707,007
% of total population	3.2%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	62	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Electronic Health Record Adoption [16]

- Close to national average EHR availability at state CHC sites (75% in Maryland compared to 79% in the U.S.)
- Scores higher than the national average in 9 of the 12 EHR functionality categories

Patient Centered Medical Home [3] [29]

- 50% of Maryland CHCs have achieved PCMH recognition or certification as of 7/1/14 compared to 58% nationally.
- In April 2010, Maryland enacted legislation which required the Maryland Health Care Commission (MHCC) to establish a Maryland Patient Centered Medical Home (PCMH) multi-year program. All payers with revenues over $90 million are required to participate.
- CHCs can share in 65% of savings for patients with Medicaid coverage, whereas other practices will be able to share in 30 to 50%.

Medicaid Policies – Highlights

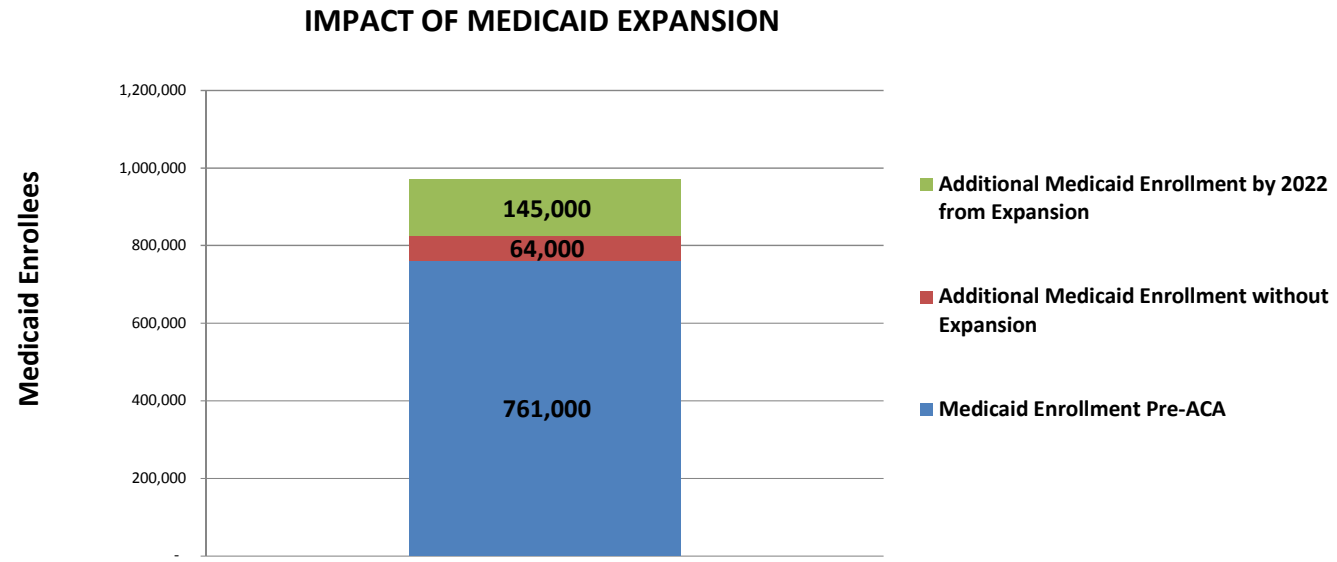
- Higher per-enrollee Medicaid spending than the national average
- Positive changes in Medicaid and medical home initiatives should increase access and expand enrollment.

	MD	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$7,046	$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	780,000	53,277,000
% of Uninsured Individuals (all ages)	13.4%	17.2%
Medicaid Enrollment Pre-ACA	761,000	52,410,000
% of Total Population	13.0%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	64,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	209,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	27.5%	40.6%
Estimated Number Remaining Uninsured After ACA	453,000	27,930,000
Estimated % Uninsured After ACA (2020)	7.0%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- State is implementing Medicaid expansion and already has a state-run health insurance exchange
- Slightly lower proportion of uninsured than U.S. average
- Proportion of residents who are uninsured is expected to decrease by from 13.4% to 7% over the next decade as a result of ACA.



Source: Kaiser State Health Facts 2012

Maryland Medicaid Spending

Maryland spends just over $7,000 per Medicaid enrollee annually – the 11th highest in the nation. [5]

Parents and children in low-income families make up over three-fourths of Medicaid and MCHP beneficiaries, but they account for a little more than one-third of Medicaid and MCHP spending. [13] Older adults and individuals with disabilities account for the majority of spending because of their intensive use of acute and long-term care services. [13]

Medicaid Coverage & Administration

NHealthChoice, Maryland's statewide mandatory Medicaid managed care program, enrolls over 80% of the state's Medicaid population. The program also enrolls children in the Maryland Children's Health Program (MCHP). [17] [18] Under the HealthChoice Rare and Expensive Case Management Program (REM), Medicaid recipients with specific rare and expensive conditions receive fee-for-service benefits and may receive an expanded set of benefits. [18]

Prior to the Medicaid expansion, Maryland provided coverage to parents of dependent children (116% FPL), pregnant woman (250% FPL), and children (300% FPL through the CHIP program). [19] [20] [21] While childless adults were not covered under Medicaid prior to the expansion, they were given limited coverage under the "Primary Adult Care" (PAC) program, using savings generated under HealthChoice. [22]

Following Medicaid expansion, eligibility was expanded for children (up to 322% through CHIP), Pregnant Women (264% FPL), and Parents of Dependent Children (138% FPL). Coverage is now available for childless adults as well (138% FPL). [9]

There are no enrollment fees for participation in the Medicaid program; however, premiums are required for individuals who earn above 200% FPL. Premiums are $50 for those living between 200% and 250% FPL, and $63 for the remainder of those eligible. Co-payments are limited for most services, but required for mental health and HIV medications. [23]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	300%	250%	122%	116%
2014	322%	264%	138%	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

CHC Medicaid Reimbursement Policies

Maryland CHCs are paid in accordance with the federal PPS system. According to the Maryland Statute, Federally Qualified Health Centers are required to be reimbursed at 100% of their "reasonable and allowable" costs. [24] The allowable costs are determined in accordance with Medicare principles of reasonable cost reimbursement:

> "Payment is to be made on the basis of current costs…All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized."

Reimbursements to CHCs are made on a per-visit basis, with CHC-specific rates that vary by service (i.e., medical and dental services have different rates). Final rate determinations are reached by including the cost of additional services (such as OB/GYN physicians) and will include adjustments based on the Medicare economic index at the end of each year. [25]

Maryland devotes only a nominal amount of funding to CHCs for indigent care just below $170,000 in 2012. [26]

A relatively wide range of types of providers are eligible to generate a reimbursable encounter. MDs, NPs, PAs, RNs, psychologists, LCSWs and certified midwives can all generate a billable encounter. [27]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
MD	Yes	No	Yes	Yes	PA, DMD

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
MD	Yes	Yes	No	No	No

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

Collaboration with CMS [28]

Maryland 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:

- **FQHC Advanced Primary Care Demonstration** – Select FQHC Grantees will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promotes better health, and lowers costs. There are 4 grantees and 7 total health centers participating in the demonstration in Maryland.
- **State Innovation Model** -- Maryland was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan. Maryland seeks to create a model that both integrates patient-centered medical care with community-based resources through a statewide expansion of Community-Integrated Medical Homes (CIMH) and enhances the capacity of local health entities to monitor and improve.

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PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

MASSACHUSETTS

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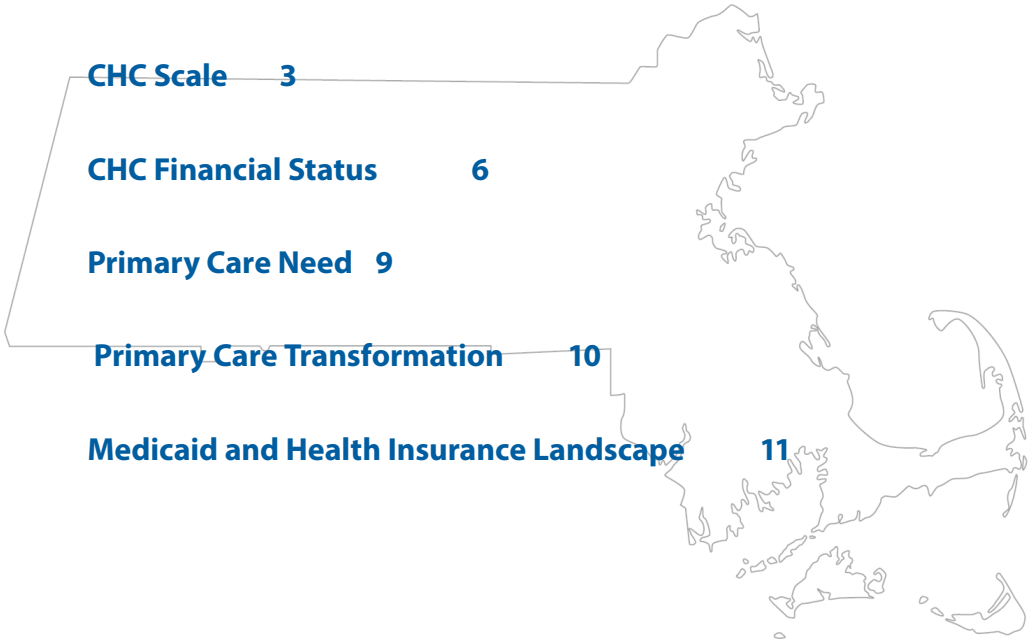


Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 37 grant-funded Federally-Qualified Health Centers (CHCs) operating 265 service delivery sites throughout the state of Massachusetts. Massachusetts CHCs provided 3,241,431 visits to 638,623 patients in 2012. [1] The PCA representing CHCs is the Massachusetts League of Community Health Centers. [2] [3]
- The number of patients served by CHCs increased by an average of 4.2% annually from 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [2]
- CHCs serve approximately 20.6% of Massachusetts' Medicaid population (US: 16%) and 10% of its overall population (US: 7%). [2]
- Medicaid enrollment, currently at 1,296,000, is projected to grow by an additional 153,000 people by 2022 (12% growth), with the uninsured rate projected to decrease from 4.8% to 2.7%. [4]

Policy & Reimbursement

- Massachusetts spends slightly more than $6,800 per Medicaid enrollee annually– the 13th highest in the nation. [5]
- Massachusetts has implemented Medicaid expansion under the ACA Medicaid Managed Care in Massachusetts is operated by MassHealth, which runs two different types of programs: the MassHealth Managed Care Organization program and the Primary Care Clinician plan. [6]
- Medicaid eligibility limits for parents and childless adults are 138% FPL, with higher limits for pregnant women (205% FPL) and children (family income up to 305% FPL). [7]
- MassHealth medical payment rates to CHCs can be adjusted if the organization can demonstrate that access to service delivery is threatened. [8]
- Massachusetts set up its own state-run exchange in 2006, under the Commonwealth Health Insurance Connector Authority, known as the "Massachusetts Health Connector." [9] [10]
- To conform to the ACA, the Health Connector required certain adjustments which proved more challenging than anticipated, and, through the first enrollment period, individuals who have selected health plans through the existing exchange reached a total of 31,695, against a goal of 250,000. [11]
- Massachusetts health centers are participating in several innovation programs, including the CMS "FQHC Advanced Primary Care Demonstration" The state was also awarded a State Innovation Model testing grant as well as approval for a Dual-Eligibles Financial Alignment Demonstration. [12]

Massachusetts CHCs Compared to CHCs Nationwide

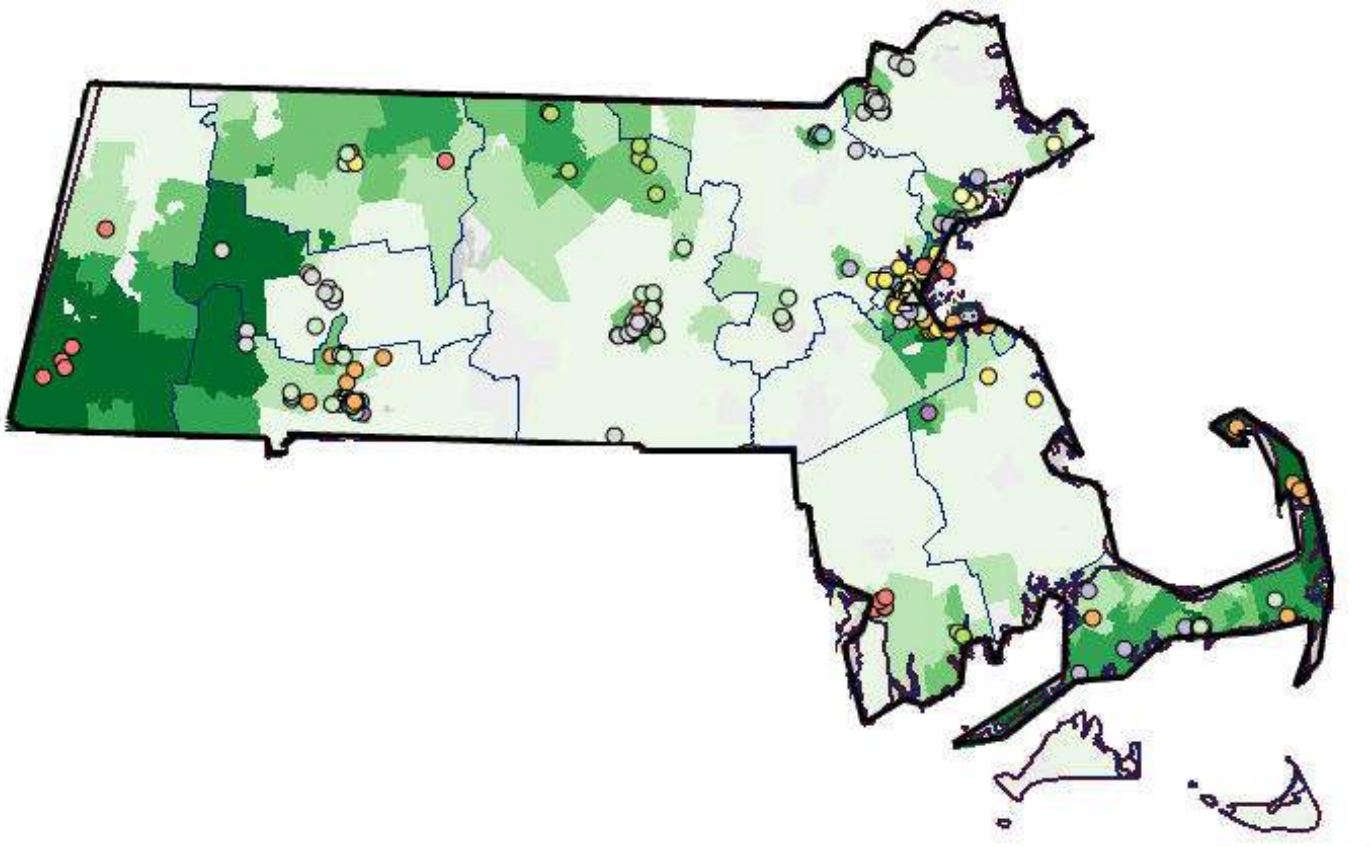
- Higher proportion of the total population served
- Higher proportion of Medicaid and low-income population served
- 30% more patient visits per CHC organization than national average
- Higher proportion of dental, mental health and case management services
- Growth rate (2010-12) in visits matches the national average, with greatest growth in mental health, and least in medical

	MA	US
Population Served (2012)		
Total patients served by CHCs	638,623	21,102,391
% of population served by CHCs	9.8%	6.8%
% of under 200% FPL served by CHCs	27.3%	15.9%
% of Medicaid Enrollees Served	20.6%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	37	1284
Total CHC Service Delivery Sites (2014)	265	9509
Average Sites per CHC (2014)	7.2	7.4
Annual Visits (Total) (2012)	3,241,431	83,766,153
Annual Visits per CHC (2012)	90,040	69,922
Annual Visits Per Patient (2012)	5.08	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	68.7%	73.6%
Dental	14.0%	12.8%
Mental Health	10.2%	7.5%
Case Management/Enabling	7.1%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	4.2%	4.1%
Total Annual Visits	4.2%	4.3%
Medical	2.5%	3.5%
Dental	8.2%	7.6%
Mental Health	10.4%	9.6%
Case Management/Enabling	5.8%	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 Massachusetts CHCs [13]



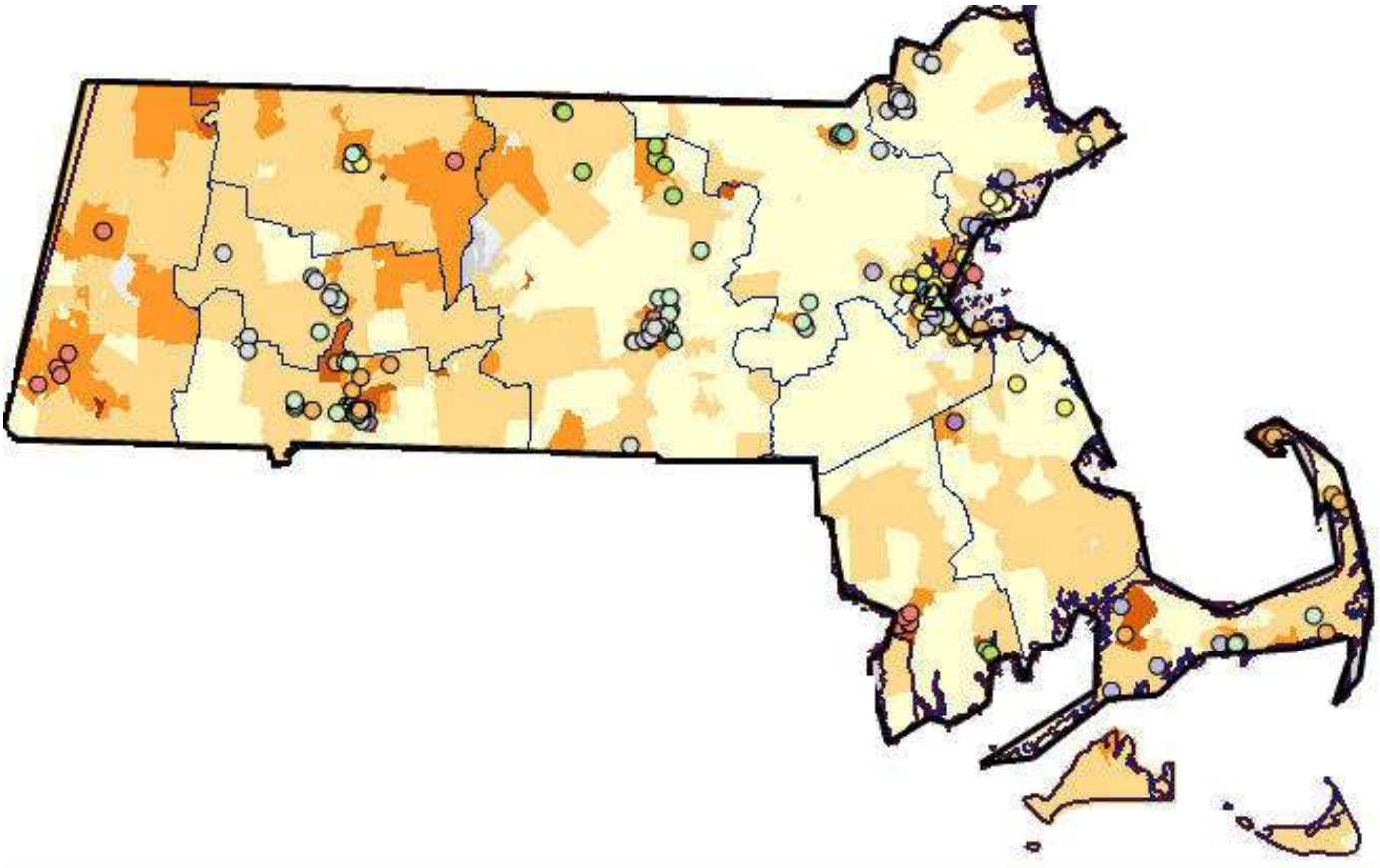
% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Source: UDS Mapper 2014

Massachusetts Low Income Population [13]



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

- < 15%
- 15 - 30%
- 30 - 45%
- 45 - 60%
- > 60%

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

Source: UDS Mapper 2014

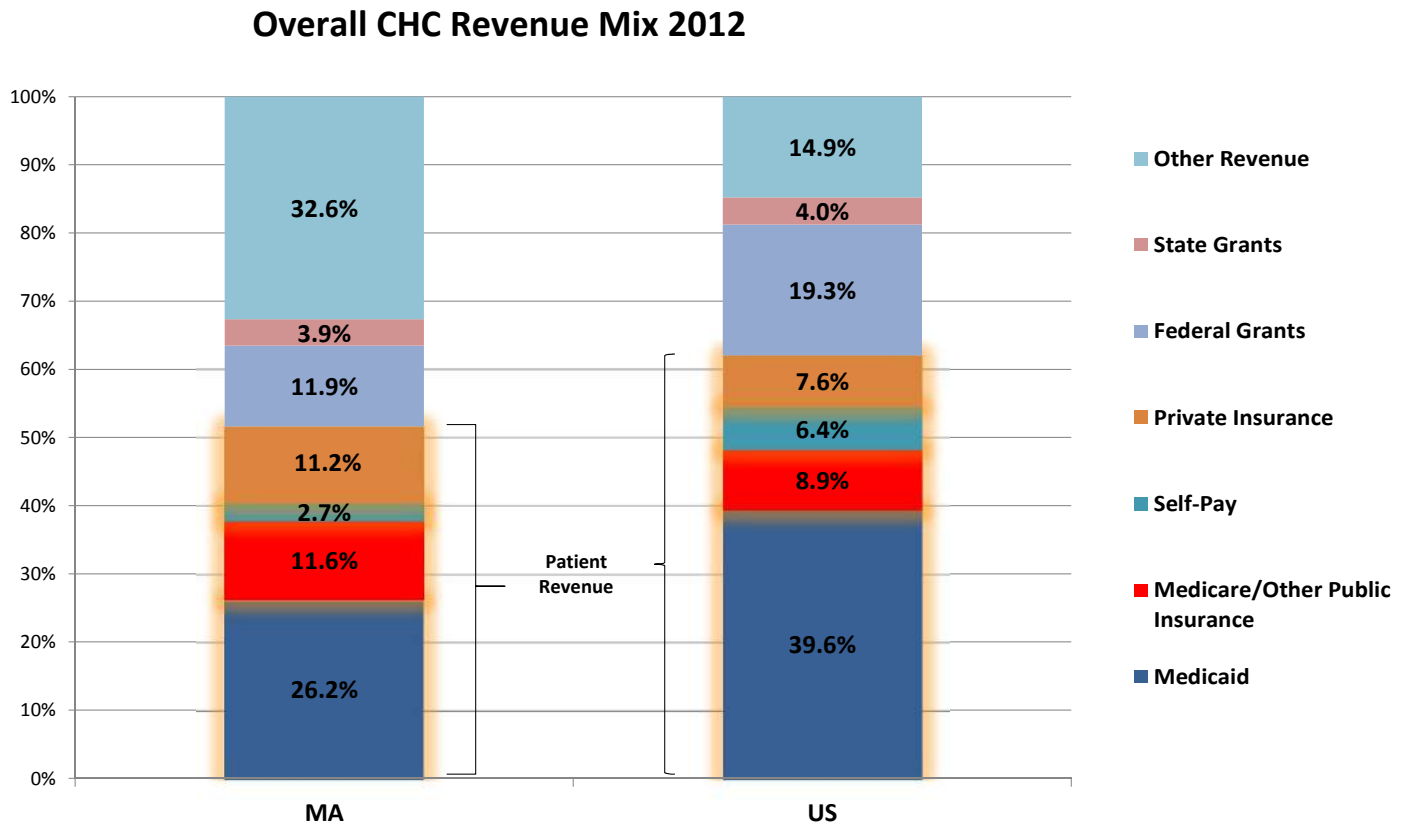
Massachusetts CHCs Compared to CHCs Nationwide, 2012

- Significantly lower proportion of revenue from patient services
- Significantly lower portion of patient revenues from Medicaid
- Higher revenues from private insurance and Medicare
- Lower reliance on federal grants
- Double the national average in "other revenue" which includes an indigent care pool and funding from local foundations.

	MA	US
CHC Revenue Mix		
Patient Revenue	51.6%	62.9%
Medicaid	26.2%	39.6%
Medicare/Other Public Insurance	11.6%	8.9%
Self-Pay	2.7%	6.4%
Private Insurance	11.2%	7.6%
Federal Grants	11.9%	19.3%
State Grants	3.9%	4.0%
Other Revenue	32.6%	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

CHC FINANCIAL STATUS

Massachusetts CHCs as a Group, 2009-2011

- Median Total Assets increased by 66%
- Median Days Cash on Hand decreased by 28%, from 37 to 27 days, just below the 30-day benchmark

MA Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$8,996,628	$9,842,493	$14,949,170	66%	N/A
Total Revenues ($)	$15,753,029	$18,052,660	$19,572,720	24%	N/A
Profitability					
Total Margin (%)	3.6%	3.0%	3.2%	-10%	N/A
Unrestricted Net Assets ($)	$4,570,232	$4,782,510	$5,575,407	22%	N/A
Liquidity					
Days Cash on Hand	37	34	27	-28%	>30 Days
Days in Accounts Receivable	38	36	38	0%	<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

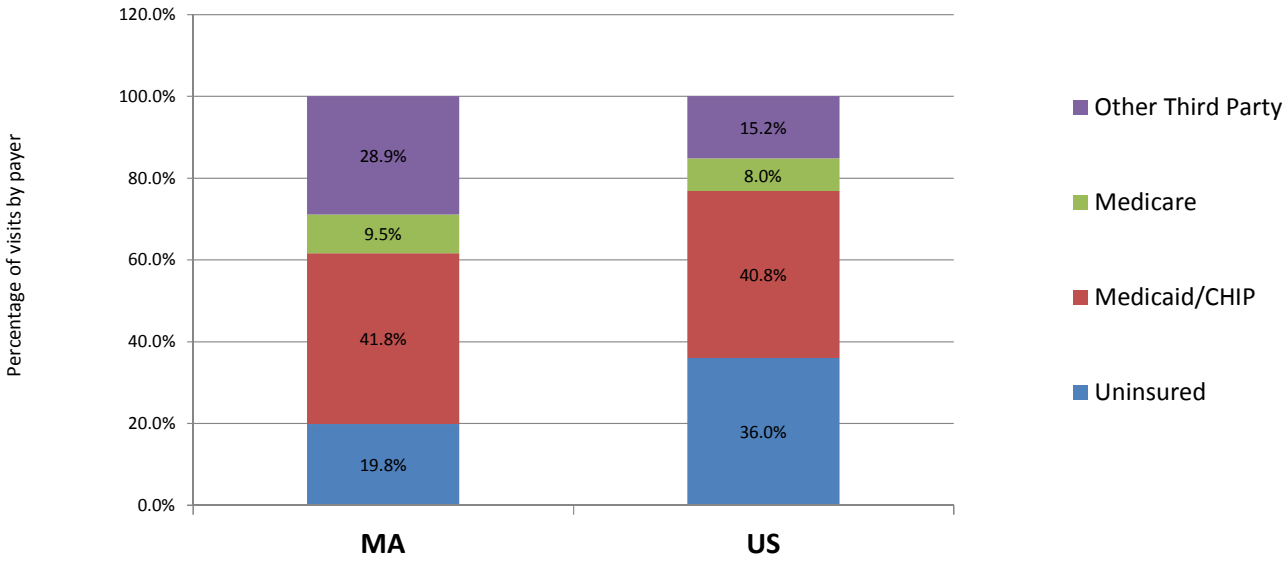
Massachusetts CHCs Visit Mix Compared to CHCs Nationwide [14]

- Slightly lower proportion of patients living at or below poverty level
- Much lower proportion of uninsured patients
- Much higher proportion of third party payers, most likely due to the availability of subsidized insurance since 2006
- Visits from Medicaid and Medicare patients near national average

	MA	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	90.6%	92.6%
Patients at or below 100% poverty level	68.1%	71.9%
Coverage Status		
Uninsured	19.8%	36.0%
Medicaid/CHIP	41.8%	40.8%
Medicare	9.5%	8.0%
Other Third Party	28.9%	15.2%

Source: UDS Summary Data 2012

CHC Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Significantly better than national average on primary care & prevention indicators
- Ranked #4 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Significantly lower proportion of population underserved for primary care and dental care

	MA	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	2.3%	5.3%
% low birthweights	7.7%	8.1%
% adults diagnosed with diabetes	7.6%	9.3%
Adult diabetes deaths per 100,000	13.3	20.8
Adult heart disease deaths per 100,000	150.0	179.1
Avoidable Hospitalizations per 1,000	72.8	66.6
America's Health Ranking (United Health Foundation)	4	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	127,383	35,057,608
% of total population	1.9%	11.3%
Estimated PCPs needed to achieve target PCP:Population	56	7067
Estimated underserved population for dental	229,124	31,707,007
% of total population	3.5%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	74	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [2] [15]

- 81% of CHCs achieved PCMH recognition or certification as of 7/1/14 compared to 58% nationally.
- In June 2009, the state began a Patient-Centered Home Medical Home Initiative (PCMHI). The participating practices, which included 500 providers and served 500,000 patients, received enhanced payments and technical assistance in exchange for meeting core standards within 18 months of project launch.
- In 2012, Massachusetts created a Health Policy Commission to create strategies to control healthcare costs. Among other strategies, it was directed to develop certification standards, a training program and a model payment system for PCMHs.
- Massachusetts is one of the six states selected to receive a CMS State Innovation Model Testing Award ($44 million) to advance patient-centered medical homes.

Electronic Health Record Adoption [16]

- Close to the national average EHR availability at state CHC sites (92% in Massachusetts compared to 88% in the U.S.)
- Achieve 11 of the 12 EHR functionalities – higher than the national average

Medicaid Policies – Highlights

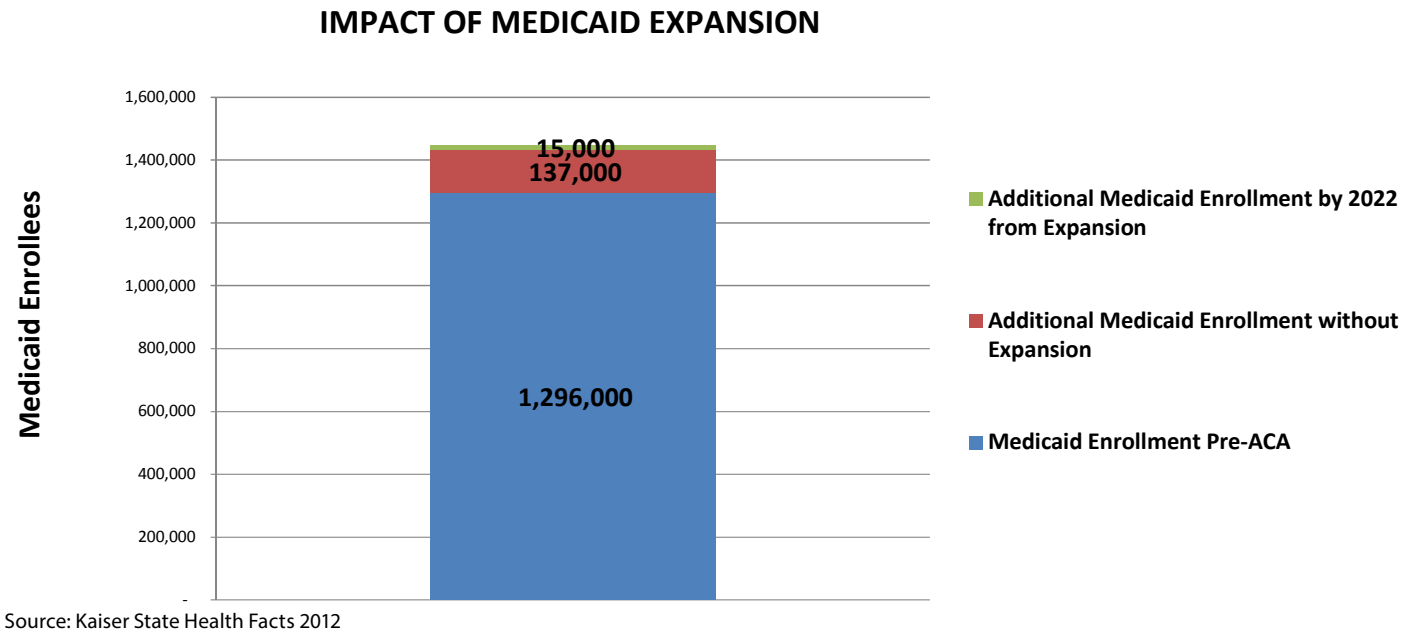
- Higher per-enrollee Medicaid spending than the national average
- Positive changes in Medicaid and medical home initiatives should increase access and expand enrollment.

	MA	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$6,841	$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	224,000	53,277,000
% of Uninsured Individuals (all ages)	3.4%	17.2%
Medicaid Enrollment Pre-ACA	1,296,000	52,410,000
% of Total Population	19.8%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	137,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	152,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	11.7%	40.6%
Estimated Number Remaining Uninsured After ACA	184,000	27,930,000
Estimated % Uninsured After ACA (2020)	2.7%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Implementing Medicaid expansion
- Has had a state-run health insurance exchange, Massachusetts Health Connector, since 2006
- Significantly lower proportion of uninsured than U.S. average
- Proportion of residents who are uninsured is expected to decrease from 4.8% to 2.7% over the next decade as a result of ACA and other state-led initiatives.



Source: Kaiser State Health Facts 2012

Massachusetts Medicaid Spending

MassHealth, Massachusetts' Medicaid and CHIP Program, spends just over $6,800 per Medicaid enrollee annually – the 13th highest in the nation for all health care services provided. [5] Overall, Total Medicaid Spending in 2012 totaled nearly $13 billion dollars. [17]

Subsidized Care Coverage & Administration

Massachusetts has long been a leader in reform efforts affecting residents' access and health benefit funding as well as providers' health care delivery and payment. In 2006, Massachusetts received federal approval of a waiver amendment to enact groundbreaking health reform to expand Medicaid and private health insurance and provide "near-universal" coverage. [18]

Beyond those earlier reforms, Massachusetts is expanding MassHealth under the ACA. The state obtained approval of a waiver amendment in October 2013 to comport with ACA provisions and take advantage of federal cost-sharing and premium assistance, while preserving and extending the state's own coverage and access advances. Key aspects that relate to primary care access include: [19]

- Expanding Medicaid and CHIP eligibility to the higher percent of FPL levels shown in the table below, which should provide coverage for thousands of newly eligible low-income adults, most of whom will transition from other state-subsidized programs that Massachusetts had previously made available for low-income individuals. [20] [21]
- Transitioning some residents previously enrolled in state-subsidized programs to Massachusetts Health Connector, Massachusetts' Health Insurance Marketplace, while maintaining and not raising the out-of-pocket costs being borne by these residents. [19]
- Providing premium assistance to residents with incomes between 138 and 305% FPL who work for small employers with access to employer-sponsored insurance and are ineligible for MassHealth or the Massachusetts Health Connector. [19]

A five-year waiver renewal announced October 31, 2014 will update and solidify these and other provisions.

MassHealth provides coverage for dental, mental health and substance abuse services, with benefit coverage varying by age and income level. [22] MassHealth enrollees can opt to enroll in a Primary Care Clinician (PCC) plan and a Managed Care Organization (MCO) plan. [9] As of 2011, 53% of the state's Medicaid Population was enrolled within one of the MCO's operating in the state. [23]

Through the Health Safety Net (HSN) Massachusetts devotes significant funding to CHCs for indigent care and for low income residents, the HSN pays for medically necessary services at Massachusetts CHCs and hospitals. [19] [24]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	300%	200%	133%	NA
2014	305%	205%	138%	138%

Source: Kaiser State Health Facts 2012

Massachusetts CHC Reimbursement Policies [8] [25]

In Massachusetts, Medicaid reimbursement is governed by an alternative payment methodology. The state lacks a scope of service definition, but has a provision to adjust rates or establish an additional separate rate for a CHC if: (1) access to the provision of care is threatened; (2) services are expanded to meet area need; or (3) the state and a CHC enter into an initiative that will increase the CHC's costs. CHCs must be able to demonstrate that they will implement within 90 days the program for which a rate adjustment is sought. The state is required to act on adjustment requests within 60 days of receipt of application. CHCs are required to file cost reports in MA and the state uses these in making rate determinations. Rate adjustments are retroactive to the application date.

Massachusetts' CHCs receive separate Medicaid rates for medical, dental and mental health services, and varying rate schedules are set for other services (e.g., lab, radiology).

Face-to-face CHC visits to an MD, DO, NP, PA, RN and psychiatrist are billable by MassHealth. CHC providers including but not limited to dentists, optometrists, opticians and podiatrists are subject to separate rates.

MassHealth allows only one medical visit to be billed per day; CHCs may also bill for visits for dental and behavioral health for the same patient on the same day. For managed care enrollees, the state channels wrap-around payments through the HMOs to the CHCs.

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
NJ	Yes	Yes	Yes	Yes	N/A

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
NJ	No	Yes	No	No	No

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

Collaboration with CMS [26]

Massachusetts continues to innovate around payment reform and quality improvement: with $44 million in funding from a CMS State Innovation Models grant, the state issued an RFP in March 2013 for a new demonstration known as the Primary Care Payment Reform Initiative (PCPRI) that will move away from fee-for-service to integrated care delivery. Specifically, the state is looking to promote primary care delivery that meets Massachusetts' definition of a patient-centered medical home and integrates outpatient behavioral health care through full-integration or co-location or inter-organization coordination. PCPRI will be comprised of three components: (1) a risk-adjusted monthly capitation payment for a specified set of primary care and behavioral health services; (2) an incentive payment for quality achievements; and (3) shared savings/risk payment options. [27] There are protections built in for CHCs if payments drop below what would otherwise be anticipated. As of October 2013, 16 CHCs had applied to participate.

Massachusetts CHCs participate in the FQHC Advanced Primary Care Demonstration, where select FQHC Grantees will receive funding to demonstrate how the patient-centered medical home model improves quality of care, promotes better health, and lowers costs. There are 8 grantees and 13 total health center sites participating in the demonstration in Massachusetts. Massachusetts has also received a duals demonstration grant from CMS to "coordinate care across primary, acute, behavioral health and long-term supports and services for dual eligible individuals"

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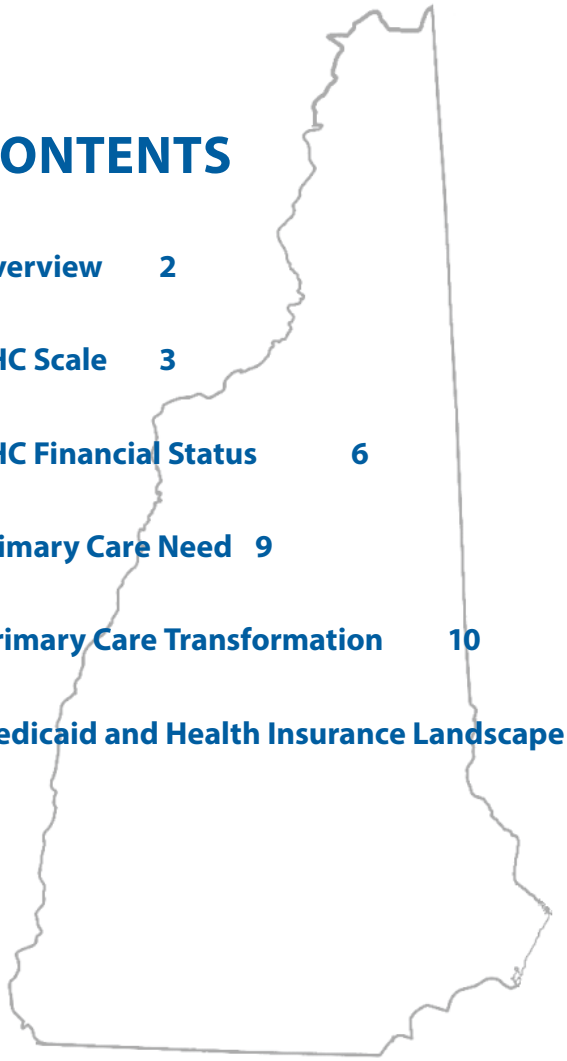
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

NEW HAMPSHIRE



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 13 CHCs operating 39 permanent clinical service delivery sites throughout the state of New Hampshire. The PCA in Vermont is the Bi-State Primary Care Association, which also represents Vermont. [1] [2]
- New Hampshire CHCs provided 279,977 visits to 67,194 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 1.0% annually over the last three years for which full data is available (through 2012), compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 13% of New Hampshire's Medicaid population (US: 16%) and 5% of its overall population (US: 7%). CHCs in New Hampshire serve 16.9% of patients with incomes market penetration of <200% FPL individuals, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 129,000, is projected to grow by an additional 50,000 people (39%) resulting from the recently passed expansion bill; the uninsured rate is projected to decrease from 9.1% to 6.7%. [4] [5]

Policy & Reimbursement

- New Hampshire spends slightly more than $6,700 per Medicaid enrollee annually– the 14th highest in the nation. [6]
- New Hampshire has implemented a hybrid Medicaid expansion under which low-income adults (up to 138% FPL) will receive subsidies to purchase private insurance. [7] Traditional Medicaid & CHIP eligibility limits are 75% FPL for parents of dependent children; 201% FPL for pregnant women and up to 323% FPL for children. [8]
- New Hampshire has a state-federal partnership for implementation of the ACA's health insurance exchange. [9] [10] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 40,262, against a goal of 19,000. [11]
- CHCs are reimbursed under the Prospective Payment System (PPS) for services provided under Medicaid. [12] Most payments to CHCs are for a standardized clinic visit encounter, which is a face-to-face encounter between a patient and a physician, a physician assistant or a nurse practitioner for primary care services. [13]
- New Hampshire is participating in several CMS Innovation programs, including the "Prevention of Chronic Disease in Medicaid Demonstration," and has several FQHCs participating in the "FQHC Advanced Primary Care Demonstration"; additionally, New Hampshire has been awarded a State Innovation Model "Design Award." [14]

New Hampshire CHCs Compared to CHCs Nationwide

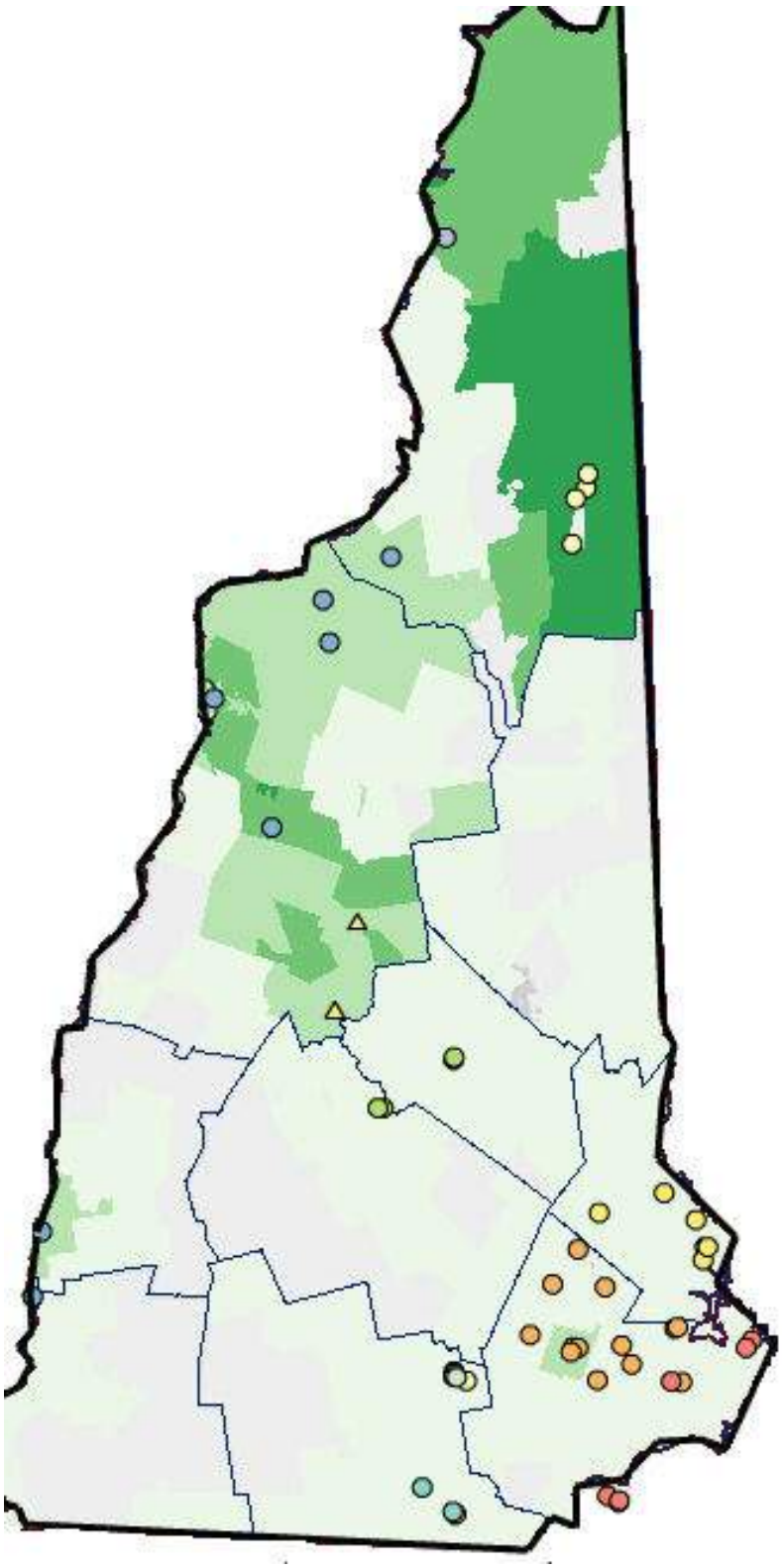
- Lower proportion of the total population served, including a lower proportion of Medicaid enrollees due to higher number of uninsured patients
- Substantially smaller than national average, providing only 40% as many visits per CHC
- Compound growth rate in total visits (2010-12) well below the national average, with growth at <1%

	NH	US
Population Served (2012)		
Total patients served by CHCs	67,194	21,102,391
% of population served by CHCs	5.2%	6.8%
% of under 200% FPL served by CHCs	16.9%	15.9%
% of Medicaid Enrollees Served	13.2%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	13	1284
Total CHC Service Delivery Sites (2014)	41	9509
Average Sites per CHC (2014)	3.2	7.4
Annual Visits (Total) (2012)	279,977	83,766,153
Annual Visits per CHC (2012)	27,998	69,922
Annual Visits Per Patient (2012)	4.17	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	86.0%	73.6%
Dental	5.5%	12.8%
Mental Health	4.8%	7.5%
Case Management/Enabling	3.7%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	1.0%	4.1%
Total Annual Visits	0.5%	4.3%
Medical	0.1%	3.5%
Dental	10.4%	7.6%
Mental Health	7.8%	9.6%
Case Management/Enabling	-9.4%	1.6%

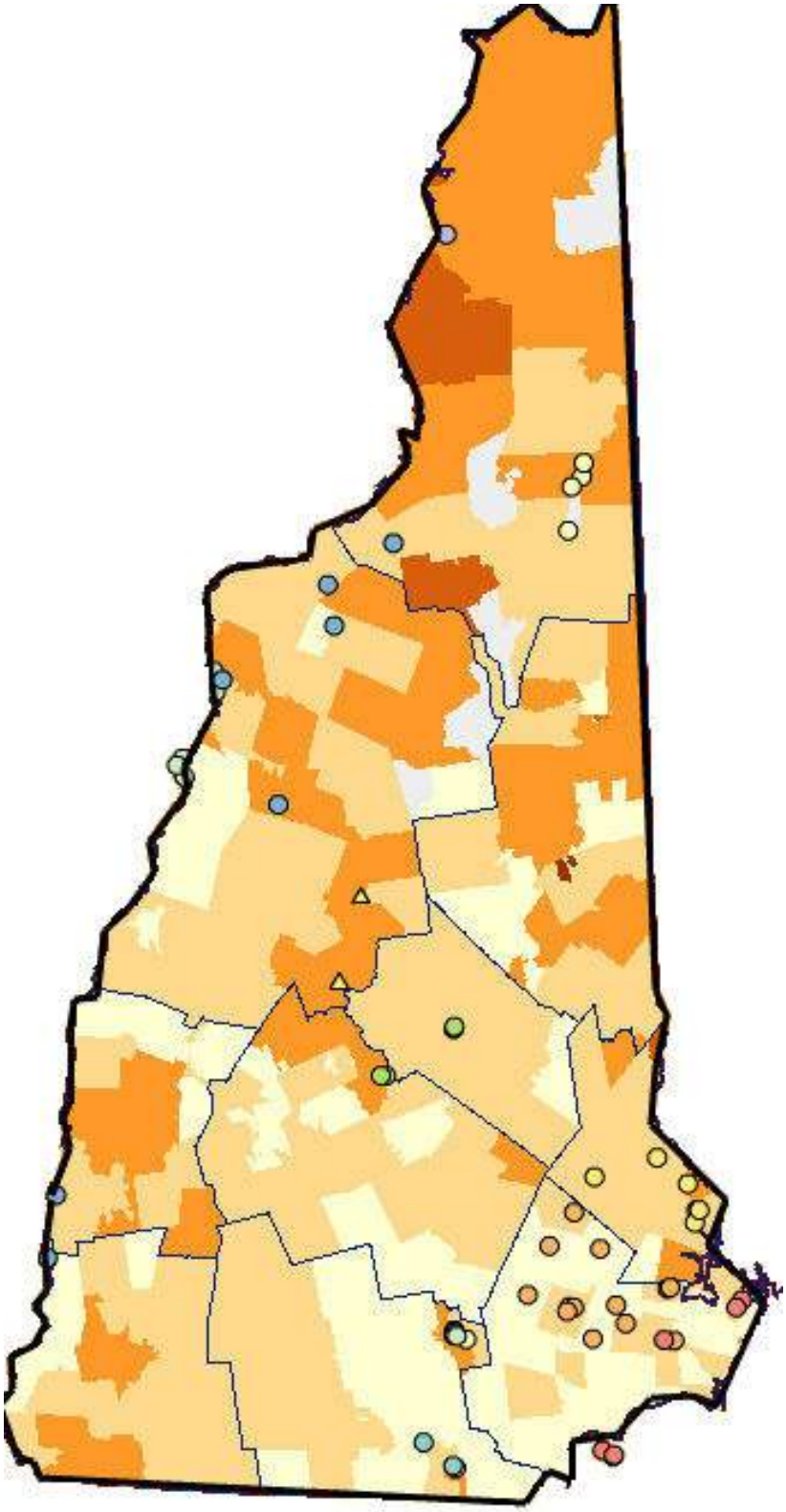
Note: All CHCs are Federally Qualifed Health Centers receiving Section 330 grants. Lookalikes not included.

Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by New Hampshire CHCs [15]



New Hampshire Low Income Population [15]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

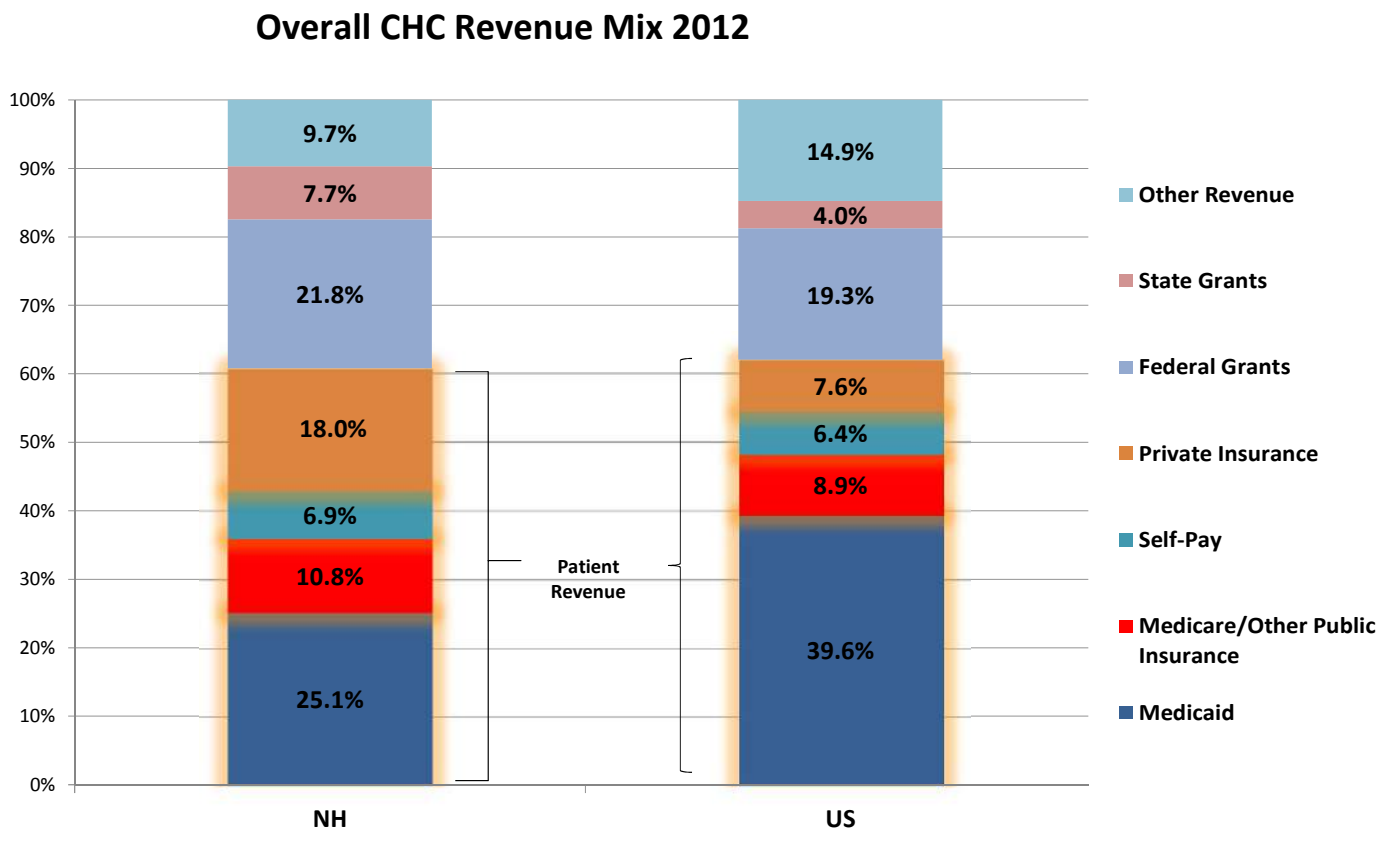
New Hampshire CHCs Compared to CHCs Nationwide, 2012

- Similar proportion of revenue from patient services
- Significantly lower portion of patient revenues from Medicaid
- Much higher proportion of revenues from private insurance
- Slightly higher reliance on federal and state grants

	NH	US
CHC Revenue Mix		
Patient Revenue	60.8%	62.9%
Medicaid	25.1%	39.6%
Medicare/Other Public Insurance	10.8%	8.9%
Self-Pay	6.9%	6.4%
Private Insurance	18.0%	7.6%
Federal Grants	21.8%	19.3%
State Grants	7.7%	4.0%
Other Revenue	9.7%	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

CHC FINANCIAL STATUS

New Hampshire CHCs as a Group, 2009-2011

- Median Total Assets increased by 77%
- Unrestricted Net Assets grew by 89%
- Median Days Cash on Hand decreased by 22%, from 19 to 14 days, well below the 30-day benchmark

NH Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$2,678,262	$3,271,243	$4,743,590	77%	N/A
Total Revenues ($)	$6,158,960	$6,680,404	$9,059,721	47%	N/A
Profitability					
Total Margin (%)	1.6%	6.0%	5.5%	250%	N/A
Unrestricted Net Assets ($)	$431,058	$871,735	$813,154	89%	N/A
Liquidity					
Days Cash on Hand	19	22	15	-22%	>30 Days
Days in Accounts Receivable	26	25	20	-23%	<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.

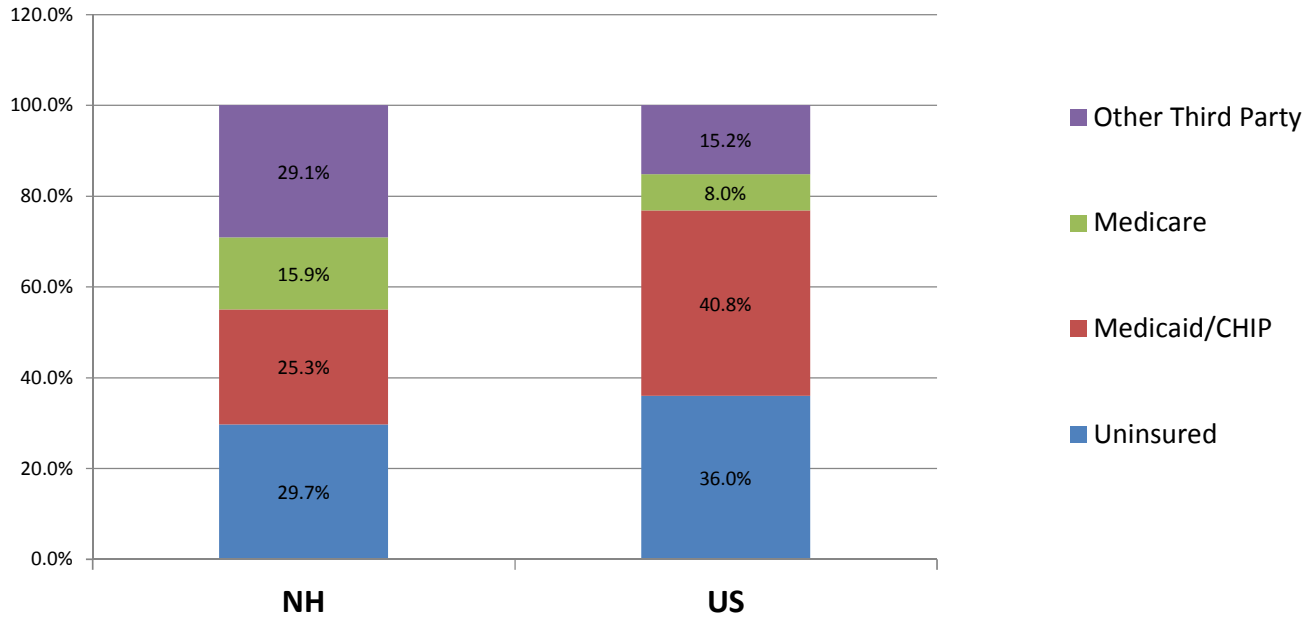
New Hampshire CHCs Visit Mix Compared to CHCs Nationwide [16]

- Proportion of patients living at or near poverty level is well below national average
- Lower proportion of visits are from the uninsured and Medicaid population
- Much higher reliance on Medicare and commercial payers

	NH	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	81.4%	92.6%
Patients at or below 100% poverty level	52.4%	71.9%
Coverage Status		
Uninsured	29.7%	36.0%
Medicaid/CHIP	25.3%	40.8%
Medicare	15.9%	8.0%
Other Third Party	29.1%	15.2%

Source: UDS Summary Data 2012

CHC Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Better than national average on most primary care & prevention indicators
- 19% lower proportion of adults affected by diabetes
- Ranked #5 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Significantly lower proportion of population is underserved for primary care.
- Underserved population for dental also significantly below national average.

	NH	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	3.1%	5.3%
% low birthweights	6.8%	8.1%
% adults diagnosed with diabetes	7.5%	9.3%
Adult diabetes deaths per 100,000	16.1	20.8
Adult heart disease deaths per 100,000	152.7	179.1
Avoidable Hospitalizations per 1,000	56.0	66.6
America's Health Ranking (United Health Foundation)	5	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	18,976	35,057,608
% of total population	1.5%	11.3%
Estimated PCPs needed to achieve target PCP:Population	5	7067
Estimated underserved population for dental	12,707	31,707,007
% of total population	1.0%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	3	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [17]

- 55% of New Hampshire's CHCs have achieved PCMH recognition or certification as of 12/31/13, as compared to 44% nationally.
- New Hampshire's NH Citizens Health Initiative has convened a multi-payer, multi-stakeholder medical home project since January 2008. [18]
- Medicaid helped design the program; it did not join as a payer but has made significant investments in care transformation.

Electronic Health Record Adoption [19]

- New Hampshire is ahead of national average EHR availability at state CHC sites (90% in New Hampshire compared to 79% in the U.S.)
- New Hampshire's CHCs are well ahead of national average in reporting notifiable diseases electronically (70% in New Hampshire compared to 45% Nationally)
- New Hampshire performs better than national average in 11 of the 12 EHR functionality categories.

Medicaid Policies – Highlights

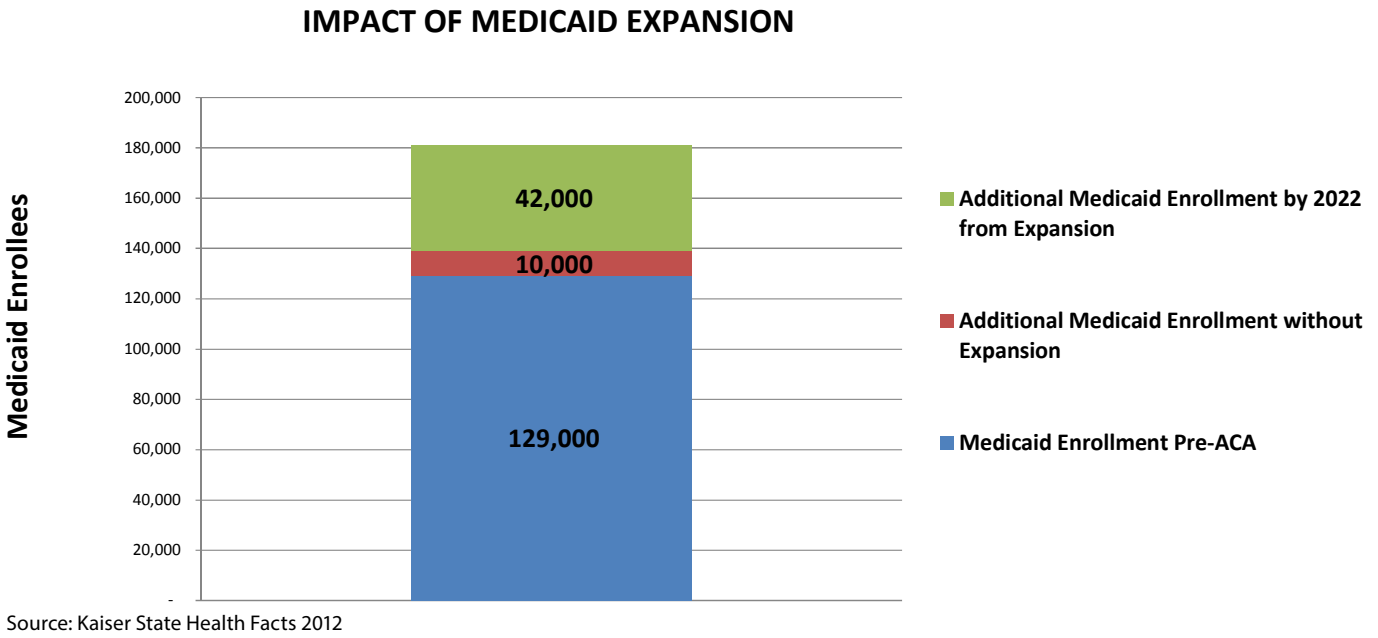
- Higher per-enrollee Medicaid spending than the national average
- Medicaid enrollment, at 9.9% of the population, is substantially below national enrollment, which stands at 16.9%
- On March 27, 2014, Governor Hassan signed legislation, effective July 1, 2014, to extend Medicaid coverage to about 50,000 low-income adults by using federal funds to pay for private insurance

	NH	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$6,748	$5,563
Federal Medical Assistance Percentage (FMAP)	50.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Open Debate	
Health Insurance Exchange	Partnership	
Total Uninsured	138,000	53,277,000
% of Uninsured Individuals (all ages)	10.6%	17.2%
Medicaid Enrollment Pre-ACA	129,000	52,410,000
% of Total Population	9.9%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	10,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	52,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	40.3%	40.6%
Estimated Number Remaining Uninsured After ACA	73,000	27,930,000
Estimated % Uninsured After ACA (2020)	4.8%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Health Insurance Exchange is known as "Covering New Hampshire."
- Proportion of residents who are uninsured is expected to decrease by from 9.1% to 6.7% as a result with the Medicaid Pilot Expansion Model.



Source: Kaiser State Health Facts 2012

New Hampshire Medicaid Spending

New Hampshire spends slightly more than $6,700 per Medicaid enrollee annually – the 14th highest in the nation for all health care services provided. [1]

Medicaid spending, from all sources, represents about one-quarter of the New Hampshire state budget. [5] Increased Medicaid enrollment was the driving factor for increased total spending in the past several years.[19] [20]

There are no premiums, enrollment fees or cost-sharing required for Medicaid or CHIP enrollees in New Hampshire. [21]

Medicaid Coverage & Administration

The New Hampshire Medicaid program is administered within the Department of Health and Human Services (DHHS). [22] New Hampshire's Medicaid program is a managed care model for all its services except dental care, in a risk-based capitated financing structure. [21] In March, 2014, New Hampshire adopted an alternative Medicaid Expansion plan that will provide health insurance to 50,000 low-income adults during a two-and-a-half year pilot program. The plan will involve the use of private insurance paid for with federal Medicaid expansion money to provide coverage. [23] The plan will cover adults earning less than 138% of the federal poverty level. [21]

Because the process for implementing the "private option" can be lengthy—with drafting the waiver and putting it up for public comment—the state will move forward with expanded coverage in the meantime. Beginning July 1, newly eligible adults will begin receiving coverage through the existing Medicaid managed care plan, and will later be transitioned onto the private market. [23]

The state anticipates that some, if not all, of the Medicaid managed care plans will become plans on the private market, which could have a significant positive impact on competition in the New Hampshire exchange, as there is currently only one insurer participating. [23]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	300%	185%	47%	N/A
2014	323%	201%	138%	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

New Hampshire CHC Reimbursement Policies

CHCs are reimbursed under the Prospective Payment System (PPS) for services provided under Medicaid. [13]

CHCs are reimbursed for a standardized clinic visit encounter, which is a face-to-face encounter between a patient and a physician, a physician assistant or a nurse practitioner for primary care services. Behavioral health can be billed as a separate encounter, but not dental. [15]

Collaboration with CMS [24]

New Hampshire is collaborating 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:

- **FQHC Advanced Primary Care Demonstration** – Select FQHC Grantees will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promote better health, and lower costs. There are 6 grantees and 12 total health centers participating in the demonstration.
- **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 Mode**l -- New Hampshire was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan.

New Hampshire's plan will lay out a framework for aligning consumer access across delivery system "silos," payer support for outcomes-based long term care services, and global accountability for cost-effectiveness and outcomes. A central tenet of the transformation activities will target opportunities for improved coordination across systems for individuals who are either in need of or at-risk for needing long-term support services. This population will be targeted due to the complex health needs and the cross-cutting nature of the services and payments needed to coordinate their care.

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PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

NEW JERSEY

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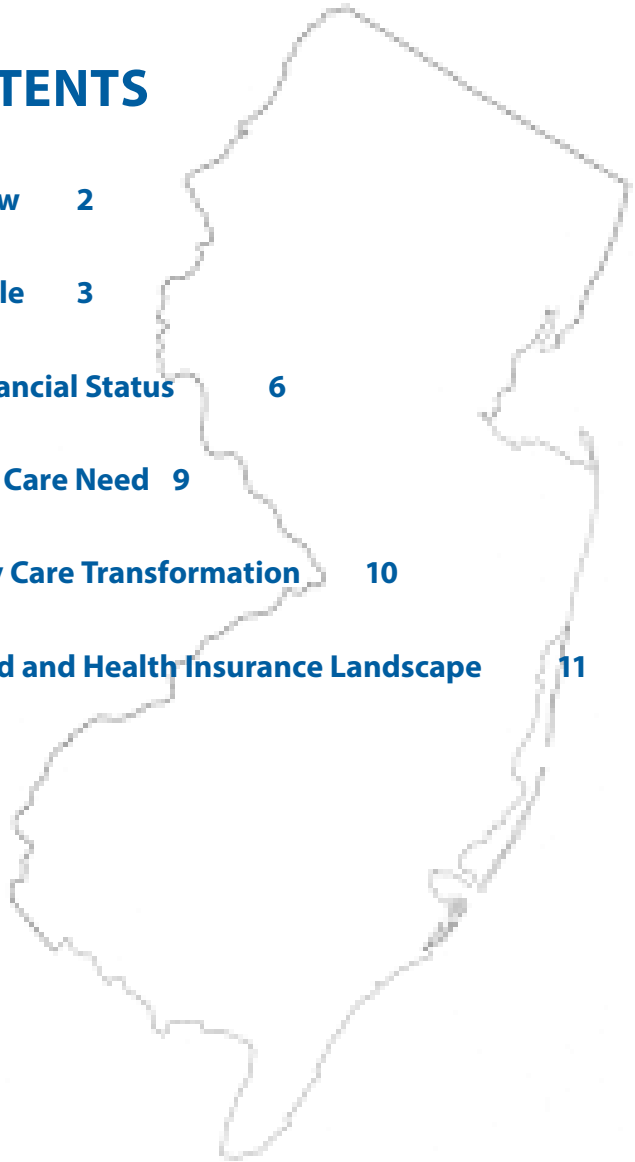


Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 20 CHCs operating 118 permanent clinical service delivery sites throughout the state of New Jersey. The State's PCA is the New Jersey Primary Care Association. (NJPCA) [1] [2]
- New Jersey CHCs provided 1,669,667 visits to 467,913 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 4.0% annually from 2010 through 2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 25.4% of New Jersey's Medicaid population (US: 16.4%) and 5% of its overall population (US: 7%). New Jersey CHCs served 16.1% of individuals with incomes <200% FPL compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 817,000, is projected to grow by an additional 441,000 people by 2022 (54% growth); the uninsured rate is projected to decrease from 16% to 9% by 2020. [3] [4]

Policy & Reimbursement

- New Jersey spends more than $8,300 per Medicaid enrollee annually – the 3rd highest in the nation. [5]
- New Jersey has implemented a Medicaid expansion per the ACA. In 2012, Gov. Christie vetoed legislation creating a state-run health exchange, resulting in the federal government operating the insurance exchange in New Jersey. [6] [7]
- Through the first enrollment period, individuals who selected health plans through the exchange reached a total of 161,775, against a goal of 96,000. [8]
- Prior to January 2014, the state set high eligibility limits for parents of dependent children, pregnant women and children. Childless adults were not covered. [9] With Medicaid expansion, both parents and childless adults will now be covered (up to 138% FPL), pregnant woman will remain covered up to 199% FPL, and children will have their coverage expanded (up to 355% FPL). [10]
- New Jersey Medicaid uses an alternative payment methodology (APM) to reimburse CHCs. Medicaid pays an interim encounter rate with a lump sum reconciliation made at the end of each quarter. Rates for services are calculated based on changes in scope of services, and inflation using the Medicare Economic Index (MEI). [11] [12]
- New Jersey permits rate adjustments as a result of changes in scope of services which include changes in sites, services, medical technology and regulated changes. [13]
- New Jersey is participating in several CMS Innovation programs, including the "Comprehensive Primary Care Initiative" (CPCI) and has several CHCs participating in the "CHC Advanced Primary Care Demonstration." [14]

CHC SCALE

New Jersey CHCs Compared to CHCs Nationwide

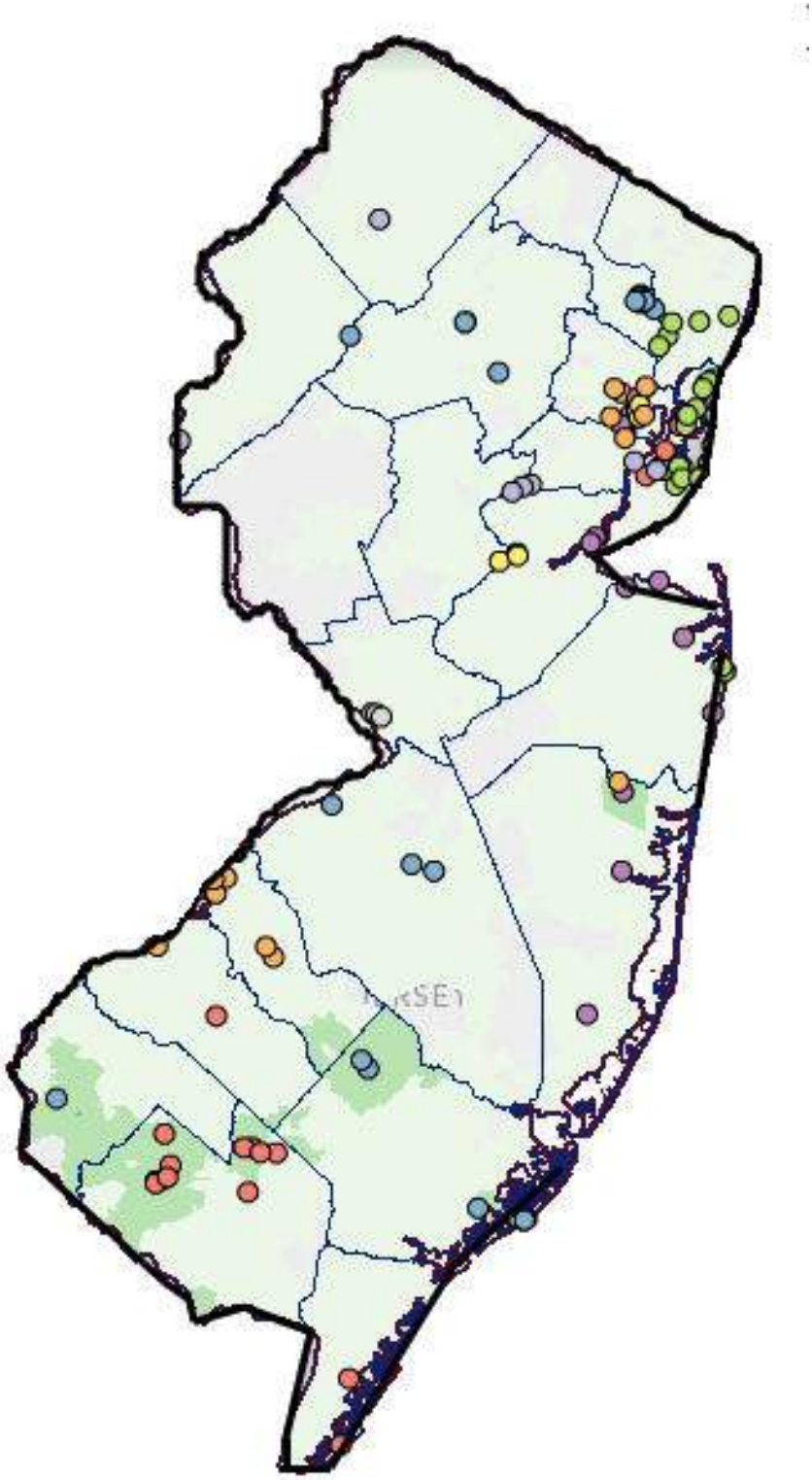
- Much higher proportion of Medicaid population served
- Lower proportion of the total population served
- 19% more visits per CHC than the national average
- Overall patient visit volume grew 4.0%, with dental and mental healthcare rising at the fastest rates from 2010 to 2012
- Higher than average annual growth rate

	NJ	US
Population Served (2012)		
Total patients served by CHCs	467,913	21,102,391
% of population served by CHCs	5.4%	6.8%
% of under 200% FPL served by CHCs	16.1%	15.9%
% of Medicaid Enrollees Served	25.4%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	20	1284
Total CHC Service Delivery Sites (2014)	115	9509
Average Sites per CHC (2014)	5.8	7.4
Annual Visits (Total) (2012)	1,669,667	83,766,153
Annual Visits per CHC (2012)	83,483	69,922
Annual Visits Per Patient (2012)	3.57	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	74.5%	73.6%
Dental	17.7%	12.8%
Mental Health	3.1%	7.5%
Case Management/Enabling	4.7%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	4.0%	4.1%
Total Annual Visits	4.9%	4.3%
Medical	3.3%	3.5%
Dental	10.5%	7.6%
Mental Health	10.7%	9.6%
Case Management/Enabling	7.4%	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 New Jersey CHCs [15]



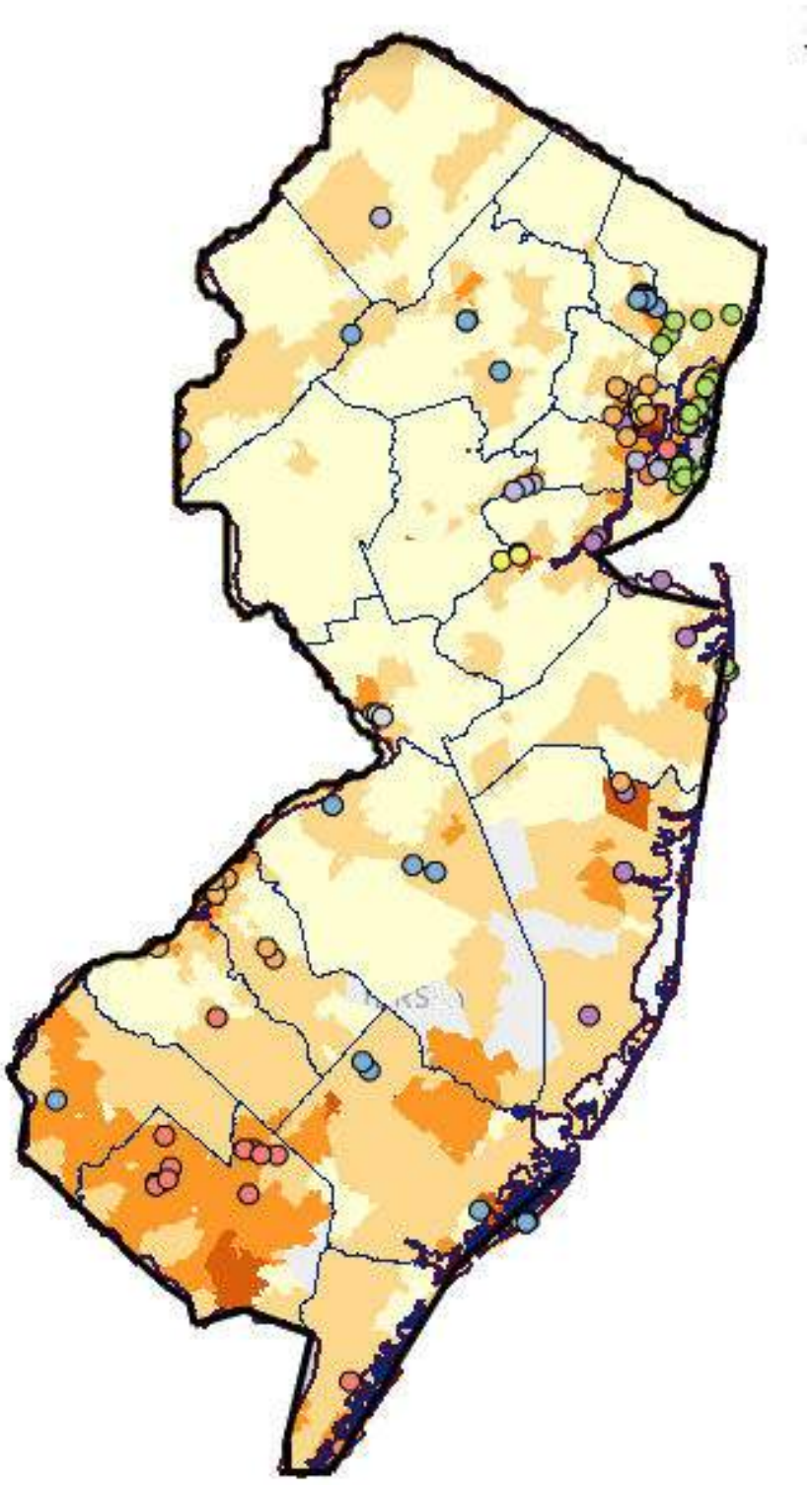
% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Source: UDS Mapper 2014

New Jersey Low Income Population [16]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

Source: UDS Mapper 2014

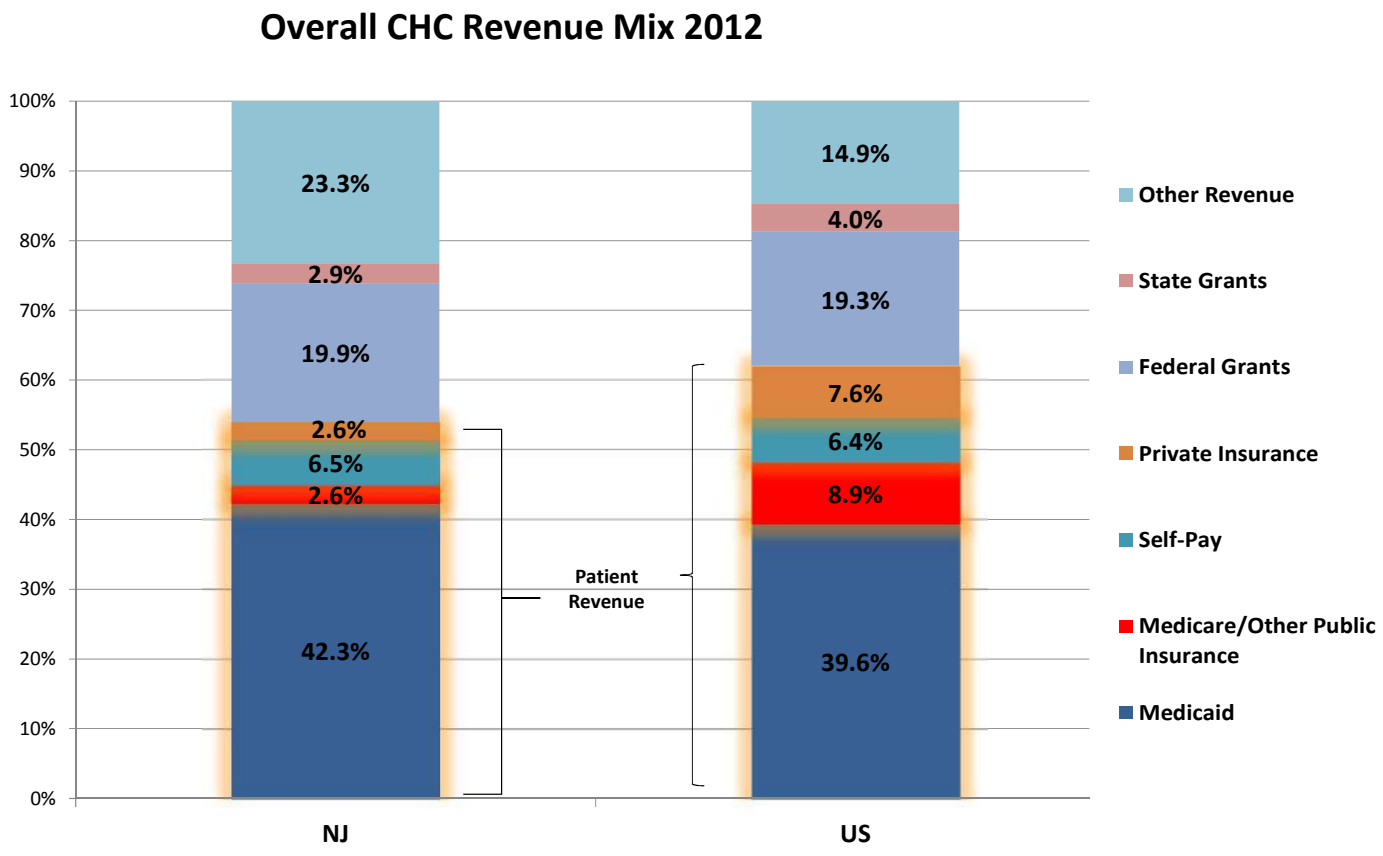
New Jersey CHCs Compared to CHCs Nationwide, 2012

- Lower proportion of revenue from patient services
- Slightly higher portion of patient revenue from Medicaid
- Much lower proportion of revenue from private insurance
- Great reliance on revenue from the state's indigent care pool (other revenue)

	NJ	US
CHC Revenue Mix		
Patient Revenue	53.9%	62.9%
Medicaid	42.3%	39.6%
Medicare/Other Public Insurance	2.6%	8.9%
Self-Pay	6.5%	6.4%
Private Insurance	2.6%	7.6%
Federal Grants	19.9%	19.3%
State Grants	2.9%	4.0%
Other Revenue	23.3%	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

CHC FINANCIAL STATUS

New Jersey CHCs as a Group, 2009-2011

- Median Total Assets increased by 35%
- Median Days Cash on Hand decreased by 49%, from 31 to 16 days, well below the benchmark range

NJ Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$6,782,781	$6,813,048	$9,129,108	35%	N/A
Total Revenues ($)	$11,233,048	$12,911,161	$13,546,590	21%	N/A
Profitability					
Total Margin (%)	3.3%	0.4%	2.7%	-18%	N/A
Unrestricted Net Assets ($)	$3,543,075	$4,257,774	$5,681,241	60%	N/A
Liquidity					
Days Cash on Hand	31	25	16	-49%	>30 Days
Days in Accounts Receivable	41	34	37	-11%	<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

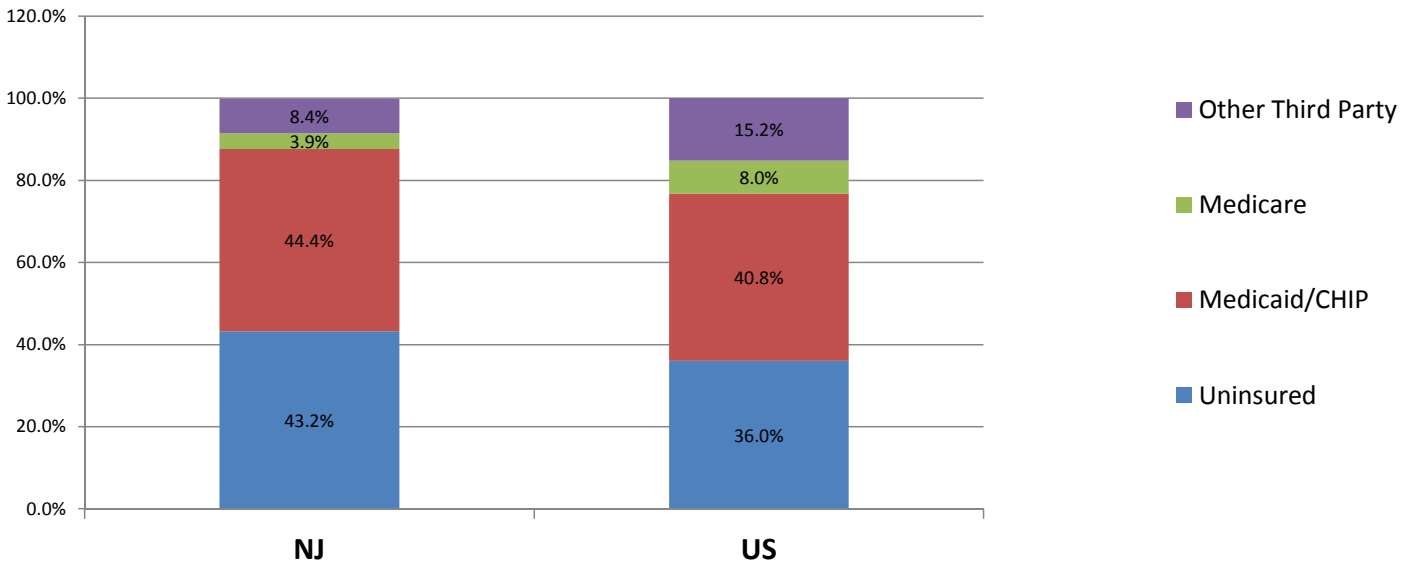
New Jersey CHCs Visit Mix Compared to CHCs Nationwide [16]

- Greater proportion of patients living at or near poverty level
- Greater proportion of uninsured visits
- Slightly higher proportion of visit mix are recipients of Medicaid
- Much lower "other third party" coverage

	NJ	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	96.9%	92.6%
Patients at or below 100% poverty level	77.6%	71.9%
Coverage Status		
Uninsured	43.2%	36.0%
Medicaid/CHIP	44.4%	40.8%
Medicare	3.9%	8.0%
Other Third Party	8.4%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near national average on most primary care & prevention indicators
- Ranked #10 in America's Health Ranking®

Statewide Primary Care Shortage & Workforce Indicators

- Much lower proportion of population is underserved for primary care*
- Population underserved for dental also significantly below national average

	NJ	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	3.6%	5.3%
% low birthweights	8.2%	8.1%
% adults diagnosed with diabetes	9.0%	9.3%
Adult diabetes deaths per 100,000	21.0	20.8
Adult heart disease deaths per 100,000	182.0	179.1
Avoidable Hospitalizations per 1,000	68.8	66.6
America's Health Ranking (United Health Foundation)	10	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	6,690	35,057,608
% of total population	0.1%	11.3%
Estimated PCPs needed to achieve target PCP:Population Ratio	11	7067
Estimated underserved population for dental	16,507	31,707,007
% of total population	0.2%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	18	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [17]

- 55% of New Jersey CHCs have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- New Jersey had a Medicaid Medical Home Demonstration Project (expired June 2014) to provide 25,000 Medicaid beneficiaries with medical home services.
- New Jersey has received a planning grant from CMS to establish health homes for Medicaid enrollees with chronic conditions.
- New Jersey is one of seven markets participating in CMS's Comprehensive Primary Care Initiative (CPCI), an initiative which promotes collaboration between public and private payers with the goal of strengthening primary care.

Electronic Health Record Adoption [18]

- A slightly higher percentage of New Jersey CHC sites use EHRs than CHC sites nationally (90% in New Jersey compared to 88% in the U.S.)
- New Jersey performs better than national average in 11 of the 12 EHR functionality categories

Medicaid Policies – Highlights

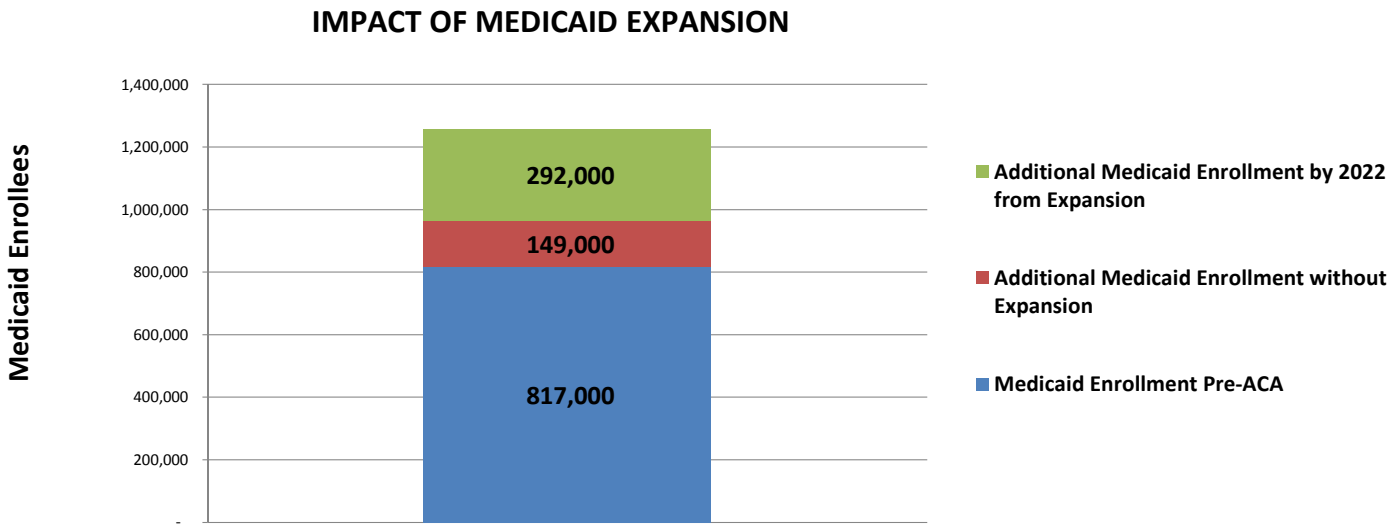
- Among the highest per-enrollee Medicaid spending in US
- Has implemented Medicaid expansion per ACA

	NJ	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$8,309	$5,563
Federal Medical Assistance Percentage (FMAP)	50.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	Federal	
Total Uninsured	1,415,000	53,277,000
% of Uninsured Individuals (all ages)	16.3%	17.2%
Medicaid Enrollment Pre-ACA	817,000	52,410,000
% of Total Population	9.4%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	149,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	441,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	54.0%	40.6%
Estimated Number Remaining Uninsured After ACA	825,000	27,930,000
Estimated % Uninsured After ACA (2020)	8.7%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Medicaid enrollment is projected to increase by 441,000 (54%) between 2012 and 2022
- The health insurance exchange in New Jersey is operated by the Federal government through healthcare.gov
- Proportion of residents who are uninsured is expected to decrease from 16.3% to 9.4% between 2012 and 2020 as a result of ACA



Source: Kaiser State Health Facts 2012

New Jersey Medicaid Spending

New Jersey spends more than $8,300 per Medicaid enrollee annually – the 3rd highest in the nation for all health care services provided. [5]

Though New Jersey reimburses at lower rates than any state in the nation, its spending per enrollee is very high because the program covers very sick people, more so than the national average. New Jersey has a greater share of spending for the elderly and people with disabilities. [19]

Medicaid Coverage & Administration

New Jersey has expanded its Medicaid program under the ACA. [20]

The New Jersey Medicaid Program is administered through the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Service. [19] The Managed Care program is contracted out and run through New Jersey Family Care. [21]

New Jersey also administers the Children's Health Insurance Program (CHIP), a federal and state funded insurance program for children and certain low-income parents and guardians. [19]

Medicaid and CHIP serve approximately 1.29 million individuals in New Jersey. Currently, more than 98% of the New Jersey Medicaid population is enrolled in managed care plans, up from 75% in 2009. [19]

New Jersey applied for and received a Medicaid waiver that encompasses nearly all services and eligible populations, which is intended to provide broad flexibility to manage the State's programs more efficiently. The waiver requires all dual-eligible (Medicare and Medicaid) individuals to receive Medicaid services through the managed care program. The initiative resulted in a 386% increase in enrollment in 2011. [19]

Under the Comprehensive Waiver, the State plans to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care with an eye toward meeting the behavioral health needs of the Medicaid expansion population in 2014. This will include reviewing rate structures to improve consistency and competitiveness of reimbursement rates across funding streams with the overall goal of adequate access to appropriate services. [22]

Following Medicaid expansion, the state now provides increased eligibility levels for all potential enrollees:

- New Jersey's childless adults, who were previously not eligible, are now eligible up to 138% FPL. [19]
- Children in families earning up to 355% FPL are eligible through the state's CHIP program. [23]
- Pregnant women are eligible up to 199% FPL and parents of Dependent Children are eligible up to 138% FPL. [23]
- In addition to providing coverage to those eligible, New Jersey Medicaid also provides coverage to certain Medicare Beneficiaries (100% FPL and whose resources does not exceed 3x SSI resource limit), Disabled and Working Adults (200% FPL). [23]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	133%	200%	200%	23%
2014	355%	205%	138%	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

New Jersey CHC Reimbursement Policies

In New Jersey, Medicaid Reimbursement uses an Alternative Payment Methodology (APM) that closely resembles the Medicare Prospective Payment System (PPS). The reimbursements will be adjusted for changes in scope of services and inflation using the percentage increases in the Medicare Economic Index. [12]

PPS rates may be adjusted for increases or decreases in the scope of services furnished by a CHC clinic. [12] A change in scope of service includes the addition of a new service; changes due to regulatory requirements; opening closing, relocating or remodeling a site; and/or changes due to technology or accepted medical practice. [12]

In New Jersey, MCOs receive prospective payments from the State based on a fixed monthly fee per patient ("capitation payment"). The MCOs, in turn, reimburse CHCs for Medicaid-covered encounters out of their capitation funds. [23]

The contracted-for payment from the MCO to the CHC for a Medicaid-covered patient encounter is often less than the amount the CHC is entitled to receive under the PPS. In this situation, the Medicaid statute requires the state to make a supplemental payment—the wraparound payment—at least once every four months, to make up the difference between the PPS rate and the MCO payment. [24]

New Jersey provides funding to CHCs for indigent care, reaching $45 million in 2012 [1], approximately 18% of total CHC funding, with funding since increased to $50 million. [24]

More categories of providers are eligible to generate a reimbursable PPS encounter than is typical in other states. MD, DMD, NP, LSCW, psychologist and registered nurse are all allowed to generate a PPS encounter. [22]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
NJ	Yes	Yes	Yes	Yes	N/A

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
NJ	No	Yes	No	No	No

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

Collaboration with CMS [22]

New Jersey has successfully applied to 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:

- Comprehensive Primary Care Initiative (CPCI) – a multi-payer collaboration between public and private payers rewarding practices which better coordinate care for their patients.
- 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. There are 3 grantees and 7 total health centers participating in the demonstration in New Jersey.

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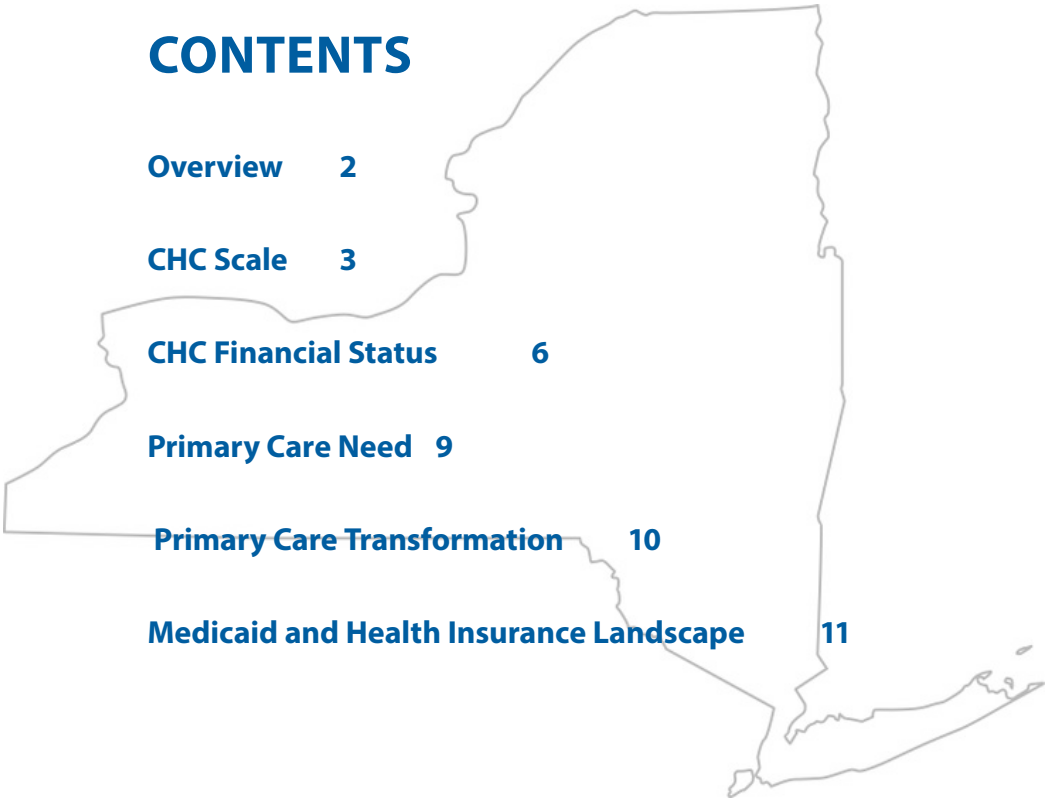
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

NEW YORK



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OVERVIEW

Market Share & Growth

- As of 2014, there were 57 CHCs operating 508 permanent clinical service delivery sites throughout the state of New York. CHCs in New York are represented by the Community Health Care Association of New York State (the primary care association for New York State.) [1] [2]
- New York CHCs provided 7,449,927 visits to 1,588,439 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 5.9% annually from 2010 - 2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 18.8% of New York's Medicaid population (US: 16%) and 8.2% of its overall population (US: 7%). CHCs in New York serve 17.2% of people with incomes <200% FPL, compared with 15.9% nationally. [3]
- New York Medicaid enrollment, currently at 4,421,000, is projected to grow by an additional 1,026,000 people by 2022 (23.2% growth) per the Urban Institute; with the uninsured rate projected to decrease from 16% to 10%. [4]
- There are considerable differences between urban and rural areas of NYS – particularly in the area of primary care workforce shortage, where rural areas struggle to recruit and retain providers.

Policy & Reimbursement

- New York spends slightly more than $8,900 per Medicaid enrollee annually– the 2nd highest in the nation, behind only Alaska. [5]
- New York has expanded Medicaid per the ACA and has created its own state health insurance exchange known as "New York State of Health." [6]
- Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 370,451, against a goal of 218,000. [7]
- Medicaid reimbursement for New York's CHCs is governed by the federal Prospective Payment System (PPS) requirements, including use of the Medicare Economic Index to adjust CHCs' per-visit rate annually. [8]
- New York is implementing structural reforms to the state's Medicaid program through its Medicaid Redesign Team (MRT) program with the goals of controlling cost and improving quality. [9] The state is currently implementing a five-year 1115 Medicaid Waiver called the "Delivery System Reform Incentive Program."
- New York's Medicaid enables a broad array of providers (including MD's, DMDs, NPs, RNs, LSWs, Psychologists, Physical Therapists and Dental Hygienists) to bill Medicaid for face-to-face visits. [10]
- New York is participating in several CMS Innovation programs, including the "Multi-Payer Advanced Primary Care Program," the "Prevention of Chronic Disease in Medicaid Demonstration," and has several CHCs participating in the "FQHC Advanced Primary Care Demonstration"; additionally, New York has been awarded State Innovation Model "Pre-Testing Award." [11]

New York CHCs Compared to CHCs Nationwide

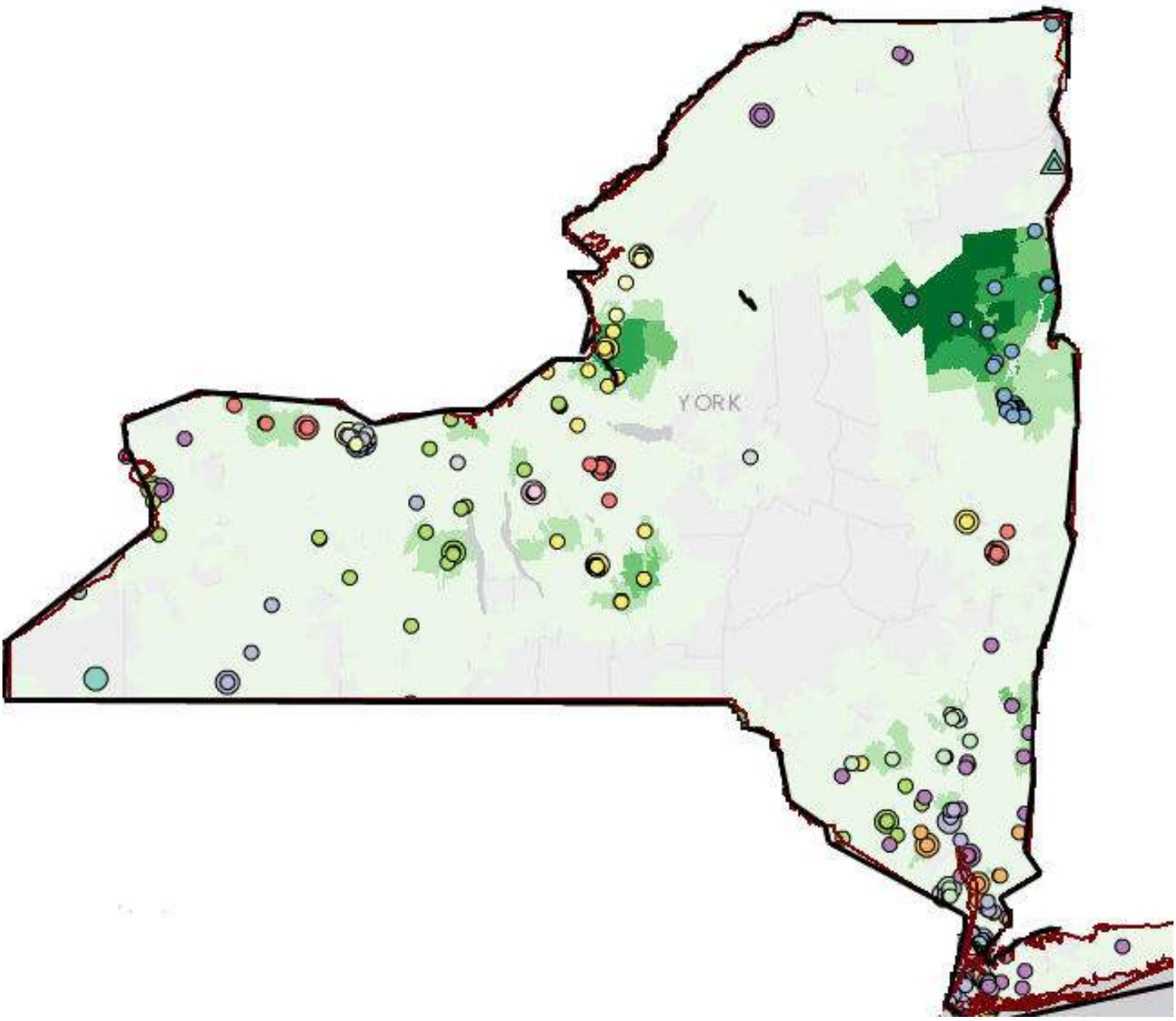
- Greater proportion of the total population served
- Slightly greater proportion of Medicaid enrollees served
- The average CHC, as measured by annual visits, is nearly twice as large as the national average
- Medical, dental & mental health visit mix is close to national average
- Visit growth rate (2010-12) is significantly higher than the national average, attributable mostly to increasing volume of medical and dental visits; however, there has been a significant decrease in the number of visits to case management/enabling services

	NY	US
Population Served (2012)		
Total patients served by CHCs	1,588,439	21,102,391
% of population served by CHCs	8.2%	6.8%
% of under 200% FPL served by CHCs	17.2%	15.9%
% of Medicaid Enrollees Served	18.8%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	59	1284
Total CHC Service Delivery Sites (2014)	508	9509
Average Sites per CHC (2014)	8.6	7.4
Annual Visits (Total) (2012)	7,449,917	83,766,153
Annual Visits per CHC (2012)	130,700	69,922
Annual Visits Per Patient (2012)	4.69	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	74.0%	73.6%
Dental	12.1%	12.8%
Mental Health	8.8%	7.5%
Case Management/Enabling	5.1%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	5.9%	4.1%
Total Annual Visits	6.5%	4.3%
Medical	7.1%	3.5%
Dental	9.9%	7.6%
Mental Health	10.0%	9.6%
Case Management/Enabling	-10.3%	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 New York CHCs [12]



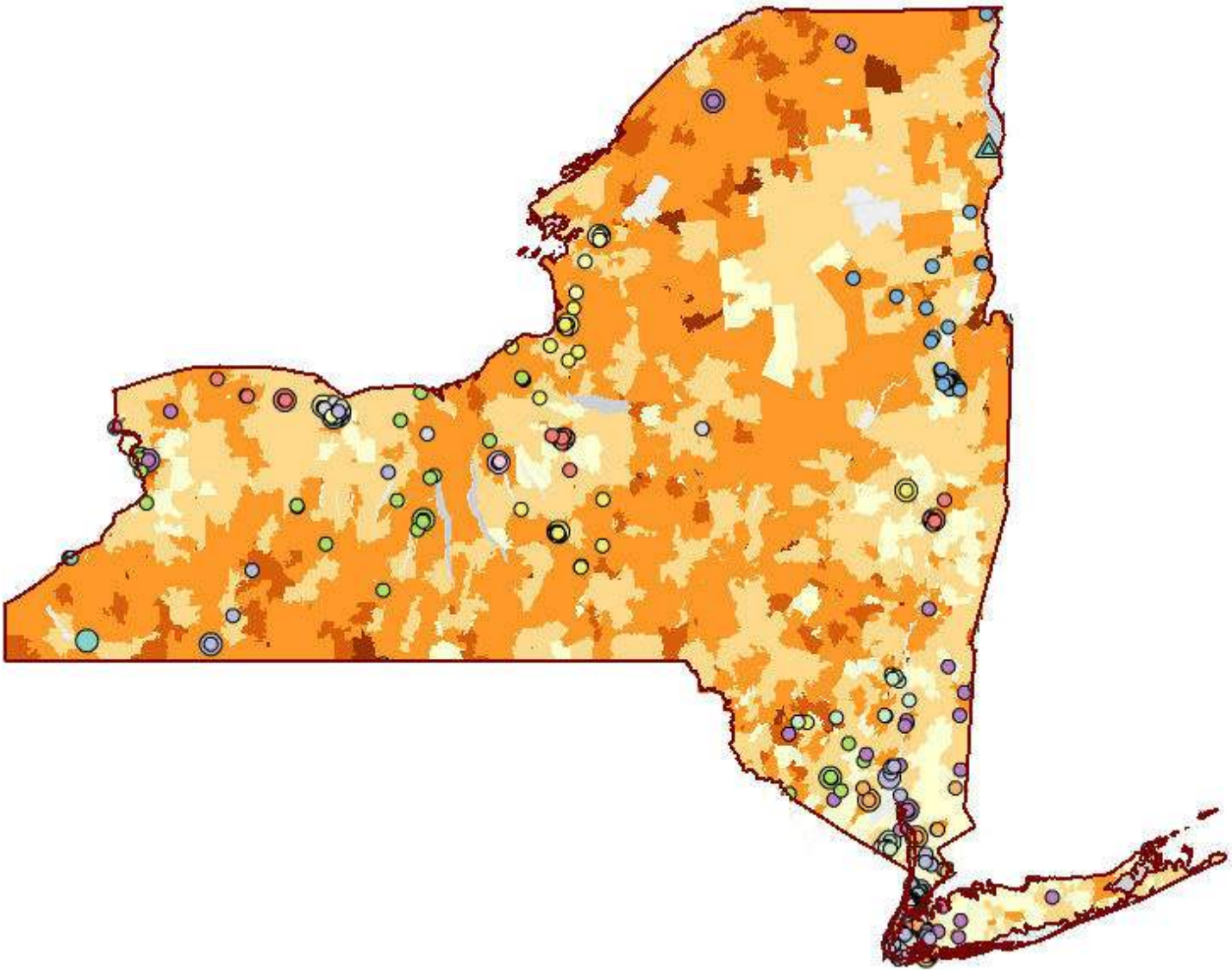
% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Source: UDS Mapper 2014

New York Low Income Population [12]



Source: UDS Mapper 2014

New York CHCs Compared to CHCs Nationwide, 2012

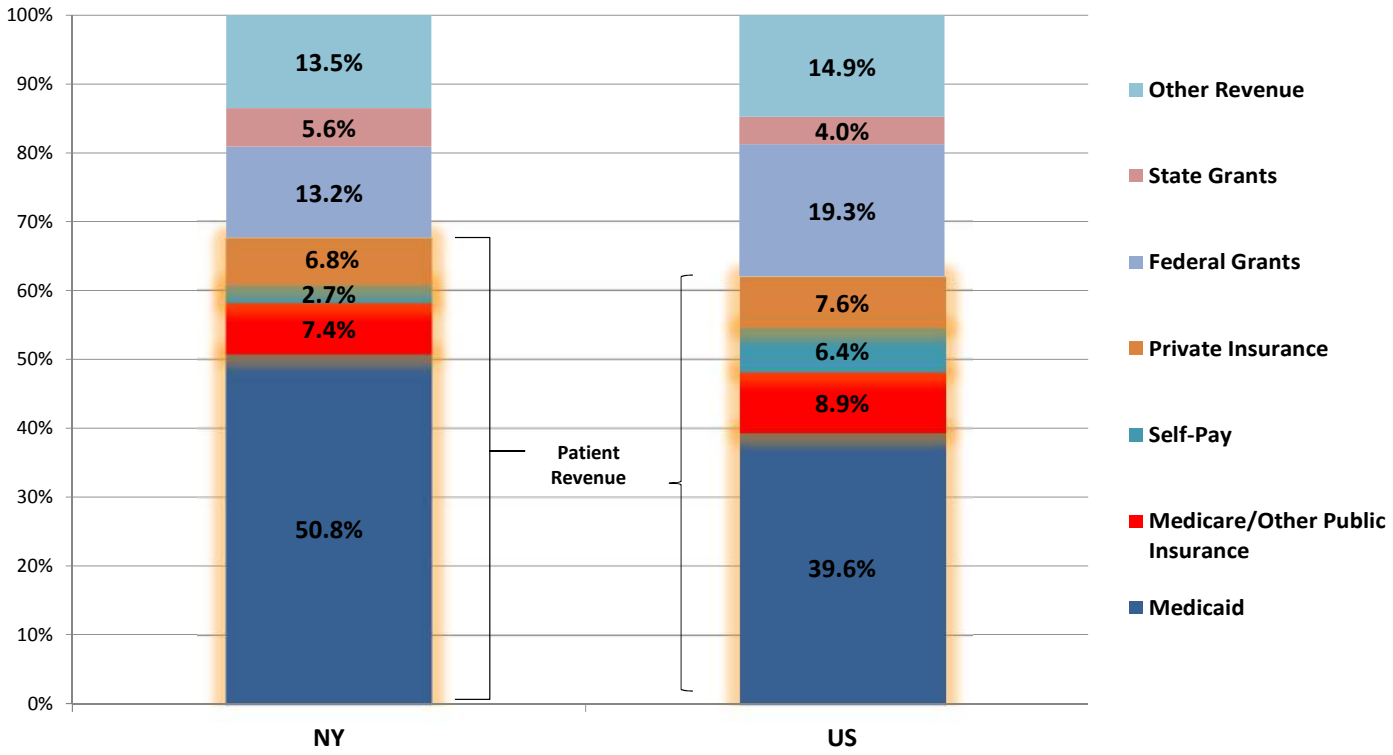
- Greater proportion of revenue from patient services
- Portion of patient revenues from Medicaid is 28% above national average
- Lower proportion of revenues from private insurance
- Less reliance on federal grants than national average

	NY	US
CHC Revenue Mix		
Patient Revenue	67.7%	62.9%
Medicaid	50.8%	39.6%
Medicare/Other Public Insurance	7.4%	8.9%
Self-Pay	2.7%	6.4%
Private Insurance	6.8%	7.6%
Federal Grants	13.2%	19.3%
State Grants	5.6%	4.0%
Other Revenue	13.5%	14.9%

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

Source: UDS Summary Data 2010-2012, 2014

Overall CHC Revenue Mix 2012



Source: UDS Summary Data 2012

CHC FINANCIAL STATUS

New York CHCs as a Group, 2009-2011 [13]

- Median Total Assets increased by 48%
- Unrestricted Net Assets grew by 76%
- Median Days Cash on Hand decreased by 7%, from 37 to 35 days, but remained within the 30-day benchmark

NY Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$6,545,654	$8,088,818	$9,669,425	48%	N/A
Total Revenues ($)	$11,176,260	$11,430,219	$14,377,023	29%	N/A
Profitability					
Total Margin (%)	4.1%	3.6%	6.3%	53%	N/A
Unrestricted Net Assets ($)	$2,414,112	$3,080,665	$4,260,757	76%	N/A
Liquidity					
Days Cash on Hand	37	32	35	-7%	>30 Days
Days in Accounts Receivable	38	43	42	11%	<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.

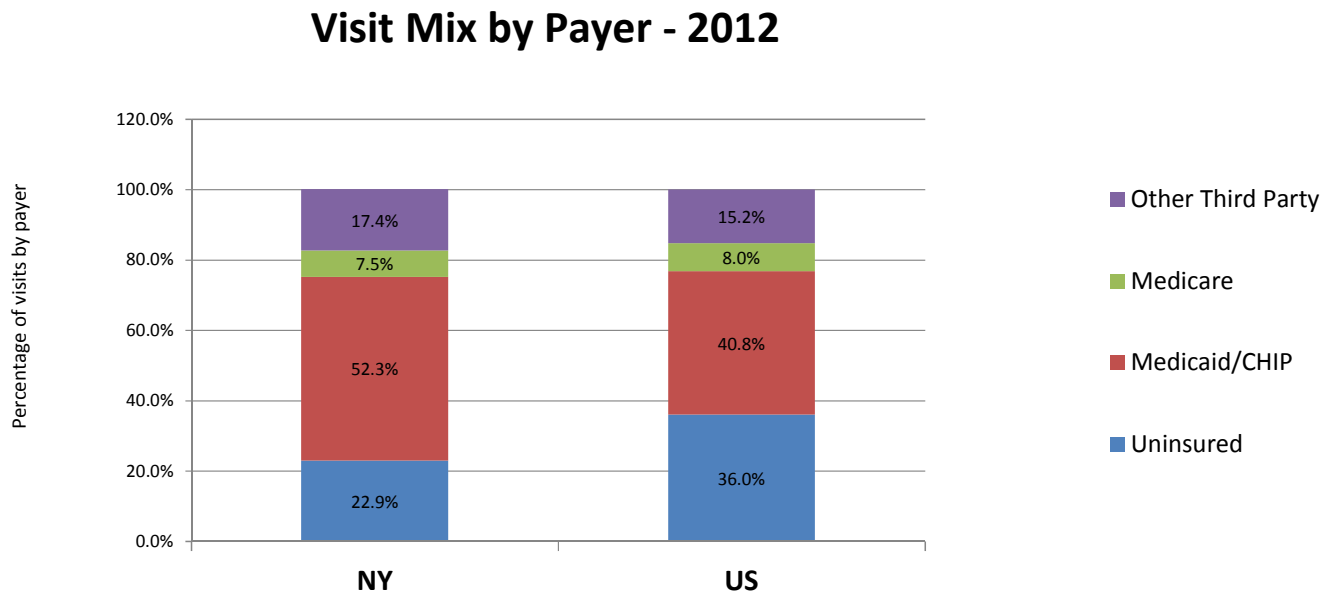
Sources: UDS Summary Data 2009-2011 and CHC Form 990s

New York CHCs Visit Mix Compared to CHCs Nationwide [3]

- Slightly lower proportion of patients living at or near poverty level than national average
- Proportion of uninsured patients is 36% below national average
- Medicaid portion of the patient mix is 28% above national average

	NY	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	86.3%	92.6%
Patients at or below 100% poverty level	69.8%	71.9%
Coverage Status		
Uninsured	22.9%	36.0%
Medicaid/CHIP	52.3%	40.8%
Medicare	7.5%	8.0%
Other Third Party	17.4%	15.2%

Source: UDS Summary Data 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near national average on many primary care & prevention indicators
- Deaths attributable to diabetes 20% below national average; those attributable to heart disease 12% above national average
- Ranked #15 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Slightly lower proportion of population is underserved for primary care.
- Underserved population for dental is significantly below national average.
- New York's regional and socioeconomic diversity means there are areas with significant primary care and dental workforce shortages far greater than the national average.
- New York's "Doctor's Across New York" and "Primary Care Service Corps program repays loans for providers who practice in underserved communities.

	NY	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	5.4%	5.3%
% low birthweights	8.2%	8.1%
% adults diagnosed with diabetes	8.9%	9.3%
Adult diabetes deaths per 100,000	16.7	20.8
Adult heart disease deaths per 100,000	199.9	179.1
Avoidable Hospitalizations per 1,000	66.3	66.6
America's Health Ranking (United Health Foundation)	15	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	1,840,732	35,057,608
% of total population	9.5%	11.3%
Estimated PCPs needed to achieve target PCP:Population	549	7067
Estimated underserved population for dental	797,525	31,707,007
% of total population	4.1%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	217	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [14]

- 68% of New York CHCs have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- New York is directly participating in two medical home demonstrations: the Adirondack Medical Home Demonstration and the Statewide Medicaid Patient-Centered Medical Home Program.
- In February 2012, CMS approved the first of three health home SPAs for "high-cost, high-need" Medicaid enrollees with chronic conditions in 10 counties.
- New York is one of eight states selected to participate in the Medicare Advanced Primary Care Practice (MAPCP) demonstration program.

Electronic Health Record Adoption [15]

- New York is ahead of national average EHR availability at CHC sites (97% in New York compared to 88% in the U.S.)
- New York performs better than national average in all 12 EHR functionality categories.
- CHCANYS has developed a Center for Primary Care Informatics that serves as a repository for aggregated primary care data.

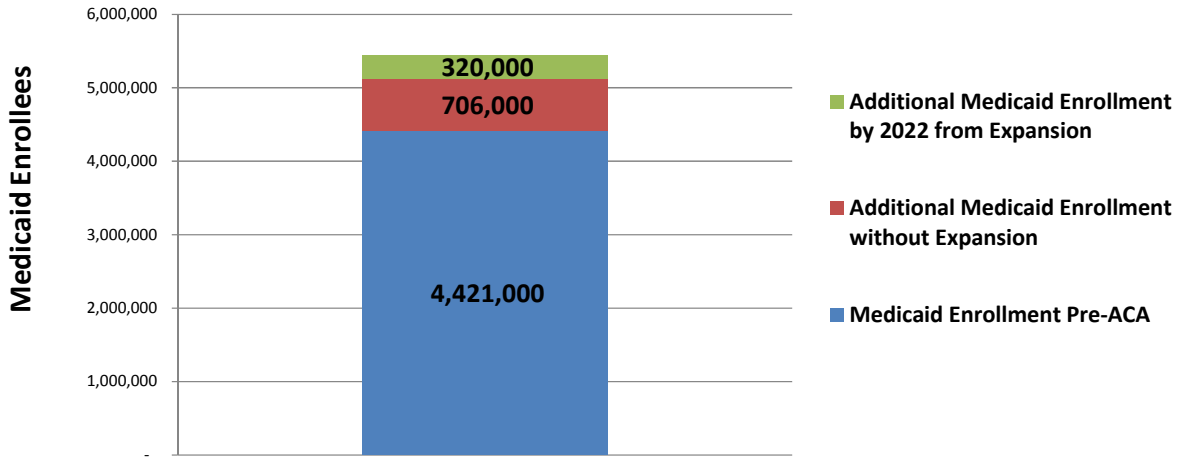
Medicaid Policies – Highlights

- Per-enrollee Medicaid spending 60% higher than national average.
- State's Medicaid Redesign program intended to lower costs, improve quality. [16]
- New York's $8 billion 1115 Medicaid Waiver seeks to reduce avoidable hospitalizations by 25% in five years and make 90% of Medicaid payments value-based.

	NY	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$8,910	$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	2,954,000	53,277,000
% of Uninsured Individuals (all ages)	15.3%	17.2%
Medicaid Enrollment Pre-ACA	4,421,000	52,410,000
% of Total Population	22.9%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	706,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	1,026,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	23.2%	40.6%
Estimated Number Remaining Uninsured After ACA	1,868,000	27,930,000
Estimated % Uninsured After ACA (2020)	9.5%	8.7%

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

IMPACT OF MEDICAID EXPANSION



Source: Kaiser State Health Facts 2012

Health Insurance & Medicaid Expansion – Highlights

- State has implemented Medicaid expansion and a State-run Health Insurance Exchange, known as "New York State of Health"
- Lower than average uninsured rate
- Proportion of residents who are uninsured is expected to decrease by from 15.3% to 9.5% over the next decade

New York Medicaid Spending

New York spends more than $8,900 per Medicaid enrollee annually and is the largest, most extensive, and comprehensive in the country. [17]

New York's Medicaid spending is projected to total approximately $54 billion in FY 2013. [18] Long term care accounts for almost half of the State's Medicaid. [19]

Federal funds account for about 45% of total Medicaid spending (rather than the 50 percent federal match rate), since the state provides some services that are not federally reimbursable. [18]

New York did not see a substantial increase in Medicaid and CHIP insurance eligibility as a result of the Affordable Care Act because the State already offered public health coverage to parents with incomes up to 200% of the Federal Poverty Level (FPL), children up to 400% of FPL, as well as to some childless adults. [20]

New York does require co-payments from Medicaid enrollees for some services and in certain settings. However, co-payments are limited to nominal amounts. [21]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	200%	200%	150%	100%
2014	405%	223%	138%	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

Health Insurance and Medicaid Coverage

New York uses a state-operated health benefits exchange, New York State of Health. Nearly 1 million New Yorkers enrolled in health plans via the Marketplace during the first open enrollment period, including 525,283 who enrolled in Medicaid.

As federally mandated, Qualified Health Plans participating in the Marketplace must include "essential community providers" who serve predominantly low income, including CHCs. The New York Marketplace is using the same network adequacy standards as the New York State Medicaid Plan: at least one CHC per county. While this may be adequate for rural counties, it is not considered so for more populous counties and large urban areas. [20]

CHC Medicaid Reimbursement Policy

CHCs are reimbursed on an all-inclusive rate basis, governed by the federal Prospective Payment System (PPS) requirements. NY uses the Medicare Economic Index (MEI) to adjust the per visit rate annually. The State pays a wraparound payment to cover the difference between the MCO payments and the PPS rate. [10] [22]

New York devotes some funding to CHCs for indigent care, about $64 million or 5% of revenue in 2012. [23] This funding includes non-CHC diagnostic and treatment centers.

The state lacks a specific scope of service definition, but will adjust rates to accommodate scope of service changes in practice. [24] Adjustments include additional costs associated with capital improvements. State funding is distributed retroactively and there are often long lags between the service year and the dates of disbursement. [20]

More categories of providers are eligible to generate a reimbursable PPS encounter than is typical in other states. An MD, DMD, NP, RN, LSCW, psychologist, physical therapist, dental hygienist, nutritionist, and midwife can all generate a PPS encounter. [10]

New York State policies are generally supportive of CHCs, but the complexity of the State's regulatory environment poses significant challenges. For example, the Certificate of Need (CON) process, which governs the establishment and licensure of new facilities and programs in New York State, is especially lengthy and cumbersome for capital projects and changes in scope of services. Recent changes expedite CON review process for HRSA-funded projects submitted by CHCs, though most capital projects are not subsidized by federal funds.

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
NY	Yes	Yes	Yes	Yes	Midwives

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
NY	Yes	Yes	Yes	Yes	Yes

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

Medicaid Redesign Plan

In late 2010, New York State began a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure. As part of these efforts, Governor Andrew Cuomo created the Medicaid Redesign Team (MRT), charged with identifying ways to reduce costs and increase quality and efficiency in the Medicaid program. CHCANYS represented the primary care sector on the MRT and continues to participate in key work groups.

The MRT's Medicaid reform plan strives to control costs by improving the health of program participants while avoiding arbitrary benefit reductions or provider rate cuts. The MRT's budget plan saved the State $4 billion in its first year and has held spending growth to less than 1%. As part of this effort, New York State has all but eliminated fee-for-service Medicaid in favor of Medicaid managed care.

The MRT plan includes a series of innovative solutions designed to better manage care and reward providers for keeping people healthy. Four of the MRT recommendations of particular interest to CHCs that have been adopted are:

- ***Office of Primary Care.*** The creation of a dedicated Office of Primary Care (now part of the Office of Health Systems Management) has given providers and stakeholders a single point of contact at the New York State Department of Health (NYS DOH) to help reduce regulatory barriers, promote the expansion of primary care and provide leadership on addressing workforce shortages.
- ***The Primary Care Service Corps (PCSC).*** The PCSC is a service-obligated scholarship program created to increase the supply of midwives, nurse practitioners, physician assistants and others who practice inunderserved communities. Eligible clinicians receive loan repayment funding in return for a commitment to practice in an underserved area.
- ***Health Home Model for Service Delivery.*** This model expands on the traditional medical home, but enhances the focus on linkages to other community and social supports to increase integration of medical and behavioral health care for persons with multiple chronic illnesses. Many CHCs throughout the state have been designated by NYS DOH as lead health homes, and almost all identified health home networks include CHCs.
- ***New York State Medicaid Medical Home Program.*** This program offers additional dollars to primary care providers who meet national medical home standards. Providers who meet these standards can earn an additional $6 to $16.75 per visit per patient through this program, or up to $6 per member per month. [20]

To support the implementation of the MRT's reform plan, New York State is operating under a n 1115 Medicaid waiver. A central part of the MRT waiver is New York State's ***Delivery System Reform Incentive Payment (DSRIP) program***, which will provide $6.42 billion to support the transformation of the State's health care delivery system aimed at improving care and outcomes and reducing costs for Medicaid beneficiaries. The State's primary objective through DSRIP is to reduce avoidable hospitalizations by 25% statewide over five years.

The State's vision for DSRIP includes coalitions of providers in New York regions coming together under lead safety net applicants to form new integrated delivery systems, called Performing Provider Systems (PPSs), which are expected to be responsible for most, if not all, attributed Medicaid beneficiaries in a given geography or medical market area and be eligible to receive performance-based payments. Participation in a PPS is focused primarily on "safety net" providers as defined by CMS and the State, based on percentage Medicaid volume and other factors.

The expectation is that by the end of five years, Medicaid managed care plans will contract directly with Performing Provider Systems to provide care for the majority of Medicaid patients and that 90% of all Medicaid payments will be paid through value-based payments. [20]

Investment in Primary Care

To accompany the $8 billion waiver, which does not include capital funding, the State has created a $1.2 Billion Capital Restructuring Finance Program. Funds will be made available over seven years. The purpose of the pool is to transform the system to be more patient-centered and improve population health.

Although the State has yet to indicate priorities for its capital program, the development of primary care service capacity by CHCs is an eligible use. In addition to CHCs, other eligible applicants include hospitals, assisted living providers, residential health care facilities, home care providers and others. [25]

In 2013, the Community Health Care Association of New York State (CHCANYS) released A Plan for Expanding Sustainable Community Health Centers in New York, which details a statewide plan for community health centers designed to increase their ability to serve more patients. Based on extensive quantitative and qualitative analyses, the plan identifies geographic areas that have the greatest need and potential for sustainable growth, estimates potential increases in capacity within the existing system and highlights strategies for creating more capacity. [26]

Collaboration with CMS [27]

New York is collaborating with the Centers for Medicare and Medicaid Services (CMS) Innovation Center on a number of different programs aimed to develop and test innovative health care payment and service delivery models.

Comprehensive Primary Care Initiative (CPCI)

New York is one of eight states participating in the Comprehensive Primary Care Initiative, a multi-payer collaboration between public and private payers aimed at strengthening primary care. In this program, CMS will provide bonus payments to Primary Care practices which better coordinate care for their patients.

Multi-Payer Advanced Primary Care Practice Initiative (MAPCP)

New York is also one of eight states participating in the Multi-Payer Advanced Primary Care Practice Initiative, which will pay a monthly care management fee for beneficiaries receiving primary care from an Advanced Primary Care (APC) practice.

State Innovation Model

New York was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan. Having successfully produced an Innovation Plan, they have received an additional "Pre-Testing Model Award" to further develop and refine its comprehensive Innovation Plan.

Health Information Technology

The 2015 New York State budget includes $65 million for the State Health Information Network of New York (SHIN-NY) to continue its efforts to establish a true statewide electronic medical record system, and establish an All Payer Claims Database (APCD). This investment will leverage up to $30 million of Federal Medicaid funds for these projects for a total of up to $95 million. [24]

CHCANYS has also developed a Center for Primary Care Informatics, which combines a data warehouse with extensive reporting capabilities and a wraparound program of technical assistance to support clinical quality improvement, health center planning, participation in delivery system and payment reform initiatives, advocacy and fund development for our members statewide. The data warehouse draws clinical, operational and financial data nightly from health center electronic health records and practice management systems and serves as a comprehensive repository for aggregated primary care data. [2]

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PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

PENNSYLVANIA

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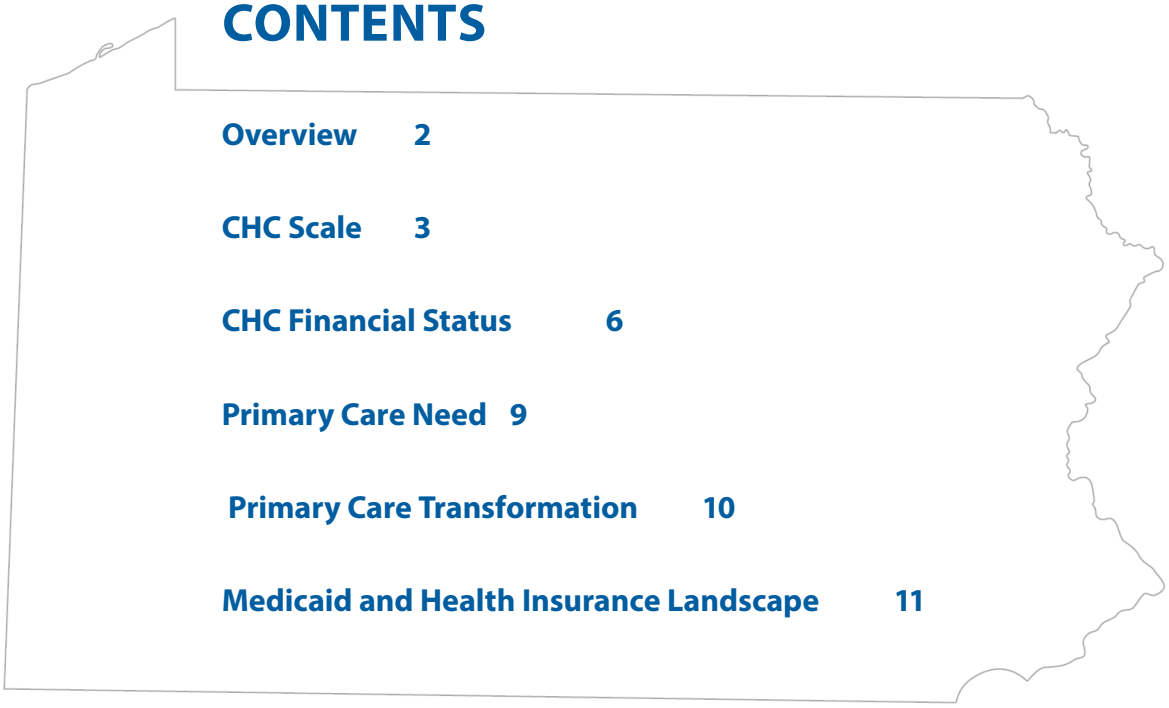

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OVERVIEW

Market Share & Growth

- As of 2014, there were 43 CHCs operating 251 permanent clinical service delivery sites throughout the state of Pennsylvania. CHCs are represented by the Pennsylvania Association of Community Health Centers. [1] [2]
- Pennsylvania CHCs provided 2,341,334 visits to 671,139 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 4.2% annually from 2010 - 2012, compared to 4.1% average annual growth nationwide. [3]
- CHCs serve approximately 15.8% of Pennsylvania's Medicaid population (US: 16.4%) and 5% of its overall population (US: 7%). Pennsylvania CHCs serve 13.6% of individuals with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment is currently at 1,904,000. The State estimates that the proposed "Healthy Pennsylvania" plan will enable approximately 520,000 additional people to access affordable health coverage. [4] The existing Medicaid program, without an ACA expansion, is currently projected to grow by 178,000 enrollees by 2022. [5]

Policy & Reimbursement

- Pennsylvania spends nearly $7,300 per Medicaid enrollee annually – the 9th highest in the nation. [6]
- Pennsylvania's Medicaid reimbursement for CHCs is governed by the federal Prospective Payment System (PPS) requirements, including use of the Medicare Economic Index to adjust CHCs' per-visit rate annually. [7] Pennsylvania permits rate adjustments only for HRSA-approved change in services offered.
- Pennsylvania is not implementing the ACA Medicaid expansion, but is instead seeking federal approval for an alternative "Healthy Pennsylvania" proposal. [4]
- As of January 2014, Pennsylvania has continued to set low eligibility limits for Medicaid to parents (38% FPL) and has not extended benefits to childless adults. [8] Pregnant women are currently eligible up to 220% FPL and children are eligible in families with income up to 319% FPL. [9] [10]
- Pennsylvania is currently allowing the Federal Government to run the ACA-mandated insurance exchange through healthcare.gov. [11]
- Through the first enrollment period, 318,077 individuals have selected health plans through the exchange, exceeding a goal of 206,000. [12]
- Pennsylvania is participating in several CMS Innovation programs, including the "Multi-Payer Advanced Primary Care Program," and has several FQHCs participating in the "FQHC Advanced Primary Care Demonstration"; additionally, Pennsylvania has been awarded a State Innovation Model Design Award. [13]

Pennsylvania CHCs Compared to CHCs Nationwide

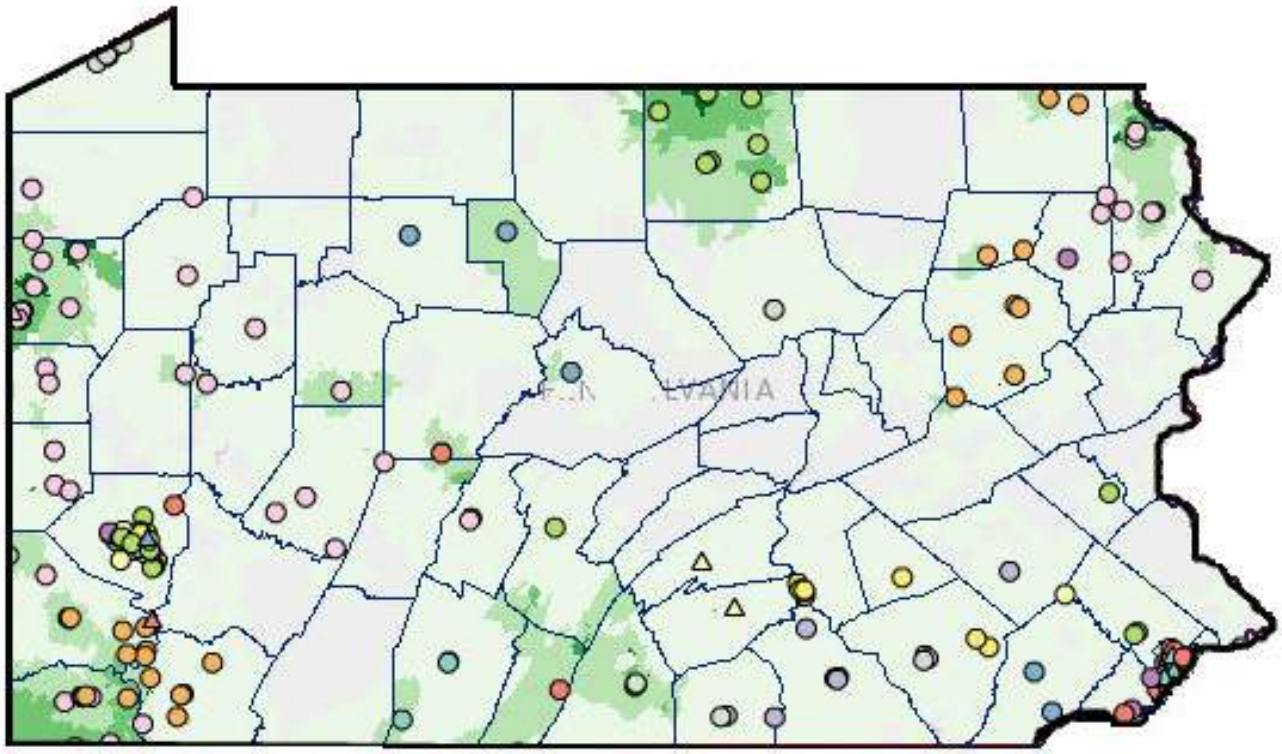
- Lower proportion of the total population served
- Slightly lower proportion of Medicaid enrollees served
- Slightly lower than national average in visits per CHC
- Growth rate near national average

	PA	US
Population Served (2012)		
Total patients served by CHCs	671,139	21,102,391
% of population served by CHCs	5.3%	6.8%
% of under 200% FPL served by CHCs	13.6%	15.9%
% of Medicaid Enrollees Served	15.8%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	43	1284
Total CHC Service Delivery Sites (2014)	251	9509
Average Sites per CHC (2014)	5.8	7.4
Annual Visits (Total) (2012)	2,341,334	83,766,153
Annual Visits per CHC (2012)	58,533	69,922
Annual Visits Per Patient (2012)	3.49	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	70.9%	73.6%
Dental	16.2%	12.8%
Mental Health	9.0%	7.5%
Case Management/Enabling	4.0%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	4.2%	4.1%
Total Annual Visits	4.8%	4.3%
Medical	2.6%	3.5%
Dental	14.3%	7.6%
Mental Health	10.2%	9.6%
Case Management/Enabling	-1.3%	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 Pennsylvania CHCs [14]



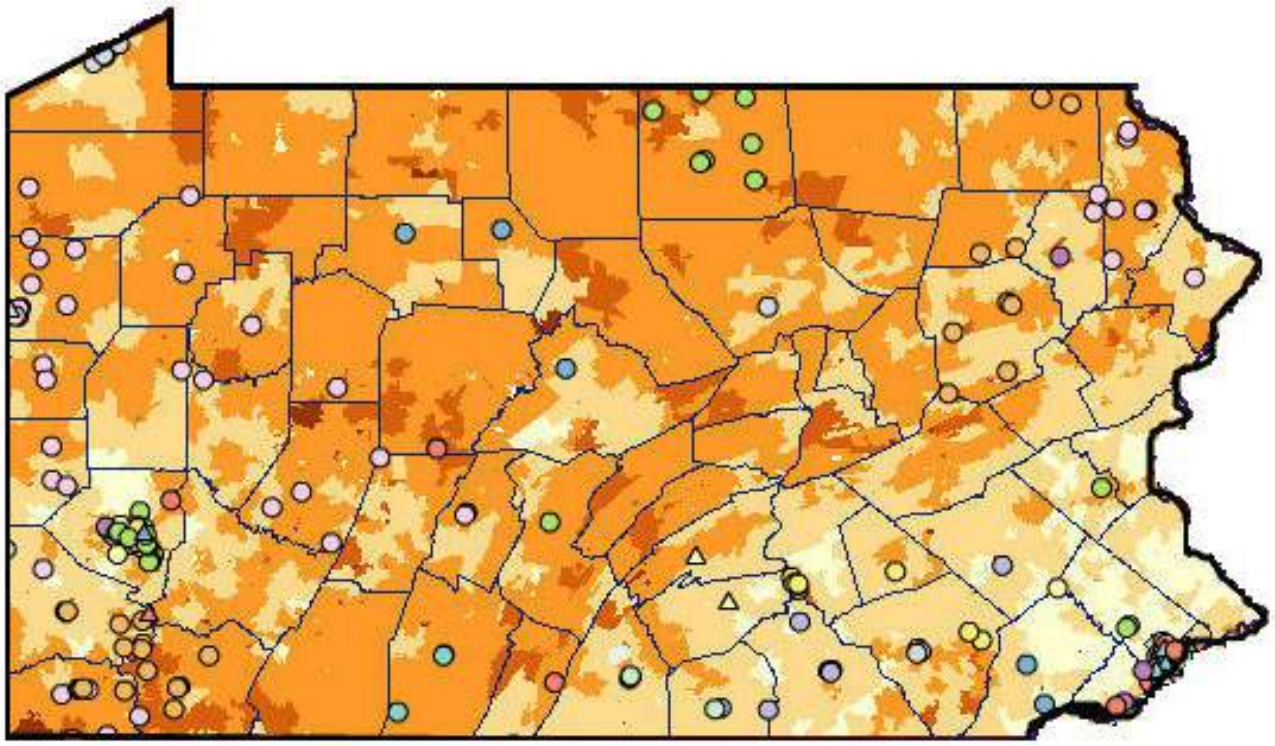
% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Source: UDS Mapper 2014

Pennsylvania Low Income Population [14]



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

- < 15%
- 15 - 30%
- 30 - 45%
- 45 - 60%
- > 60%

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

Source: UDS Mapper 2014

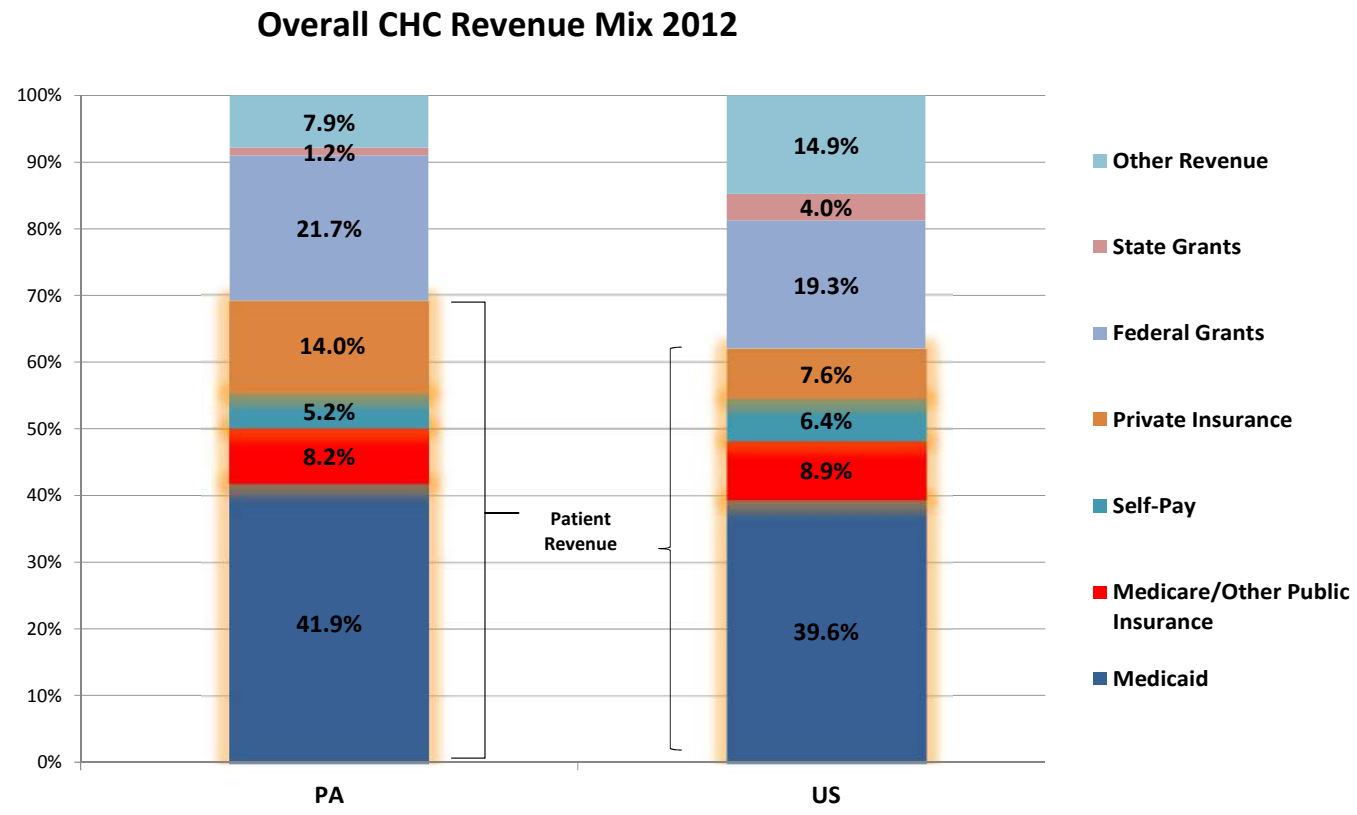
Pennsylvania CHCs Compared to CHCs Nationwide, 2012

- Greater proportion of revenue from patient services
- Slightly greater portion of patient revenue from Medicaid
- Double the proportion of revenue from private insurance

	PA	US
CHC Revenue Mix		
Patient Revenue	69.3%	62.9%
Medicaid	41.9%	39.6%
Medicare/Other Public Insurance	8.2%	8.9%
Self-Pay	5.2%	6.4%
Private Insurance	14.0%	7.6%
Federal Grants	21.7%	19.3%
State Grants	1.2%	4.0%
Other Revenue	7.9%	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

Pennsylvania CHCs as a Group, 2009-2011 [15]

- Median Total Assets increased by 51%
- Unrestricted Net Assets grew by 29%
- Median Days Cash on Hand decreased by 28%, from 32 to 23 days, falling below the 30-day benchmark
- Median Days Payable increased by 8%, from 79 to 85 days, well above the benchmark range

PA Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$2,742,156	$3,531,532	$4,144,071	51%	N/A
Total Revenues ($)	$5,758,363	$6,886,636	$7,349,335	28%	N/A
Profitability					
Total Margin (%)	0.6%	6.3%	4.7%	717%	N/A
Unrestricted Net Assets ($)	$1,887,676	$2,179,314	$2,440,097	29%	N/A
Liquidity					
Days Cash on Hand	32	27	23	-28%	>30 Days
Days in Accounts Receivable	32	31	29	-10%	<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

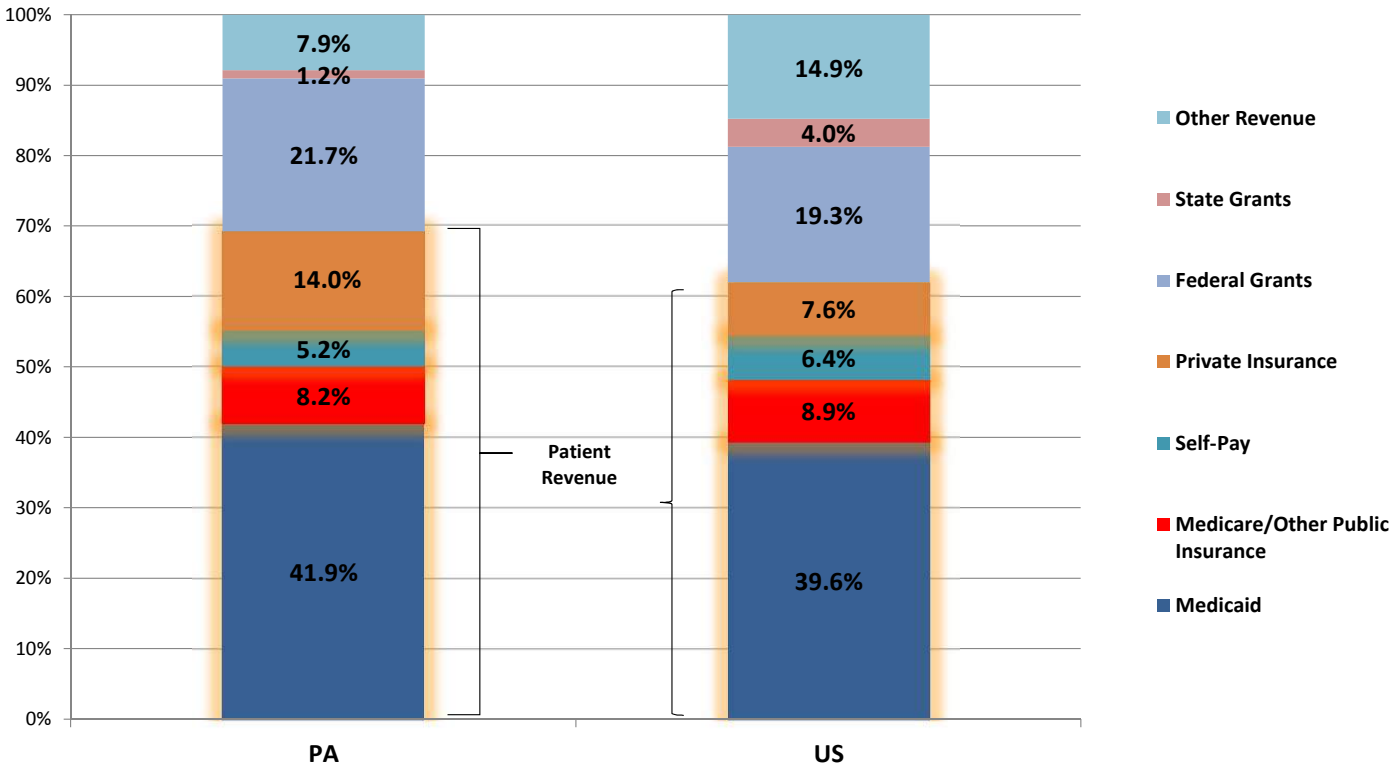
Pennsylvania CHCs Visit Mix Compared to CHCs Nationwide [3]

- Uninsured proportion of visit mix is 25% lower than national average
- Slightly higher proportion of visit mix is recipients of Medicare and Medicaid
- Proportion of patients seen living at or near poverty level is in line with national averages

	PA	US
CHC Payer and Revenue Mix		
Patient Revenue	69.3%	62.9%
Medicaid	41.9%	39.6%
Medicare/Other Public Insurance	8.2%	8.9%
Self-Pay	5.2%	6.4%
Private Insurance	14.0%	7.6%
Federal Grants	21.7%	19.3%
State Grants	1.2%	4.0%
Other Revenue	7.9%	14.9%

Source: UDS Summary Data 2012

Overall CHC Revenue and Payer Mix 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near national average on most primary care & prevention indicators
- Ranked #29 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Pennsylvania has a significantly lower proportion of population underserved for primary care
- Population underserved for dental at about the national average

	PA	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	6.5%	5.3%
% low birthweights	8.3%	8.1%
% adults diagnosed with diabetes	9.5%	9.3%
Adult diabetes deaths per 100,000	20.0	20.8
Adult heart disease deaths per 100,000	187.0	179.1
Avoidable Hospitalizations per 1,000	69.6	66.6
America's Health Ranking (United Health Foundation)	29	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	184,750	35,057,608
% of total population	1.5%	11.3%
Estimated PCPs needed to achieve target PCP:Population Ratio	86	7067
Estimated underserved population for dental	1,252,724	31,707,007
% of total population	9.9%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	276	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [16]

- 43% of Pennsylvania CHC sites have achieved PCMH sites recognition or certification as of 7/31/14.
- Pennsylvania's Chronic Care Initiative (CCI), including patient-centered medical home adoption, was staged in seven regional rollouts. Four of the seven rollouts featured ongoing enhanced reimbursement from multiple payers; three offered more limited assistance, without ongoing payment for medical home expenses
- Pennsylvania is one of eight states selected to participate in the Medicare Advanced Primary Care Practice (MAPCP) demonstration program

Electronic Health Record Adoption [17]

- Pennsylvania is at the national average with EHR availability at CHC sites (85% in Pennsylvania vs. 88% in U.S.)
- Pennsylvania performs better than national average in 7 of 12 EHR functionality categories

Medicaid Policies – Highlights

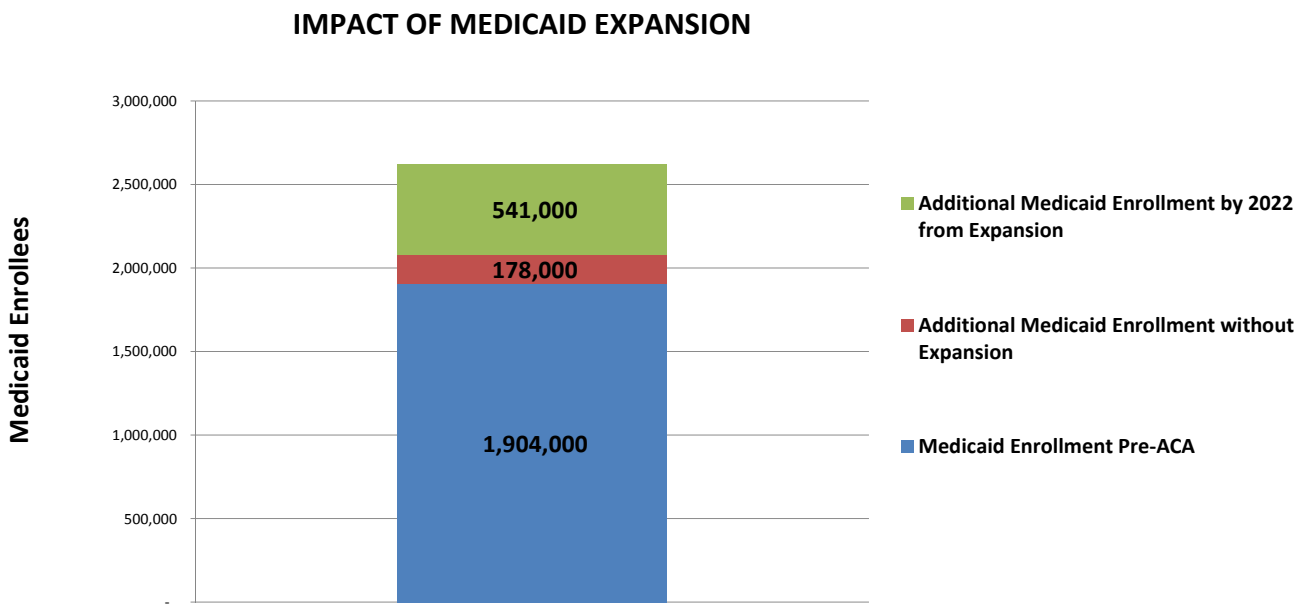
- 9th highest per-enrollee Medicaid spending in US
- Has not implemented ACA Medicaid expansion, but has developed alternative expansion proposal
- Medicaid coverage in Pennsylvania is currently limited to children, pregnant woman and disabled adults
- Under current policies, with no expansion of eligibility limits, Medicaid enrollment is expected to grow 9% over the next 10 years. Alternatively, growth will be substantially higher, at an additional 27% through the Healthy Pennsylvania proposal and/or 28% through an ACA-style expansion.

	PA	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$7,288	$5,563
Federal Medical Assistance Percentage (FMAP)	54.3%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Open Debate	
Health Insurance Exchange	Federal	
Total Uninsured	1,357,000	53,277,000
% of Uninsured Individuals (all ages)	10.7%	17.2%
Medicaid Enrollment Pre-ACA	1,904,000	52,410,000
% of Total Population	15.0%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	178,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	719,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	37.8%	40.6%
Estimated Number Remaining Uninsured After ACA	652,000	27,930,000
Estimated % Uninsured After ACA (2020)	5.1%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Pennsylvania is seeking approval from HHS for a modified Medicaid expansion program ("Healthy Pennsylvania" proposal)
- Pennsylvania is allowing Federal Government to run health exchange
- Uninsured rate 28% lower than national average
- Coverage growth under Healthy Pennsylvania plan is estimated by Pennsylvania at 500,000, vs. estimated 719,000 if state chooses to expand Medicaid per ACA.
- Proportion of residents who are uninsured is projected to decrease from 10.7% to 5.2% as a result of the Healthy Pennsylvania plan.



Source: Kaiser State Health Facts 2012

Pennsylvania Medicaid Spending

Pennsylvania spends nearly $7,300 per Medicaid enrollee annually – the 9th highest in the nation for all health care services provided. [6] In total, Pennsylvania spends nearly $24 Billion on Medicaid annually, including state and federal contributions. [4]

Medicaid Coverage & Administration

Pennsylvania is one of 25 states that have chosen (as of April 2014) to not expand its Medicaid program under the ACA. Pennsylvania's Medicaid Program went to Statewide Medicaid Manual Care, HealthChoices, last year. Few people are still eligible for Medicaid fee-for-service. [18]

Under the HealthChoices program, eligible Medicaid recipients also have the option to sign up for plans with Managed Care Organizations (MCOs). HealthChoice divides MCOs into five "Regional Zones" of the state, with each region including three to five different Medicaid Managed Care plans and includes options from major carriers such as AETNA and United Healthcare to smaller local plans such as Health Partners of Philadelphia, Inc. and Keystone Health. [19]

Medicaid eligibility limits are:

- Parents – up to 38% FPL
- Children – family incomes up to 319% FPL through the state's CHIP program.
- Pregnant women – up to 220% FPL.
- Childless adults are not currently eligible in Pennsylvania Medicaid but are eligible for one of two state-funded General Assistance (GA) programs, the "Categorically Needy" and "Medically Needy" for adults living with chronic illnesses and who cannot afford to pay out-of-pocket. [20]
- In addition to providing coverage to those eligible as shown in the table below, the State offers Medicaid coverage to disabled adults and to Dual-eligible adults 65 and older through its Healthy Horizons program. [21]
- Other specialized Medicaid services offered include Case Management for individuals with HIV/AIDS; Transportation for those with no means of travel; and hospice care for end-of-life treatment. [22]
- Pennsylvania Medicaid has a limited cost-sharing structure as co-pays are only required for certain services such as pharmacy, selected physician and hospital visits, Diagnostic radiology and Nuclear Medicine. Co-payments typically range between $1 and $3. [19]

Behavioral health services are administered primarily by the HealthChoices Behavioral Health program which contracts with MCOs to manage the mental health of patients placed onto health plans. [23] [24] MCOs must assure that Members are provided reasonable access to Behavioral Health Services provided by CHCs, wherever CHC Behavioral Health Services are available. [23]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	N/A	185%	58%	N/A
2014	0%	258%	138%	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

Pennsylvania CHC Reimbursement Policies

Medicaid reimbursement is governed by the federal Prospective Payment System (PPS) requirements (i.e., not an alternative payment methodology though this is permitted under federal regulations.) PPS requires that the rate be escalated by a cost inflation factor. Pennsylvania uses the Medicare Economic Index (MEI) to adjust the per visit rate annually. [7]

A change of the state's scope of service definition is described as a change that "involves the addition of a service that was never provided before or the discontinuance of an existing service." For a rate change triggered by a HRSA-approved change of scope, health centers must submit a cost report after completion of two years of operations at the relevant site, capturing all costs including new capital costs such as interest and depreciation. [7]

Pennsylvania does not provide funding to CHCs for indigent care.

The Pennsylvania PROMISe Provider Portal allows providers, alternates, billing agents and out-of-network providers with the proper security access to submit claims, verify recipient eligibility, check on claim status and update enrollment information. [19]

The Department of Public Welfare uses a quarterly reconciliation process to connect reimbursement to a CHC by managed care organizations with the health center's PPS rate. If the MCO reimburses the CHC through monthly capitation checks or a fee schedule that is below what the PPS rate per encounter reimbursement would represent, CHCs are "made whole" to their full PPS rate by DPW through submission of quarterly MCO Settlement Reports. [7]

Pennsylvania Medicaid allows for one medical, dental, and behavioral visit per day. There are no limits on the number of Billable Visits per year. [13] [14]

Categories of providers eligible to generate a reimbursable PPS encounter are typical to most states. MDs, DMDs, NPs, LSCWs, psychologists, and expanded scope dental hygienists are allowed to generate a PPS encounter. [13] [14]

Managed care plans in Pennsylvania provide incentive payments for preventive services such as immunizations, cancer screenings and smoking cessation, as well as for improved outcomes for chronically ill patients. The size of these payments varies depending on the contracts negotiated between the CHC and the MCO. [25]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
PA	Yes	Yes	Yes	Yes	Expanded Scope Dental Hygienists

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
PA	No	Yes	No	No	No

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

Collaboration with CMS [26]

Pennsylvania has been collaborating 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:

- **FQHC Advanced Primary Care Demonstration** – Select FQHC Grantees will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promotes better health and lowers costs. There are 12 grantees and 14 total health centers participating in the demonstration in Pennsylvania.
- **Multi-Payer Advanced Primary Care Practice Initiative (MAPCP)** – a Medicare program promoting Advanced Primary Care (APC) practices.
- **State Innovation Model** – Pennsylvania was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan. The Pennsylvania plan places strong emphasis on the need for innovative models on transitions of care, telemedicine and care management. The state aims to develop a model that deploys community-based care teams to provide more appropriate services to "super-utilizers" and enhance access to public health preventive services by better integrating the services into the provider community.

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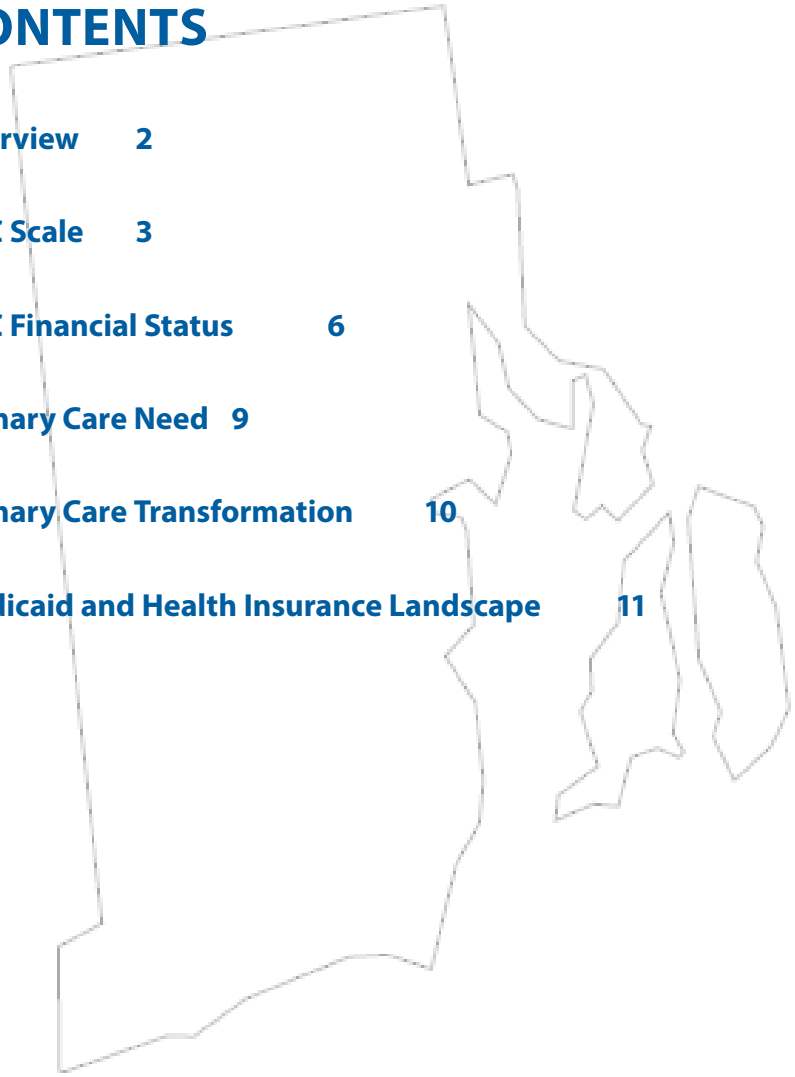

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OVERVIEW

Market Share & Growth

- As of 2014, there were 8 CHCs operating 37 permanent clinical service delivery sites throughout the state of Rhode Island. The primary care association representing CHCs is the Rhode Island Health Center Association. [1] [2]
- Rhode Island CHCs provided 564,446 visits to 134,905 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 5% annually between 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 31.1% of Rhode Island's Medicaid population (US: 16%) and 13.1% of its overall population (US: 7%). Rhode Island CHCs serve 32% of individuals with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 174,000, is projected to grow by an additional 48,000 people by 2022 (28% growth); the uninsured rate is projected to decrease from 12.2% to 6.2%. [3] [4]

Policy & Reimbursement

- Rhode Island spends slightly over $8,200 per Medicaid enrollee annually – the 5th highest in the nation. [5]
- Rhode Island CHCs reimbursed by Medicaid use an alternative payment methodology which largely incorporates the Federal Prospective Payment System (PPS). [6]
- Rhode Island has implemented Medicaid expansion. With Medicaid expansion, Rhode Island has set eligibility limits for adults at 138% FPL; for pregnant women at 258%; and for children at a family income up to 266% FPL. [7]
- Almost all CHC patients who are Medicaid beneficiaries are mandatorily enrolled in Rhode Island's managed care program. [8]
- Rhode Island has established its own state-run health insurance exchange called healthsourceri.com. [9] [10] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 28,485, surpassing a goal of 12,000. [11]
- Rhode Island is participating in several CMS Innovation programs, including the "Multi-Payer Advanced Primary Care Program" and been awarded a State Innovation Model "Design Award." [12]

Rhode Island CHCs Compared to CHCs Nationwide

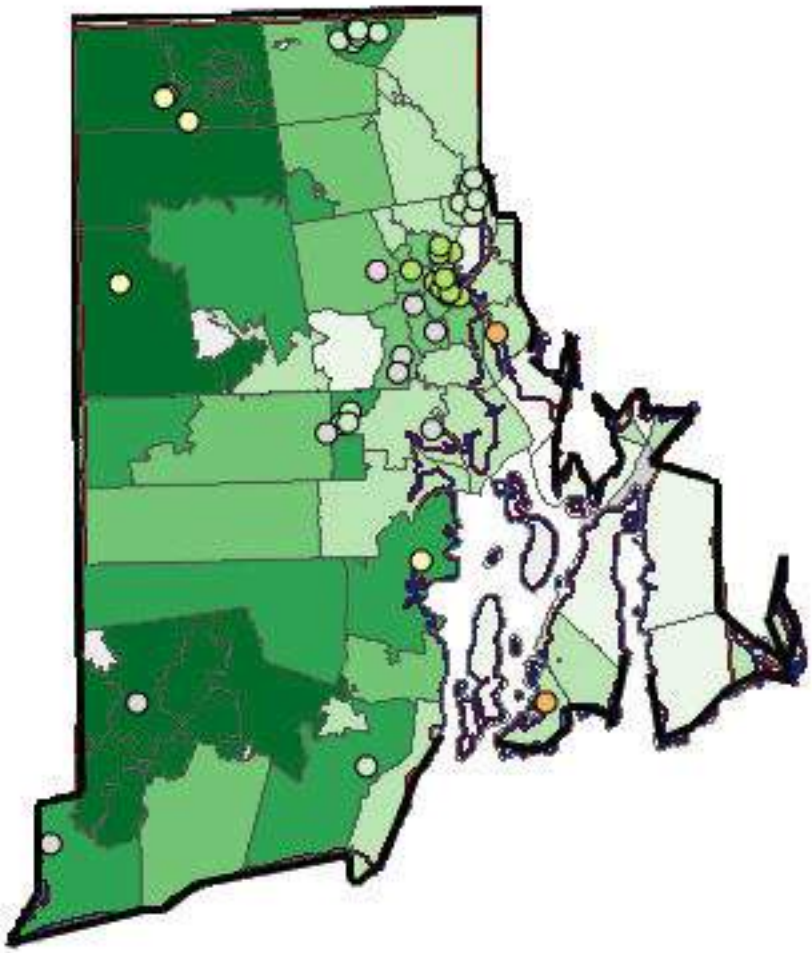
- Nearly double the percentage of the total population and Medicaid enrollees served
- Near the national average in visits per CHC
- Significantly higher proportion of dental visits
- Higher than average annual growth rate

	RI	US
Population Served (2012)		
Total patients served by CHCs	134,905	21,102,391
% of population served by CHCs	13.1%	6.8%
% of under 200% FPL served by CHCs	32.0%	15.9%
% of Medicaid Enrollees Served	31.1%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	8	1284
Total CHC Service Delivery Sites (2014)	37	9509
Average Sites per CHC (2014)	4.6	7.4
Annual Visits (Total) (2012)	564,446	83,766,153
Annual Visits per CHC (2012)	70,556	69,922
Annual Visits Per Patient (2012)	4.18	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	66.9%	73.6%
Dental	22.2%	12.8%
Mental Health	6.0%	7.5%
Case Management/Enabling	4.9%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	5.0%	4.1%
Total Annual Visits	5.2%	4.3%
Medical	4.3%	3.5%
Dental	5.7%	7.6%
Mental Health	8.3%	9.6%
Case Management/Enabling	11.1%	1.6%

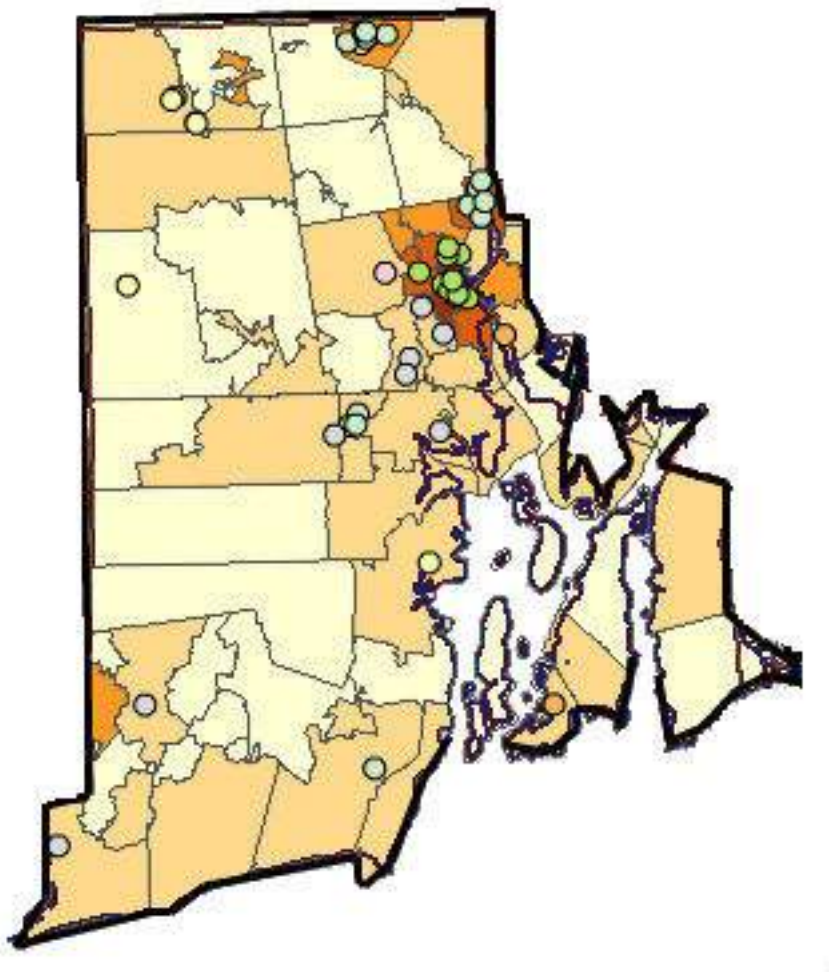
Note: All CHCs are Federally Qualifed Health Centers receiving Section 330 grants. Lookalikes not included.

Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by Rhode Island CHCs [13]



Rhode Island Low Income Population [14]



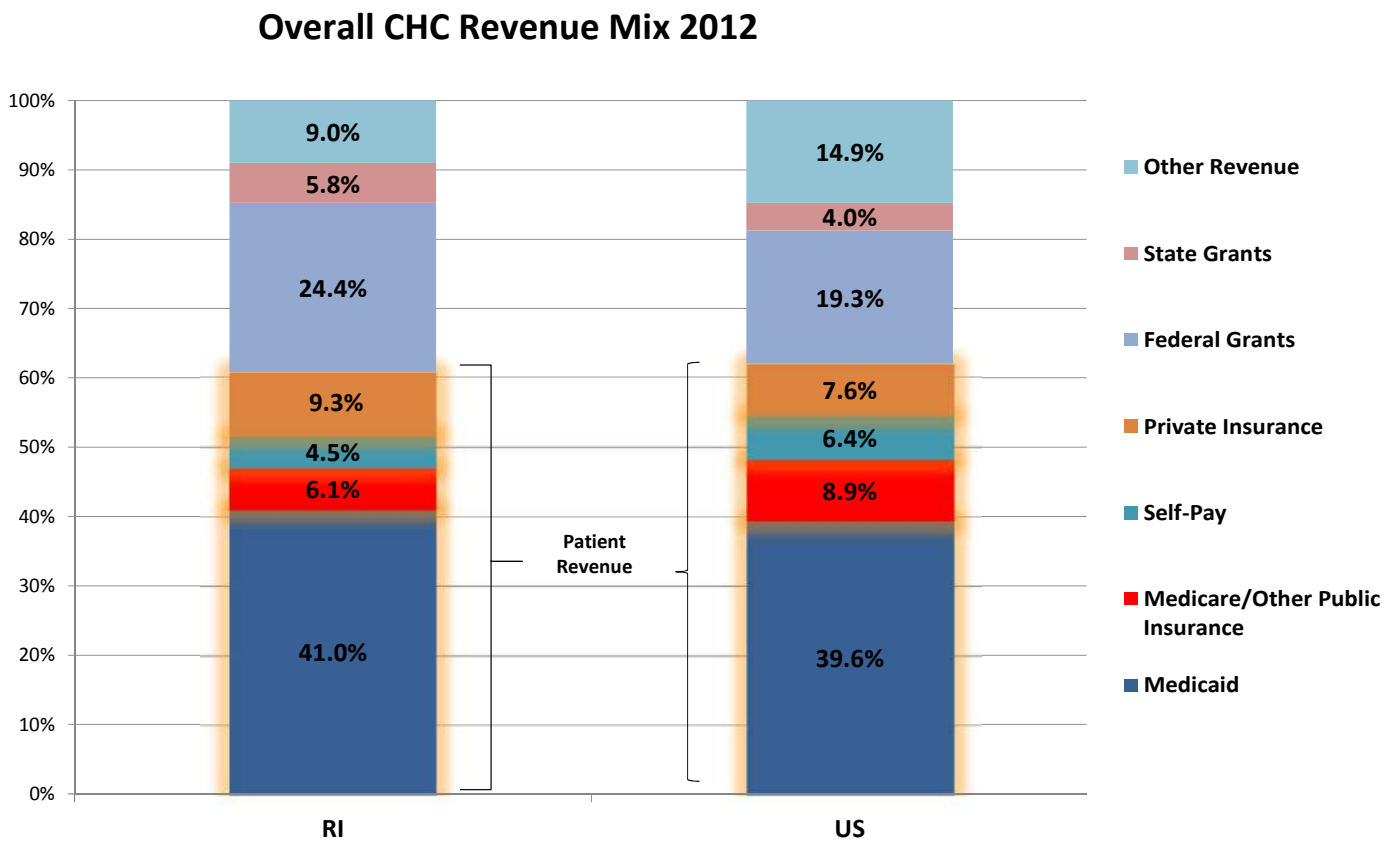
Rhode Island CHCs Compared to CHCs Nationwide, 2012

- Similar proportion of revenue from patient services
- Similar proportion of patient revenue from Medicaid
- Slightly higher proportion of revenue from private insurance
- Greater proportion of federal grants

	RI	US
CHC Revenue Mix		
Patient Revenue	60.9%	62.9%
Medicaid	41.0%	39.6%
Medicare/Other Public Insurance	6.1%	8.9%
Self-Pay	4.5%	6.4%
Private Insurance	9.3%	7.6%
Federal Grants	24.4%	19.3%
State Grants	5.8%	4.0%
Other Revenue	9.0%	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

CHC FINANCIAL STATUS

Rhode Island CHCs as a Group, 2009-2011

- Median Total Assets increased by 31%
- Unrestricted Net Assets grew by 30%
- Median Days Cash on Hand rose by 23%, from 46 to 56 days, well above the 30-day benchmark

RI Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$9,183,247	$9,742,650	$12,000,593	31%	N/A
Total Revenues ($)	$9,683,825	$11,335,074	$10,629,236	10%	N/A
Profitability					
Total Margin (%)	6.2%	6.1%	1.0%	-84%	N/A
Unrestricted Net Assets ($)	$6,531,313	$8,485,269	$8,517,442	30%	N/A
Liquidity					
Days Cash on Hand	46	60	56	23%	>30 Days
Days in Accounts Receivable	33	22	27	-18%	<60 Days

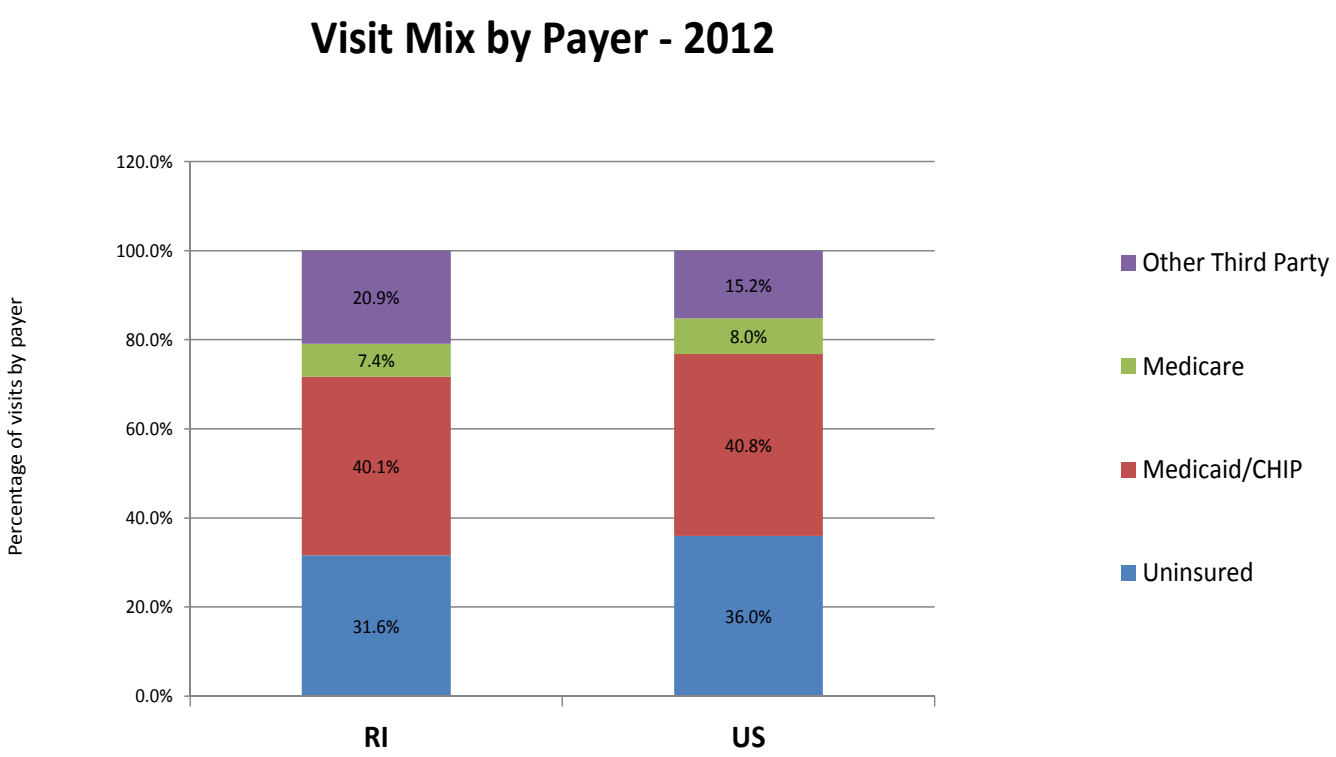
Note: CHC 990s have limitations, and certain indicators could not be accurately analyzed as a result. For a more complete picture of CHC financials, audited financial statements should be consulted.

Rhode Island CHCs Visit Mix Compared to CHCs Nationwide

- Near national average is most categories
- Slightly lower proportion of visits from uninsured population
- Other third party payments, typically commercial insurance, is above national average

	RI	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	90.8%	92.6%
Patients at or below 100% poverty level	70.5%	71.9%
Coverage Status		
Uninsured	31.6%	36.0%
Medicaid/CHIP	40.1%	40.8%
Medicare	7.4%	8.0%
Other Third Party	20.9%	15.2%

Source: UDS Summary Data 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Better than national average on most primary care & prevention indicators
- Ranked #19 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Slightly lower proportion of population is underserved for primary care.
- Population underserved for dental is at about the national average.

	RI	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	1.3%	5.3%
% low birthweights	7.7%	8.1%
% adults diagnosed with diabetes	7.5%	9.3%
Adult diabetes deaths per 100,000	16.0	20.8
Adult heart disease deaths per 100,000	167.1	179.1
Avoidable Hospitalizations per 1,000	70.6	66.6
America's Health Ranking (United Health Foundation)	19	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	97,567	35,057,608
% of total population	9.4%	11.3%
Estimated PCPs needed to achieve target PCP:Population	36	7067
Estimated underserved population for dental	102,810	31,707,007
% of total population	10.0%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	33	6531

*Percent of total population underserved for primary care is calculated based on the number of primary care physicians in designated HPSAs and total HPSA population. Since HPSA designations are not automatic, but rather require an application process, it is speculated that the estimated underserved population is understated and reflects the fact that certain areas do not have HPSA designations.

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [15]

- 88% of Rhode Island CHC sites have achieved PCMH recognition or certification as of 12/31/13, compared to 44% nationally.
- The Chronic Care Sustainability Initiative (CSI-RI) invested $100 million in primary care; payment to participating practices began in October 2008; five payers including Medicaid fee-for-service, Medicaid Managed Care, and commercial plans have supported the project; the project now has participation of nearly 100% of Rhode Island payers and purchasers.
- In 2009, the Rhode Island Health Insurance Commissioner enacted a policy requiring all insurers to increase their spending on primary care as a proportion of total health spending by one percentage point per year over five years.
- In 2011, Rhode Island enacted the Rhode Island All-Payer Patient Centered-Medical Home Act, which requires the participation of state-regulated health insurers going forward in a PCMH collaborative.
- Rhode Island is one of the eight states selected to participate in the Medicare Advanced Primary Care Practice (MAP-CP) demonstration program.
- Rhode Island was awarded a $15.9 million Beacon Community grant in July 2010 to increase the effective use of Health Information Technology in medical homes.

Electronic Health Record Adoption [16]

- 100% of Rhode Island's CHC sites are using EHRs
- Rhode Island performs better than the national average in 11 of 12 EHR functionality categories

Medicaid Policies – Highlights

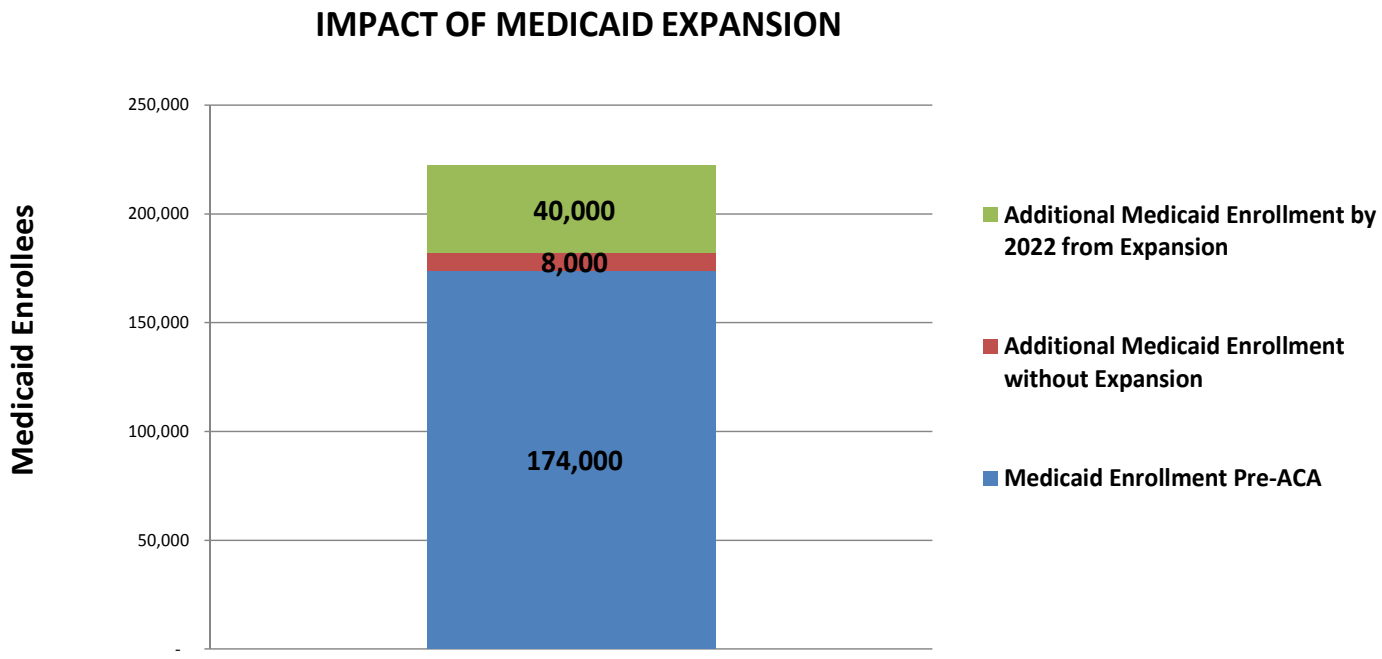
- Among the highest per-enrollee Medicaid spending in US
- Expanded coverage to childless adults and increased provider payments will likely increase access [17]

	RI	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$8,229	$5,563
Federal Medical Assistance Percentage (FMAP)	51.3%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	State	
Total Uninsured	126,000	53,277,000
% of Uninsured Individuals (all ages)	12.2%	17.2%
Medicaid Enrollment Pre-ACA	174,000	52,410,000
% of Total Population	16.8%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	8,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	48,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	27.6%	40.6%
Estimated Number Remaining Uninsured After ACA	72,000	27,930,000
Estimated % Uninsured After ACA (2020)	6.2%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Implementing Medicaid expansion
- Growth in Medicaid enrollment expected to be over 25%.
- Set up a state-run health insurance exchange called healthsourceri.com
- Proportion of uninsured lower than national average
- Proportion of residents who are uninsured projected to decline from 12.2% to 6.2% from 2012 through 2020



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

Rhode Island Medicaid Spending

Rhode Island spends just over $8,200 per Medicaid enrollee annually – the 5th highest in the nation for all health care services provided. [5]

Rhode Island's Medicaid program spent approximately $1.8 billion in FY 2012. The State's Medicaid expenditure is divided among several state agencies, with $1.4 billion of total expenditure managed by the Office of Health and Human Services (OHHS), and $366 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH). [18]

Children and families, who are the predominant CHC clientele, account for 69% of total enrollment and 27% of total expenditure, with total 2012 expenditure of $474 million for all services, ambulatory, hospital and other services. The largest share of Medicaid expenditures are for adults with disabilities and the elderly. [18]

Medicaid expenditures are highly concentrated, as the top seven percent of users account for nearly two-thirds (66%) of expenditures.17 Eighty-three percent of expenditure for high cost users is for Elders and Adults with Disabilities. The largest categories of expenditure for high cost users are nursing facilities and residential and rehabilitation facilities for persons with developmental disabilities. [18]

Expanded Spending on Primary Care [19]

In 2009 the Office of the Health Insurance Commissioner, a state agency with broad regulatory authority over commercial health insurers, embarked on a process to strengthen and expand primary care in the state.

In their efforts, the agency created a series of standards for achieving their goals and developed a policy for increasing payments to primary care providers.

The regulation required each insurer's proportion of medical expense allocated to primary care for the twelve months starting January 2010 to be one percentage point higher than actual spending for the twelve months starting January 2008. This proportion was then to increase by one percentage point per year for five years. At the end of 2014, on average, 11 percent of commercial insurers' medical expenses were to be devoted to primary care.

Medicaid Coverage & Administration

Rhode Island operates its Medicaid program pursuant to its 1115 waiver approved by CMS in 2009. it has a block grant-like structure, with an aggregate state and federal funding cap of $12.1 billion over a five year period. [20]

Eligibility limits under the Medicaid expansion are:

- Family income up to 266% FPL for children
- Up to 258% FPL for pregnant woman
- Up to 138% FPL for parents and childless adults [21]

Rhode Island does not require any co-payments for residents participating in the state Medicaid program. Premium payments are limited to those above 151% FPL. [22]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	250%	185%	181%	N/A
2014	266%	258%	138%	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

Rhode Island CHC Reimbursement Policies

Rhode Island has adopted a Medicaid per visit reimbursement methodology for community health centers, which is compliant with the prospective payment system.[10] Rhode Island devotes a nominal amount of funding to CHCs for indigent care.

The rate determination methodology recognizes the reasonable costs of providing services and provides for monthly wraparound payments to fully compensate CHCs for services to patients in health plans. Reimbursement rates for any one CHC are capped at 125% of the median rate for all Rhode Island CHCs.

More categories of providers are eligible to generate a reimbursable PPS encounter than is typical in other states. MD, DMD, NP, LSCW and nutritionist face-to-face visits generate a PPS encounter. [23]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
RI	Yes	Yes	Yes	Yes	DO

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
RI	No	Yes	No	Yes	No

Source: Kaiser State Health Facts 2012

Collaboration with CMS [24]

Rhode Island is collaborating 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. There are 3 grantees and 3 total health centers participating in the demonstration in Rhode Island.
- **Multi-Payer Advanced Primary Care Practice Initiative (MAPCP)** – a Medicare program promoting Advanced Primary Care (APC) practices.
- **State Innovation Model** – Rhode Island was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan.

The model is expected to leverage the opportunities provided by the state's Health Benefits Exchange and Medicaid initiatives. Planning activities will facilitate a multi-stakeholder process to review current state payment and delivery system reform initiatives, identify data sources and baseline data for outcomes measures and financial analysis, and identify policy lever changes available and needed to effectuate the State Health Care Innovation Plan.

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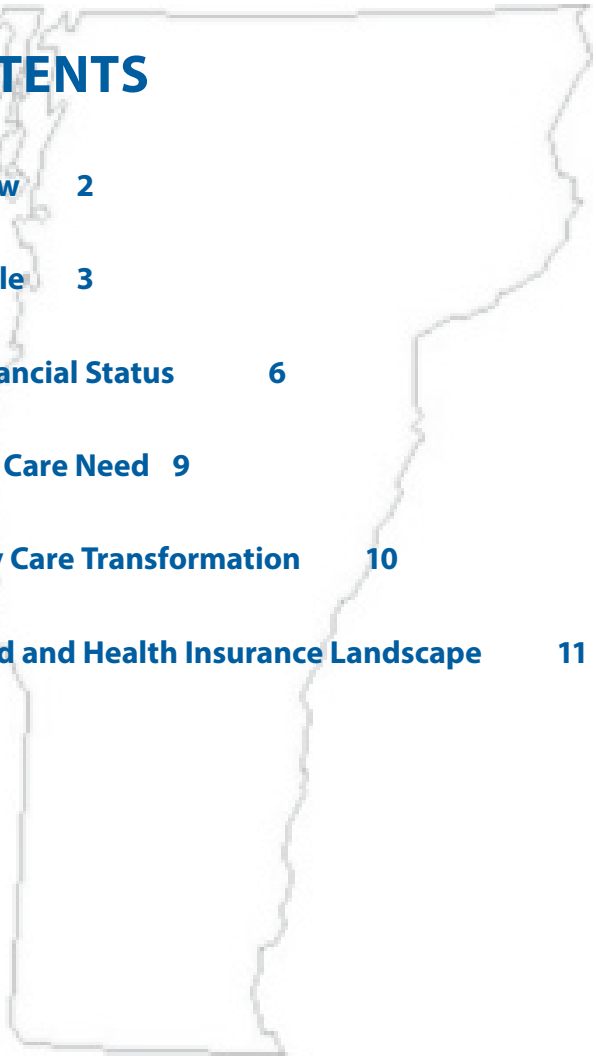
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

VERMONT



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 11 CHCs operating 65 service delivery sites throughout Vermont. The PCA in Vermont is the Bi-State Primary Care Association, which also represents New Hampshire. [1] [2]
- Vermont's CHCs provided 535,187 visits to 130,659 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 7.6% annually from 2010 - 2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 25.7% of Vermont's Medicaid population (US: 16%) and 21.2% of its overall population (US: 7%). CHCs in Vermont serve 46.1% of people with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 139,000 is projected to grow by an additional 14,000 people by 2022 (10% growth); the uninsured rate is projected to decrease from 11% to 6%. [3] [4]

Policy & Reimbursement

- Vermont spends slightly less than $6,200 per Medicaid enrollee annually – the 19th highest in the nation. [5]
- Vermont has implemented a Medicaid expansion; Medicaid eligibility limits are set at 138% FPL for parents and childless adults, 213% FPL for pregnant women and family income of up to 318% FPL for children. [6]
- Vermont has set up its own health insurance exchange, which is run through Vermont Health Connect. [7] [8] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 38,048, against a goal of 57,000. [9]
- Medicaid reimbursement is governed by an alternate payment methodology (APM), rather than the federal Prospective Payment System (PPS). [10]
- In 2011, the Vermont state government enacted a law functionally establishing the first state-level single-payer health care system in the United States. Green Mountain Care creates a system in the state designed to provide universal health care coverage. The legislation will not be fully implemented until 2017, and up to that point, Vermont will continue with provisions of the Affordable Care Act. [11]
- Vermont is one of six states selected in February 2013 by CMS to receive a State Innovation Model Testing Award. Vermont received $45 million to implement and test its State Health Care Innovation Plan, which will expand the Medicare Shared Savings ACO model to Medicaid and commercial payers, and pilot other models of payment reform. [12]

CHC SCALE

Vermont CHCs Compared to CHCs Nationwide

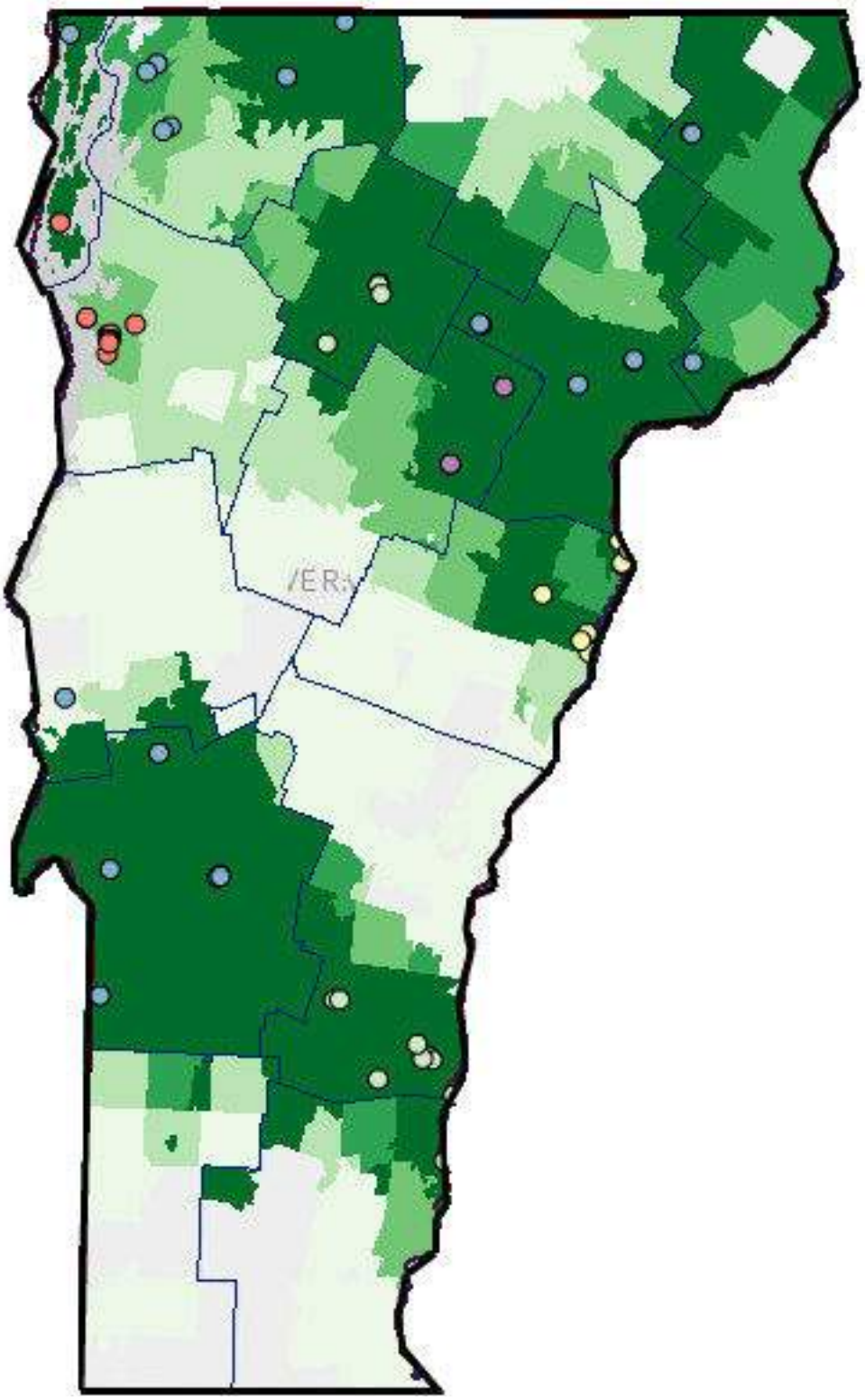
- More than triple the total population served
- Higher proportion of Medicaid enrollees served
- Visits per CHC comparable to the national average
- Nearly double the annual growth rate for visit volume
- More than triple the annual growth rate for mental health services

	VT	US
Population Served (2012)		
Total patients served by CHCs	130,659	21,102,391
% of population served by CHCs	21.2%	6.8%
% of under 200% FPL served by CHCs	46.1%	15.9%
% of Medicaid Enrollees Served	25.7%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	11	1284
Total CHC Service Delivery Sites (2014)	65	9509
Average Sites per CHC (2014)	5.9	7.4
Annual Visits (Total) (2012)	535,187	83,766,153
Annual Visits per CHC (2012)	66,898	69,922
Annual Visits Per Patient (2012)	4.10	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	77.7%	73.6%
Dental	12.0%	12.8%
Mental Health	9.0%	7.5%
Case Management/Enabling	1.3%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	7.6%	4.1%
Total Annual Visits	8.3%	4.3%
Medical	5.6%	3.5%
Dental	11.7%	7.6%
Mental Health	31.5%	9.6%
Case Management/Enabling	31.2%	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 Vermont CHCs [13]

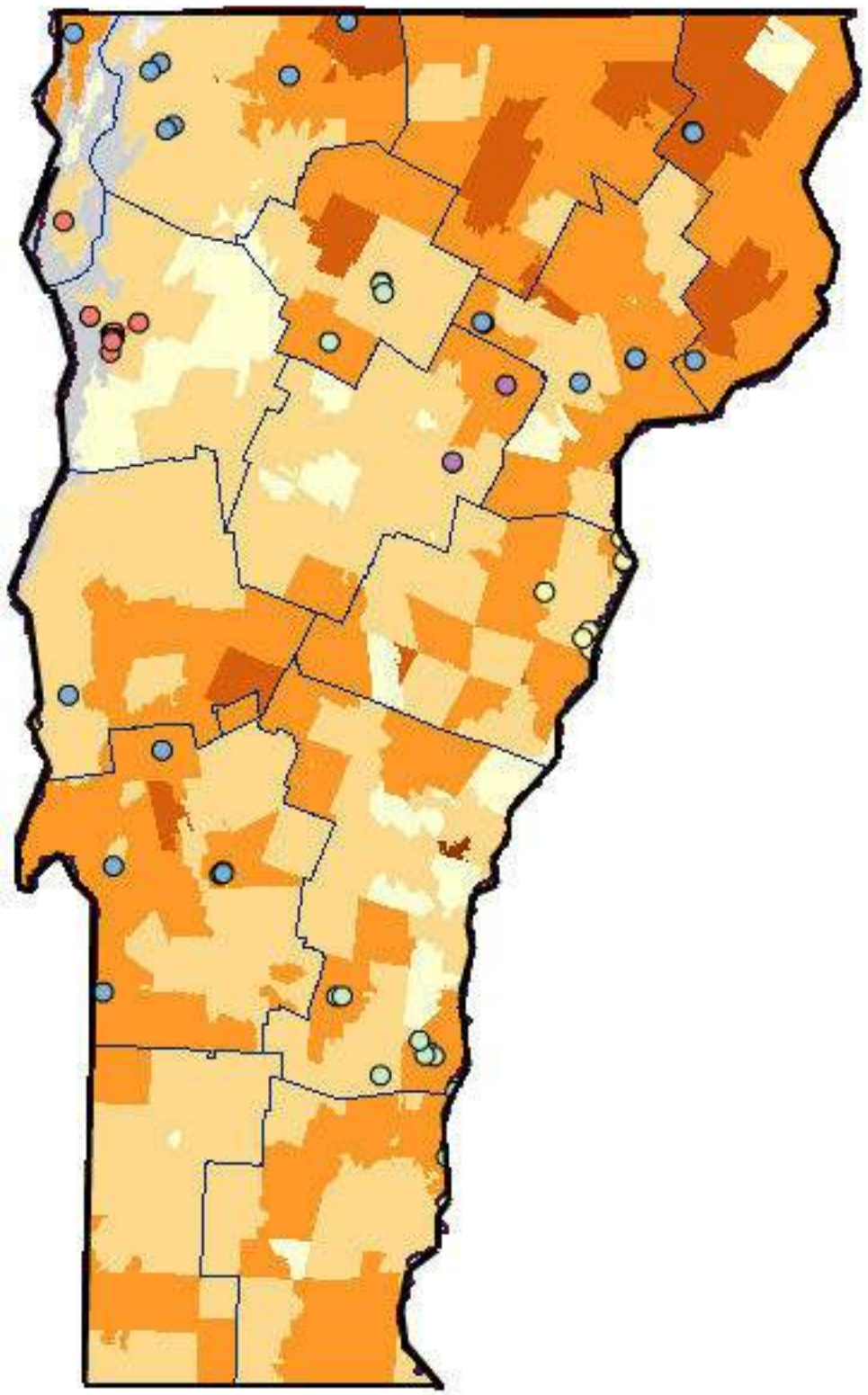


% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Vermont Low Income Population



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

- < 15%
- 15 - 30%
- 30 - 45%
- 45 - 60%
- > 60%

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

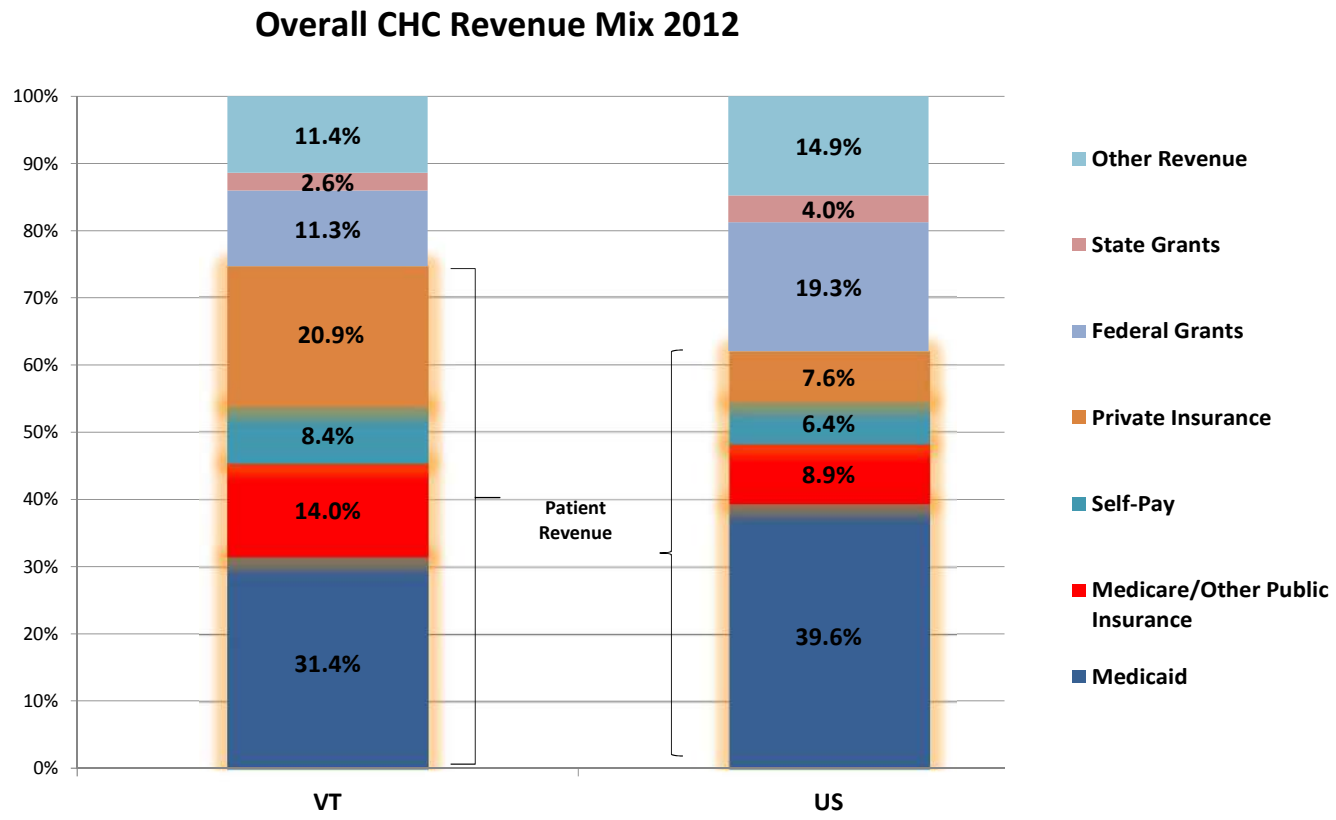
Vermont CHCs Compared to CHCs Nationwide, 2012

- Proportion of revenue from patient services above national average
- Revenue mix is typical of predominantly rural CHCs with below national average in patient revenues from Medicaid and significantly higher proportion of revenues from private insurance and Medicare
- Less reliance on federal grants

	VT	US
CHC Revenue Mix		
Patient Revenue	74.7%	62.9%
Medicaid	31.4%	39.6%
Medicare/Other Public Insurance	14.0%	8.9%
Self-Pay	8.4%	6.4%
Private Insurance	20.9%	7.6%
Federal Grants	11.3%	19.3%
State Grants	2.6%	4.0%
Other Revenue	11.4%	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

CHC FINANCIAL STATUS

Vermont CHCs as a Group, 2009-2011

- Median Total Assets increased by 20%
- Unrestricted Net Assets rose 20%
- Median Days Cash on Hand increased slightly from 32 to 33 days, remaining above the 30-day benchmark

VT Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$6,113,343	$6,846,442	$7,354,368	20%	N/A
Total Revenues ($)	$6,108,942	$10,698,129	$11,023,138	80%	N/A
Profitability					
Total Margin (%)	4.2%	5.8%	8.0%	89%	N/A
Unrestricted Net Assets ($)	$3,999,035	$4,567,659	$4,807,869	20%	N/A
Liquidity					
Days Cash on Hand	32	30	33	3%	>30 Days
Days in Accounts Receivable	45	34	31	-31%	<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.

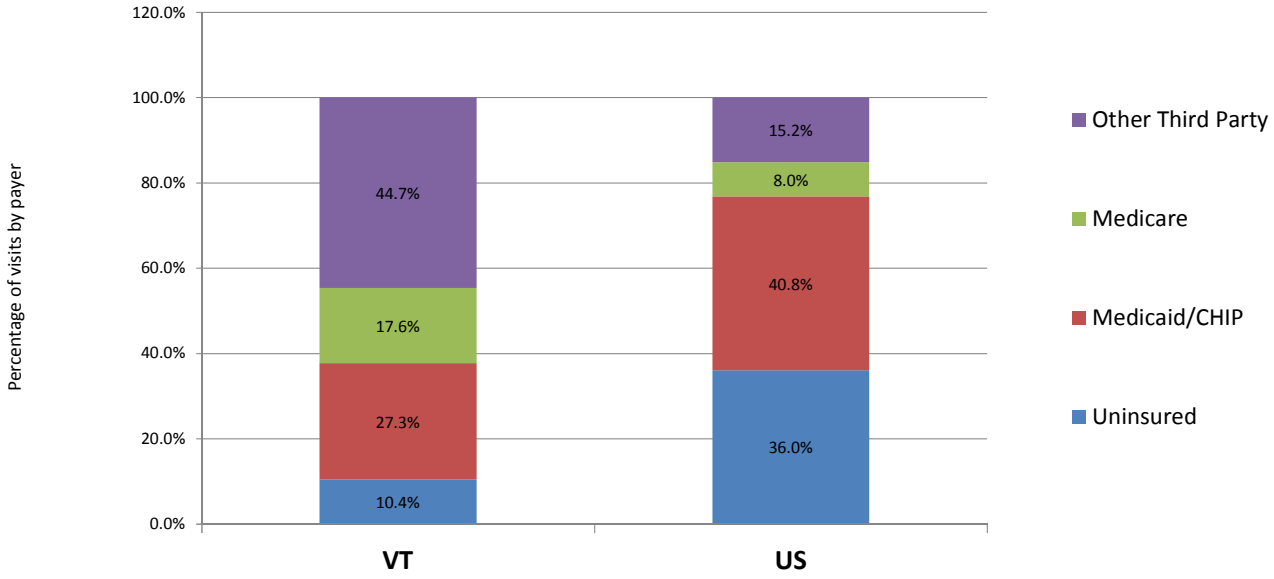
Vermont CHCs Visit Mix Compared to CHCs Nationwide [14]

- Much lower proportion of patients living at or near poverty level
- Much lower percentage of uninsured patients
- Significantly higher proportion of patient visits covered under a third party carrier

	VT	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	68.4%	92.6%
Patients at or below 100% poverty level	36.1%	71.9%
Coverage Status		
Uninsured	10.4%	36.0%
Medicaid/CHIP	27.3%	40.8%
Medicare	17.6%	8.0%
Other Third Party	44.7%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Better than national average on most primary care & prevention indicators
- Significantly better than national average in prevalence of diabetes and proportion of woman with late/no prenatal care
- Ranked #2 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Very low proportion of population is underserved for primary care
- Population of underserved areas for dental is also very low

	VT	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	2.2%	5.3%
% low birthweights	6.1%	8.1%
% adults diagnosed with diabetes	6.4%	9.3%
Adult diabetes deaths per 100,000	20.7	20.8
Adult heart disease deaths per 100,000	153.6	179.1
Avoidable Hospitalizations per 1,000	50.6	66.6
America's Health Ranking (United Health Foundation)	2	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	3,097	35,057,608
% of total population	0.5%	11.3%
Estimated PCPs needed to achieve target PCP:Population	1	7067
Estimated underserved population for dental	3,301	31,707,007
% of total population	0.5%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	0	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [15]

- 100% of Vermont CHCs have achieved PCMH recognition or certification as of 12/31/13, as compared to 44% nationally.
- Vermont's approach for medical homes began with a pilot in 2008. Three communities were selected to pilot an integrated care model, centered on providing patient-centered medical homes supported by community health teams.
- The pilot communities were part of Vermont's "Blueprint for Health," the state's chronic care prevention and management plan.
- The state has succeeded in spreading its program statewide: as of December 2011, Blueprint practices and community health teams were active in all of the state's services areas, serving more than 350,000 patients.
- Vermont is one of six states selected in February 2013 by CMS to receive a State Innovation Model Testing Award. Vermont received $45 million to implement and test its State Health Care Innovation Plan, which will expand the Medicare Shared Savings ACO model to Medicaid and commercial payers and pilot other models of payment reform.

Electronic Health Record Adoption [16]

- Vermont is ahead of the national average EHR availability at state CHC sites (88% in Vermont compared to 79% in the U.S.)
- Vermont performs better than national average in 11 of the 12 EHR functionality categories

Medicaid Policies – Highlights

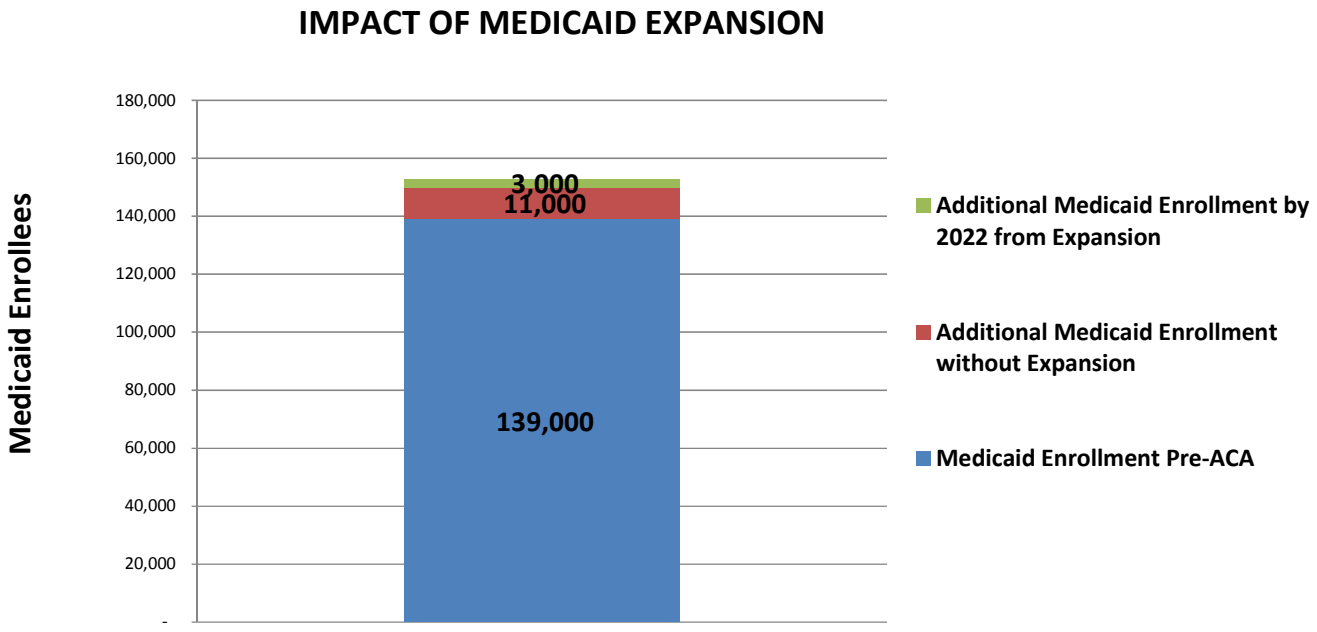
- Above national average in per-enrollee Medicaid spending.

	VT	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$6,158	$5,563
Federal Medical Assistance Percentage (FMAP)	56.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	State	
Total Uninsured	61,000	53,277,000
% of Uninsured Individuals (all ages)	9.9%	17.2%
Medicaid Enrollment Pre-ACA	139,000	52,410,000
% of Total Population	22.6%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	11,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	14,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	10.1%	40.6%
Estimated Number Remaining Uninsured After ACA	39,000	27,930,000
Estimated % Uninsured After ACA (2020)	5.6%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Vermont is implementing Medicaid expansion and has set up its own state-run health insurance exchange known as Vermont Health Connect
- Vermont is shifting to the state run-exchange people who, prior to the ACA were enrolled in a state-funded program that provided coverage for people up to 191% of FPL.
- The proportion of uninsured in Vermont is significantly lower than the national average
- Growth in Medicaid Enrollment expected to be only 10% over the next 10 years
- The proportion of residents who are uninsured is expected to decline from 11% to 6% over the next decade
- The universal coverage experiment (i.e. "single payer"), which was passed into law in 2011, is scheduled to be fully implemented in 2017.



Source: Kaiser State Health Facts 2012

Vermont Medicaid Spending

Vermont spends about $6,158 per Medicaid enrollee annually – the 19th highest in the nation for all health care services provided. [5]

Medicaid Coverage & Administration

Vermont has adopted the new Medicaid eligibility limits under the ACA. It should be noted, however, that Vermont is expanding its Medicaid coverage only for children and for pregnant women. Vermont is cutting Medicaid coverage for approximately 19,000 adults. The reason for this is that under the ACA, these 19,000 adults are eligible for federal subsidies through the state health insurance exchange, called Vermont Health Connect. [17]

While Vermont does not make special payments for indigent care, [18] its Medicaid program continues to support expanded coverage beyond federal requirements:

- Adult Coverage: Prior to the passage of the ACA, Vermont went far above its federal minimum requirement. The state provided coverage to jobless parents with incomes up to 185% FPL and working parents with incomes up to 191% FPL. Additionally, although pre-ACA there was no requirement to provide coverage to childless adults, Vermont Medicaid covered childless adults with incomes between 150-160% FPL (depending on their work status). Post-ACA, Vermont decreased its eligibility limit to 138% for all non-pregnant adults. The state expects that all individuals who are cut due to this change will be eligible for federal subsidies through Vermont Health Connect. [19]
- Coverage of Children and Pregnant Women: Pre-ACA, Vermont Medicaid covered children of families with incomes of up to 225% FPL. Post-ACA, this was expanded to include children of families with incomes up to 318% FPL. Eligibility limits for pregnant women increased slightly as well, from 200% FPL to 213% FPL. [20] [21]

  Summary of Benefits:

  - The Dr. Dynasaur Medicaid Plan (which covers children and pregnant women) covers a comprehensive list of services. [22] However, Medicaid for non-pregnant adults does not cover some services, including eyeglasses, dentures and orthodontics. [23]
  - Copayments are never required for individuals in a long-term care facility, individuals under age 21, or individuals who are pregnant or within 60 days post-pregnancy. For other individuals covered by Green Mountain Care, co-pays are only required for prescriptions (maximum co-pay is $3), dental visits ($3/visit), and outpatient visits ($3/day/hospital). [22]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	133%	200%	185%	150%
2014	317%	213%	138%	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

CHC Medicaid Reimbursement Policies

Medicaid reimbursement is governed by an alternate payment methodology (APM), rather than the more standard federal Prospective Payment System (PPS) requirements.

CHCs receive an encounter rate from Medicaid for medical and dental services. The Vermont Medicaid program allows for up to five CHC physician encounters per month. Multiple encounters on the same day may occur if the patient has different symptoms. Vermont does not have Medicaid Managed care, and thus has no capitation payments or wrap-around process. [10]

Vermont Medicaid allows encounter reimbursement for the following categories of providers: MD, DMD, NP, PA, LSCW, psychologists and certified nurse midwives.

Compared to those of other states, Vermont's state statutes are comprehensive and generous in reimbursement for telemedicine. Vermont's Medicaid program will reimburse for CHC live video telemedicine charges related to diagnosis, consultation or treatment, with certain limitations. [24] Vermont also provides enhanced per-member per-month payments ranging from $1.20-$2.39 based on NCQA PCHM recognition scores. [15]

Vermont does not adjust reimbursement rates based on the Medicare Economic Index (MEI). Instead, it caps the rate at 130% of the Medicare rate and the reimbursement rate increases annually only if the Medicare rate increases. Dental services use the same methodology as medical services, but are not subject to a cap (though Medicaid dental benefits for adults are capped). [10]

The state lacks a standardized rate increase process. However, Vermont CHCs can fill out a form for a change in scope of service. While many CHCs express appreciation for the comprehensive and inflation-linked characteristics of the APM, some assert the cap is not high enough for CHCs. [10]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
VT	Yes	Yes	Yes	Yes	Pas, CNM

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
VT	No	Yes	No	No	No

Source: Kaiser State Health Facts 2012

Collaboration with CMS [25]

Vermont is collaborating 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:

- **Multi-Payer Advanced Primary Care Practice Initiative (MAPCP)** – a Medicare program promoting Advanced Primary Care (APC) practices.
- **State Innovation Model** – Vermont was one of 16 states to receive Model Design funding to produce a State Health Care Innovation Plan. Having successfully produced an Innovation Plan, they are a recipient of the "Model Testing Award" to implement their State Health Care Innovation Plan.

The Vermont model aims to increase both organization coordination and financial alignment between clinical specialists and advanced primary care practices; implement and evaluate value-based payment methodologies; coordinate with other payment reforms on developing a financing and delivery model for enhanced care management and new service options for Vermonters eligible for Medicare and Medicaid; and accelerate the development of a learning health system infrastructure that will support delivery system redesign and state evaluation activities.

Future Plans – Single Payer

In 2011, Vermont enacted a bill that started the process toward a single-payer health system. The new system would be a state-funded-and-managed insurance pool that would provide near-universal coverage to residents. [26] Similar to a modified Medicare-for-all plan, this would be the first universal, publicly financed health care system in the United States. Paid for in part by a large business payroll tax, the new system is expected to launch in 2017. Estimates for the cost of the new program born by the state range from $1.6 – $2.2 billion. The single-payer system is intended to cut healthcare costs, keep small business in the state and help the middle class. [27]

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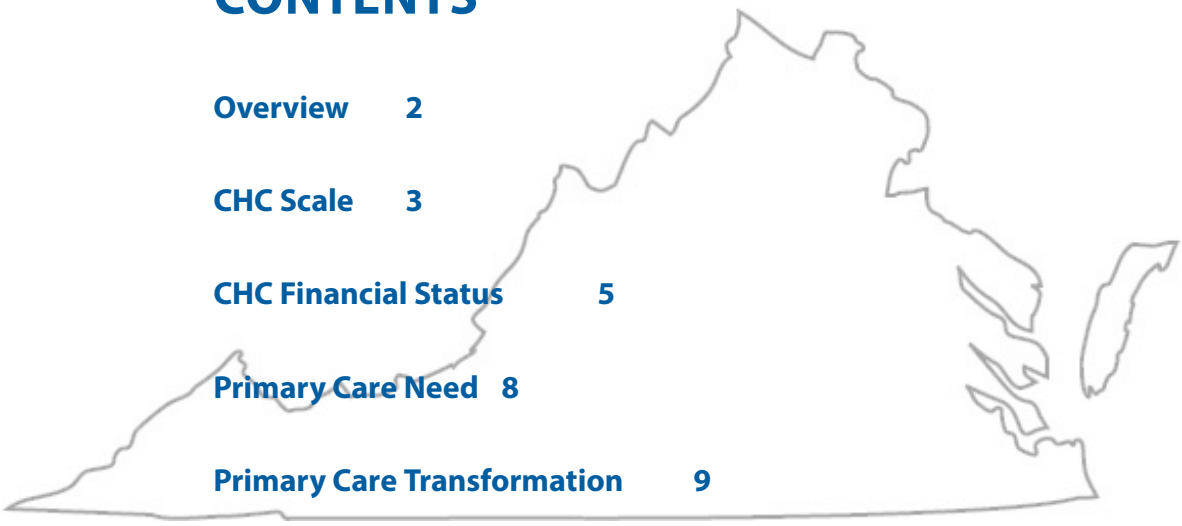
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

VIRGINIA

CONTENTS



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 28 CHCs operating 135 permanent clinical service delivery sites throughout the State of Virginia. The CHCs are represented by the Virginia Community Healthcare Association. [1] [2]
- Virginia CHCs provided 1,018,316 visits to 283,906 patients in 2012. [3]
- The number of people served by Virginia CHCs increased by an average of 1.9% annually from 2010-2012, compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 8.0% of Virginia's Medicaid population (US: 16%) and 3.6% of its overall population (US: 7%). Virginia CHCs serve 9.4% of individuals with incomes <200% FPL, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 769,000, is projected to grow to 80,000 individuals (10.4%) under current eligibility standards. If Virginia adopts the expanded ACA eligibility standards, enrollment would grow by an additional 407,000 individuals (52.9%) and the uninsured rate would be projected to decrease from 13.5% to 5.8%. [4]

Policy & Reimbursement

- Virginia spends slightly less than $6,000 per Medicaid enrollee annually– the 25th highest in the nation. [5]
- Virginia's Medicaid program and eligibility limits for parents of dependent children are 52% FPL. Eligibility limits for pregnant women (148% FPL) and children (family income up to 205% FPL under CHIP) are much higher. [6]
- Virginia Medicaid uses an alternative payment methodology based on reasonable cost using Medicare principles of reimbursement. Under the methodology, the state makes interim payments to CHCs and reconciles actual costs via year end cost reports. Rates are calculated by adjusting previous years' rates based on changes in scope of services, and inflation using the Medicare Economic Index (MEI). [7]
- Virginia provides Medicaid to individuals through two delivery models: commercial managed care organizations (MCOs) and Fee-for-Service. Virginia has been increasing its use of the MCO program. [8]
- Virginia has not expanded Medicaid. Expansion is supported by the governor, but opposed by the Legislature. [9] [10]
- The federal government operates the health insurance exchange through healthcare.gov. [11] Through the first enrollment period, individuals who have selected health plans through the exchange reached a total of 216,356, surpassing a goal of 127,000. [12]
- Virginia has several CHCs participating in the "CHC Advanced Primary Care Demonstration" program, a program funded by the CMS Innovation Center. [13]

Virginia CHCs Compared to CHCs Nationwide

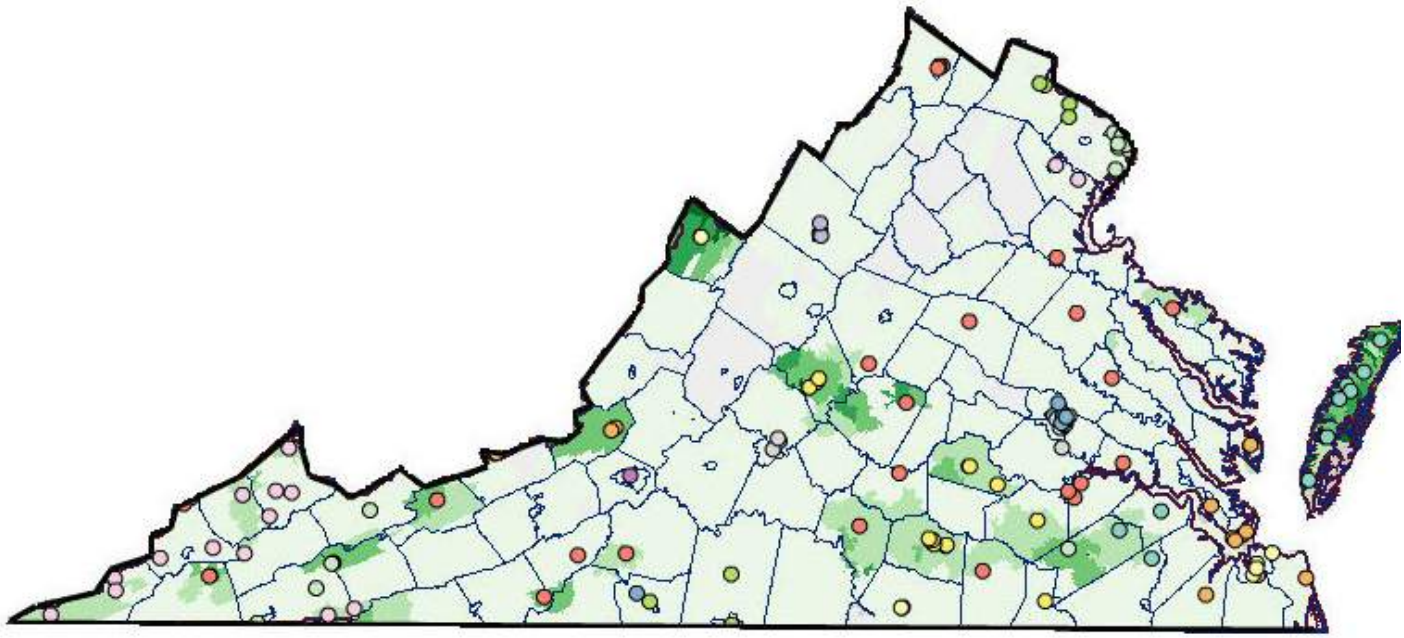
- Approximately half the proportion of the total population served and Medicaid enrollees served as nationally
- Approximately 80% the visit volume as CHCs nationally
- Visit volume growth slower than national average

	VA	US
Population Served (2012)		
Total patients served by CHCs	283,906	21,102,391
% of population served by CHCs	3.6%	6.8%
% of under 200% FPL served by CHCs	9.4%	15.9%
% of Medicaid Enrollees Served	8.0%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	26	1284
Total CHC Service Delivery Sites (2014)	135	9509
Average Sites per CHC (2014)	5.2	7.4
Annual Visits (Total) (2012)	1,018,316	83,766,153
Annual Visits per CHC (2012)	42,430	69,922
Annual Visits Per Patient (2012)	3.59	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	83.5%	73.6%
Dental	8.2%	12.8%
Mental Health	4.0%	7.5%
Case Management/Enabling	4.3%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	1.9%	4.1%
Total Annual Visits	2.9%	4.3%
Medical	2.4%	3.5%
Dental	3.5%	7.6%
Mental Health	13.8%	9.6%
Case Management/Enabling	2.0%	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 Virginia CHCs [14]

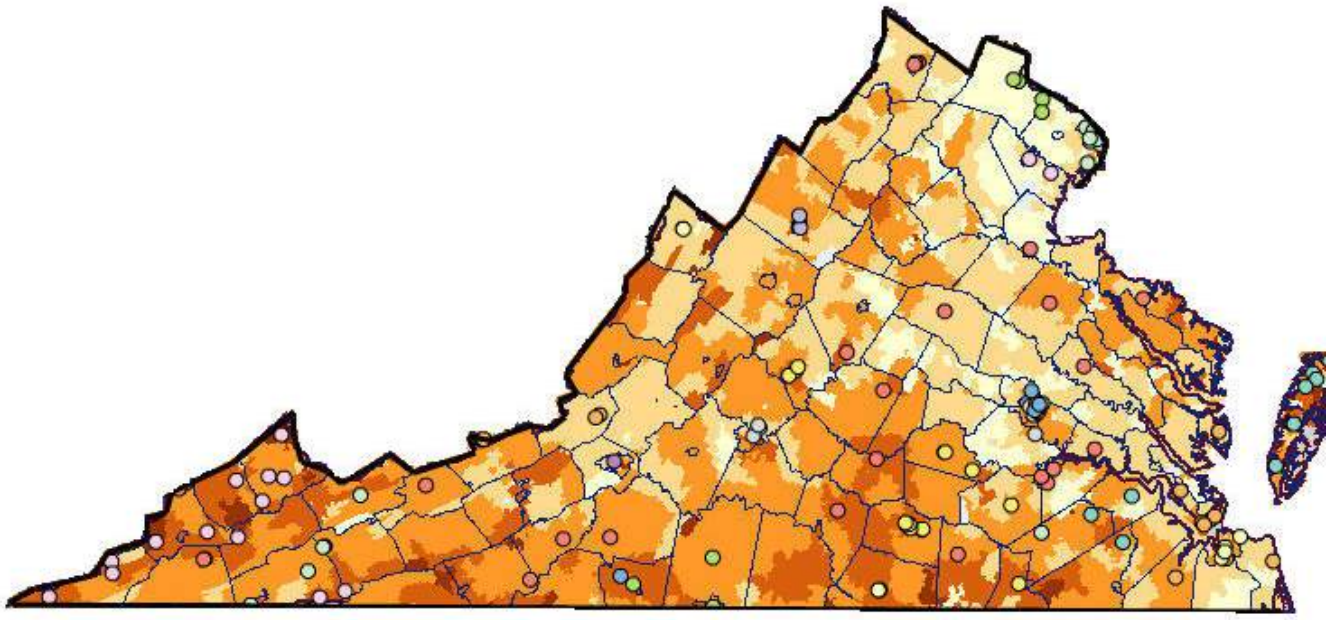


% of Total Population Served by CHCs

< 20%	60 - 80%
20 - 40%	> 80%
40 - 60%	

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

Virginia Low Income Population [14]



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

< 15%	45 - 60%
15 - 30%	> 60%
30 - 45%	

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

Source: UDS Mapper 2014

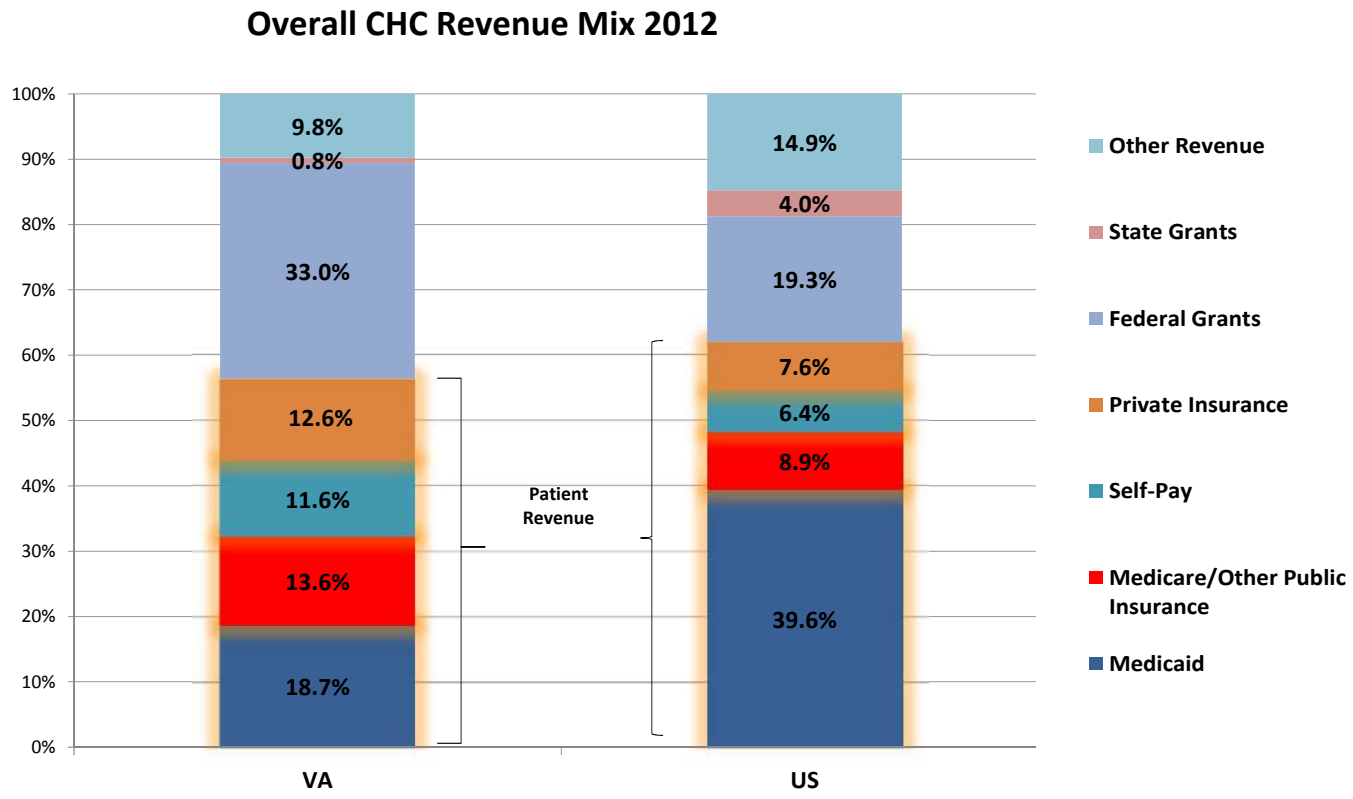
Virginia CHCs Compared to CHCs Nationwide, 2012

- Lower proportion of revenue from patient services
- Lower proportion of patient revenue from Medicaid
- Higher proportion of revenue from Medicare, self-pay, and private insurance
- Much higher reliance on federal grants than national average

	VA	US
CHC Revenue Mix		
Patient Revenue	56.4%	62.9%
Medicaid	18.7%	39.6%
Medicare/Other Public Insurance	13.6%	8.9%
Self-Pay	11.6%	6.4%
Private Insurance	12.6%	7.6%
Federal Grants	33.0%	19.3%
State Grants	0.8%	4.0%
Other Revenue	9.8%	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

CHC FINANCIAL STATUS

Virginia CHCs as a Group, 2009-2011 [15]

- Median Total Assets increased by 22%
- Unrestricted Net Assets grew 22%
- Median Days Cash on Hand decreased by 8%, from 57 to 53 days, remaining well above 30-day benchmark

VA Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$3,067,603	$3,521,386	$3,734,092	22%	N/A
Total Revenues ($)	$4,352,262	$5,162,266	$5,379,076	24%	N/A
Profitability					
Total Margin (%)	3.6%	8.4%	1.9%	-47%	N/A
Unrestricted Net Assets ($)	$1,404,950	$1,687,560	$1,710,146	22%	N/A
Liquidity					
Days Cash on Hand	58	71	53	-8%	>30 Days
Days in Accounts Receivable	27	23	27	-1%	<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

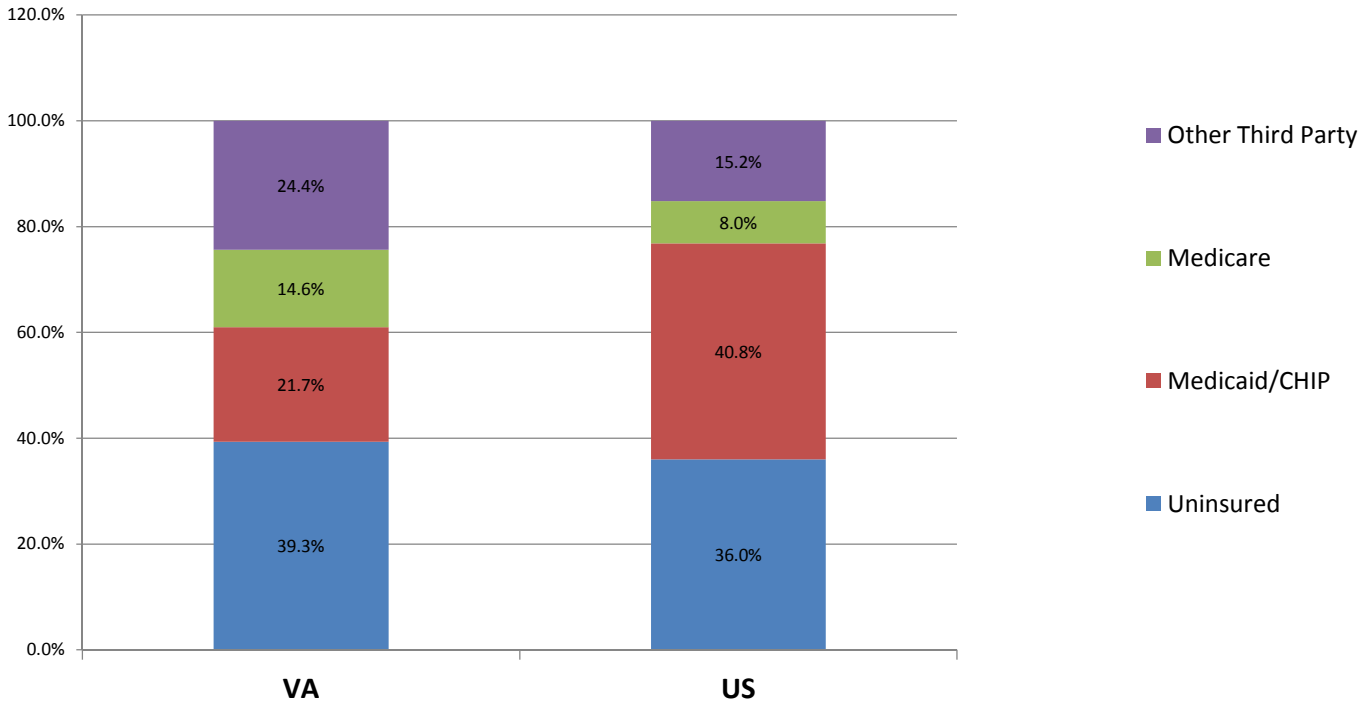
Virgina CHCs Visit Mix Compared to CHCs Nationwide [16]

- Lower proportion of patients living in poverty than national average.
- Higher proportion of patients are uninsured
- Lower proportion of patients covered under Medicaid/CHIP
- Higher proportion of patients covered by private insurance

	VA	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	82.5%	92.6%
Patients at or below 100% poverty level	56.7%	71.9%
Coverage Status		
Uninsured	39.3%	36.0%
Medicaid/CHIP	21.7%	40.8%
Medicare	14.6%	8.0%
Other Third Party	24.4%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Near national average on most primary care & prevention indicators
- Ranked #26 in America's Health Ranking ®

Statewide Primary Care Shortage & Workforce Indicators

- Lower proportion of population underserved for primary care
- Lower proportion of population underserved for dental care

	VA	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	3.9%	5.3%
% low birthweights	8.2%	8.1%
% adults diagnosed with diabetes	8.4%	9.3%
Adult diabetes deaths per 100,000	18.8	20.8
Adult heart disease deaths per 100,000	168.5	179.1
Avoidable Hospitalizations per 1,000	58.3	66.6
America's Health Ranking (United Health Foundation)	26	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	578,287	35,057,608
% of total population	7.3%	11.3%
Estimated PCPs needed to achieve target PCP:Population	93	7067
Estimated underserved population for dental	478,881	31,707,007
% of total population	6.1%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	123	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Electronic Health Record Adoption [17]

- CHC sites ahead of national average in EHR availability (96% in Virginia compared to 88% in the US)
- Virginia CHCs perform better than the national average in 7 of 12 EHR functionality categories.

Patient Centered Medical Home [3] [18]

- 73% of Virginia CHCs have achieved PCMH recognition or certification as of 7/31/14, compared to 58% nationally.
- In 2010, the Virginia Department of Medical Assistance Services (DMAS) began developing plans for a medical home pilot with a CHC in southwest Virginia called Southwest Community Health Services. A focus of the pilot includes review of the infrastructure and system investments needed to deliver care and reward practices for demonstrating high quality efficient care.

Medicaid Policies – Highlights

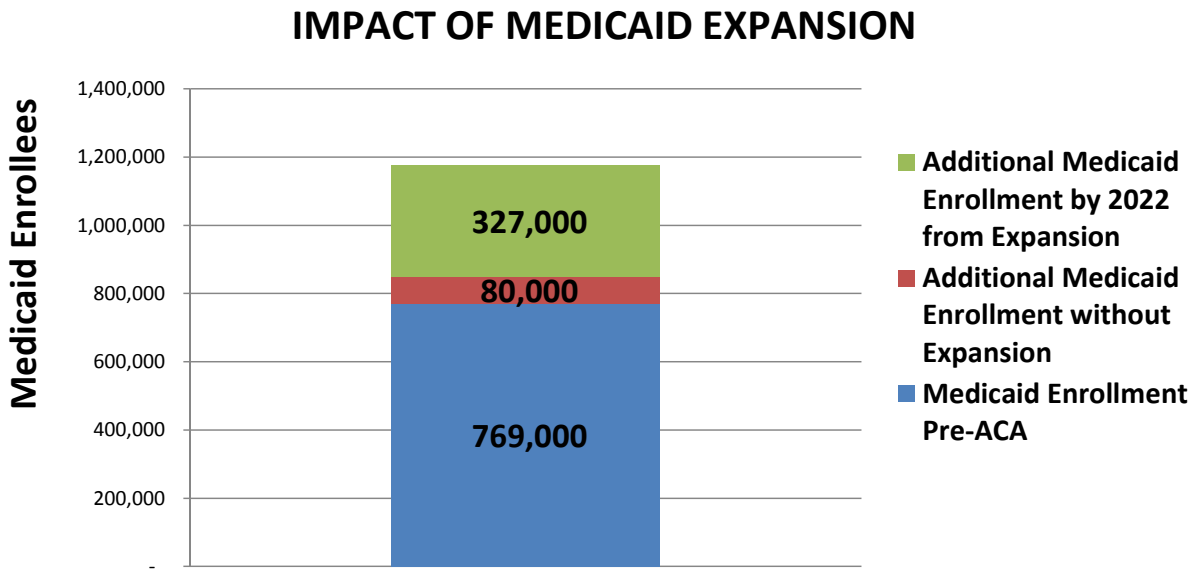
- Near national average in per-enrollee Medicaid spending.
- Has not implemented Medicaid expansion.

	VA	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$5,985	$5,563
Federal Medical Assistance Percentage (FMAP)	50.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Open Debate	
Health Insurance Exchange	Federal	
Total Uninsured	1,071,000	53,277,000
% of Uninsured Individuals (all ages)	13.5%	17.2%
Medicaid Enrollment Pre-ACA	769,000	52,410,000
% of Total Population	9.7%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	80,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	407,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	52.9%	40.6%
Estimated Number Remaining Uninsured After ACA	517,000	27,930,000
Estimated % Uninsured After ACA (2020)	5.8%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- Virginia is using the Federal healthcare.gov health exchange
- Under current policies, with no expansion, Medicaid enrollment is expected to grow 10.4% over the next 10 years. If the state does adopt expansion, growth will be greater than 50%.
- Proportion of residents who are uninsured, if expansion is adopted, would be expected to decline from 13.5% to 5.8% by 2020, without expansion, uninsured are expected to decline to just over 8%.



Source: Kaiser State Health Facts 2012

Virginia Medicaid Spending

Virginia spends nearly $6,000 per Medicaid enrollee annually – the 25th highest in the nation for all health care services provided. [5]

While children, pregnant women and parents of dependent children make up 73% of the Medicaid population, the elderly and disabled account for 65% of total expenditures. [8]

Expenditures on disabled clients and elderly adults in long term care average nearly $50,000 per recipient, whereas expenditures on non-disabled adults and children are about $5,000 and $3,000 respectively. [19]

Medicaid Coverage & Administration

Though Virginia has yet to implement a Medicaid expansion, the Department of Medical Assistance Services (DMAS) has prepared requests and recommendations should the State choose to expand Medicaid.

Generally, if Medicaid is ultimately expanded, DMAS expects to:

- Use incentives and disincentives to that reward the responsible use of the health care system;
- Shape the service benefit package to more closely resemble services that citizens receive through private health insurance; and
- Update payment and reimbursement processes to reward high quality and effective delivery of care. [20]

MEDICAID AND HEALTH INSURANCE LANDSCAPE

The Virginia Medicaid program covers medical services, nursing facility services and behavioral health. Virginia enrollees may also receive coverage through home and community-based "waivers," which provide community-based long-term care services as an alternative to institutionalization. [8]

Virginia's managed care program, known as the "Medallion II" covers approximately two-thirds of Medicaid enrollees; 94% of the state's CHIP enrollees are also covered under a managed care health plan. [19] The CHIP program in Virginia is called Family Access to Medical Insurance Security Plan (FAMIS). [21] The majority of individuals still receiving services through fee-for-service include those residing in long-term care, and dual eligibles (Medicaid and Medicare). [21]

MCOs cover the majority of services for individuals enrolled in their program; however, some services for MCO enrollees continue to be covered through the fee-for-service system. These "carved out" services include community behavioral health services, early intervention and dental services for children. [21]

Medicaid eligibility limits are:

- Up to 52% FPL for parents of dependent children;
- Up to 205% FPL for children.
- Up to 148% FPL for pregnant women.
- Childless adults are not currently eligible in Virginia. [21]

Virginia has a limited cost sharing structure with no premiums required and no co-payments required for enrollees below 134% FPL. [22] For those required to pay co-payments, the state limits payments to only select services and only for nominal amounts, ranging from $1 to $3 for adults (except for inpatient hospital visits) and $5 to $25 for children. [22]

VA Medicaid and CHIP Income Eligibility Limits as % of FPL				
	Children Ages 0-19	**Pregnant Woman**	**Parents of Dependent Children**	**Non-Disabled Adults (individual)**
2013	133%	133%	30%	N/A
2014	205%	148%	52%	0%

*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

Virginia CHC Reimbursement Policies

Medicaid reimbursement is the second largest revenue source for CHCs in Virginia after federal grants. [23] State CHCs can choose either the Prospective Payment System (PPS) or an alternative payment methodology similar to PPS for reimbursement.

Using the alternative method, the state will make interim payments on a per-visit basis and reconcile to actual costs via the year-end cost report. The methodology used to determine payment amount is: (i) agreed to by the state and the CHC and (ii) results in payment to the center or clinic of an amount that is at least equal to the PPS rate.

CHCs that adopt the alternative payment methodology have their initial payments established through pro forma cost reporting methods. At the end of the cost reporting cycle, the state compares the alternative per-visit rate to the PPS rate and reimburses the CHC at the higher of the alternative rate or the PPS rate for the number of visits recorded during the reporting period.

CHCs that do not select the alternative payment methodology, are provided payments consistent with the traditional Prospective Payment System (PPS).

The baseline PPS rate is determined by averaging 100% of FCHCs reasonable costs of providing Medicaid-covered service adjusted to take into account any increase or decrease in scope of services furnished and adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services. [7]

Only a limited number of categories of providers are eligible to generate a reimbursable PPS encounter. MDs, NPs, and psychologists can generate a PPS encounter for face-to-face visits. [24]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
VA	Yes	No	Yes	Yes	None

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
VA	No	No	No	No	No

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

Collaboration with CMS [22]

Virginia is collaborating with the Centers for Medicare and Medicaid Services (CMS) Innovation Center on a **CHC Advanced Primary Care Demonstration.** Under the program, 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. There are 6 grantees and 6 total health centers participating in the demonstration in Virginia.

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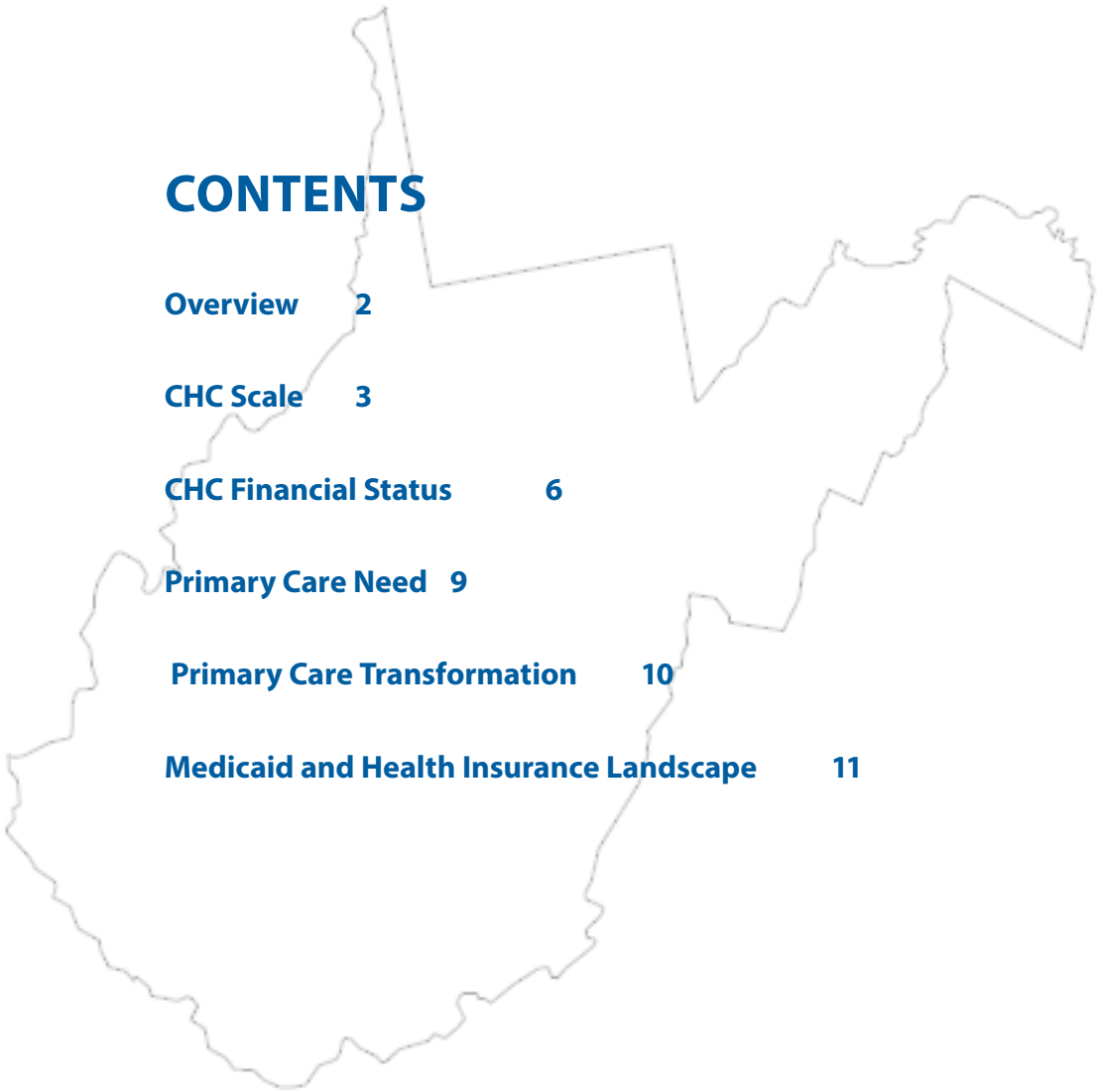
PRIMARY CARE DEVELOPMENT CORPORATION

COMMUNITY HEALTH CENTER GROWTH AND SUSTAINABILITY
STATE PROFILES

WEST VIRGINIA



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Supported by the RCHN Community Health Foundation

OVERVIEW

Market Share & Growth

- As of 2014, there were 28 CHCs operating 240 permanent clinical service delivery sites throughout the state of West Virginia. This includes 101 school based health center sites. 21 CHCs operate school based health centers. The Primary Care Association representing CHCs is the West Virginia Primary Care Association. [1] [2]
- West Virginia's CHCs provided 1,431,112 visits to 382,182 patients in 2012. [3]
- The number of people served by CHCs increased by an average of 2.5% annually over the last three years for which full data is available (through 2012), compared to 4.1% average annual growth experienced by CHCs nationwide. [3]
- CHCs serve approximately 27.4% of Virginia's Medicaid population (US: 16%) and 21.1% of its overall population (US: 7%). West Virginia CHCs serve 42.9% of individuals with incomes <200% FPL individuals, compared with 15.9% nationally. [3]
- Medicaid enrollment, currently at 363,000 is projected to grow by an additional 130,000 people by 2022 (36% growth) per the Urban Institute; the uninsured rate is projected to decrease from 20% to 5%. [3] [4]

Policy & Reimbursement

- West Virginia spends slightly less than $6,100 per Medicaid enrollee annually– the 20th highest in the nation. [7]
- Medicaid reimbursement of CHCs is not on cost-based, and uses an Alternative Payment Methodology (APM) that provides interim reimbursements with annual reconciled reimbursement adjustments based on Medicare cost reports. [5]
- A successful lawsuit by CHCs is compelling West Virginia to determine and established a PPS rate and retroactively compensate CHCs to October 2012. [6]
- West Virginia has implemented a Medicaid expansion. [8] Over 150,000 have been enrolled in Medicaid, far exceeding projections.
- West Virginia's health insurance exchange is run as a partnership between state regulators and the federal government exchange. [9]
- Through the first enrollment period, individuals who have selected health plans through the existing exchange reached a total of 19,856, against a goal of 24,000. [10]

West Virginia CHCs Compared to CHCs Nationwide

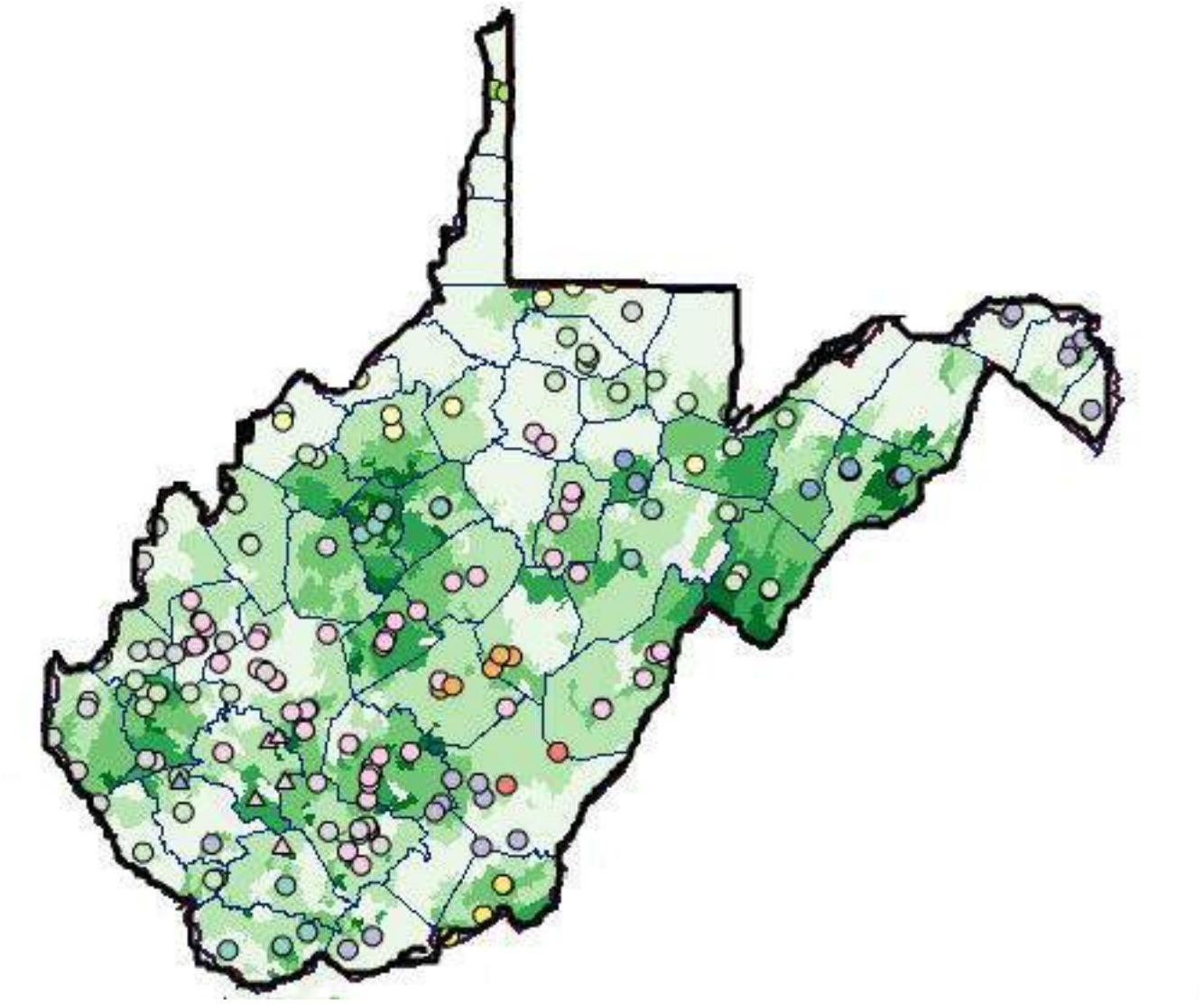
- Greater proportion of state population served
- Greater proportion of Medicaid enrollees served
- Fewer patient visits per CHC, reflecting rural makeup
- Significantly lower proportion of dental and mental health visits
- Lower than average annual growth rate

	WV	US
Population Served (2012)		
Total patients served by CHCs	382,182	21,102,391
% of population served by CHCs	21.1%	6.8%
% of under 200% FPL served by CHCs	42.9%	15.9%
% of Medicaid Enrollees Served	27.4%	16.4%
CHC Characteristics and Volume		
Number of CHCs (2014)	29	1284
Total CHC Service Delivery Sites (2014)	185	9509
Average Sites per CHC (2014)	6.4	7.4
Annual Visits (Total) (2012)	1,431,112	83,766,153
Annual Visits per CHC (2012)	53,004	69,922
Annual Visits Per Patient (2012)	3.74	3.97
Visit Mix (% of Annual Visits by Service Type) (2012)		
Medical	85.7%	73.6%
Dental	4.9%	12.8%
Mental Health	3.9%	7.5%
Case Management/Enabling	5.5%	6.2%
Compound Annual Growth Rate (2010-2012)		
Total Patients	2.5%	4.1%
Total Annual Visits	3.2%	4.3%
Medical	2.9%	3.5%
Dental	6.6%	7.6%
Mental Health	11.1%	9.6%
Case Management/Enabling	1.3%	1.6%

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

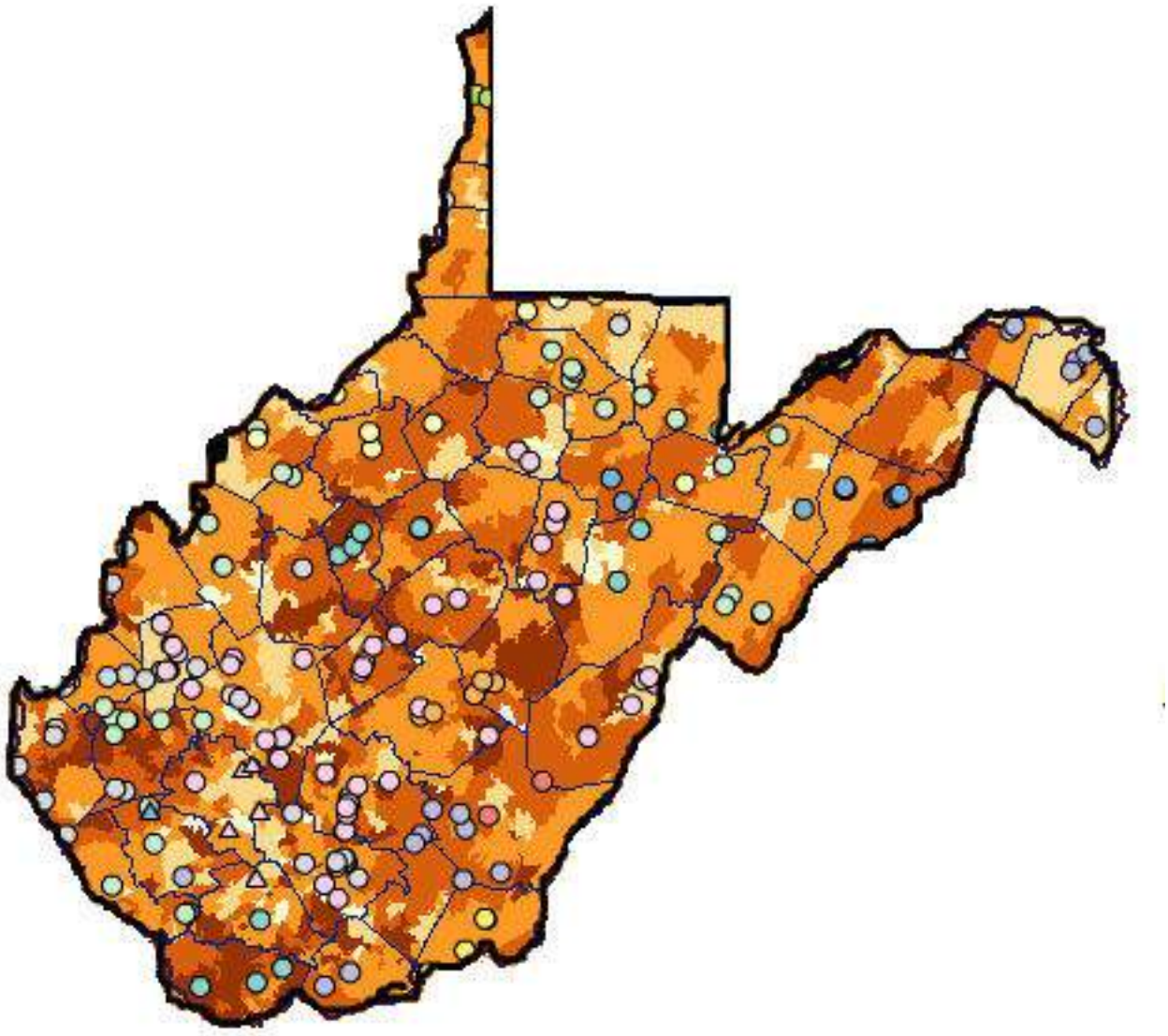
Source: UDS Summary Data 2010-2012, 2014

Share of Population Served by West Virginia CHCs [11]



Source: UDS Mapper 2014

West Virginia Low Income Population [11]



Source: UDS Mapper 2014

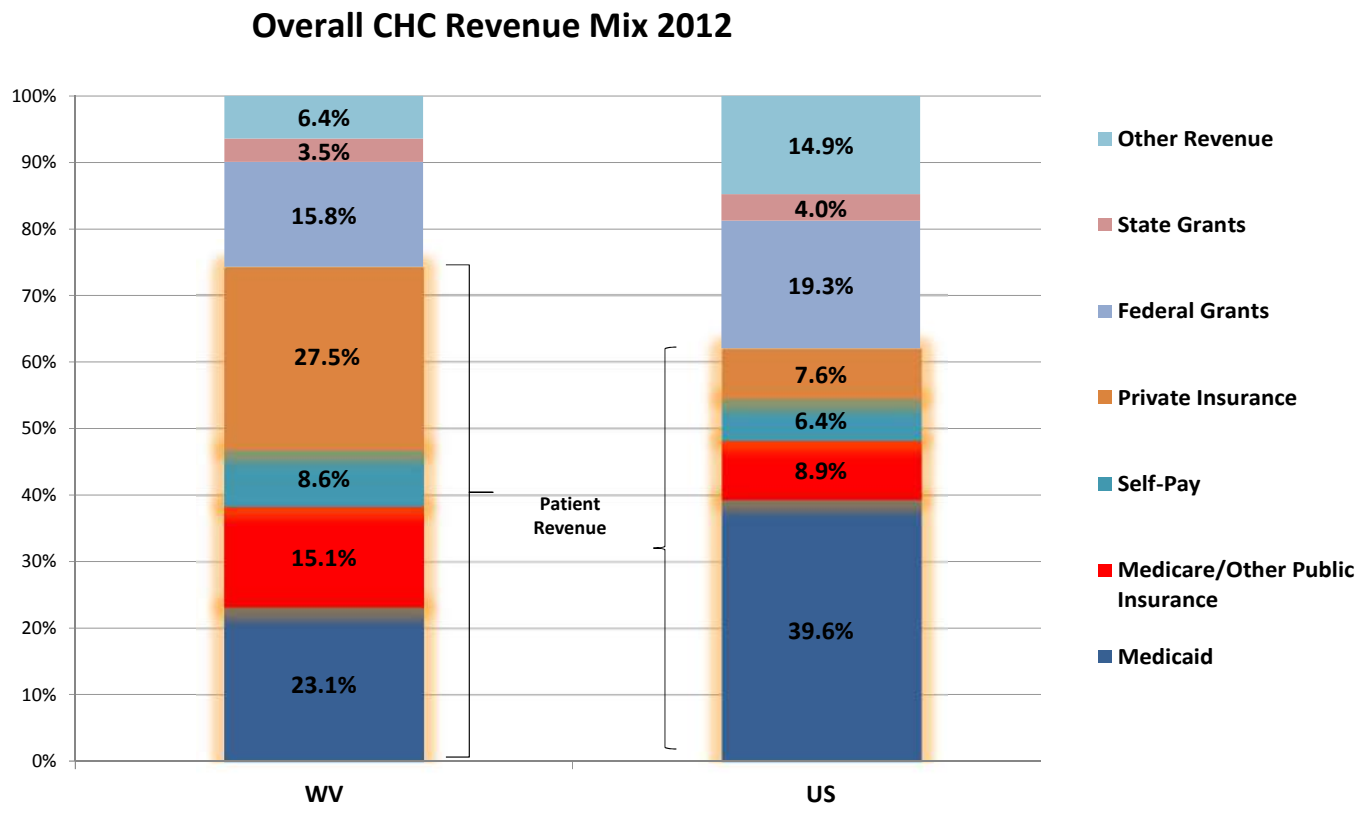
West Virginia CHCs Compared to CHCs Nationwide, 2012

- Greater proportion of revenue from patient services
- Revenue mix fits the model of those CHCs, largely rural, that serve a broader mix of the population than is typical for CHCs, with below-average patient revenues from Medicaid and much higher proportion of revenues from private insurance and Medicare
- Slightly lower reliance on federal grants

	WV	US
CHC Revenue Mix		
Patient Revenue	74.3%	62.9%
Medicaid	23.1%	39.6%
Medicare/Other Public Insurance	15.1%	8.9%
Self-Pay	8.6%	6.4%
Private Insurance	27.5%	7.6%
Federal Grants	15.8%	19.3%
State Grants	3.5%	4.0%
Other Revenue	6.4%	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

West Virginia CHCs as a Group, 2009-2011

- Median Total Assets increased by 39%
- Unrestricted Net Assets grew by 46%
- Median Days Cash on Hand decreased by 5%, from 39 to 37 days, but remained above the 30-day benchmark

WV Financial Performance 2009- 2011					
	Statewide CHC Medians			% Change	Benchmark
	2009	2010	2011		
Growth					
Total Assets ($)	$2,496,144	$3,027,911	$3,474,466	39%	N/A
Total Revenues ($)	$4,481,122	$6,227,305	$6,192,738	38%	N/A
Profitability					
Total Margin (%)	1.47%	2.56%	3.55%	142%	N/A
Unrestricted Net Assets ($)	$1,343,565	$1,468,825	$1,963,057	46%	N/A
Liquidity					
Days Cash on Hand	39.38	42.97	37.5	-5%	>30 Days
Days in Accounts Receivable	32.52	28.79	30.09	-7%	<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

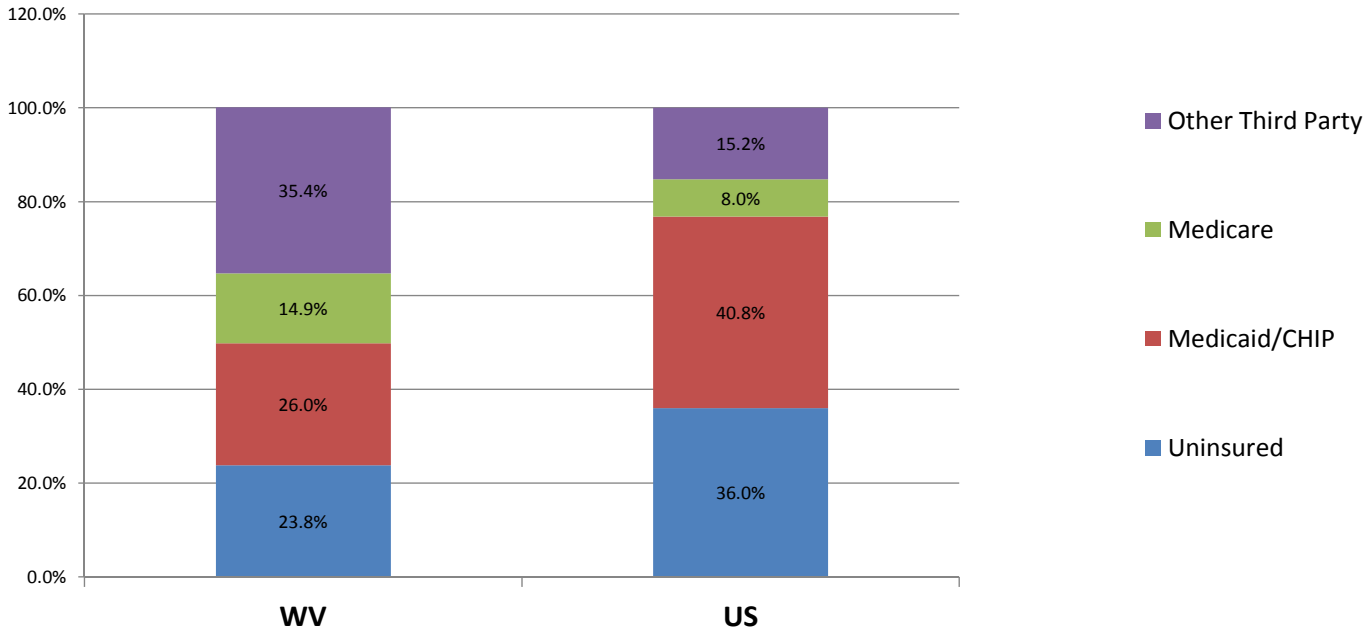
West Virgina CHCs Visit Mix Compared to CHCs Nationwide [12]

- Much lower proportion of patients living at or near poverty level than national averages
- Much lower proportion of patients are uninsured
- Significantly higher portion of patients covered by Medicare and private insurance

	WV	US
CHC Visit Mix - 2012		
Income Status		
Patients at or below 200% poverty level	83.7%	92.6%
Patients at or below 100% poverty level	49.9%	71.9%
Coverage Status		
Uninsured	23.8%	36.0%
Medicaid/CHIP	26.0%	40.8%
Medicare	14.9%	8.0%
Other Third Party	35.4%	15.2%

Source: UDS Summary Data 2012

Visit Mix by Payer - 2012



Source: UDS Summary Data 2012

PRIMARY CARE NEED

Statewide Primary Care & Prevention Clinical Indicators

- Worse than national average on most primary care & prevention indicators
- Significantly worse than national average in prevalence of diabetes and rate of deaths from diabetes and heart disease
- Significantly lower proportion of woman who gave birth with late/no prenatal care, although low birth weight babies slightly exceed average
- Ranked #46 in America's Health Rankings®

Statewide Primary Care Shortage & Workforce Indicators

- Much lower proportion of population is underserved for primary care
- Population underserved for dental is slightly below national average

	WV	US
Primary Care & Prevention Clinical Indicators		
% births to women with late/no prenatal care	2.7%	5.3%
% low birthweights	9.2%	8.1%
% adults diagnosed with diabetes	12.2%	9.3%
Adult diabetes deaths per 100,000	32.9	20.8
Adult heart disease deaths per 100,000	211.2	179.1
Avoidable Hospitalizations per 1,000	99.1	66.6
America's Health Ranking (United Health Foundation)	46	NA
Primary Care Shortage and Workforce Indicators		
Estimated underserved population for primary care	60,355	35,057,608
% of total population	3.3%	11.3%
Estimated PCPs needed to achieve target PCP:Population	21	7067
Estimated underserved population for dental	140,919	31,707,007
% of total population	7.8%	10.2%
Estimated dental providers needed to achieve target Practitioner:Population ratio	31	6531

Source: Kaiser State Health Facts 2012

PRIMARY CARE TRANSFORMATION

Patient Centered Medical Home [3] [13] [14]

- 61% of West Virginia CHCs have achieved PCMH recognition or certification as of 7/31/14, as compared to 58% nationally.
- The West Virginia Bureau of Medical Services (Medicaid) has actively partnered with the multi-stakeholder West Virginia Health Improvement Institute (WVHII) to promote medical home development.
- Recently, West Virginia completed a two-year Medical Home Performance Incentive Pilot; three payers, including Medicaid managed care, funded technical assistance to support NCQA Patient-Centered Medical Home recognition. Participating practices were eligible to receive shared savings.
- West Virginia has received a planning grant from CMS to health homes for Medicaid enrollees with chronic conditions.

Electronic Health Record Adoption [15]

- A higher percentage West Virginia CHC sites use EHRs than CHC sites nationally (93% in West Virginia compared to 88% in the U.S.)
- West Virginia performs lower than national average in all 12 EHR functionality categories.
- With a HRSA grant, the West Virginia PCA is developing a data repository to help health centers link to the WV Health Information Network to enable health information exchange.

Medicaid Policies – Highlights

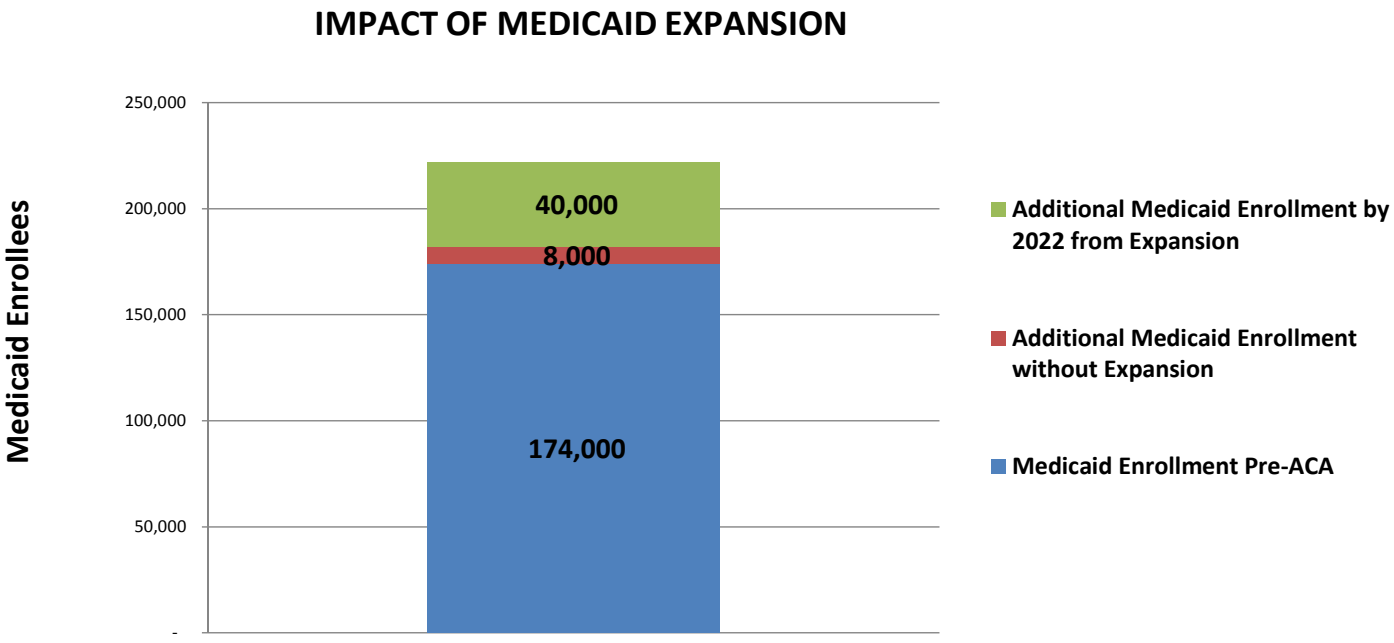
- Slightly above national average in per-enrollee Medicaid spending.
- Expanded Medicaid coverage to parents, childless adults, and children, and increased provider payments.

	WV	US
Medicaid Policies		
Medicaid Payments Per Enrollee	$6,099	$5,563
Federal Medical Assistance Percentage (FMAP)	72.0%	50.0%
Health Insurance & Medicaid Expansion		
Implementing Medicaid Expansion	Implementing	
Health Insurance Exchange	Partnership	
Total Uninsured	273,000	53,277,000
% of Uninsured Individuals (all ages)	15.1%	17.2%
Medicaid Enrollment Pre-ACA	363,000	52,410,000
% of Total Population	20.0%	16.9%
Additional Enrollment with ACA but no Medicaid Expansion	13,000	5,659,000
Additional Enrollment with ACA and Medicaid Expansion	130,000	21,280,000
% Growth in Medicaid Enrollment from ACA + Expansion	35.8%	40.6%
Estimated Number Remaining Uninsured After ACA	89,000	27,930,000
Estimated % Uninsured After ACA (2020)	4.9%	8.7%

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

Health Insurance & Medicaid Expansion – Highlights

- West Virginia is implementing Medicaid expansion.
- West Virginia has a partnership with the federal government to administer the state's health insurance exchange.
- Growth in Medicaid Enrollment projected at 36% by 2020.
- Proportion of residents who are uninsured expected to decline from 20% to 5% over the next decade.



Source: Kaiser State Health Facts 2012

West Virginia Medicaid Spending

West Virginia spends just under $6,100 per Medicaid enrollee annually – the 20th highest in the nation for all health care services provided. [7] In FY 2012, West Virginia spent nearly $2.8 billion on its Medicaid program. [16]

53% of spending was classified as acute care services, which includes payments to CHCs, 44% was for utilization of Long-Term Care needs, and 3% was categorized as Disproportionate Share payments. [17] While one-third of Medicaid beneficiaries are elderly and/or people with disabilities, two-thirds of all spending pays for services for this population. [16]

To offset West Virginia's relatively low-income population, the state has one of the highest Federal Medical Assistance Percentage in FY2013: 72%. [18] Under this formula, for every dollar the state spends on Medicaid, it receives roughly $3 from the federal government. [19]

Medicaid Coverage & Administration

The Bureau for Medical Services is the designated single state agency responsible for the administration of the State's Medicaid program. [20] [21]

The Medicaid Managed care program is known as the Mountain Health Trust program. While the program originally excluded services for behavioral health, personal care, pediatric dentistry and non-emergency medical transportation, under the Medicaid expansion, those services will now be included. [20] [21] [22]

West Virginia initiated a risk-based managed care program for certain groups of Medicaid recipients in September 1996. Under this program, the Bureau has contracts with four MCO's for the provision of medically necessary services currently provided by the State, [21] including one formed by the CHCs and the West Virginia Primary Care Association.

With the Medicaid expansion under the ACA, West Virginia now has the following eligibility limits:

- Has expanded eligibility to parents and childless adults
- Up to 138% FPL for parents and childless adults [23]
- Up to 305% FPL family income for children through the CHIP program [24]
- Up to 163% FPL for pregnant woman [25]

Medicaid and CHIP Income Eligibility Limits as % of FPL

	Children Ages 0-19	Pregnant Woman	Parents of Dependent Children	Non-Disabled Adults
2013	250%	185%	181%	N/A
2014	266%	258%	138%	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

The Medicaid program requires premiums from some individuals within certain income brackets; co-payments are also required for some services and prescription drugs, but only at nominal prices. [26]

Beginning in 2014, there were new cost-sharing regulations put into place for Medicaid recipients. Individual co-pays ranged from $0 to $8 per outpatient visit dollars depending on a beneficiaries financial status. [27]

As of 2011, 51% of the state's Medicaid Population was enrolled within one of the MCO's operating in the state.[28] Under the expansion, the state has also streamlined financial eligibility determination process through the use of the modified adjusted gross income (MAGI) and electronic data sources. [27]

West Virginia CHC Reimbursement Policies

West Virginia Medicaid reimbursement for CHCs Is not on cost-based, and uses an Alternative Payment Methodology (APM) that provides interim reimbursements with annual reconciled reimbursement adjustments based on Medicare cost reports. [29] West Virginia devotes about $8.6 million in funding to CHCs for indigent care. [30]

As of 2011, West Virginia Medicaid had yet to establish guidelines for CHCs on how to request a scope of service rate adjustment. [13]

The state's CHCs brought a lawsuit against the West Virginia Bureau of Medical Services (BMS) regarding the calculation of their reimbursement rates, which they argued had resulted in lower revenues, service cuts, and severe financial stress on its health centers. The lawsuit was successful, and is compelling West Virginia to determine and established a PPS rate and retroactively compensate CHCs to October 2012. [31]

West Virginia defines a billable encounter as a face-to-face visit with a specific set of provider types. CHCs can bill for more than one encounter per patient per day (one medical, one dental and one behavioral health) and the state deducts copays from CHC payments. [5] Dental service providers operate under a markedly different reimbursement methodology than primary care physicians. West Virginia limits Medicaid coverage for dentistry to trauma care including surgery and emergency treatment for the relief of pain and infection. [32]

The categories of providers eligible to generate a reimbursable PPS encounter for a face-to-face visit are: MD/DO, NP, PA, LCSW, PhD level psychologist, DMD or a dental hygienist. [5]

Primary Providers Eligible for Reimbursement

State	MD	DMD	NP	Psychologist	Other
RI	Yes	Yes	Yes	Yes	DO

Secondary Providers Eligible for Reimbursement

State	RN	LCSW	Physical Therapist	Dental Hygienist	Nutritionist
RI	No	Yes	No	Yes	No

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

Collaboration with CMS [33]

Several West Virginia CHCs are participating in the "FQHC Advanced Primary Care Demonstration" and will receive funding to demonstrate how the patient-centered medical home (PCMH) model improves quality of care, promotes better health and lowers costs. There are 5 grantees and 13 total health center sites participating in the demonstration in West Virginia.

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