Covering Connecticut 2016

Because coverage is the foundation for good health.

Materials Prepared for:

XXXXXXX

Connecticut Health FOUNDATION

Connecticut Health
FOUNDATION

September, 2016

Dear Candidate,

The Connecticut Health Foundation (CT Health) is the state's largest independent health philanthropy dedicated to improving lives through a systems change approach. Since it was established in 1999, the foundation has granted $59 million to nonprofit organizations and public entities throughout the state to expand health equity, promote children's mental health early identification and intervention, and increase access to oral care for low income families.

Supporting Key State Initiatives

CT Health has recognized the tremendous opportunity for building a better, healthier Connecticut through the landmark reforms written into the Affordable Care Act (ACA). As Connecticut has led the nation in the implementation of health reform, CT Health has partnered to ensure health equity is incorporated into the state's implementation with several of the state's key initiatives:

- Funding for Access Health CT to support a mystery shopper to test the adequacy of plan's networks
- Funding of the state's cost containment study to ensure expert consultation to meet the legislature's charge
- Providing policy analysis regarding the benefits of Community Health Workers and funding for the State Innovation Model (SIM) Community Health Worker Advisory Committee
- Funding of the Connecticut Hospital Association to address asthma-related emergency department visits and readmissions by developing models to link community and clinical care -- one of the objectives of the SIM

Connecticut has made tremendous strides in advancing coverage with an uninsured rate of 3.8%, and now is focused on transforming the health delivery system through the State Innovation Model. Central to this transformation is the elimination of health inequities. With all the advances seen in Connecticut, it is unacceptable that African Americans are dying at three times the rate of whites, and Latinos are suffering from asthma at significantly higher rates.

Key focus for 2017

The ACA is founded upon the "Triple Aim": (1) Improved Patient experience, (2) Improved quality and outcomes, and (3) Affordability. In Connecticut, amazing outcomes have been achieved in enrollment and delivery reform. Now Connecticut must take on the issue of affordability.

Despite improvements in health insurance coverage in Connecticut over the past decade, the combination of insurance premiums and point of service out-of-pocket costs makes access to affordable health care difficult for many Connecticut residents. The Connecticut Health Foundation and several other health foundations have funded in partnership with the state a study of best practices in state

health care cost containment strategies in order to provide policy options to tackle rising health care costs. These recommendations are due to the legislature at the end of the year.

There is much more to do to ensure health equity for every Connecticut resident, and CT Health is committed to work in partnership to transform healthcare to be more affordable, of higher quality, and more responsive to the people who need it.

In this candidate briefing packet, you will find:

- The **organizations CT Health has grant funded**. We would be pleased to discuss the health needs and opportunities you see in your community at any time.

- Health **access data by town** so that you can look up information pertinent to the people of your district.

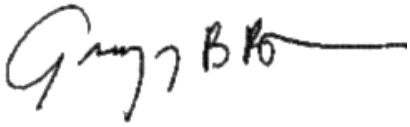
- One of the foundation's health reform **policy briefs** on the need to integrate **Community Health Workers (CHWs)** into Connecticut's policy agenda. To meet the new quality standards, providers must find new, low-cost ways to reach out to patients. Community health workers (CHWs) can help clinicians fill the gap between current practice and new expectations. CHWs can help improve health outcomes and contain costs.

- A CT Health funded **policy brief** that considers how the state government might use **program waivers** (Medicaid section 1115 and Affordable Care Act section 1332) as a policy tool to improve affordability and access for Connecticut residents.

As both a funder and health reform expert, we hope that you will consider CT Health a resource. Please do not hesitate to contact us at 860.724.1580 or pat@cthealth.org.

You can find us online at www.cthealth.org or on Twitter @cthealth.

Sincerely,



Patricia Baker
President & CEO

Gregory B. Butler
Chairman, Board of Directors

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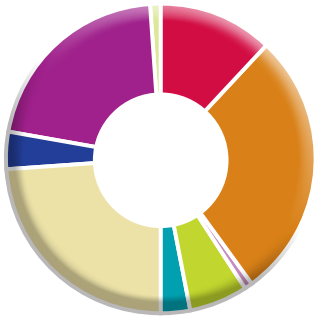
GRANT TOTALS BY PRIORITY INITIATIVE*

9%	Health Equity	$5,576,885
27%	Racial and Ethnic Health Disparities	$15,768,207
23%	Oral Health	$13,741,052
24%	Children's Mental Health	$14,221,912
9%	Cross Priority	$5,101,895
8%	Other	$5,011,867
	Grand Total	**$59,421,818**

GRANT TOTALS BY COUNTY*

12%	Fairfield	$7,034,865
28%	Hartford	$16,692,631
1%	Litchfield	$277,500
6%	Middlesex	$3,507,922
3%	National	$2,220,599
24%	New Haven	$14,036,994
4%	New London	$2,529,100
21%	Statewide	$12,503,494
1%	Windham	$618,713
	Grand Total	**$59,421,818**



** Includes grants approved from 1/1/1999 through 8/9/2016*

Connecticut Health Foundation Grantee Organizations with Statewide Impact

The Connecticut Health Foundation (CT Health) funds grants to nonprofit organizations and public entities. The organizations listed here have received CT Health grants to implement projects and initiatives with statewide reach and impact. Organizations out of state were funded for projects that benefited the health of the people of Connecticut.

GRANTEE ORGANIZATION
• 1000 Friends of Connecticut, Inc.
• Access Health CT*
• American Academy of Pediatrics, Connecticut Chapter*
• American Medical Association Foundation
• Asian & Pacific Islander American Health Forum
• Aspen Institute Roundtable of Community Change
• Center for Medicare Advocacy, Inc.*
• Child Health & Development Institute of Connecticut, Inc.*
• Children's Dental Health Project*
• Children's Health Council*
• Community Catalyst*
• Community Foundation of Greater New Britain
• Community Health Center Association of Connecticut*
• Community Health Center, Inc.*
• Connecticut Advisory Commission on Multicultural Health*
• Connecticut AIDS Resource Coalition
• Connecticut Alliance for Basic Human Needs
• Connecticut Appleseed Center for Law and Justice, Inc.*
• Connecticut Association for Human Services
• Connecticut Association for United Spanish Action, Inc. (CAUSA)*
• Connecticut Association of Directors of Health*
• Connecticut Association of Nonprofits*
• Connecticut Association of School Based Health Centers*
• Connecticut Center for Patient Safety*
• Connecticut Chapter of the American Academy of Pediatrics*
• Connecticut Children's Medical Center*
• Connecticut Choosing Wisely Collaborative*
• Connecticut Commission on Children*
• Connecticut Council for Philanthropy*
• Connecticut Department of Mental Health & Addiction Services
• Connecticut Department of Public Health*
• Connecticut Department of Social Services*
• Connecticut Early Childhood Alliance
• Connecticut Health I-Team*
• Connecticut Health Policy Project, Inc.*
• Connecticut Juvenile Justice Alliance*
• Connecticut Legal Services Collaborative* (Fiscal Sponsors: Greater Hartford Legal Aid/New Haven Legal Assistance Association)

** Organizations that have received multiple grants from CT Health.*

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Connecticut Health Foundation Grantee Organizations with Statewide Impact

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GRANTEE ORGANIZATION
• Connecticut Mission of Mercy* (Fiscal Sponsor: Connecticut Foundation for Dental Outreach)
• Connecticut National Association for the Advancement of Colored People (NAACP)*
• Connecticut Office of the Healthcare Advocate*
• Connecticut Oral Health Initiative*
• Connecticut Public Broadcasting Inc.*
• Connecticut Public Health Association
• Connecticut State Medical Society*
• Connecticut Voices for Children*
• Connecticut Department of Public Health*
• Education Development Center*
• Families USA Foundation*
• FAVOR, Inc.*
• Foodshare*
• Foundation for Children, Inc.*
• Foundation for Educational Advancement*
• General Assembly's Commission on Equity and Opportunity
• Greater New England Minority Supplier Development Council (GNEMSDC)
• Hartford HealthCare*
• Health Equity Solutions, Inc.*
• Health Justice CT* (Fiscal Sponsor: Society for New Communications Research)
• NAMI CT*
• New Haven Independent* (Online Journalism Project)
• One Connecticut*
• Operation Fuel, Inc.*
• Planned Parenthood of Southern New England, Inc.*
• Texas Health Institute
• The Connecticut Food Bank*
• The Connecticut Healthcare Research and Education Foundation, affiliate of Connectict Hospital Association, Inc.*
• The Connecticut Mirror* (The Connecticut News Project, Inc.)
• The Institute for Community Research*
• Universal Health Care Foundation of Connecticut, Inc.*
• University of Connecticut Health Center*
• University of Connecticut School of Dental Medicine*
• University of Connecticut*
• URU, The Right To Be, Inc.*
• Welcoming Light

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Connecticut Health FOUNDATION

The Connecticut Health Foundation has made grants to the following leading organizations located in and/or serving the people residing in the towns listed below. Towns are listed alphabetically.

TOWN	GRANTEE ORGANIZATION
Ansonia	Healthy Divas
Avon	The Legacy Foundation of Hartford, Inc.*
Bloomfield	Covenant to Care for Children
Bloomfield	Operation Fuel, Inc.*
Bloomfield	West Hartford-Bloomfield Health District
Bridgeport	Action for Bridgeport Community Development, Inc.
Bridgeport	American Red Cross of SE Fairfield County*
Bridgeport	Bridgeport Child Advocacy Coalition*
Bridgeport	Bridgeport Community Health Center
Bridgeport	Bridgeport Hospital Foundation*
Bridgeport	City of Bridgeport*
Bridgeport	Mercy Learning Center of Bridgeport, Inc.
Bridgeport	Mount Aery Development Corporation*
Bridgeport	Optimus Health Care, Inc.*
Bridgeport	Park Project
Bridgeport	Prayer Tabernacle Church of Love*
Bridgeport	Regional Youth/Adult Substance Abuse Project
Bridgeport	Sickle Cell Association
Bridgeport	Southwest Community Health Center, Inc.*
Bridgeport	Witness Project of Connecticut, Inc.*
Canton	Focus Alternative Learning Center, Inc.
Danbury	Connecticut Institute for Communities, Inc.
Danbury	Danbury Public Schools Administration Center*
Danbury	Danbury Visiting Nurse Association, Inc.
Danbury	Danbury Youth Services
Danbury	Greater Danbury FFP
Danbury	Hispanic Center of Greater Danbury, Inc.*
Danbury	The Community Action Agency of Western Connecticut
Danielson	Northeast District Dept. of Health

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Darien	Center for Hope
Derby	Griffin Hospital*
Derby	LNV Parent Child Resource Center, Inc.*
Derby	Yale-Griffin Prevention Research Center*
East Hartford	Greater Hartford Oral Health Network
Fairfield	Operation Hope of Fairfield, Inc.
Farmington	Advocacy for Patients with Chronic Illness, Inc.*
Farmington	Citizens for Economic Opportunity*
Farmington	Connecticut Area Health Education Center Program, UCHC*
Farmington	Ethel Donaghue TRIPP Center
Farmington	FaithCare, Inc.
Farmington	The Foundation for Mental Health*
Farmington	Tunxis Community College
Glastonbury	Connecticut Family Support Network
Hamden	Hamden Public Schools
Hartford	Active City, Inc.
Hartford	AFCAMP*
Hartford	Asian Family Services, Inc.*
Hartford	BSL Educational Foundation*
Hartford	Capitol Region Education Council Foundation*
Hartford	Catholic Charities*
Hartford	Center City Churches, Inc.
Hartford	Center for Children's Advocacy*
Hartford	Center for Conflict Transformation, Inc.
Hartford	Central AHEC, Inc.*
Hartford	Christian Activities Council*
Hartford	City of Hartford, Health Department*
Hartford	Community Health Services, Inc.*
Hartford	Community Partners in Action*
Hartford	Community Works of Connecticut

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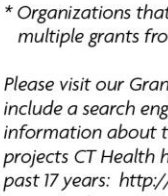
Hartford	Connecticut Center for a New Economy*
Hartford	Connecticut Children's Medical Center Foundation*
Hartford	Connecticut Citizens Research Group*
Hartford	Connecticut Coalition for Environmental Justice*
Hartford	Connecticut Renewal Team, Inc.
Hartford	Corporation for Supportive Housing*
Hartford	CSEA SEIU Local 2001
Hartford	Danolas Productions
Hartford	E.B. Kennelly Elementary School
Hartford	End Hunger Connecticut, Inc.*
Hartford	Faith Congregational Church*
Hartford	Family Life Education
Hartford	Foundation for Connecticut Women, Inc.
Hartford	Greater Hartford Interfaith Coalition for Equity & Justice*
Hartford	Greater Hartford Legal Aid*
Hartford	Harriet Beecher Stowe Center
Hartford	HartBeat Ensemble
Hartford	Hartford Action Plan on Infant Health, Inc.
Hartford	Hartford Behavioral Health*
Hartford	Hartford Communities That Care, Inc.*
Hartford	Hartford Community Partnership*
Hartford	Hartford Food System*
Hartford	Hartford Foundation for Public Giving
Hartford	Hartford Public Access Television
Hartford	Hartford Youth Peace Initiative
Hartford	Hartford's Camp Courant
Hartford	Hispanic Health Council*
Hartford	La Casa De Puerto Rico, Inc.
Hartford	Latino Community Services*



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Hartford	Latinos/as Against AIDS
Hartford	Lawyers for Children America, Inc.
Hartford	Leadership Greater Hartford
Hartford	Malta House of Care Foundation, Inc.*
Hartford	My Sisters' Place
Hartford	Nutmeg Big Brothers Big Sisters*
Hartford	O.N.E./C.H.A.N.E., Inc.
Hartford	Office of Health Reform & Innovation
Hartford	Open Communities Alliance*
Hartford	Partnership for Strong Communities*
Hartford	Phillips Metropolitan Christian Methodist Episcopal Church*
Hartford	Saint Francis Hospital and Medical Center*
Hartford	The Academy for Parents
Hartford	The Community Renewal Team, Inc.
Hartford	The Conference of Churches*
Hartford	The Connecticut Forum*
Hartford	United Connecticut Action for Neighborhoods, Inc.*
Hartford	Urban League of Greater Hartford*
Hartford	YMCA of Metropolitan Hartford*
Litchfield	Education Connection
Manchester	Town of Manchester
Manchester	Town of Manchester Youth Service Bureau*
Manchester	True Colors, Inc.*
Mashantucket	Mashantucket Pequot Tribal Nation*
Meriden	Child Guidance Clinic for Central Connecticut, Inc.
Meriden	Health Ministry Partnership/Community Health & Wellness
Meriden	Rushford Foundation, Inc.

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Middlebury	Northwestern AHEC*
Middlebury	Prevent Blindness Connecticut
Middletown	Advanced Behavioral Health, Inc.
Middletown	Connecticut Legal Rights Project, Inc.*
Middletown	Connecticut Peer Review Organizations dba Qualidigm
Middletown	Cross Street Training and Academic Center*
Middletown	Middlesex Hospital Center for Behavioral Health
	Family Advocacy*
Middletown	United Action Connecticut
Milford	Bridges*
New Britain	Citizens for Quality Sickle Cell Care, Inc.*
New Britain	Community Health Center of New Britain
New Britain	Community Mental Health Affiliates, Inc.
New Britain	Family Services of Central Connecticut, Inc.
New Britain	Human Resources Agency of New Britain*
New Britain	Legal Assistance Resource Center of Connecticut*
New Britain	New Britain Police Department
New Britain	New Britain Youth & Family Services
New Britain	Pediatric Dentristry PC*
New Britain	VNA of Central Connecticut, Inc.
New Haven	Actual Food LLC
New Haven	Agency on Aging of South Central Connecticut
New Haven	AIDS Interfaith Network, Inc.
New Haven	Association of Yale Alumni in Public Health
New Haven	ChildSight Connecticut
New Haven	Christian Community Action, Inc.*
New Haven	Clifford W. Beers Guidance Clinic, Inc.*
New Haven	Community Action Agency of New Haven, Inc.*
New Haven	Community Foundation of Greater New Haven*

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New Haven	Connecticut State Medical Society Physician Health & Education Fund*
New Haven	Cornell Scott Hill Health Center*
New Haven	Fair Haven Community Health Center*
New Haven	Fit Haven, Inc.
New Haven	IRIS-Integrated Refugee & Immigrant Services*
New Haven	Junta for Progressive Action, Inc.*
New Haven	New Haven Adult and Continuing Education
New Haven	New Haven Family Alliance, Inc.*
New Haven	New Haven Independent* (Online Journalism Project)
New Haven	New Haven Legal Assistance Association*
New Haven	New Haven Public Schools*
New Haven	One World Progressive Institute*
New Haven	Pequenas Ligas Hispanas de New Haven, Inc.*
New Haven	Regional Data Cooperative for Greater New Haven dba. DataHaven
New Haven	Sage Services of CT, Inc.
New Haven	Saint Raphael Healthcare System*
New Haven	Sickle Cell Disease Association of America of Southern Connecticut (SCDDAA of So. CT)
New Haven	Southern Connecticut State University*
New Haven	St. Andrews Episcopal Church
New Haven	St. Luke's Services, Inc.
New Haven	Student Health Outreach
New Haven	The Consultation Center*
New Haven	Yale Child Study Center
New Haven	Yale University*
New London	Eastern AHEC, Inc.*
New London	Families United for Children's M.H.*
New London	Hispanic Alliance of Southeastern Connecticut*

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TOWN	GRANTEE ORGANIZATION
New London	Lawrence & Memorial Hospital
New London	Ledge Light Health District*
New London	Proyecto El Parto, Inc.*
Newtown	Newtown Savings Bank
North Haven	Environment and Human Health, Inc.*
North Haven	Quinnipiack Valley Health District
Norwalk	Child Guidance Center of Mid-Fairfield County*
Norwalk	Human Services Council
Norwalk	Norwalk Community Health Center
Norwalk	Norwalk Department of Youth Services
Norwich	Hospice St. Joseph
Norwich	Norwich Adult Education
Norwich	United Community & Family Services Inc.*
Old Lyme	SE Mental Health System of Care*
Old Saybrook	Town of Old Saybrook, Youth and Family Services/Social Services
Plainville	Saint Philip House, Inc.
Plainville	Wheeler Clinic*
Rocky Hill	Brain Injury Association of CT, Inc.
Shelton	Southwestern AHEC*
South Windsor	Hartford/East Hartford Oral Health Collaborative*
Stamford	Child Guidance Center of Southern CT, Inc.*
Stamford	Stamford Oral Health Collaborative*
Stamford	Student Health Services of Stamford*
Stamford	The Dental Center*
Stamford	The New Covenant House of Hospitality
Stratford	Emerge, Inc.
Stratford	St. James Roman Catholic Church
Torrington	c/o TAYSB
Torrington	Charlotte Hungerford Hospital*

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Torrington	Community Health & Wellness Center of Greater Torrington
Torrington	Family Strides, Inc.
Torrington	Maria Seymour Brooker Memorial Inc.
Wallingford	Connecticut League for Nursing
Wallingford	Town of Wallingford
Waterbury	Chase FRC at City of Waterbury Board of Education
Waterbury	Child Guidance Clinic of Greater Waterbury
Waterbury	Family Services of Greater Waterbury, Inc.*
Waterbury	Naugatuck Valley Community College Nursing Program
Waterbury	Naugatuck Valley Project, Inc.*
Waterbury	StayWell Health Care Inc.*
Waterbury	Waterbury Youth Service System, Inc.*
West Hartford	Connecticut Health Quarterly, Inc.
West Hartford	Khmer Health Advocates, Inc.*
West Hartford	Lao Association of Connecticut, Inc.*
West Hartford	Saint Joseph College
West Hartford	The Donaghue Foundation
West Hartford	University of Hartford
West Haven	West Haven Community House, Inc.
Westport	Hall-Brooke Behavioral Health Services
Willimantic	Access Agency
Willimantic	Covenant Soup Kitchen
Willimantic	Generations Family Health Center, Inc.*
Windsor	Community Health Resources*

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Connecticut Health FOUNDATION
Changing Systems, Improving Lives.

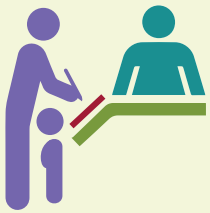
A NEW FOCUS ON EXPANDING HEALTH EQUITY

HOW WE DEFINE IT

When some think of Health Equity, they see an end – in other words, that we should all enjoy the same level of health. When we think of health equity, we see the beginning – that first we must all have a fair shot to take ownership of our health. So while we continue to believe in the importance of eliminating disparities, our immediate focus will be to expand health equity by helping more people gain access to better care – especially those who disproportionately lack it now, people of color.

HOW WE ACHIEVE IT

We will leverage our resources and relationships so more people can:



1 Get Enrolled

It starts by helping people get enrolled and stay enrolled in an affordable health insurance plan.

2 Navigate The System

Once enrolled, show them how to navigate the health care system to get the kind of care they need, when they need it. This includes bringing care to where they are – including community health centers, hospital clinics and school-based health centers.

3 Access Better Care

Finally, make sure that their providers are offering the kind of care we all want to receive – care that is affordable, comprehensive (including mental, oral and physical health), and accountable to the goal of improving our health.

WHAT DOES IT SAY WHEN 32% OF INSURED AMERICANS WITH LOW OR MIDDLE INCOME FREQUENTLY WENT WITHOUT NEEDED CARE LAST YEAR?

cov·er·age ‘kəv(ə)rij/ noun

Coverage is not measured by how many people have insurance. It is measured by how well people are using that insurance. In other words, do they understand their insurance coverage? Are they able to access the health care system appropriately? Will this allow them to be as healthy as they can be?

In Connecticut, we have had one of the most successful healthcare exchanges in the country – with more than 600,000 customers and counting. Today almost **97%** of our residents have coverage in part because of our collective sprint to enroll the uninsured.

But the road to better health is not a sprint – it is a marathon.

Having a health insurance card is just the first step toward ‘better health’ which can lead to health equity. The next one is making sure people know when, where and how best to use the card.

To meet that goal, there is a crucial need to apply the same level of resources, commitment and passion to the next phase of our collective work – from focusing on getting people covered to using that coverage to get better care.

HOW THIS FITS INTO OUR MISSION

Our mission states, “Everyone deserves the opportunity for optimal health, regardless of race, ethnicity, background, or income level. We are dedicated to improving the health of all Connecticut residents.” We will only do this when we realize the full potential of ACA. That means rethinking what being covered really means for our residents. Our approach is simple:

1 GET ENROLLED

While most of residents have a card, we need to make sure they stay enrolled and get the right kind of plan for them. Currently, too many are just selecting plans based on premium costs, inadvertently creating disincentives to get proper care when they realize these plans come with high deductibles and co-pays.

2 NAVIGATE THE HEALTHCARE SYSTEM

Our effort must now shift to helping people answer four basic questions:

- *How do I use the card (i.e., literacy around what is covered, what co-pays and co-insurance mean)?*
- *Where do I use the card (i.e., helping them find a medical home and understanding who takes coverage and why)?*
- *When do I use the card (i.e., educating people about the prevention and wellness benefits that go above and beyond urgent or emergency needs)?*
- *Why do I use this card (i.e., when we use our insurance wisely, we are healthier and happier)?*

3 ACCESS BETTER CARE

Finally, make sure that their providers are offering the kind of care we all want to receive – care that is affordable, comprehensive (including mental, oral and physical health) and accountable to the goal of improving our health.

- *There are longer term concerns that also need to be addressed.*
- *How can we make sure the right incentives are there for payers, providers and patients to cover, provide and receive quality care?*
- *How do we help payers and providers navigate their end of the equation in a way that alleviates anxieties and keeps them from “checking out”?*

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Changing Systems, Improving Lives.

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Connecticut has made tremendous strides in advancing coverage with an uninsured rate of 3.8% since the landmark passing of the Affordable Care Act (ACA). Below are town-by-town numbers so that you can reference how the people of your district have been positively affected by statewide efforts to increase access to health insurance coverage.

Town	Percent Enrolled in Medicaid State FY 2016* (July 2015-June 2016) (Source: DSS)	Enrolled in Access Health CT Qualified Health Plan (As of Feb 1, 2016) (Source: Access Health CT)	Total Kids Enrolled in HUSKY (As of July 1, 2016) (Source: DSS with analysis by CT Voices for Children)
Andover	12.02%	98	142
Ansonia	30.48%	565	2454
Ashford	19.17%	140	345
Avon	6.53%	550	357
Barkhamsted	11.65%	128	177
Beacon Falls	12.26%	178	248
Berlin	11.94%	657	714
Bethany	7.46%	190	127
Bethel	15.01%	825	1111
Bethlehem	13.08%	182	154
Bloomfield	22.98%	566	1472
Bolton	9.91%	155	166
Bozrah	16.63%	71	147
Branford	16.46%	1196	1368
Bridgeport	44.39%	4462	27440
Bridgewater	7.22%	76	36
Bristol	26.96%	1834	6094
Brookfield	10.69%	743	699
Brooklyn	20.26%	271	625
Burlington	7.74%	289	282
Canaan	57.18%	250	245
Canterbury	18.12%	146	378
Canton	9.57%	367	331
Chaplin	20.06%	103	168
Cheshire	8.72%	803	738
Chester	15.14%	158	145
Clinton	16.19%	517	723
Colchester	15.06%	475	847

(continued)

Town	Percent Enrolled in Medicaid State FY 2016* (July 2015-June 2016) (Source: DSS)	Enrolled in Access Health CT Qualified Health Plan (As of Feb 1, 2016) (Source: Access Health CT)	Total Kids Enrolled in HUSKY (As of July 1, 2016) (Source: DSS with analysis by CT Voices for Children)
Colebrook	7.03%	55	36
Columbia	11.65%	119	233
Cornwall	17.41%	162	91
Coventry	13.26%	391	621
Cromwell	14.06%	417	642
Danbury	24.31%	3316	9853
Darien	4.32%	564	356
Deep River	15.83%	253	251
Derby	27.77%	419	1411
Durham	7.48%	178	176
East Granby	9.89%	163	213
East Haddam	10.92%	330	343
East Hampton	13.24%	393	546
East Hartford	36.29%	1607	7613
East Haven	24.16%	958	2365
East Lyme	12.08%	596	742
East Windsor	19.69%	329	764
Eastford	11.31%	60	80
Easton	6.83%	352	177
Ellington	9.73%	517	595
Enfield	18.27%	1101	3143
Essex	10.43%	278	192
Fairfield	9.76%	2182	1874
Farmington	10.58%	845	787
Franklin	12.17%	54	76
Glastonbury	8.56%	1058	1026
Goshen	10.31%	118	133
Granby	8.44%	360	360
Greenwich	9.24%	2171	2023
Griswold	23.44%	440	1115
Groton	17.02%	754	2455
Guilford	9.07%	816	596
Haddam	9.15%	222	313
Hamden	17.78%	1631	3765
Hampton	19.75%	102	140
Hartford	55.56%	3094	26312
Hartland	10.27%	59	100
Harwinton	10.99%	204	241
Hebron	8.61%	277	291
Kent	14.89%	185	148
Killingly	29.72%	477	1826
Killingworth	7.99%	276	169

(continued)

Town	Percent Enrolled in Medicaid State FY 2016* (July 2015-June 2016) (Source: DSS)	Enrolled in Access Health CT Qualified Health Plan (As of Feb 1, 2016) (Source: Access Health CT)	Total Kids Enrolled in HUSKY (As of July 1, 2016) (Source: DSS with analysis by CT Voices for Children)
Lebanon	16.49%	213	374
Ledyard	13.74%	354	829
Lisbon	15.83%	NO DATA	259
Litchfield	14.02%	377	387
Lyme	7.63%	NO DATA	69
Madison	7.30%	639	386
Manchester	26.61%	1842	5990
Mansfield	6.29%	347	579
Marlborough	9.70%	252	211
Meriden	35.02%	1503	8432
Middlebury	9.47%	234	237
Middlefield	10.83%	144	153
Middletown	23.97%	1249	3856
Milford	14.15%	1801	2329
Monroe	8.98%	653	549
Montville	16.62%	449	1342
Morris	14.33%	100	136
Mystic	NO DATA	530	NO DATA
Naugatuck	25.32%	1083	3320
New Britain	46.03%	2229	13365
New Canaan	4.26%	646	275
New Fairfield	9.88%	510	524
New Hartford	10.87%	233	275
New Haven	41.40%	2817	21794
New London	45.22%	770	4456
New Milford	16.31%	1276	1716
Newington	15.41%	1024	1484
Newtown	8.56%	1026	854
Norfolk	12.68%	91	68
North Branford	11.36%	461	532
North Canaan	6.61%	NO DATA	61
North Haven	12.31%	798	893
North Stonington	14.02%	228	276
Norwalk	21.97%	4178	8476
Norwich	36.19%	1053	5626
Old Lyme	9.60%	440	248
Old Saybrook	14.34%	449	444
Orange	8.78%	476	408
Oxford	8.43%	449	412
Plainfield	28.47%	390	1793
Plainville	19.27%	552	1121
Plymouth	20.05%	421	897

(continued)

Town	Percent Enrolled in Medicaid State FY 2016* (July 2015-June 2016) (Source: DSS)	Enrolled in Access Health CT Qualified Health Plan (As of Feb 1, 2016) (Source: Access Health CT)	Total Kids Enrolled in HUSKY (As of July 1, 2016) (Source: DSS with analysis by CT Voices for Children)
Pomfret	12.81%	126	215
Portland	14.20%	258	455
Preston	15.11%	159	250
Prospect	12.82%	327	337
Putnam	30.80%	248	1035
Redding	5.65%	483	215
Ridgefield	5.87%	939	449
Rocky Hill	12.72%	621	758
Roxbury	8.27%	165	55
Salem	12.84%	106	232
Salisbury	12.93%	222	135
Scotland	7.68%	33	47
Seymour	18.41%	569	1106
Sharon	16.59%	157	137
Shelton	14.66%	1352	2008
Sherman	9.76%	191	142
Simsbury	7.56%	743	609
Somers	8.92%	284	324
South Windsor	10.45%	741	892
Southbury	11.81%	682	457
Southington	13.44%	1240	2014
Sprague	31.00%	80	392
Stafford	18.88%	332	835
Stamford	21.21%	5446	12134
Sterling	17.99%	141	287
Stonington	20.86%	734	1248
Stratford	21.51%	1675	4386
Suffield	8.00%	400	429
Thomaston	16.35%	232	436
Thompson	18.04%	230	668
Tolland	8.35%	334	445
Torrington	30.06%	1118	3771
Trumbull	10.72%	1197	1261
Union	6.91%	NO DATA	16
Vernon	23.97%	860	2538
Voluntown	18.76%	91	187
Wallingford	15.58%	1396	2430
Warren	8.77%	NO DATA	57
Washington	11.06%	270	152
Waterbury	49.78%	3156	22071
Waterford	16.42%	606	1047
Watertown	16.47%	645	1188

(continued)

Town	Percent Enrolled in Medicaid State FY 2016* (July 2015-June 2016) (Source: DSS)	Enrolled in Access Health CT Qualified Health Plan (As of Feb 1, 2016) (Source: Access Health CT)	Total Kids Enrolled in HUSKY (As of July 1, 2016) (Source: DSS with analysis by CT Voices for Children)
West Hartford	14.97%	2049	3035
West Haven	28.98%	1641	6444
Westbrook	14.50%	273	288
Weston	4.14%	437	162
Westport	5.67%	1102	416
Wethersfield	15.15%	822	1325
Willington	12.59%	142	260
Wilton	6.42%	731	293
Winchester	26.98%	387	3789
Windham	39.90%	456	2091
Windsor	19.72%	887	975
Windsor Locks	19.94%	401	1068
Wolcott	15.29%	527	853
Woodbridge	8.86%	309	273
Woodbury	10.05%	481	329
Woodstock	12.94%	266	440
Total	**N/A**	**115,665**	**307,253**

* Adults and children



Connecticut Health
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POLICY
Brief

JULY 2015

HIGHLIGHTS

- **CHWs engage patients in their communities, extending health care beyond the clinic walls.**
- **Research shows that CHWs can improve health outcomes and contain costs.**
- **CHWs can help clinical practices meet new quality standards and earn higher payments from health plans.**
- **New federal rules make it easier for state Medicaid programs to pay for CHW services.**
- **Connecticut can enact legislation to develop a credentialing process for CHWs and integrate CHWs into the state health care workforce.**
- **Integrating CHWs into Connecticut's delivery and payment systems will improve sustainability for their vital services.**

Tomorrow's Health Care System Needs Community Health Workers: A Policy Agenda for Connecticut

WHY DOES CONNECTICUT NEED COMMUNITY HEALTH WORKERS?

Health care providers are under increased pressure to meet ambitious quality of care standards, such as providing recommended preventive screenings while reducing the need for expensive emergency department visits.

Physicians know that when they talk to their patients about health measures, such as diabetes management, asthma care, or improved diet, some patients follow the prescribed regimen exactly, while others do not. Physicians often feel frustrated that they cannot influence their patients' actions once patients leave the office.

To meet the new quality standards, providers must find new, low-cost ways to reach out to patients. Community health workers (CHWs) can help clinicians fill the gap between current practice and new expectations. CHWs can help improve health outcomes and contain costs.

Community health workers can help clinicians fill the gap between current practice and new expectations.

Research on CHWs has highlighted a number of programs in which CHWs have been effective in improving patients' health and health care by reducing health disparities, expanding access to coverage and care, improving quality outcomes, and increasing health care cultural and linguistic competency.

WHO EXACTLY IS A COMMUNITY HEALTH WORKER?

CHWs are public health workers who are trusted members of the communities they serve. CHWs typically share ethnicity, culture, language, socioeconomic status, and life experiences with community members. Because they understand the context of patients' lives—where they come from, how they do things, what their families and friends expect, what foods they cook—CHWs can coach a patient to implement care recommendations, such as diet, exercise, medications, and asthma-sensitive cleaning strategies, that are manageable and that fit their lifestyles.

Although CHWs are not required to have a college or an advanced degree and do not deliver medical care, their in-depth knowledge about their communities enables them to connect patients with health and community services. CHWs are able to bring their unique, firsthand knowledge of their culture into the community settings and into the patient's home. They culturally and linguistically understand what motivates the patient.

CHWs help patients take control of their health by

- **providing culturally and linguistically appropriate health education and information;**
- **providing informal counseling, social support, care coordination, and health screenings;**
- **assisting patients with chronic condition self-management;**
- **coaching patients to follow through with smoking cessation, exercise, diet, and health screenings;**
- **conducting home visits to assess health risks;**
- **ensuring that people receive the services they need; and**
- **advocating for individual and community needs.**[1,2]

WHAT ARE CHW EMPLOYMENT MODELS?

Health care providers can employ CHWs directly or contract for CHW services. For example, Baystate High Street Medical Center in Springfield, Massachusetts, contracts CHW services through Springfield Partners for Community Action. Springfield Partners employs CHWs from several ethnic and linguistic communities. The Baystate High Street interdisciplinary care team, which includes doctors, nurses, and a dietician, identifies patients with poorly controlled conditions who would benefit from CHW services. The CHW provides the service, which is overseen by a supervisor. The CHW reports back to the team on the outcome.[3]

HOW CAN COMMUNITY HEALTH WORKERS IMPROVE HEALTH OUTCOMES?

Research on CHWs has highlighted a number of programs in which CHWs have been effective in improving patients' health and health care by reducing health disparities, expanding access to coverage and care, improving quality outcomes, and increasing health care cultural and linguistic competency.

CHW programs that include some key components have been shown to be very effective, while programs lacking those components are less effective.

The Institute for Clinical and Economic Review (ICER), on behalf of the New England Comparative Effectiveness Public Advisory Council (CEPAC), reviewed US studies published from 1980 to 2008 and measured CHWs' effectiveness in helping patients manage chronic conditions. ICER cited studies that showed positive effects of well-designed CHW involvement in diabetes management, asthma control and improved activity levels, blood pressure, dietary habits, and follow-up care for individuals with cardiovascular disease and hypertension.[4]

ADDING VALUE, EXTENDING HEALTH CARE'S REACH – CONNECTICUT CHILDREN'S MEDICAL CENTER: The Children's Center for Community Research (C3R) received grant funding to add home visits and monthly telephone calls provided by CHWs to its Steps to Growing Up Healthy childhood obesity prevention study. The goal of the study was to develop a brief, evidence-based approach to obesity prevention that providers could use with children age 2-4 to encourage adoption of healthy eating and exercise. C3R hypothesized that it could more effectively prevent obesity and enhance health with Hartford's Latino and African-American families when CHWs followed-up monthly with mothers. This created regular community-based, culturally and linguistically tailored opportunities to reinforce messages and extend care provided in the pediatrician's office.

CEPAC concluded that certain CHW interventions provide "reasonable value" or "high value," that is, improved cost-efficient patient outcomes in state Medicaid programs and Accountable Care Organizations (ACOs). CEPAC identified four program components that likely contribute to improved health outcomes:

1. **The CHW has received at least 40 hours of training.**
2. **The CHW visits a patient's home or environment.**
3. **The CHW has in-person interaction with a patient for at least 60 minutes.**
4. **The CHW shares a community, ethnicity, or health condition with a patient.**[5]

Another comprehensive literature review examined 43 studies from 14 countries, including 24 studies from the United States, through 2002. A number of CHW interventions (called "lay health workers" in this study) showed promising benefits in increasing immunizations in children and adults, in breast-feeding success, and in pulmonary tuberculosis cure rates. Other interventions studied did not result in clinically significant improvements, however. These findings highlighted the need for best-practice program designs.[6]

HOW CAN COMMUNITY HEALTH WORKERS HELP PRACTICES SUCCEED IN TOMORROW'S HEALTH CARE SYSTEM?

CHWs can help a clinical practice meet new practice requirements and earn higher payments from health plans. These higher payments can cover the cost of the CHW intervention and other services.

Across the country, insurers and employers have been moving away from the traditional fee-for-service payment system to new value-based purchasing: paying for services in a way that rewards health care providers for delivering better care at lower cost.

Traditionally, commercial health insurers, Medicare, and Medicaid have paid hospitals, doctors, and other health care providers a fee for every service rendered. For example, a physician may receive high fees for treating complications from poorly controlled diabetes, such as kidney disease and nerve damage, but may not be able to bill for services designed to help patients manage their diabetes. This payment system rewards health care providers for providing *more services* but not necessarily for providing *better care*.

Under alternative payment methods, however, health care providers receive the highest payment for meeting the highest standards for quality care. For example, a practice may receive a standard payment for each patient with diabetes. That standard payment amount might be higher if a greater number of these patients have well-controlled diabetes. These payment methods aim to hold health care providers accountable for providing high quality care while containing costs.

CHWs' interventions help patients to understand and to adhere to physicians' instructions following a doctor visit. CHWs' efforts can help a practice meet quality standards and earn higher payments from health plans. The practice can then use the higher payments to cover the cost of CHW services and other interventions.

HOW CAN CONNECTICUT MEDICAID SUPPORT COMMUNITY HEALTH WORKERS?

Many of the people who would benefit most from CHW services are covered through HUSKY, the Connecticut Medicaid program. Medicaid could provide sustainable funding for CHW services through an alternative payment system. Or it could provide funding through its existing administrative and payment structure. A recent change in federal rules makes it easier for state Medicaid programs to pay fee-for-service for CHW services.

In July 2013, the federal Centers for Medicare and Medicaid Services (CMS) adopted a change in the federal regulation (42 CFR 440.130(c)) governing the set of services for which state Medicaid programs can pay. Previously, Medicaid programs could pay for preventive services that were *provided* by a physician or other clinician. The rule change allows Medicaid programs to pay for preventive services *recommended* by a physician or other clinician.

This rule change gives state Medicaid programs an opportunity to pay directly for CHWs to provide preventive services. CMS has said that it does not plan to issue additional guidance about this rule change; rather, it is looking to states to design Medicaid State Plans in compliance with the rule.

This rule change gives state Medicaid programs an opportunity to pay directly for CHWs to provide preventive services. CMS has said that it does not plan to issue additional guidance about this rule change; rather, it is looking to states to design Medicaid State Plans in compliance with the rule.[7]

To fund CHW services, Connecticut's Medicaid State Plan would need to be amended to include:

- **the preventive services for which the state Medicaid program will pay (including any quality standards and documentation requirements);**
- **who can provide these services (including required training/education, experience, credentialing/registration, and supervision);**
- **which patients can receive these services;**
- **the conditions under which the services can be provided;**
- **how the services will be "recommended" by a clinician and reported back to the referring clinician;**
- **who can bill for these services; and**
- **what method and rate Medicaid will use to pay for services.**

Medicaid programs in Minnesota and in Pennsylvania support CHW services directly, while those in a number of other states make monthly payments to clinical practices to cover CHWs and other services.[8] Connecticut Medicaid could propose to pay primary care practices an hourly rate for CHW services provided to patients with poorly controlled chronic conditions.

Historically, CHWs have faced sustainability challenges that come with being mostly grant-funded. Integrating CHWs into Connecticut's delivery and payment systems will help ensure long-term viability.

WHAT ELSE CAN CONNECTICUT DO TO SUPPORT COMMUNITY HEALTH WORKERS?

The Connecticut General Assembly could enact legislation to establish a CHW certification process and integrate CHWs seamlessly into the health care workforce, providing a state mandate for and building on the plan established in Connecticut's State Innovation Model (SIM) Test grant. In December 2014, CMS awarded Connecticut a $45 million SIM grant to transform the state's health care delivery system. This grant earmarked almost $1 million over four years to develop a CHW workforce, including funding to: "conduct [a] workforce needs assessment; develop training curriculum and certification program; develop [a] placement and community college partnership program; evaluate [this] program; develop sustainability models; and facilitate stakeholder meetings/annual conference."[9]

Ten states have established a certification process to formalize CHW knowledge and skills and to increase recognition of the CHW workforce.[10] Health care providers are more likely to hire certified CHWs, and Medicaid programs and private health insurers are more likely to approve payments for services provided by certified CHWs.

An effective CHW certification process should not bar low-income and non-English-speaking community members. These individuals may be best suited to work within a community. Many states are considering a voluntary certification program, and several have certification exceptions that allow current CHWs to count experience toward training requirements.

State legislatures have taken actions to promote CHWs. For example, in 1999, Texas became the first state to adopt legislation that requires state health and human services agencies to use CHWs (or *promotores de salud*) and charged the state Medicaid agency with exploring sustainable funding for CHWs.

FACILITATING HIGH TOUCH CARE – PROJECT ACCESS OF NEW HAVEN: Patient navigators working with Project Access–New Haven, a nonprofit dedicated to connecting underserved community members with urgent medical needs with donated specialty care, have reduced the rate of no-show medical appointments from 34 percent to 3 percent. Navigators help address barriers such as language and access to transportation and assist patients in navigating the health care system. As a result of this "high touch" care and navigation, Project Access patients have reported improved health, quality of life, and access to care when surveyed one year after enrollment.

Project Access–New Haven, http://pa-nh.org/; Connecticut Hospitals annual report, http://pa-nh.org/wp-content/uploads/2014/05/CHA-Annual-Report.pdf

Additional legislation included developing and implementing training and certification programs.[11] A 2012 agency report to the legislature featured a survey of entities that employed CHWs or potentially could employ CHWs. Respondents supported maintaining and even expanding CHW services. The report also recommended considering other states' Medicaid models, amending the state uniform managed care contract to include CHWs, integrating CHWs into Patient Centered Medical Home interdisciplinary care teams, and explore including CHWs in the state's Medicaid 1115 waiver.[12]

The Oregon legislature began integrating CHWs into primary care practice in 2008 through the development of a statewide network in conjunction with the Northwest Regional Primary Care Association. In 2011, Oregon enacted two laws. One required the Oregon Health Authority to explore methods of improving birth outcomes among women of color. The second established coordinated care organizations (CCOs) for enhanced focus on prevention, reducing disparities, and improving health equity for recipients of medical assistance. This law also required that women have access to personal health navigators and qualified CHWs.[13]

CONCLUSION: A CHW POLICY AGENDA FOR CONNECTICUT

CHWs can offer a bridge from the doctor's office to the communities they serve. CHWs can also help patients access appropriate health care services, navigate the health care system, and adhere to prescribed health care regimens. By filling gaps in the health care system, CHWs can help health care providers to achieve better health outcomes at an efficient cost.

CONNECTICUT CAN TAKE THESE KEY STEPS TO CULTIVATE A ROBUST CHW WORKFORCE:

1. Enact legislation establishing a process for certifying CHWs, along with training and experience requirements, to document CHWs' skills for potential employers and insurers.
2. Implement the state's SIM plan to establish training programs for CHWs and CHW supervisors to improve and standardize knowledge and skills.
3. Add CHW services to the set of Medicaid-covered services and establish a Medicaid payment rate to provide sustainable funding for these cost-effective services.
4. Provide training programs for health care providers on how they can use CHWs to help achieve practice transformation goals.
5. Establish a CHW task force to promote and coordinate this agenda.

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Connecticut Health FOUNDATION

Community Health Worker Certification Requirements by State

Prepared by: Katharine London, Margaret Carey and Kate Russell, UMass Medical School Center for Health Law and Economics

Community Health Workers (CHW) are increasingly recognized for their powerful potential role in improving today's health care system. Recent studies have demonstrated that CHWs can help to reduce costs and improve care – key goals of most state's health care priorities.[1] For this reason, many states are currently working to promote and formalize Community Health Workers' role within the state health care system. Though there are some common themes in approaches states are choosing to develop CHW models, there is great variability in models and levers they are using to develop CHW models. The wide breadth of CHW models provides many options for states considering developing a CHW certification process.

The chart on the following pages includes 15 states that are moving toward or have established training and/or a certification process for CHWs as of December 2015. States' processes may have evolved after that date. Information in the chart below were gathered from both national resources such as The National Academy for State Health Policy (NASHP) and its State Refor(u)m, as well as state agency and regional CHW organization websites.

Community Health Worker Legislation and Payment

Ten of these states' efforts (AK, IL, MD, MA, MN, NM, OH, OR, RI, TX) are guided by legislative authority that either establishes a board or workgroup to make recommendations around CHW certification and training, or requires certain credentials of CHWs in order to receive payment for publicly funded health care services.

Community Health Worker Certification

In many states private nonprofit organizations that focus on the promotion of the CHWs have a key role in training and certifying CHWs. Certification typically includes classroom training on core competencies, a practicum or internship experience and an evaluation of skills and/or knowledge. It is important to note that in most states that have established CHW certification processes, certification is voluntary. Certification is required in four states (TX, OR, MN, SC) to be eligible for payments from public payers such as Medicaid. Almost every state that has or is in the process or establishing a certification process is offering a "grandfathering" process to recognize current CHWs' experience and expertise and count it toward CHW certification.

1 Katharine London, Margaret Carey, and Kate Russell. *Tomorrow's Health Care System Needs Community Health Workers: A Policy Agenda for Connecticut*. Connecticut Health Foundation, July 2015.

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
ALASKA	Alaska operates the Community Health Aide Program (CHAP) which provides community health aide grants for third-parties to train community health aides as Community Health Practitioners (CHPs). Trainees must complete an examination at the conclusion of the training.	The CHAP Certification Board has a certified 3-4 week intensive training course; completion of designated number of practice hours and patient encounters; post-session learning needs and practice checklists; 200 hours village clinical experience; preceptorship; 80% or higher on CHAP exam, and 100% on statewide math exam. Four regional training centers. Physician supervision is required for reimbursement for CHA services.	**1. An understanding of problem specific complaints** (acute care) of body systems (eye, ear, respiratory, digestive and skin) **2. Competency in following subjects:** • Role of the community health aides • Community health aide's and practitioner's general scope of work • Medical ethics, including patient confidentiality and rights • Community health aide's and practitioner's medical-legal coverage • State of Alaska reporting requirements • Consent for treatment issues • Introductory interviewing skills • General health/wellness and disease processes • Infection and communicable diseases • Introductory anatomy and function of the human body • Introductory medical vocabulary/abbreviations • Importance of thorough documentation of patient encounter • Introductory mental health issues, including suicide and other emergencies • Introductory pharmacology, including identification and treatment of severe allergic reactions • Emergency care including facial trauma, altered level of consciousness, potentially serious chest pain, acute orthopedic injuries, burns, hypothermia, poisoning, and uncomplicated emergency delivery **3. Satisfactory performance of various health care related skills** *(See Certification Board Standards and Procedures for full list).*	All Community Health Aides and Practitioners must document a minimum of 48 hours of ongoing education or CME every two years. CHPs much take at least 144 hours of CME every 6 years to become recertified.	Community Health Aide Program Board
ARIZONA	No legislation currently exists around CHWs. The Arizona Department of Health Services is currently creating standards for CHW training and preparation as a step in the certification process. Legislation on CHW is being explored by the Arizona CHW Workforce Coalition for 2016.	Arizona Community Health Outreach Worker Association is developing a voluntary certification process for CHWs which will include a grandfathering option.	**AZ CHW Workforce Coalition Core Competencies:** 1. Communication 2. Interpersonal Skills 3. Knowledge Base 4. Service Coordination 5. Capacity Building 6. Advocacy 7. Teaching 8. Organizational Skills	-	Currently three voluntary CHW certifications are available through Community Colleges in the state.
CALIFORNIA	California's CalSIM Workforce Group is developing recommendations regarding CHW training and credentialing. (continued)	Pending	**The Workforce Work Group Report outlines several components of CHW Core Competencies:** **Personal Qualities:** • Cultural connection/relationship to the community • Empathy, compassion • Interpersonal relationship building • Motivational • Leadership • Flexible and problem solving ability (continued)	-	TBD

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
CALIFORNIA *(continued)*	(continued from page 2) The CA State Innovation Model (CalSIM) Design Grant, approved by CMS in April 2013, required production of a Statewide Health Care Innovation Plan (SHCIP). Six private sector work groups reported on payment and public policy recommendations for the state's final SCHIP submitted to CMMI; the CalSIM Workforce Work Group is one of these 6 work groups.		(continued from page 2) **Skills:** • Listening skills • Communication skills • Service coordination skills • Training/ability to teach • Facilitation • Health promotion/education • Advocacy skills • Research skills • Knowledge base • Health coaching **Innovation Plan Initiative-specific skills:** • Ex. knowledge of particular disease or condition **Work-setting related skills:** • Organizational skills • Computer skills • Data entry skills for electronic health records	-	TBD
FLORIDA	The Florida CHW Coalition (FCHWC) is moving towards voluntary certification, administered by the Florida Certification Board. A written exam will be developed in 2015, with full credentialing in 2016. Certified CHW (CCHW) designation was extended from Jan 1 2015 to June 30 2016; the purpose of this grandfathering is to provide current practitioners an opportunity to earn certification without taking additional trainings or exams.	The Florida CHW Coalition (FCHWC) has developed 30 hours of training for certification: 20 hours from 5 domains, 10 hours of electives. To be grandfathered, CHWs must: • Document at least 500 hours of paid or volunteer experience providing CHW services in the past 5 years • Document at least 30 hours of training in the core competencies in the past 5 years • Submit two letters of reference validating the CHW's experience and training	**30 hours of training for Grandfathering certification includes 28 CHW tasks in five performance domains (4 hours each) and 10 hours of electives:** 1. Communication and Education 2. Resources 3. Advocacy 4. Foundations of Health 5. Professional Responsibility	Certified CHWs must renew their certification every two years.	The certifying entity will be a third-party entity approved by the Florida Department of Health.
ILLINOIS	Illinois established a Community Health Worker Advisory Board by legislation in November 2014. The Board is charged with advising the governor and legislature on core competencies, a training and certification process, reimbursement options, and other issues.	Pending	Pending **The 2014 legislation includes a list of core competencies for consideration by the board, including, but not limited to:** 1. Outreach methods and strategies; 2. Client and community assessment; 3. Effective community-based and participatory methods, including research; 4. Culturally competent communication and care; (continued)	Pending	Pending

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
ILLINOIS *(continued)*		Pending	(continued from page 3) 5. Health education for behavior change; 6. Support, advocacy, and health system navigation for clients; 7. Application of public health concepts and approaches; 8. Individual and community capacity building and mobilization; and 9. Writing, oral, technical, and communication skills.	Pending	Pending
INDIANA	An Integrated Care Community Health Worker and Certified Recovery Specialist Training and Certification Program has been approved by the Indiana Division of Mental Health and Addiction and the State Department of Health.	CHWs are required to complete a 3 day training and final exam. Certified CHWs may serve in outpatient medical/behavioral setting, including hospitals, medical clinics, schools, churches and community centers.	**Training modules include:** • Communication skills • Engagement skills • Motivational interviewing • Cultural understanding • Prevention • Chronic illness • Behavioral health • Home visiting • Outreach • Advocacy	14 hours of continuing education credits are requested each year to maintain certification.	Training is provided by the Affiliated Service Providers of Indiana as a state selected vendor. The training is jointly approved by the Indiana Division of Mental Health and Addiction and the State Department of Health.
KENTUCKY	The Kentucky CHW Workgroup is developing recommendations and a process for certification. Lead state agency is the Department for Public Health.	Kentucky Homeplace was established in 1994 for rural coal-mining populations. Its training program requires 40 hours of classroom and online instruction and an 80-hour practicum.	**No current state training. Kentucky Homeplace competencies include:** 1. Introduction to Community Health Workers 2. Communication and Health Literacy 3. Use of Public Health Concepts and Approaches 4. Health Coaching Chronic Conditions 5. Outreach and Advocacy 6. Care Coordination and System Navigation 7. Documentation Reporting and Outcomes Management 8. Legal, Ethical and Professional Conduct 9. Research	-	-
MASSACHUSETTS	Massachusetts established a CHW certification board in the Department of Public Health, as authorized by Chapter 322 (enacted 2010). Regulations are awaiting approval by an independent CHW certification board and then by the state.	80 hours class room training in a combination of core competencies and special health topics from a state-approved training program. Credentialing pathway for individuals with 4,000 hours relevant work experience. "Work only" pathway will be phased out 3 years after the state certification program begins.	1. Outreach Methods and Strategies 2. Individual and Community Assessment 3. Effective Communication 4. Culturally-based communication and care 5. Health Education for Behavior Change 6. Support, Advocacy and Coordination of Care for Clients 7. Application of Public Health Concepts and Approaches 8. Advocacy and Community Capacity Building 9. Documentation 10. Professional Skills and Conduct	15 hours continuing education every 2 years.	Massachusetts Board of Certification of Community Health Worker, located within the Department of Public Health Division of Health Professions Licensure.

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
MARYLAND	The Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA) created a stakeholder workgroup to study and make recommendations regarding CHW Workforce Development, as mandated by HB856/ SB592 (enacted 2014). The final report to the General Assembly was submitted June 2015.	Workgroup recommendations: 2 tier certification process: • Tier 1 – pre-certified CHW requiring 80 hours of training • Tier 2 – Certified CHW requiring 160 hour training curriculum that be a flexible combination of classroom and practicum	Workgroup recommendations: **Core Competencies** 1. Effective oral and written communication skills 2. Cultural competency 3. Knowledge of local resources and system navigation 4. Advocacy and community capacity building skills 5. Care coordination skills 6. Teaching skills to promote healthy behavior change 7. Outreach methods and strategies 8. Ability to bridge needs and identify resources 9. Understanding of public health concepts and health literacy 10. Understanding of ethics and confidentiality issues 11. Ability to use and understand health information technology	N/A	TBD Workgroup recommended creating a certification board that would approve CHW curriculum and CHW training programs.
MINNESOTA	Minnesota requires CHW Certification for billing for CHW services covered under Minnesota Health Care Programs (MHCP) and Medicaid. However, CHW certification is not required for employment.	14 credit hours. One semester for full-time and 2 semesters for part time students. To work as a Medicaid-approved provider CWH must be supervised by a physician, advanced practice nurse, public health nurse work in a unit of government, dentists and mental health professional who is also enrolled in the MN Medicaid Program. Grandfathering is available to CHWs who have at least 5 years of experience supervised by an enrolled clinician.	**Core Competencies** 1. Role, Advocacy and Outreach 2. Organization and Resources 3. Teaching and Capacity Building 4. Legal and Ethical Responsibilities 5. Communication and Cultural Competence **Health Promotion Competencies** 1. Healthy Lifestyles 2. Heart Disease & Stroke 3. Maternal, Child and Teen Health 4. Diabetes 5. Cancer 6. Oral Health 7. Mental Health	Continuing education is not mandatory but often available through worksites and in the community.	Accredited Minnesota post-secondary schools offering CHW curricula *(The training entity provides the certificate. The Medicaid Program grants a Medicaid provider number with proof of certification.)*
MISSOURI	The Missouri Department of Health and Senior Services is establishing a pilot project in Kansas City area to certify CHWs and standardize curriculum. Metro Community College offers a CHW certificate training program adapted from Minnesota's CHW curriculum. The MO Department of Health and Senior Services to decide if this curriculum will become the state standard.	160 hours, 60 service (practicum hours)	**Core competencies include:** 1. Communication 2. Organization and resources 3. Life style choices 4. Cultural beliefs and healthcare 5. Legal and ethical considerations 6. Employability skills.	Tuition reimbursement will be available for those enrolling in a CHW Certificate program.	No central certifying entity.

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
MISSISSIPPI	Tougaloo College/ Central Mississippi Area Health Education Center (CMAHEC) is currently working with the Mississippi State Department of Health's Office of Preventive Health and other organizations to develop a standardized program for certifying community health workers (CHW) within the state of Mississippi. As of 2015, Mississippi covers CHW services under the auspice of "general education" and not a specific billing code.	Tougaloo College/Central Mississippi Area Health Education Center and the state Department of Health	-	-	Tougaloo College
NEW MEXICO	The New Mexico Department of Health administers a voluntary, statewide certification program for CHWs.	**For New CHWs:** • 100 hour core competency training through the Office of CHWs or complete a Department of Health endorsed curriculum. • Application to OCHW • Background check **For CHW with previous experience grandfathering certification:** • Verification by a current or former supervisor of proficiency in the core competencies. • Two letters of reference on agency/program letterhead. • Applicants must provide formal, verifiable documentation to support each requirement. • 2000 clock hours of formal CHW work and/or volunteer CHW experience within the scope of work and core competency field. • Grandfathering application and background check.	1. CHW Profession 2. Effective Communication 3. Interpersonal skills 4. Health coaching 5. Service Coordination 6. Advocacy 7. Technical Teaching 8. Community Health Outreach 9. Community Knowledge & Assessment 10. Clinical Support Skills (optional)	30 hours of CEUs as approved by the Department of Health every 2 years **Re-certification required every 2 year:** • Application fee ($45) • Proof of at least 30 CEUs • Criminal history screening every 4 years.	New Mexico CHW Certification Board, New Mexico Department of Health

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
NEW YORK	There are presently no regulations for CHWs. NYSHealth Foundation is investing in a statewide CHW initiative through partnerships with CHWs statewide and Columbia University's Mailman School of Public Health to establish sustainable financing for the CHW workforce. Also, CHWs are optional team members of Health Home care teams in NY's 2012-2013 state plan amendment (SPA).	None identified	None identified but the 2011 report from the NYS CHW Initiative reported that the work group created a CHW Scope of Practice: Roles and Related Tasks, including: • Outreach and community mobilization • Case management and care coordination • Home-based support • Health promotion and health coaching • System navigation • Participatory research	-	None identified
OHIO	The Ohio Board of Nursing issues and renews CHW certificates, as authorized by HB 95 (enacted 2003). The certifications are to be renewed biennially.	Training program must be approved by the Board of Nursing; at least 100 hours of classroom instruction and 130 hours of clinical instruction, standard training exam. Certification needed in order to perform tasks delegated by a nurse. Only an RN may supervise a CHW when performing delegated activities related to nursing care. Grandfathering for those employed as CHWs before 2005.	The standard minimum curriculum for community health workers shall include courses, content, and expected outcomes, relative to the defined role of the community health worker, in the following major areas: 1. Health care 2. Community resources 3. Communication skills 4. Individual and community advocacy 5. Health education 6. Service skills and responsibilities The standard minimum curriculum for community health workers shall also educate students on needs throughout the span of a lifetime including the following: 1. The family during childbearing years 2. The family during pregnancy 3. The newborn, infant, and young child 4. Adolescents 5. Special health care and social needs of target populations such as grandparents raising grandchildren, adults caring for aging parents, and children and adults with disabilities	15 hours continuing education every 2 years.	Ohio Board of Nursing
OREGON	The Oregon Health Authority certifies Traditional Health Workers. (continued)	80 hours of mandatory training to qualify for reimbursement by the Oregon Health Plan (Medicaid). (continued)	1. Outreach Methods; 2. Community Engagement, Outreach and Relationship Building; 3. Communication Skills, including cross-cultural communication, active listening, and group and family dynamics; 4. Empowerment Techniques; (continued)	20 hours of continuing education are required every 3 years for Traditional Health Workers (THW). Continuing education offered statewide.	Oregon Health Authority certifies Traditional Health Workers who provide services funded by Medicaid. (continued)

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
OREGON *(continued)*	(continued from page 7) HB 3407 (2013) established the Traditional Health Worker Commission, which oversees CHWs, Peer Support and Peer Wellness Specialists, Personal Health Navigators, and Doulas. HB 3650 (enacted 2011) mandated the Oregon Health Authority to develop education and training requirements that meet federal requirements to qualify for financial participation. The Oregon Health Policy Board established the Non-Traditional Health Worker Subcommittee to create core competencies, education and training requirements.	(continued from page 7) Certification requires a written exam, performance based demonstration, and a professional portfolio of the CHWs previous work, experience, skills, and accomplishments. Grandfathering is available to those who have worked over 3,000 hours in the past five years, and completed additional training.	(continued from page 7) 5. Knowledge of Community Resources; 6. Cultural Competency and Cross Cultural Relationships, including bridging clinical and community cultures; 7. Conflict Identification and Problem Solving; 8. Social Determinants of Health; 9. Conducting Individual Needs Assessments; 10. Advocacy Skills; 11. Building Partnerships with Local Agencies and Groups; 12. The Role and Scope of Practice of Non-Traditional Health Workers; 13. Roles and Expectations for Working in Multidisciplinary Teams; 14. Ethical Responsibilities in a Multicultural Context; 15. Legal Responsibilities; 16. Data Collection and Types of Data; 17. Crisis Identification, Intervention and Problem-Solving; 18. Professional Conduct, including culturally-appropriate relationship boundaries and maintaining confidentiality; 19. Navigating Public and Private Health and Human Service Systems, including state, regional, local; 20. Working with Caregivers, Families, and Support Systems, including paid care workers; 21. Introduction to Disease Process including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help); 22. Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization); 23. Health Across the Life Span; 24. Adult Learning Principles 25. Teaching and Coaching; 26. Stages of Change; 27. Health Promotion Best Practices; 28. Self-Care; and 29. Health Literacy Issues.		(continued from page 7) Private training entities may apply to the certification board for approval of training programs.
RHODE ISLAND	Rhode Island does not require licensure or certification, but endorses the Community Health Worker Association of Rhode Island training program.	30 hours of classroom learning and 80 hours of field experience. No grandfathering process.	**Skills outlined in CHWARI Training:** 1. Advocacy 2. Current Workforce Issues 3. Working with Children and Families 4. Communication Skills 5. Cultural Competency Committee of CHW employers and supporters developed the certification curriculum, using standards approved by national CHW interest groups, as well as needs defined by RI stakeholders.	RIC Outreach and Community Health Worker Association of Rhode Island (CHWARI). Training is supported and endorsed by the Rhode Island Department of Health.	The Community Health Worker Association of Rhode Island (CHWARI) offers certification training for CHW. Training is endorsed by the Rhode Island Department of Health.

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
SOUTH CAROLINA	The South Carolina Department of Health created the Health Access at the Right Time (HeART) Committee, which is working to create a standard definition of CHW and a scope of practice. In 2013, the HeART Committee established the CHW Pilot Project that is currently in Phase I and connects with primary care practices that employ CHWs with supervision. The Department of Health also created a CHW certification demonstration program. The HeART Committee is currently seeking a formal body to certify CHWs and other non-clinical providers. The Department of Health is developing a Medicaid State Plan Amendment to authorize Medicaid payment for CHW services.	120 classroom hours; internship/mentorship required. Grandfathering requires at least 3 years of experience with community outreach. Documentation from employer is required, and CHW candidate must pass the CHW certification exam. CHWs must have a designated supervisor.	1. Outreach methods and strategies 2. Client and Community Assessment 3. Effective Communication 4. Culturally Appropriate Communication and Care 5. Health Education and Behavior Change 6. Information about Common Chronic Diseases 7. Support, Advocate and Coordinate Care for Clients 8. Apply Public Health Concepts and Approaches 9. Community Capacity Building 10. Writing and Technical Communication Skills 11. Ethics	After one year grant period, ongoing training will be the responsibility of the primary care practice or MCO employer.	The South Carolina Department of Health and Human Services certifies CHWs.
TEXAS	Texas was the first state to develop legislation to govern CHW activities in 1999. Texas offers a Promotor(a) or CHW certification program and requires CHW programs in health and human services agencies to hire state-certified CHWs when possible. A 2001 law required the Department of State Health Services (DSHS) to establish a CHW training program.	160 classroom hours State requires CHWs to show completion of an approved training program to receive certification, but there is no direct evaluation or assessment of their skills and knowledge. Experience can substituted for completion of training for CHWs with 1000 cumulative hours of CHW services within most recent 6 years.	**The established core competencies include:** 1. Communication skills 2. Interpersonal Skills 3. Service Coordination Skills 4. Capacity-Building Skills 5. Advocacy Skills 6. Teaching Skills 7. Organizational Skills 8. Knowledge Base on Specific Health Issues	20 contact hours of continuing education every two years.	Department of State Health Services

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POLICY BRIEF | October 2015

Using Waivers to Improve Health Care Affordability and Access to Health Insurance in Connecticut

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Introduction

Despite improvements in health insurance coverage in Connecticut over the past decade, the combination of insurance premiums and out-of-pocket costs at the point of service makes access to affordable health care difficult for some Connecticut residents. This brief considers how the state government might use program waivers as a policy tool to improve affordability and access for Connecticut residents. For more detail on waiver mechanics, see our companion brief, "How Waivers Work: ACA Section 1332 and Medicaid Section 1115."

Thanks to the Affordable Care Act's (ACA) coverage expansions through HUSKY (the state's Medicaid program) and the availability of subsidized insurance through Access Health CT, Connecticut's uninsured rate fell to four percent of the population as of 2014.[1] Extending health insurance to more of the population is an important strategy for states pursuing the "Triple Aim" for their health care systems: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

States may use waivers to make health insurance more accessible and affordable for their low income residents by:

- **Simplifying the health care system through administrative reforms and/or publicly-financed coverage.**
- **Making Medicaid available to more people.**
- **Using Medicaid funds to purchase private insurance.**
- **Streamlining eligibility processes.**

However, recent HUSKY reductions may partly reverse Connecticut's insurance coverage gains.[2] In addition, recent affordability research shows that while insurance facilitates access to health care, insurance doesn't guarantee access.[3]

Connecticut has addressed cost concerns in several ways. A multi-payer initiative to reform

health care delivery is being financed by a federal State Innovation Model (SIM) grant.[4] Recent state legislation addresses transparency and patient billing practices.[5] In addition to these efforts, it may be appropriate for Connecticut to consider pursuing federal waivers of Medicaid law or the ACA to further facilitate affordable health care.

Waivers could address the following concerns:

Many may still find health insurance coverage unaffordable. Connecticut is both a wealthy state and a costly state to live in. A family of four with an income of $47,000 – twice the federal poverty level (FPL) – would pay about $3,000 per year in premiums (6.3 percent of its income) for a subsidized health plan through Access Health CT, plus additional out-of-pocket expenses when receiving care, in the form of deductibles and copayments. In a recent survey of Access Health CT customers, 30 percent of respondents who purchased private coverage said they thought they were paying too much for insurance. The same survey reported that lack of affordability was the most frequent reason given for terminating coverage, cited by about one respondent in five.[6]

Facing high costs, families of limited means may choose to delay or forgo needed care.[7] The Connecticut Health Care Survey, conducted in 2012 and 2013, found that one-tenth of respondents with health insurance did not get care they needed during the prior year, and another one-quarter delayed care. Many of these respondents cited health care costs as the reason for forgoing care.[8] Many parents who lost Connecticut Medicaid coverage during the summer of 2015 due to state budget action may find their health care costs are much higher on Access Health CT.[9] Waivers could be used to make health insurance more affordable to Connecticut residents.

Some face challenges maintaining their coverage. Individuals and families may lose coverage temporarily because of income that fluctuates between eligibility levels for HUSKY and for subsidized coverage through Access Health CT.[10] The loss of health insurance, even for a short time, can negatively affect a person's health care access, finances, and health status. Waivers could be used to reduce the negative effects of this eligibility volatility, known as churn.

Some working families cannot access federal subsidies. Individuals may purchase subsidized insurance through Access Health CT if they do not otherwise have access to affordable health insurance.[11] Affordability of employer-sponsored insurance, the most common source of insurance, is determined based on an employee's contribution for individual coverage, not family coverage. High premiums for employer-sponsored family coverage may thus be considered affordable under the law, which excludes an employee's spouse and children from access to subsidies through Access Health CT. Waivers could be used to extend help to these working families.

Some immigrants cannot access federal subsidies. The ACA allows only U.S. citizens, nationals, and lawfully present immigrants to use Access Health CT.[12] Undocumented immigrants are not allowed to purchase insurance on Access Health CT, even at full price. Individuals who lack marketplace access have little or no option to insure themselves for future catastrophic care. Having this population insured would reduce hospitals' liabilities for uncompensated care. Waivers could be used make Access Health CT available to more immigrants.

Some individuals may have an unexpected tax liability. Individuals purchasing subsidized insurance through Access Health CT receive their premium tax credits in advance. The total credit is calculated when the individual files her federal tax return. If income has fluctuated during the year the advanced credits might exceed the total credit, in which case the individual would need to return some of the overpayment to the federal government. The Kaiser Family Foundation estimates that about half the people who received subsidies in 2014 owed some amount in repayment to the federal government.[13] Waivers could help mitigate or eliminate such unexpected tax liabilities.

What are Waivers?

Connecticut might consider reforms to its health care system to address these issues if evidence suggests any of these issues create barriers to quality affordable care that improves the health of the population. Federal waivers are among the policy tools the state could use to accomplish its goals. Two types of waivers that allow broad changes to how health care programs are designed and administered are ACA Section 1332 Waivers and Medicaid Section 1115 Waivers.

The **ACA Section 1332 waiver**, also known as the ACA Innovation Waiver, would allow states to opt out of fundamental elements of the coverage expansion section of the law, including: the creation of a marketplace (Access Health CT); the establishment of qualified health plans available for purchase in the marketplace; federal subsidies for individuals purchasing coverage in the marketplace; and the mandate for individuals to purchase insurance and employers to offer it.[14] To qualify for a waiver, a state would have to demonstrate that its alternative program would provide equally comprehensive coverage to a comparable number of people, provide coverage that is at least as affordable, and not increase the federal deficit. To finance its innovation, a state could receive amounts from the federal government equal to what would have been paid as subsidies to individuals. Section 1332 waivers become available in 2017.

Medicaid Section 1115 waivers have become a basic policy tool for many states' Medicaid programs; 43 states plus the District of Columbia currently have at least one 1115 waiver in place.* With approval of the federal Medicaid oversight agency, a state may waive many aspects of its Medicaid state plan, if the federal agency deems the waiver is "likely to assist in promoting the objectives of the program."[15] Section 1115 waivers may be used to increase income eligibility limits, expand eligibility categories, add benefits not ordinarily covered by Medicaid, launch a pilot program in one area of the state, and more. Programs administered under a Medicaid waiver may not result in federal spending that is greater than what it would be under a traditional Medicaid program. A state may apply for a Section 1115 waiver at any time; these waivers often take months or even years to design and have approved.

Using Waivers to Address Affordability and Access Issues

ACA Section 1332 and Medicaid Section 1115 waivers offer policy makers opportunities to tailor publicly administered or subsidized health insurance programs to the needs of their states. With careful design, these options could address the affordability and access issues that might impede

* Included in this state count are 1115 waivers for the Children's Health Insurance Program (CHIP), which is often integrated with a state's Medicaid program. Not included in this state count are 1115 waivers for TANF and other programs.

Connecticut residents' access to health care. Options include:

Simplifying the health care system. Complexity in the health care system leads to added costs for both providers and participants. Connecticut could use Section 1332 and 1115 waivers to reduce complexity and its associated costs. Several options are available, varying in the level of state involvement required. For example, Connecticut could build on a recent billing statute and use waiver authority to standardize billing and claiming processes across all third party payers.[16] A recent survey of Connecticut physicians found that a majority of respondents considered the lack of uniformity in insurance forms "very challenging."[17] Connecticut could also offer a publicly financed health plan to compete in the health insurance marketplace. Much of the design for this type of product was accomplished as part of SustiNet, an earlier Connecticut health care initiative. Or, Connecticut could pool public funds with private sources to finance the coverage of all state residents through a single, state-sanctioned structure.

Offering an affordable continuum of care. Connecticut could use ACA Section 1332 and Medicaid Section 1115 waivers to expand HUSKY eligibility to all individuals with incomes under 200 percent of FPL who are not currently eligible. This reform could reduce low income residents' out-of-pocket expenses with subsidized coverage purchased through Access Health CT. This approach is similar to the Basic Health Program (BHP) option in the ACA. The waiver would allow Connecticut to configure this expansion to fit with the existing HUSKY administrative structure.

Offering flexibility to health care entities in order to promote population health. Recent research highlights the contribution of non-medical factors to worse health and higher health care costs. Through its SIM grant, Connecticut is moving to a multi-payer model in which health care entities take more responsibility for population health and health costs, in return for greater flexibility to address health more holistically. Connecticut could use Section 1332 and 1115 waivers to support and sustain the SIM grant work.

Extending health care to more immigrants. By buying health insurance, individuals can both safeguard their financial futures and promote the sustainability of hospitals and other providers who care for them. The ACA excludes immigrants not "lawfully present" from purchasing insurance in an insurance marketplace, even at full price.[18] Using an ACA Section 1332 waiver, Connecticut could extend the offer to buy full-priced insurance to more immigrants.[19] A similar proposal was considered by the California legislature in 2015.[20] In addition, Connecticut could use state-only funds to provide subsidies for those individuals.[21]

Streamlining processes to make it easier to maintain coverage. States may use Medicaid Section 1115 waivers to institute processes that would help stabilize enrollment and reduce coverage gaps.[22] One example is to allow adults who are enrolled in HUSKY to remain eligible for 12 continuous months, regardless of changes that might affect eligibility such as income or family composition.

Potential Pitfalls

There are potential unintended consequences in using waivers to provide an alternative path to coverage for low-income residents. The projected federal revenue to support a reform could put state finances at risk if the parameters on which projections are based are not accurate. The administrative structure of a new program must mesh well with existing ones, lest uncoordinated transitions across programs cause coverage gaps. Removing a group of people from the marketplace could affect Access Health CT, hindering its clout in the market and curtailing its financing base. And changes in the political climate also present a potential risk for waiver programs that rely on federal approval of future waiver renewals. Policy-makers should be aware of these potential pitfalls and take steps to minimize their likelihood.

An Action Agenda for Connecticut

Connecticut state government and interested observers can take a number of short-term steps to help determine whether and which options discussed in this paper are needed to enhance affordability and access to coverage, including:

Monitor accessibility and affordability. Interested parties can use data to monitor how Connecticut residents are faring under ACA reforms, as indicators of whether it may be necessary to pursue some of the options described here.

Share information. Once access and affordability information is gathered, interested parties could engage in information sharing and advocacy, including informing the public, engaging legislators, and working with the Connecticut Healthcare Advocate.

Develop and pursue options. If the situation calls for further reform, policy options could be developed that use waivers or other tools. In the course of developing options, state agencies, legislators, and other stakeholders should be engaged to explore shared goals and potential solutions to affordability issues.

Conclusion

The Affordable Care Act created a default structure for making available affordable coverage. To increase the likelihood that as many people as possible have the opportunity for adequate, affordable coverage, the ACA also provides options for states to depart from the default. If, as ACA implementation proceeds, it appears that a sizeable number of its residents still cannot afford coverage, Connecticut may consider using one of the waiver options described in this brief to improve access to and affordability of health care coverage for its residents.

Endnotes

[1] Access Health CT. Connecticut's Statewide Uninsured Rate Cut in Half: Nearly 140,000 Enrollees Were Previously Uninsured. Press Release (August 6, 2014).

[2] Rachel Gershon, Robert Seifert, and Katharine London. How Proposed HUSKY Cuts Will Harm Low-Income Families (March 2015).

[3] Arielle Levin Becker. Survey: 36% of CT Obamacare Customers Haven't Used their Insurance (July 22, 2015); Gary Claxton, Matthew Rae, and Nirmita Panchal. Consumer Assets and Patient Cost Sharing, Kaiser Family Foundation (March 2015).

[4] Connecticut State Insurance Model. SIM at a Glance. http://www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf (accessed July 30, 2015).

[5] Connecticut Public Act No. 15-146 (2015).

[6] The Pert Group. Access Health CT: Enrollee/Leaver Satisfaction and Understanding Study. Access Health CT (July 2015). Affordability-related reasons for termination include answers that coverage was generally too expensive (14%) or that specifically cited copays and deductibles (2%), premiums (2%), or prescriptions (1%).

[7] Jonathan Gruber and Ian Perry. Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable? The Commonwealth Fund (April 2011).

[8] Universal Health Care Foundation of Connecticut. Access to Coverage and Care: Targeting Implementation of the Affordable Care Act to Improve Health in Connecticut. Connecticut Health Care Survey (May 2014).

[9] Rachel Gershon, Robert Seifert, and Katharine London. How Proposed HUSKY Cuts Will Harm Low-Income Families (March 2015); Arielle Levin Becker, Connecticut Mirror. Few Who Lost Medicaid Have Purchased Insurance (September 2015).

[10] Benjamin Sommers and Sara Rosenbaum. Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges. Health Affairs 30:2 (February 2011).

[11] ACA § 1401, 26 U.S.C. §36B(c)(2)(C)(i).

[12] ACA § 1312(f)(3), 42 U.S.C. § 18032. ACA regulations define people with deferred action as lawfully present (42 C.F.R. §152.2). However, administration policy appears to exclude individuals recently eligible for deferred action under Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parental Accountability (DAPA). See Remarks by the President in Address to the Nation on Immigration (November 20, 2014), http://www.whitehouse.gov/the-press-office/2014/11/20/remarks-president-address-nation-immigration (accessed July 30, 2015).

[13] Cynthia Cox, Anthony Damico, Gary Claxton, et. al., Kaiser Health Foundation. Repayments and Refunds: Estimating the Effects of 2014 Premium Tax Credit Reconciliation (March 2015).

[14] ACA § 1332, 42 U.S.C. 18052.

[15] Section 1115 of the Social Security Act, 42 U.S.C. 1315.

[16] Connecticut Public Act No. 15-146 (2015).

[17] Rob Aseltine, Paul Cleary, Elizabeth Schilling, et.al. Physician Perspectives on Care Delivery Reform: Results from a Survey of Connecticut Physicians (April 2015), http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-04-09/presentation_physician_survey_04092015_final.pdf (accessed July 30, 2015).

[18] ACA § 1312(f)(3), 42 U.S.C. § 18032(f)(3)

[19] Section 1332 of the ACA allows for a waiver of 42 U.S.C. 18032(f)(3), which bans certain immigrants from using Access Health CT.

[20] California Senate Bill 10 (2015)

[21] Using federal funds derived from the aggregate amount in ACA §1332(a)(3) might also be allowable, depending on interpretation of federal law.

[22] Centers for Medicare and Medicaid Services. State Health Official/State Medicaid Director Letter #13-003, "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" (May 17, 2013)

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