Cover Sheet for Example Documentation

Please complete the following form and submit along with your documentation. If you have any questions, please email us at accreditation@astho.org.

The following documentation has been submitted to ASTHO for the Accreditation Library as a potential example of Health Department documentation that might meet the **PHAB Domain** 7 **Standard** 1 **Measure** 1.

This document is not intended to be a template, but is a reference as state health agencies develop and select accreditation documentation specific to the health department's activities.

Please note that the inclusion of documentation in this library does not indicate official approval or acceptance by PHAB.

Document Title:	Supplement Excerpt Chapter 2
Document Date:	2012

Version of Standards and Measures Used: 1.5

Related PHAB Standard and Measure Number

Domain:	7	Standard:	1	Measure:	1	Required Documentation:	3

Short description of how this document meets the Standard and Measure's requirements:

This is an excerpt from the two statewide health care facilities and services plan documents provided earlier to demonstrate that they have considered emerging issues such as the impact of the Affordable Care Act and health care market competition on the delivery of health care services.

Submitting Agency:	Connecticut Department of Public Health
Staff Contact Name:	Melissa Touma
Staff Contact Position:	Accreditation Coordinator
Staff Contact Email:	Melissa.touma@ct.gov
Staff Contact Phone:	860 509 7179

Statewide Health Care Facilities and Services Plan

October 2012

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Connecticut Department Of Public Health
Office Of Health Care Access
410 Capitol Avenue • Hartford, CT 06134

TABLE OF CONTENTS

SECTION THREE

ACKNOWLEDGEMENTS

Connecticut Department of Public Health

Jewel Mullen, MD, MPH, MPA
Commissioner

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

Katharine Kranz Lewis, PhD, MSN, MPH, RN
Deputy Commissioner

Kimberly Martone
Office of Health Care Access Director of Operations

The Department of Public Health Office of Health Care Access expresses appreciation to the many individuals who provided invaluable help in publishing the 2012 Statewide Health Care Facilities and Services Plan. In addition to the Plan's Advisory Body and Subcommittee members, the Office recognizes the following Department of Public Health employees for their contributions:

Chris Andresen
Olga Armah
Carol Bower
Marc Carmado
Brian Carney
Ron Ciesones
Carmen Cotto
Barbara Dingfelder
Laurie Greci
Leslie Greer
Leonard Guercia
Paolo Fiducia
Jennifer Filippone
Valerie Fisher
Tillman Foster
Kevin Hansted
Salina Hargrove
Jack Huber
Margaret Hynes
Cindy Kozak
Steven Lazarus
Paragi Mehta
Barbara Olejarz
Christine Parker
Mary Pettigrew
Kaila Riggott
Karen Roberts
Gloria Sancho
Kristin Sullivan
Kristen Veneziano
Alla Veyberman

The Office of Health Care Access greatly appreciates the cooperation and assistance of all who contributed to the 2012 Plan.

EXECUTIVE SUMMARY

OVERVIEW

The Department of Public Health (DPH) Office of Health Care Access' (OHCA) planning and regulatory activities are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services. Section 19a-634 of the Connecticut General Statutes (CGS) charges OHCA with the responsibility of developing and maintaining a *Statewide Health Care Facilities and Services Plan (the Plan)*, along with establishing and maintaining an inventory of all Connecticut health care facilities and services and conducting a biennial utilization study.

It is through the Plan that OHCA's regulatory and planning functions converge, as the Plan is noted in one of nine enumerated statutory guidelines,[1] specifying that when reviewing a Certificate of Need (CON) application, OHCA must take into consideration the relationship of the proposed project to the Plan.

The Plan, considered an advisory document, is intended to be a blueprint for health care delivery in Connecticut, serving as a resource for policymakers and those involved in the CON process and providing information, policies and projections of need to guide planning for specific health care facilities and services.

It includes standards/guidelines/methodologies for Acute Care Bed Need, Outpatient Surgery, Cardiac Services and Imaging Services/Equipment that, when adopted into regulation, will be utilized in the Certificate of Need review process.[2] In addition, the Plan examines unmet need and identifies possible gaps in services.

The Plan also incorporates available health care facilities and services utilization data that provide important information regarding shifts in the use of health care resources and services, identify what types of care specific populations use and how frequently, assist in examining the impact of new medical technologies or procedures, and may also indicate areas that warrant further study. These data serve as a foundation for projecting future health care needs and are the basis for determining resource needs. Additionally, through the inventorying of and reporting on utilization of services, the Plan will provide a means of monitoring the adequacy of access.

An Advisory Body and three service-specific subcommittees (Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care), and an Imaging Workgroup, consisting of representatives from a cross-section of the health care industry and State government, provided guidance on the development of the Plan. Developed with their input, the Plan's standards and guidelines are intended to guide the CON review and decision-making process, and improve the accessibility and quality of health care services provided.

The Plan identifies key issues surrounding the delivery of health care in Connecticut:

-
- Based on acute care bed need projections for 2015, Connecticut has an adequate supply of acute care inpatient beds statewide, however further study is necessary to determine if gaps in service-specific beds exist in certain regions of the state.
- As part of OHCA's planning effort, focus groups were conducted in an effort to identify concerns about behavioral health (mental health and substance use treatment) patients treated in Emergency Departments (EDs) and their

[1]Connecticut General Statutes Section 19a-639, as amended by Public Act 12-170
[2]These standards and guidelines are not final until adopted as regulation pursuant to Chapter 54 of the Connecticut General Statutes.

ability to access behavioral health services. Three common themes emerged from focus group meetings: (1) behavioral health patients presenting at EDs, although other treatment settings would be more appropriate, (2) limited access to behavioral health services (especially inpatient adult or residential youth services and (3) lack of coordination of care between EDs and community based services. Focus group participants expressed concern that these issues will continue as long as EDs are the only "24/7" treatment option available.

- Market trends over the past several years have affected the environment in which hospitals and free-standing imaging centers operate. In the past, there was a steady and ongoing migration of imaging services out of the hospital setting, mostly to physician-owned free-standing imaging centers. Today however, reimbursement issues, access to capital, vendor relationships and physician employment are initiating a wave of acquisitions of imaging equipment at free-standing imaging centers by hospitals.[3] CON approval is required for these acquisitions and purchasers must demonstrate clear public need for the equipment.
- [redacted]
- [redacted]

[redacted]

NEXT STEPS/RECOMMENDATIONS

Next steps and recommendations had several sources; they were either suggested directly by subcommittee and advisory body members, evolved from subcommittee and advisory body discussions, or were suggested by reviewers of the Plan.

ACUTE CARE/AMBULATORY SURGERY

The next steps/recommendations on acute care/ambulatory surgery are intended to build upon the first Plan's efforts.

- Explore whether and how data on observation days should be collected and submitted to OHCA and determine how the inclusion of bed days would affect the bed need methodology.
- Examine service type by region to determine if gaps in service exist on a regional basis.
- Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas.
- Explore the formation of a statewide task force comprising key industry stakeholders to further examine action steps and solutions needed to address the concerns identified by the ED Focus Groups about inappropriate use of the ED.
- Evaluate ED capacity issues on an on-going basis.
- Examine availability of on-call specialty physicians to EDs.
- Further study Behavioral Health/ED Focus Group findings with the Connecticut Hospital Association (CHA)/ Department of Mental Health and Addiction Services (DMHAS) to determine if access to behavioral health services is a significant problem at Connecticut's EDs and if there are any opportunities to help improve access.
- Examine the effect on hospital EDs of increasing reimbursement for outpatient behavioral health programs.
- Examine the benefits of increasing the number of intermediate care center (ICC) beds.
- Examine cardiac program quality measures, including risk-adjusted outcomes, institutional and operator performance.

[3] Jeter, E. & Sorensen, T. (2010, May 17). The Reconsolidation of Imaging Centers. *ImagingBiz*. Retrieved from http://www.imagingbiz.com/articles/view/the-reconsolidation-of-imaging centers.

2.0 OVERARCHING ISSUES

The PPACA contains a number of provisions aimed at increasing health insurance coverage, including an optional State expansion of Medicaid to cover individuals in households with incomes below 133% of the federal poverty level (FPL); a requirement that states (or the federal government) develop and run health insurance exchanges through which individuals and small businesses can purchase health insurance coverage; a requirement that large and mid-size employers provide employee coverage or face possible penalties; and a requirement that most individuals obtain coverage through a private source or a public program or be penalized for non-compliance.[16]

Connecticut has a relatively low uninsured rate. Approximately 13% of the state's non-elderly are uninsured, compared to a national average of 18%.[17] This rate reflects, in part, the state's high rate of employer-sponsored coverage, relatively generous Medicaid eligibility limits and a new Medicaid program for low-income adults that replaced its State-Administered General Assistance (SAGA) medical program. It is estimated that, with health care reform, the proportion of Connecticut residents with health insurance will increase from 89 to 95%, or 170,000 residents, by 2016. Additionally, enrollment in Medicaid is estimated to increase by 130,000, or 31%.[18] Although expanded coverage options offered under the PPACA will likely result in a surge in demand for health care services statewide, some individuals are likely to remain uninsured (e.g., undocumented persons will not be eligible to purchase coverage from a health insurance exchange).

Consequently, beginning in 2014, payments to hospitals through the Disproportionate Share Hospital (DSH) program[19] will be significantly reduced by 75%.[20] After the initial reduction, payment increases will be based on the percentage of the population that is uninsured and the amount of uncompensated care provided. Hospitals have expressed concern however, that the increase in insured individuals may not make up for the decrease in revenue.

---

[16]Auerbach, D., Nowak, S., Ringel, J.S., Girosi, F., Eibner, C., McGlynn, E.A. & Wasserman, J. (2011). *Rand Health Technical Report*. The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut. An Analysis from RAND COMPARE. 1.
Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR973.1.pdf

[17]Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey (CPS: Annual Social and Economic Supplements).
Retrieved from http://www.statehealthfacts.org/comparetable.jsp?ind=126&cat=3

[18]Auerbach, et al.

[19]Designed to assist hospitals financially with their uncompensated and undercompensated care costs.

[20]Main, D. C. & Starry, M.M. (2010). *The Effect of Health Care Reform on Hospitals: A Summary Overview*. 4. Retrieved from http://www.pillsburylaw.com/siteFiles/Publications/2C9547A6BFCBB37D8366EA2272190123.pdf

Healthcare coverage, alone, does not guarantee access to health care services. Successful implementation of federal health care reform will depend on Connecticut's response to access issues including workforce and infrastructure capacity, and the regional supply of health care services. Access to health care will depend on the adequacy of the state's health care infrastructure (e.g., hospitals, clinics, etc.), available technology and necessary workforce capacity.[21] The capacity of the state's workforce is discussed later in this chapter.

Hospitals' community needs assessments should collectively encompass all of the state's 169 towns. Once completed by all of Connecticut's non-profit hospitals, they will become a valuable resource for hospital planning for future versions of the Plan as they will assist the State in identifying communities' health needs and establish priorities for addressing them.

With approximately 385,600[22] currently uninsured persons in Connecticut, providing charity care has historically been a significant portion of hospital community benefit activities. As noted above, the PPACA includes coverage, subsidy and penalty provisions that will extend insurance coverage to an estimated 170,000 state residents.[23] As the provisions of health care reform are implemented, Connecticut's hospitals will likely have fewer patients relying on charity care. To ensure that nonprofit hospitals continue to provide community benefit, the PPACA establishes a new set of requirements for hospitals to maintain their tax-exempt status. The PPACA also requires non-profit hospitals to conduct a community needs assessment every three years and to adopt implementation strategies to meet identified community health needs. Under the Act, hospitals are required to give increased attention to working with others to determine community health needs and take action to meet those needs, and to implement financial assistance and billing and collection polices that protect consumers. Hospitals will be obligated to collaborate with public health agencies, align patient payment requirements with patient financial capacity, advance community participation and promote public knowledge regarding hospital practices.[24] This emphasis on hospital engagement in consultative processes with relevant stakeholders is intended to ensure that hospital community benefit activities reflect an inclusive and interactive planning process.[25]

As part of this mandate, non-profit hospitals are required to submit audited financial statements as evidence of the community benefits they report. Although the law does not base federal tax exemption on a nonprofit hospital's provision of community benefits at any specific quantitative level, the IRS will apply a 'facts and circumstances' test to determine whether the benefits a hospital provides to its community are sufficient to warrant its federal tax exemption.[26]

Hospitals' community needs assessments should collectively encompass all of the state's 169 towns. Once completed by all of Connecticut's non-profit hospitals, they will become a valuable resource for hospital planning for future versions of the Plan as they will assist the State in identifying communities' health needs and establish priorities for addressing them. Vulnerable populations and their needs may vary substantially from one community to another, and through implementation of its Statewide Health Care Facilities and Services Plan, DPH may have the opportunity to play a role in planning to channel community benefit efforts appropriately.[27] The state's acute care hospitals are actively working

[21]Taylor, M. (2010). The Patient Protection and Accordable Care Act: An Overview of Its Potential Impact on State Health Programs. *California Legislative Analyst's Office*. 28. Retrieved from http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf
[22]Urban Institute.
[23]Auerbach, et al.
[24]Folkemer, D.C., Spicer, L.A., Mueller, C.H., Somerville, M.H., Brow, A.L.R., Milligan, Jr., C. & Boddie-Willis, C.L. (2011, January) Hospital Community Benefits after the ACA: The Emerging Federal Framework. *The Hilltop Institute*. 4. Retrieved from http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief-January2011.pdf
[25]Somerville, M.H., Mueller, C.H., Boddie-Willis, C.L., Folkemer, D.C. & Grossman, E.R. Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement. *The Hilltop Institute*. (2012, February). 2-3 Retrieved from http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf
[26]Somerville, et al. 6.
[27]CGS 19a-634 (b) states that the DPH commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the statewide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate State agencies concerning innovations or changes that may affect future health planning.

on their Community Needs Assessments that must be completed by 2014 to be in compliance with the PPACA. They are profiling communities, identifying partners and looking at common elements. DPH and the Connecticut Hospital Association (CHA) are communicating on the coordination of Community Needs Assessments with the statewide health improvement planning process.

Non-profit hospitals are required to adopt, implement and widely publicize a written financial assistance policy. This policy must include the eligibility criteria for financial assistance and whether it includes free or discounted care, the basis for calculating patient charges and the process for applying for financial assistance. Each hospital must also adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent discrimination in providing emergency care, including denial of service, against those eligible for financial assistance under the hospital's financial assistance policy or government assistance.[28] It is expected that there will be increased administrative costs for non-profit facilities to implement this provision.[29]

The PPACA includes provisions that will significantly affect providers and their reimbursement. Two payment systems have been established that directly tie reimbursement to performance –Value Based Purchasing (VBP) and bundled payments.

Effective October 1, 2012, the PPACA mandates a value based purchasing model for all hospitals, where incentive payments are given to hospitals that meet or exceed benchmarks set by the Centers for Medicare and Medicaid Services (CMS).[30] Beginning in 2013, under this provision, a percentage of payments to hospitals will be tied to their performance on certain quality measures for acute myocardial infarction, heart failure, pneumonia, surgeries and healthcare associated infections. It is expected that these quality measures and the accompanying reporting requirements will increase administrative costs. It is not yet known if the increased payments would offset the anticipated administrative costs.

In addition to the VBP reimbursement model, the PPACA established a 5-year Medicare voluntary bundled payment pilot, beginning in January 2013, for integrating care across hospitals, physicians and post-acute care providers during an episode of care for certain medical conditions. This pilot program pays for the overall management of a patient's health rather than discrete health care services, with a single reimbursement covering an entire episode of care[31] rather than separate payments to hospitals and doctors involved in different aspects of a patient's care. Parallel goals of this effort are to correct the inefficiency of the current fee-for-service model and to lower hospital readmission rates. If the pilot is successful in reducing costs while maintaining quality, the Act allows for program expansion in 2016.[32]

There are also health care reform provisions designed to encourage higher-quality care. Hospitals will need to improve their infection control programs or face reduced Medicare payments. Medicare payments to hospitals will also be reduced for preventable readmissions for certain conditions.

---

[28]Kasprak, J. (2011, May 10). Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement. *Connecticut Office of Legislative Research*, OLR Research Report. 1-2.
[29]Main & Starry. 6.
[30]Sharamitaro, A. & Drew, C. (2011). Healthcare Reform: Impact on Hospitals. Health Capital Topics: 4. 1. Retrieved at http://www.healthcapital.com/hcc/newsletter/1_11/aca.pdf
[31]Beginning three days prior to hospital admission and ending thirty days after a patient is discharged.
[32]Main & Starry. 3.

Federal health care reform includes numerous incentives and opportunities for states, health care providers and others to improve health care quality, access, delivery and outcomes. The Prevention and Public Health Fund is intended to provide ongoing support to public health and prevention programs at the national, state and local level. The burden of chronic disease (e.g., heart disease, cancer, stroke, and diabetes) presents a significant public health challenge to Connecticut. Since enactment of the PPACA in March 2010, the Department of Health and Human Services has awarded approximately $8.28 million in grants to organizations in Connecticut through this fund for wellness and prevention efforts.[33] These include $790,000 for community and clinical prevention efforts, $593,000 for strengthening the public health infrastructure and $6,901,000 to support the expansion of the public health workforce.

Health care reform is leading to innovations in the delivery of health care, focusing on primary care, care coordination and chronic disease management. They include:

- Accountable Care Organizations (ACOs), which are networks of physicians, hospitals and other health professionals, that coordinate patient care and share in the savings generated for the government by keeping Medicaid patients healthy. It should be noted that it remains to be seen if the success of ACOs in achieving goals (reducing duplication of services, improving care and saving money), and consequently reducing hospital utilization, will create direct competition between physicians and hospitals, as the physicians will be incentivized to reduce hospital admissions;
- Medical homes, which are health care settings such as a primary care practice, that serve as the central coordinator for a patient's health care needs; and
- Health Information Technology improvements, discussed in more detail in the section below.

2.2

The healthcare system in Connecticut and across the country is facing increasing costs, inconsistent payer rates, and independent information systems. One of the strategies to address these challenges is the coordination of health information exchange to improve health status and the experience of care for patients while reducing the cost of care. Health information technology and exchange (HITE) makes it possible for health care providers to better manage patient care through secure use and sharing of health information. A key component of HITE is the use of electronic health records (EHRs) instead of paper medical records to report patients' diagnostic data among healthcare providers serving that patient.

The 2009 American Recovery and Reinvestment Act (ARRA) includes the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) that sets forth a plan for advancing the appropriate use of health information technology to improve quality of care and establish a foundation for health care reform. The Act committed more than $48 billion over five years to develop data exchange systems and to encourage 'meaningful use' of health data exchange in a secure technological environment. These efforts, along with healthcare practices, support the five-year goals of better technology and information to transform health care for providers, payers and patients.

Healthcare professionals in all fields will be required to assess and modify clinical practice, adapt roles and responsibilities, and create an environment that encourages innovation in practice through health IT/HIE. Direct patient care organizations such as hospitals, community clinics and private practices represent key settings for transforming the way health information is used to support improvements in the quality of care and efficiency of the Connecticut healthcare system.

In Connecticut, the HITECH Act authorized over $13 million for multiple projects to advance health information exchange. The Connecticut Department of Public Health (DPH) serves as advocate, regulator, and consumer of health

[33]HealthCare.gov. The Affordable Care Act's Prevention and Public Health Fund in Your State: Connecticut. Retrieved at http://www.healthcare.gov/news/factsheets/prevention/states/ct.html

to a disruption of support networks, inaccessible supplies and durable medical equipment, and interruptions of services due to a disaster or public health emergency begin with an assessment of the communities' health and safety needs, and the community-based service providers that provide support and health care.

7.4.9 RURAL COMMUNITY HEALTH PLANNING[139]

Public transportation is one of the top barriers to care in rural areas. Moreover, community health centers and rural hospitals experience difficulty in recruiting and retaining professional staff.[140] The 61 rural communities in Connecticut are well serviced by a network of community based primary care providers, mental health and substance abuse providers, and hospitals. Primary care providers are based closer to hospitals and therefore are not easily accessible to rural residents, most of whom have no private transportation. Residents have to travel out of their local areas to major medical centers to obtain specialty services. Although specialty care providers have opened satellite locations in suburban towns close to some rural towns, most providers are either not accepting new patients or Medicaid patients, making specialty medical care inaccessible to low-income residents of rural towns. Health care providers in rural towns have identified transportation, substance abuse, domestic violence, and translation services as the top five health care related services needed.

As part of rural community health planning activities involving DPH, several towns bordering rural areas have been designated HPSAs to assist with health care professional related capacity issues. The Connecticut State Office of Rural Health (CT-ORH) has recommended interfacing with DPH to ensure that public health planning activities take into account the needs of rural areas. CT-ORH assists rural communities to locate funding sources and partners with philanthropic funders to help develop and implement plans that promote healthy communities. For example in 2011, CT-ORH assisted Northwestern Connecticut Community College in establishing a new associate nursing degree program; through the Community Health Centers Association grant, the office participated in the Student Experiences And Rotations Health (SEARCH) program to offer students clinical experience and placement in the area; and also offered competitive grants for preventive health care, behavioral health and emergency medical services training. To improve transportation-related barriers in rural communities over time, the Connecticut Department of Transportation (DOT) has implemented two initiatives, the Locally-Coordinated Public Transit Human Services Transportation Plan, which identifies transportation types, destinations, funding sources and gaps in services in these communities; and United We Ride, which is a federal initiative to coordinate transportation services in the state.

DSS funds and provides a free or low-cost health insurance coverage program for low-income elderly, blind, or disabled persons, and families with children. The Medicaid program is administered by DSS in adherence to Title XIX of the Social Security Act, the federal Medicaid law, to qualify for 50% reimbursement from the federal government. The program provides different plans and benefits to low-income subpopulations. Payments for health care services provided under each plan are made directly to providers.

The Healthcare for UninSured Kids and Youth (HUSKY) plan provides coverage for children and teenagers less than 20 years of age, based on family income, and pays for services such as doctor visits, prescriptions, and vision and dental care. Children under 19, their parents or relative caregivers and pregnant women with family income up to 185% of federal poverty level (FPL) receive coverage under HUSKY A; uninsured children in families with incomes between 185% and 300% and their families may qualify for coverage under HUSKY B on a sliding scale.

The plan for the aged, the blind or disabled individuals between ages 18 and 65, HUSKY C or Title 19, is based on

[139]Connecticut Office of Rural Health. (2011, November). *Annual Report*. Retrieved from http://ruralhealthct.org/assets/Annual_Report_2011.pdf

[140]State of Connecticut Office of Rural Planning. (2006, June). *Rural Community Health in Connecticut: Challenges and Opportunities*. Prepared by Holt, Wexler & Farnam, LLP.

[141]Connecticut Department of Social Services. (2012). *HUSKY and Medicaid*. Retrieved from http://www.ct.gov/dss/cwp/view.asp?a=2353&q=490478

income and asset limits.[142] Benefits under the plan include approved medical goods and services; outpatient, hospital and nursing home care; prescriptions; and private health insurance premium assistance, if cost effective.

In 2010, Connecticut was the first state to expand the Medicaid program to cover recipients of State Administered General Assistance (SAGA) under PPACA. This program, HUSKY D or Medicaid for low-income adults, provides health insurance coverage for single adults or married adults between ages 19 and 64, who are not pregnant and do not receive federal Supplemental Security Income or Medicare, with incomes below 56% of federal poverty levels.[143] Beneficiaries receive full Medicaid benefits, long term care, home health care and non-emergency transportation.

DSS contracts with the Health Reinsurance Association to operate Connecticut's Pre-Existing Condition Insurance Plan (CT PCIP). Formerly the temporary high-risk pool program, CT PCIP currently provides federal subsidies available through the PPACA. CT PCIP is open to Connecticut residents who have qualified, diagnosed medical conditions and have been uninsured for 6 months. The plan premium is a flat rate pre-approved by the federal government and provides comprehensive medical benefits coordinated through the UnitedHealthcare provider network.

The Charter Oak Health Plan is a State-funded health insurance program administered by DSS since 2008 and offered to uninsured adults of all incomes, from ages 19 through 64 who do not qualify for the pre-existing condition insurance plan or HUSKY Health. Charter Oak offers a full range of coverage, including preventive care, emergency room and hospital visits, primary care and specialist physicians, pharmacy, behavioral health services, prescription medications and a total lifetime benefit of $1 million. By statute, Charter Oak enrollees cannot have been covered by health insurance during the preceding six months. However, applicants can request an exception to this waiting period for factors such as job loss, financial hardship or loss of HUSKY Plan eligibility due to age or income. Premiums are subsidized based on income levels and family size.

7.6 HEALTH INSURANCE EXCHANGE

The PPACA enabled creation of health insurance exchanges (HIE) by states for individuals and small employers with fewer than 100 employees to purchase health insurance coverage in an organized and competitive market. HIEs will provide consumers a choice of health plans at competitive rates developed with a set of rules for offering and pricing in this market; accessible easy to understand information on and how to enroll in plans; make the plans portable so that an individual will continue to have coverage even when he/she changes jobs; and reform the insurance market with respect to ensuring non-denial of coverage for pre-existing conditions and minimizing arbitrary premium increases.[146]

Since September 2010, Connecticut has received nearly $115 million in federal funding for activities related to establishing a State HIE to increase access to affordable health coverage and reduce Connecticut's almost 378,000 underinsured and uninsured. Funded activities include background research, consulting with stakeholders, making legislative and regulatory changes, establishing the administrative structure, staff and a customer support program for the exchange, and developing an IT system and a system for ensuring program oversight and integrity by December 2014.

Through the Governor's Office of Health Reform and Innovation, as part of PPACA implementation, the State is also receiving technical support from the National Academy of State Health Policy to educate health reform leaders on health equity issues, strategies to address disparities, and to measure effectiveness; to create a system to maximize participation of rural and, low-income and minority populations in Medicaid and HIE; and to improve Medicaid clients' transition to a person-centered system of service delivery.[147]

[142]Connecticut Department of Social Services, Adult Services, Bureau of Assistance Programs. (2012, January). *The Medicaid Program in Connecticut; Basic Eligibility for the Elderly, Blind and Disabled*. Retrieved from http://www.ct.gov/dss/lib/dss/pdfs/basicmaabd.pdf

[143]Connecticut Department of Social Services. (2010, June). *In Brief: Connecticut's New Medicaid for Low-Income Adults*. Retrieved from http://www.ct.gov/dss/lib/dss/pdfs/brochures/medicaid_lia_in_brief.pdf

[144]Connecticut Department of Social Services. *Connecticut Pre-Existing Condition Insurance Plan*. Retrieved from http://www.ct.gov/dss/cwp/view.asp?a=2345&q=463668

[145]State of Connecticut Charter Oak Health Plan. Retrieved from http://www.charteroakhealthplan.com/coh/cwp/view.asp?a=3542&q=418264

[146]Henry J. Kaiser Family Foundation. (2009, May). *Explaining Health Care Reform: What Are Health Insurance Exchanges?* Focus on Health Reform. Retrieved from http://www.kff.org/healthreform/upload/7908.pdf

[147]Office of Health Reform & Innovation. *NASHP Project – Health Equity in Health Reform*. Retrieved from http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2749&q=333704