Board of Directors Meeting

May 19, 2016

access health CT

Agenda

A. Call to Order and Introductions
B. Public Comment
C. Review and Approval of Minutes

April 21, 2016 Regular Meeting Minutes (Vote)
May 10, 2016 Special Meeting Minutes (Vote)

D. CEO Report
E. Finance – Budget (Vote)
F. Texas Health Institute Presentation - Marketplace Health Equity Assessment
G. APCD Update
H. Adjournment

access health CT

Votes

- April 21, 2016 Regular Meeting Minutes
- May 10, 2016 Special Meeting Minutes

access health CT

CEO Report

access health CT

2017 Fiscal Year Budget
&
2017 Financial Sustainability
May 2016

access health CT

2017 Fiscal Year Budget Overview

- Compared to 2016, the 2017 AHCT budget of $34.6M is $2.0M or 6.1% more than the 2016 forecast of $32.6M. On a gross expense basis, 2017 is $66.4M , which is $12M or 15.3% less than the 2016 forecast of $78.4M.
- The increase in the AHCT budget relates to the culmination of Federal grant funding and start-up for the new call center. Offsetting the increase is the continued maturation of the Integrated Eligibility System (IES) resulting in less design, development and implementation (DDI) activity.
- The AHCT budget includes costs for the All Payer Claim Database (APCD) for both operations and DDI. A delay and shift in the DDI schedule results in 2017 AHCT expenses that otherwise would have been funded by Federal grants that have now culminated.
- The decrease in gross expense relates to a reduction in DDI activity overall and directly billing DDI to both AHCT and the Department of Social Services (DSS) for their specific DDI activity. Previously, AHCT was billed and then shared costs with DSS.

Access Health CT Budget Cycle

Funding:

Primarily federally funding by Level 2 Supplemental, 2013 Level I and 2014 Level I Grants. Partial Marketplace Assessment revenue.

Expense Structure:

Design, Development and Implementation (DDI) as well as Operational costs.

Funding:
Primarily Marketplace Assessment revenue with federal funding by Level 2 Supplemental, 2013 Level I and 2014 Level I Grants.

Expense Structure:
Operational costs with some continuing DDI that is primarily enhancements and resolving issues.

Funding:

Primarily Marketplace Assessment revenue with federal funding by 2014 Level I Grant.

Expense Structure:

Operational costs with limited DDI that is primarily enhancements.

access health CT

2017 Fiscal Year Budget
2017 vs. 2016 Fiscal Year Forecast

Fiscal Year 2017

Access Health CT	Budget	DSS Reimb	Grant	AHCT
Salaries	$ 8,065,818	$ -	$ -	$ 8,065,818
Fringe Benefits	$ 2,419,745	$ -	$ -	$ 2,419,745
Temporary Staffing	$ 2,021,349	$ 1,585,079	$ -	$ 436,270
Contractual	$ 38,865,708	$ 18,082,305	$ 2,054,556	$ 18,728,847
Equipment and Maintenance	$ 13,803,144	$ 10,064,566	$ -	$ 3,738,578
Supplies	$ 31,550	$ -	$ -	$ 31,550
Travel	$ 118,500	$ -	$ -	$ 118,500
Other Administrative	$ 1,061,813	$ -	$ -	$ 1,061,813
Total Expense	**$ 66,387,627**	**$ 29,731,950**	**$ 2,054,556**	**$ 34,601,121**

Fiscal Year 2016

Access Health CT	Forecast	DSS Reimb	Grant	AHCT
Salaries	$ 7,180,710	$ -	$ (168,050)	$ 7,348,760
Fringe Benefits	$ 2,154,213	$ -	$ 24,526	$ 2,129,687
Temporary Staffing	$ 3,246,287	$ 1,783,286	$ 320,617	$ 1,142,384
Contractual	$ 52,814,746	$ 26,717,644	$ 8,661,585	$ 17,435,517
Equipment and Maintenance	$ 11,550,356	$ 8,535,570	$ (83,120)	$ 3,097,905
Supplies	$ 38,252	$ -	$ (6)	$ 38,258
Travel	$ 252,715	$ -	$ (5,590)	$ 258,304
Other Administrative	$ 1,202,628	$ -	$ 29,400	$ 1,173,227
Total Expense	**$ 78,439,906**	**$ 37,036,500**	**$ 8,779,364**	**$ 32,624,043**

FY17 v FY16 Variance

Access Health CT	Variance	DSS Reimb	Grant	AHCT
Salaries	$ 885,107	$ -	$ 168,050	$ 717,058
Fringe Benefits	$ 265,532	$ -	$ (24,526)	$ 290,059
Temporary Staffing	$ (1,224,938)	$ (198,207)	$ (320,617)	$ (706,114)
Contractual	$ (13,949,038)	$ (8,635,339)	$ (6,607,030)	$ 1,293,330
Equipment and Maintenance	$ 2,252,788	$ 1,528,996	$ 83,120	$ 640,673
Supplies	$ (6,702)	$ -	$ 6	$ (6,708)
Travel	$ (134,215)	$ -	$ 5,590	$ (139,804)
Other Administrative	$ (140,815)	$ -	$ (29,400)	$ (111,415)
Total Expense	**$ (12,052,280)**	**$ (7,304,550)**	**$ (6,724,808)**	**$ 1,977,078**

Variances

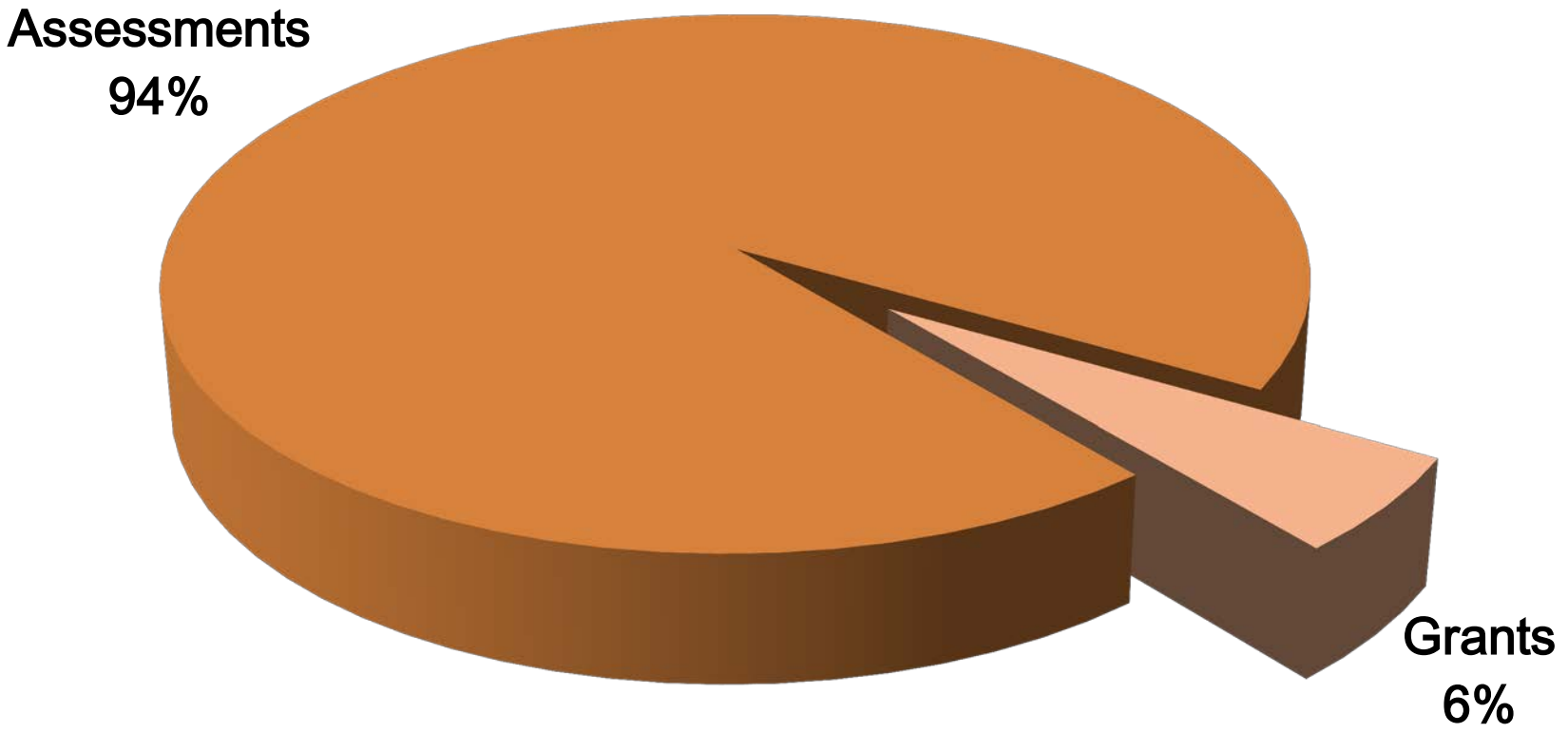
- **Salary & Fringe costs increases due to conversion of Temp Staff to permanent and timing of hiring FY16 positions.**
- **Temporary Staffing, Contractual, and Equipment and Maintenance – See page 5 for detail**

access health CT

2017 Fiscal Year Budget
Analysis of Shared Costs with DSS

DSS Allocable Breakout	Q3, FY16 RFCST	FY17 Budget	Variance	Allocation %	Q3, FY16 RFCST	FY17 Budget	Variance
IT Allocable	**$ 8,459,815**	**$ 706,072**	**$ 7,753,743**		**$ 4,586,091**	**$ 593,100**	**$ 3,992,990**
Development (Old)	$ 4,621,429	$ -	$ 4,621,429	28.53%	$ 1,318,494	$ -	$ 1,318,494
Development (New)	$ 539,538	$ 200,000	$ 339,538	84.00%	$ 453,212	$ 168,000	$ 285,212
Security (Old)	$ 175,000	$ -	$ 175,000	28.53%	$ 49,928	$ -	$ 49,928
Security (M&O)	$ 481,853	$ -	$ 481,853	80.00%	$ 385,482	$ -	$ 385,482
Testing	$ 1,643,872	$ 506,072	$ 1,137,800	84.00%	$ 1,380,852	$ 425,100	$ 955,752
DSS Only Projects	$ 998,123	$ -	$ 998,123	100.00%	$ 998,123	$ -	$ 998,123
Non- Allocable	**$ 16,690,490**	**$ 16,299,130**	**$ 391,360**		**$ -**	**$ -**	**$ -**
Accounting	$ 132,000	$ 80,000	$ 52,000	0.00%	$ -	$ -	$ -
APCD	$ 1,325,272	$ 1,410,330	$ (85,058)	0.00%	$ -	$ -	$ -
Legal	$ 1,066,343	$ 635,800	$ 430,543	0.00%	$ -	$ -	$ -
Marketing	$ 4,432,993	$ 4,686,700	$ (253,707)	0.00%	$ -	$ -	$ -
SHOP	$ 643,774	$ 543,000	$ 100,774	0.00%	$ -	$ -	$ -
Plan Management	$ 422,992	$ 340,000	$ 82,992	0.00%	$ -	$ -	$ -
Verifications (Xerox)	$ 2,500,000	$ 1,500,000	$ 1,000,000	0.00%	$ -	$ -	$ -
IT Development	$ 5,847,960	$ 7,000,000	$ (1,152,040)	0.00%	$ -	$ -	$ -
1095 Projects	$ 67,010	$ 75,000	$ (7,990)	0.00%	$ -	$ -	$ -
Other	$ 252,146	$ 28,300	$ 223,846	0.00%	$ -	$ -	$ -
Non- IT Allocable	**$ 27,664,442**	**$ 21,861,506**	**$ 5,802,936**		**$ 22,131,553**	**$ 17,489,205**	**$ 4,642,348**
Call Center	$ 23,978,360	$ 18,761,506	$ 5,216,854	80.00%	$ 19,182,688	$ 15,009,205	$ 4,173,483
Operations	$ 3,686,082	$ 3,100,000	$ 586,082	80.00%	$ 2,948,866	$ 2,480,000	$ 468,866
Contractual	**$ 52,814,746**	**$ 38,866,708**	**$ 13,948,038**		**$ 26,717,644**	**$ 18,082,305**	**$ 8,635,339**
BEST Staffing (DDI Old)	$ 196,072	$ -	$ 196,072	28.53%	$ 55,939	$ -	$ 55,939
BEST Staffing (DDI New)	$ 749,598	$ -	$ 749,598	84.00%	$ 629,662	$ -	$ 629,662
BEST Staffing (M&O)	$ 1,108,967	$ 1,682,002	$ (573,035)	80.00%	$ 887,174	$ 1,345,602	$ (458,428)
AHCT Staffing (DDI New)	$ 106,600	$ -	$ 106,600	84.00%	$ 89,544	$ -	$ 89,544
AHCT Staffing (M&O)	$ 151,208	$ 299,347	$ (148,139)	80.00%	$ 120,966	$ 239,477	$ (118,511)
AHCT Staffing	$ 933,842	$ 40,000	$ 893,842	0.00%	$ -	$ -	$ -
Temporary Staffing	**$ 3,246,287**	**$ 2,021,349**	**$ 1,224,938**		**$ 1,783,286**	**$ 1,585,079**	**$ 198,207**
Dev (LMS, Contact Center etc.)	$ 147,440	$ -	$ 147,440	84.00%	$ 123,849	$ -	$ 123,849
M&O (Old)	$ (361,690)	$ -	$ (361,690)	56.00%	$ (202,546)	$ -	$ (202,546)
M&O (New)	$ 10,767,834	$ 5,143,207	$ 5,624,627	80.00%	$ 8,614,267	$ 4,114,566	$ 4,499,701
M&O (New FY17)	$ -	$ 7,000,000	$ (7,000,000)	85.00%	$ -	$ 5,950,000	$ (5,950,000)
M&O (APCD, Equipment etc.)	$ 996,772	$ 1,658,937	$ (662,165)		$ -	$ -	$ -
Equipment & Maintenance	**$ 11,550,356**	**$ 13,802,144**	**$ (2,251,788)**		**$ 8,535,570**	**$ 10,064,566**	**$ (1,528,996)**
GRAND TOTAL	**$ 67,611,389**	**$ 54,690,201**	**$ 12,921,188**		**$ 37,036,500**	**$ 29,731,950**	**$ 7,304,550**

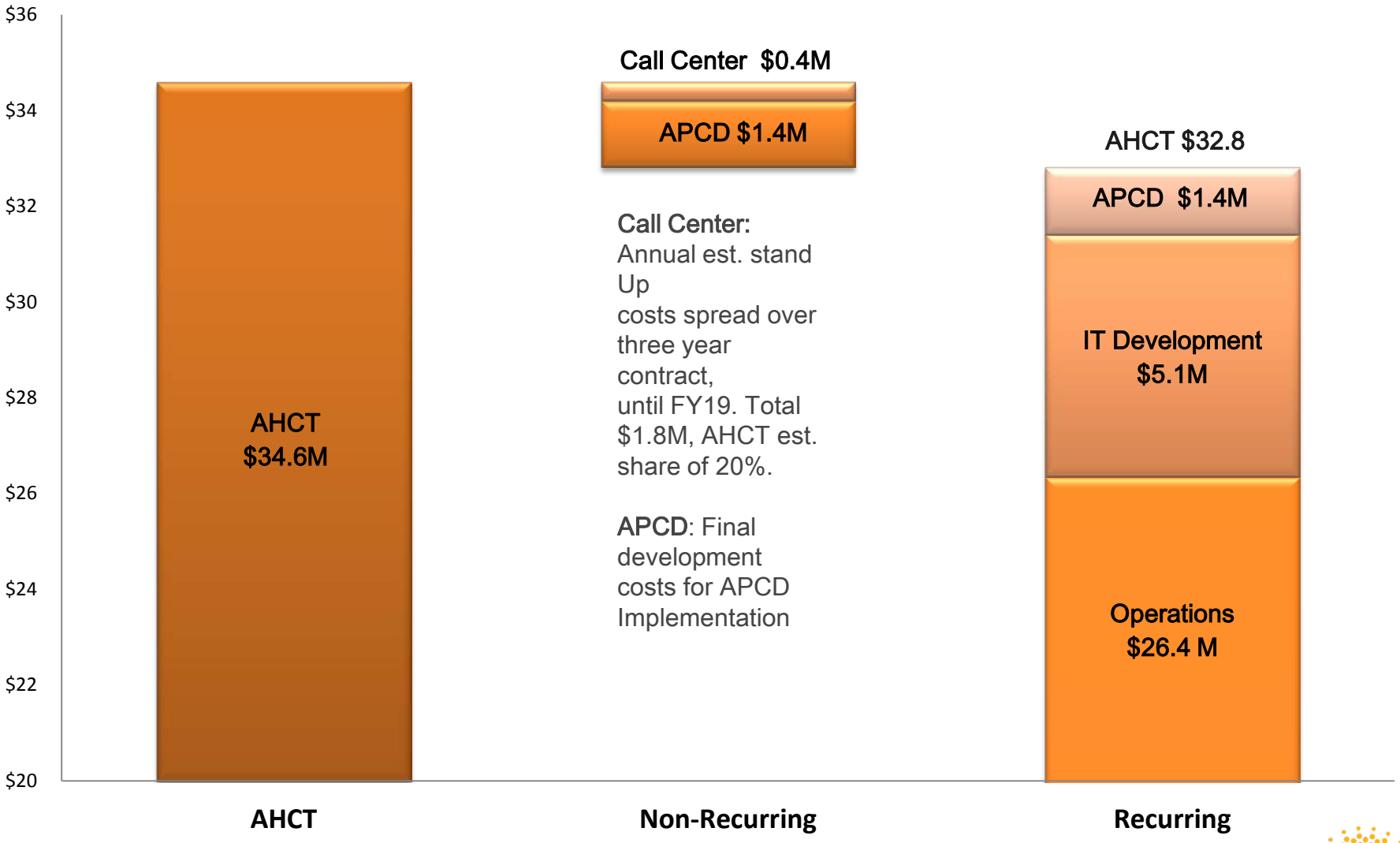
AHCT 2017 Fiscal Year Budget – Funding Sources



AHCT has one remaining grant that culminates on December 15, 2016.

access health CT

AHCT 2017 Fiscal Year Budget – Total vs Recurring



access health CT

2017 Fiscal Year Budget
FY17 Salaries

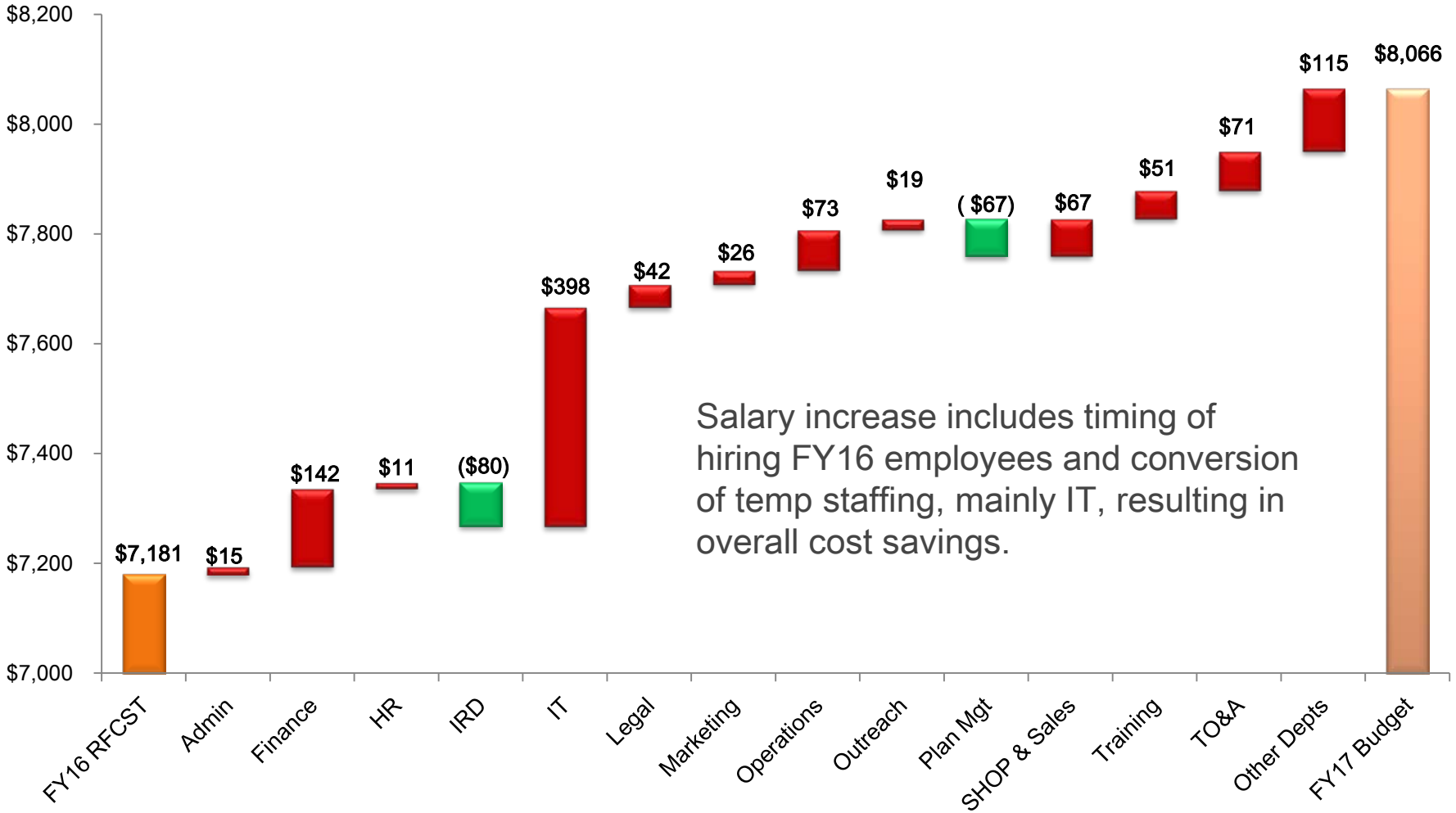
Department	Salaries	FTE
Administration	$ 542,813	4
Finance	$ 957,735	10
HR	$ 310,307	4
IRD	$ 920,547	16
IT	$ 993,574	10
Legal	$ 641,039	8
Marketing	$ 380,287	4
Operations	$ 673,651	10
Outreach	$ 443,103	9
Plan Management	$ 392,937	4
SHOP & Sales	$ 464,836	5
Training	$ 379,783	5
TO&A	$ 313,245	4
Other Depts	$ 651,961	5
Grand Total	**$ 8,065,818**	**100**

Salary of $8M excludes a 30% benefits load.

FTEs include:

- 88 Permanent employees
- 30 Durational employees (12 FTEs)

2017 Fiscal Year Budget
FY16 vs. FY17 Salaries



Salary increase includes timing of hiring FY16 employees and conversion of temp staffing, mainly IT, resulting in overall cost savings.

access health CT

2017 Fiscal Year Budget
Risks and Opportunities

- Risks and opportunities to the AHCT 2017 budget include
  - Risks
    - Transition and start-up of new call center vendor
    - System maintenance & operations (M&O) contract in process
    - Expanding mobile app to Medicaid
    - Cost sharing with DSS
    - Insurance renewal costs
  - Opportunities
    - New call center
    - Cost sharing with DSS
    - M&O contract
    - Business Process Outsourcing (BPO)

2017 Fiscal Year Budget
2016 Fiscal Year 3Q Forecast vs. Actuals

AHCT Through 10 Months*

Category	Q3 Reforecast April YTD	Actuals April YTD	Variance April YTD
Salaries	$5,943,553	$5,877,926	$65,627
Fringe Benefits	$1,812,882	$1,838,437	($25,555)
Temporary Staffing	$693,581	$674,289	$19,293
Contractual	$14,629,968	$14,452,639	$177,329
Equipment and Maintenance	$2,276,830	$2,083,824	$193,006
Supplies	$29,618	$26,941	$2,677
Travel	$143,972	$96,431	$47,541
Other Administrative	$843,753	$828,444	$15,309
Total Expense	**$26,374,156**	**$25,878,930**	**$495,226**

*Total gross expenses for April were $62.9M vs. a forecast of $64.6M, $1.7M favorable. Variances are similar to those for AHCT above.

Note: As part of the 2017 budget process, the third quarter reforecast of FY 2016 was completed. The 2016 Q3 forecast for AHCT of $32.6M is $2.3M less than the 2016 Q2 forecast of $34.9M. The decrease relates to a reduction in design, development and implementation (DDI) activity for the Integrated Eligibility System.

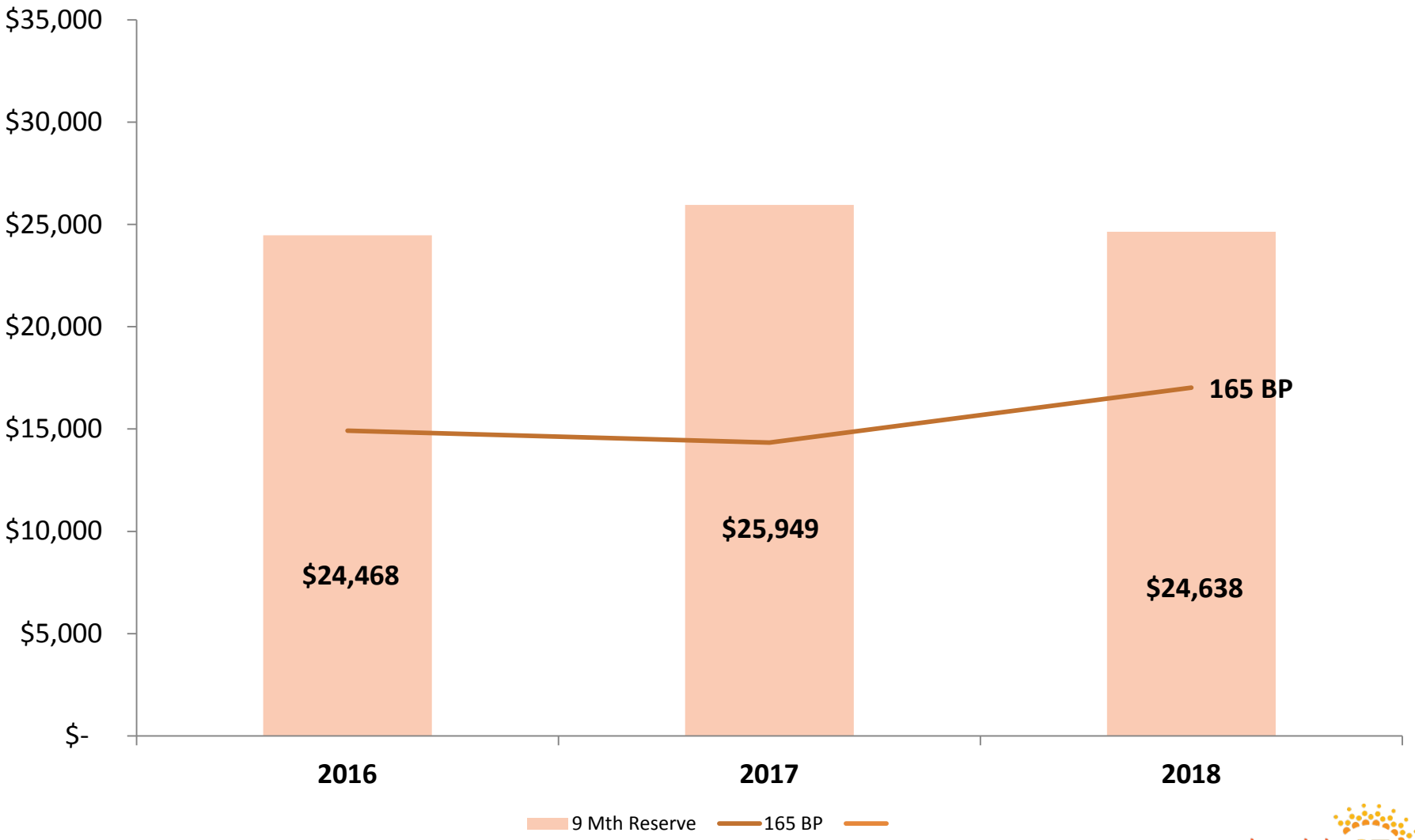
2017 Financial Sustainability

access health CT

2017 Fiscal Sustainability Overview

- The marketplace assessment was approved in 2013 and was charged for the first time in CY 2014 based on Statewide Individual, Small Group and Dental premium.
- 2017 will be the fourth year of the marketplace assessment. The actual assessment will be calculated on CY 2015 premium. This timing is used to be able to rely on the most recent officially filed data by licensed carriers in the State.
- In 2015, the Board of Directors approved a marketplace assessment rate of 165 bps for two calendar years, 2016 and 2017.
- The analysis that follows displays the historical results of the marketplace assessments since inception and an estimated projection of 2017 assessments at 165 bps. Based on this a cash reserve of approximately 5 months is anticipated.

Fiscal Year Assessments



access health CT

Fiscal Year Assessments – Historical and Projection

165 BP in 2016 and 2017 ($'s in 000's)						
Premium Base Year	Marketplace Premium	Assessment Collection Year	Assessment Rate	Calendar Year Marketplace Assessment	Fiscal Year Marketplace Assessment	Year End Reserve
2012	$ 1,846,453	2014-15	0.0135	$ 24,927	$ 12,464	$ 24,479
2013	$ 2,141,986	2015-16	0.0135	$ 28,917	$ 26,922	$ 16,376
2014	$ 2,025,492	2016-17	0.0165	$ 33,421	$ 31,169	$ 14,921
2015	$ 2,098,035	2017-18	0.0165	$ 34,618	$ 34,019	$ 14,341
2016	$ 2,208,813	2018-19	0.0165	$ 36,445	$ 35,531	$ 17,022

Assessment is calculated on a calendar basis and remains at 165bps, which was set at 75% of requirement

Advancing Health Equity in the Health Insurance Marketplace

FINDINGS FROM CONNECTICUT'S MARKETPLACE HEALTH EQUITY ASSESSMENT TOOL (M-HEAT)

Presentation to AHCT Board of Directors
May 19, 2016 | Hartford, CT

Dennis Andrulis, PhD, MPH
Senior Research Scientist

Nadia Siddiqui, MPH
Director for Health Equity Programs

Texas Health Institute
EDUCATION ★ AWARENESS
★POLICY DEVELOPMENT★
PREVENTION
www.texashealthinstitute.org

Supported by W.K. Kellogg Foundation & Connecticut Health Foundation

OVERVIEW

- About Texas Health Institute
- Marketplace Health Equity Assessment Tool
  - Background & Design
  - Results
- Moving Forward

ABOUT TEXAS HEALTH INSTITUTE

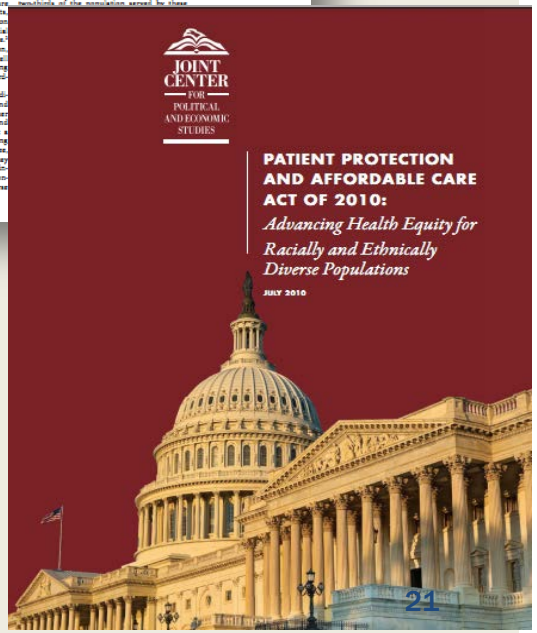
- Non-partisan, nonprofit public health research and policy institute based in Austin, Texas
- Monitoring national health reform from a health equity lens since 2007 across 5 key areas:
  - Health insurance
  - Health care safety net
  - Health care workforce
  - Data & quality
  - Public health & prevention


NATIONAL PRIORITIES

By Dennis P. Andrulis and Nadia J. Siddiqui

Health Reform Holds Both Risks And Rewards For Safety-Net Providers And Racially And Ethnically Diverse Patients

ABSTRACT The Affordable Care Act of 2010 creates both opportunities and risks for safety-net providers in caring for low-income, diverse patients. New funding for health centers; support for coordinated, patient-centered care; and expansion of the primary care workforce are some of the opportunities that potentially strengthen the safety net. However, declining payments to safety-net hospitals, existing financial hardships, and shifts in the health care marketplace may intensify competition, thwart the ability to innovate, and endanger the financial viability of safety-net providers. Support of state and local governments, as well as philanthropies, will be crucial to helping safety-net providers transition to the new health care environment and to preventing the unintended erosion of the safety net for racially and ethnically diverse populations.



M-HEAT BACKGROUND & DESIGN

M-HEAT ORIGIN & IMPETUS

- Diverse populations comprise a large proportion of marketplace eligible
- A handful of leading state marketplaces recognized the importance of reaching diverse populations and built it into their foundation from the start (e.g., AHCT & Covered CA)
- At the start of OEI challenges emerged to enrolling hard-to-reach and diverse individuals

Value in having a tool to help marketplaces
take stock of progress and performance over time
in planning for, enrolling, and improving health care access for diverse and hard-to-reach individuals.

M-HEAT OBJECTIVES

- To monitor and report on how and how well the marketplace is working to advance health equity.
- To identify strengths and successes as well as areas for improvement and advocacy.
- To foster a constructive marketplace and stakeholder dialogue and drive collaboration.
- To offer metrics for ongoing monitoring and accountability initiatives focused on equity.
  - Qualitative
  - Quantitative

M-HEAT FRAMEWORK

M-HEAT Topics

1. Organizational Commitment to Health Equity: strategic and financial commitment, leadership and staff diversity, organizational policies

2. Plan Management and Health Equity: active purchasing, REL data collection, network adequacy

3. Community Engagement and Collaboration: diverse community stakeholder engagement, tribal consultation, cross-sector collaboration

4. Navigator and In-Person Assistance Program: Scope and reach or NIPA, training and certification, language and interpreter services

5. **Marketing and Outreach:** Marketing channels, messaging, vetting, website content and use

6. Marketplace Outcomes: Enrollment, renewals, churn, and coverage to care utilization

DEFINITION OF HEALTH EQUITY

Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. **Health disparities** will be eliminated when health equity is achieved.

Population Focus of M-HEAT:

Low SES

Race/Ethnicity

Limited English Proficiency (LEP)

LGBTQ

M-HEAT DESIGN

- 2 M-HEAT Versions
  - Marketplace Assessment (87-items): assessing equity commitment and progress across marketplace functions
  - Community Stakeholder Assessment (46-items): identifying stakeholder perceptions of marketplace commitment and progress toward equity

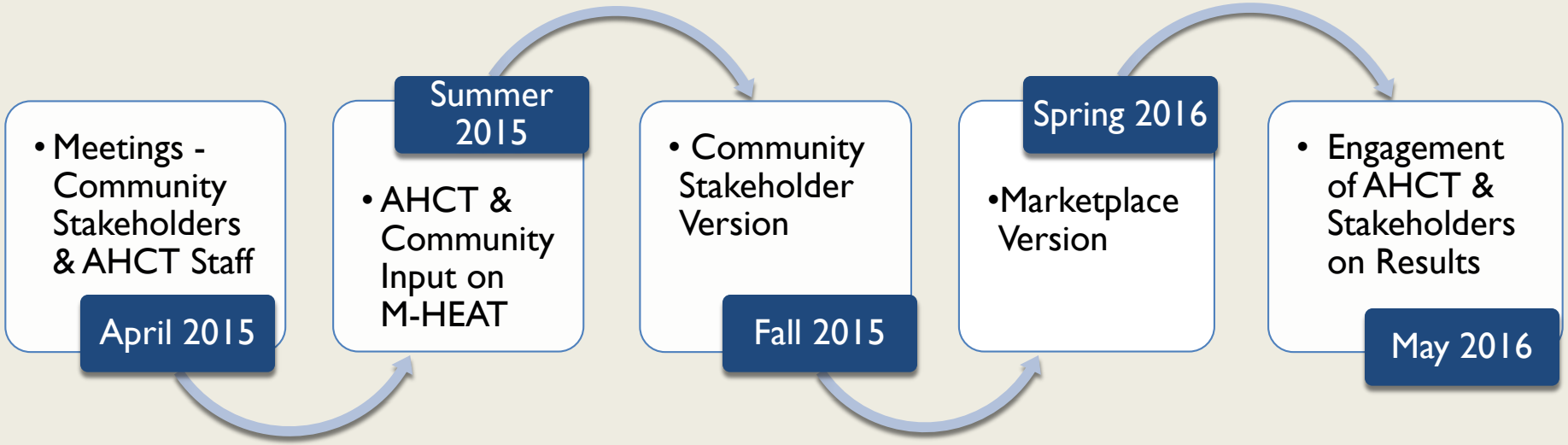
Completed Jan - Apr 2016

Completed Oct - Dec 2015

Data & Experiences for OE1 – OE3

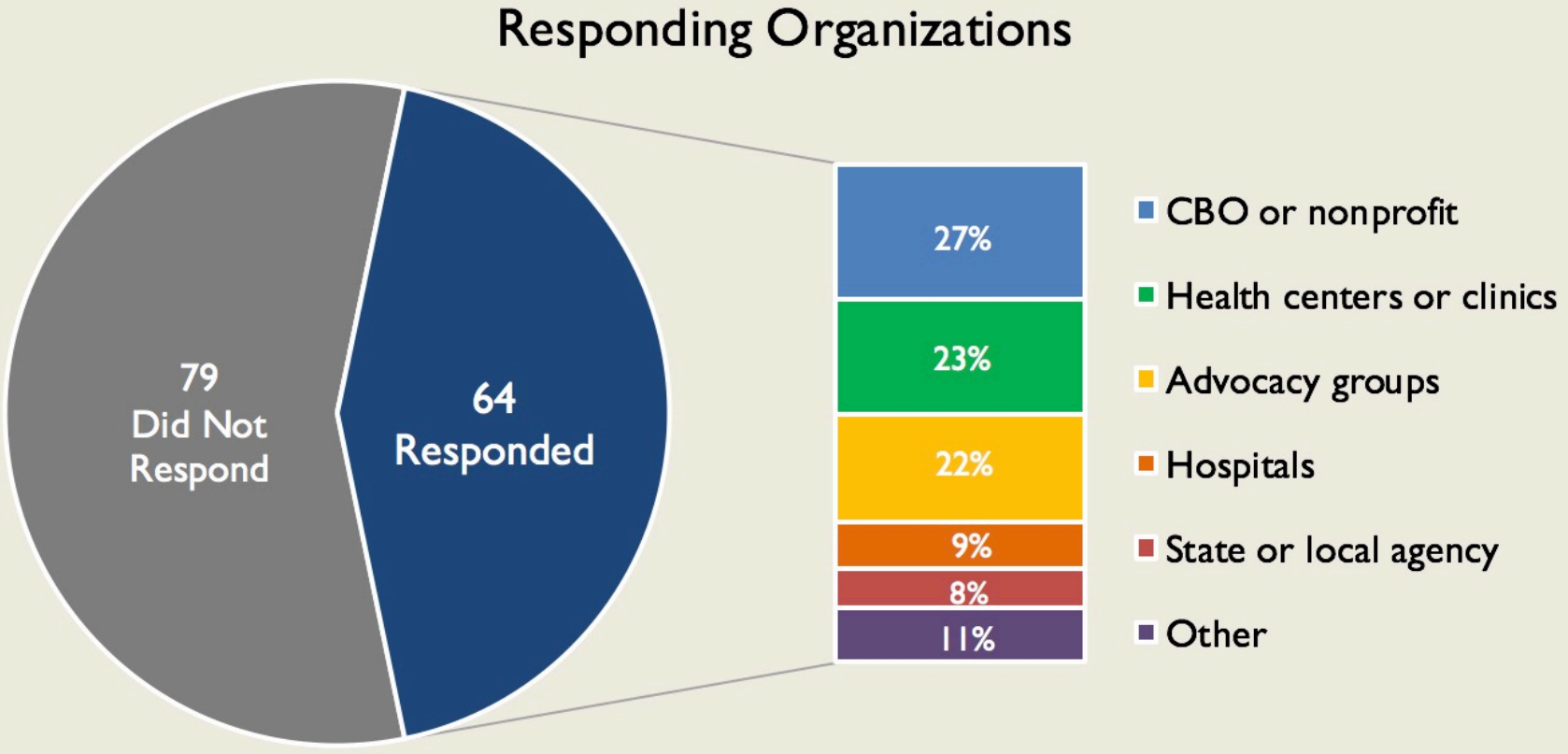
M-HEAT DEVELOPMENT & ADMINISTRATION

Ongoing Engagement of AHCT Staff and Community Stakeholders through Development and Administration, Spring 2015-2016



M-HEAT RESULTS

STAKEHOLDER RESPONDENTS

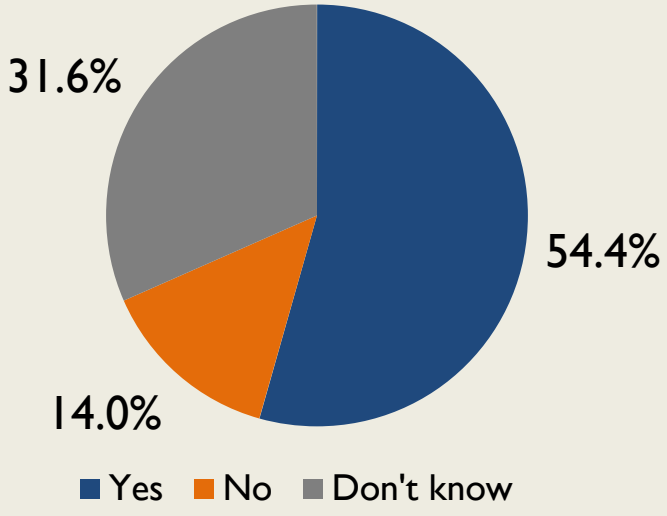


Over 3 in 4 respondents target non-White populations
2 in 3 respondents target LGBTQ populations
Nearly 70% had some role in outreach, education, enrollment

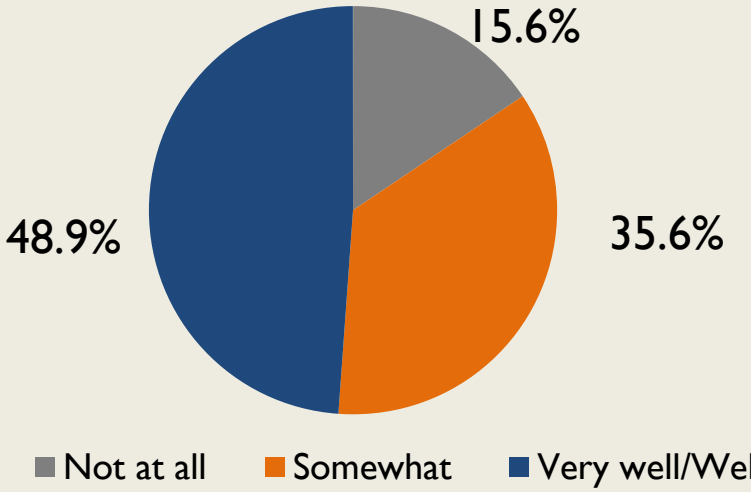
ORGANIZATIONAL COMMITMENT TO HEALTH EQUITY

- AHCT has an explicit and growing commitment to health equity
  - Mission: "reduce health disparities"
  - Principle: "address longstanding, unjust disparities in health access and outcomes"
  - Per latest strategic plan, infusion of "disparities reduction" across all functions

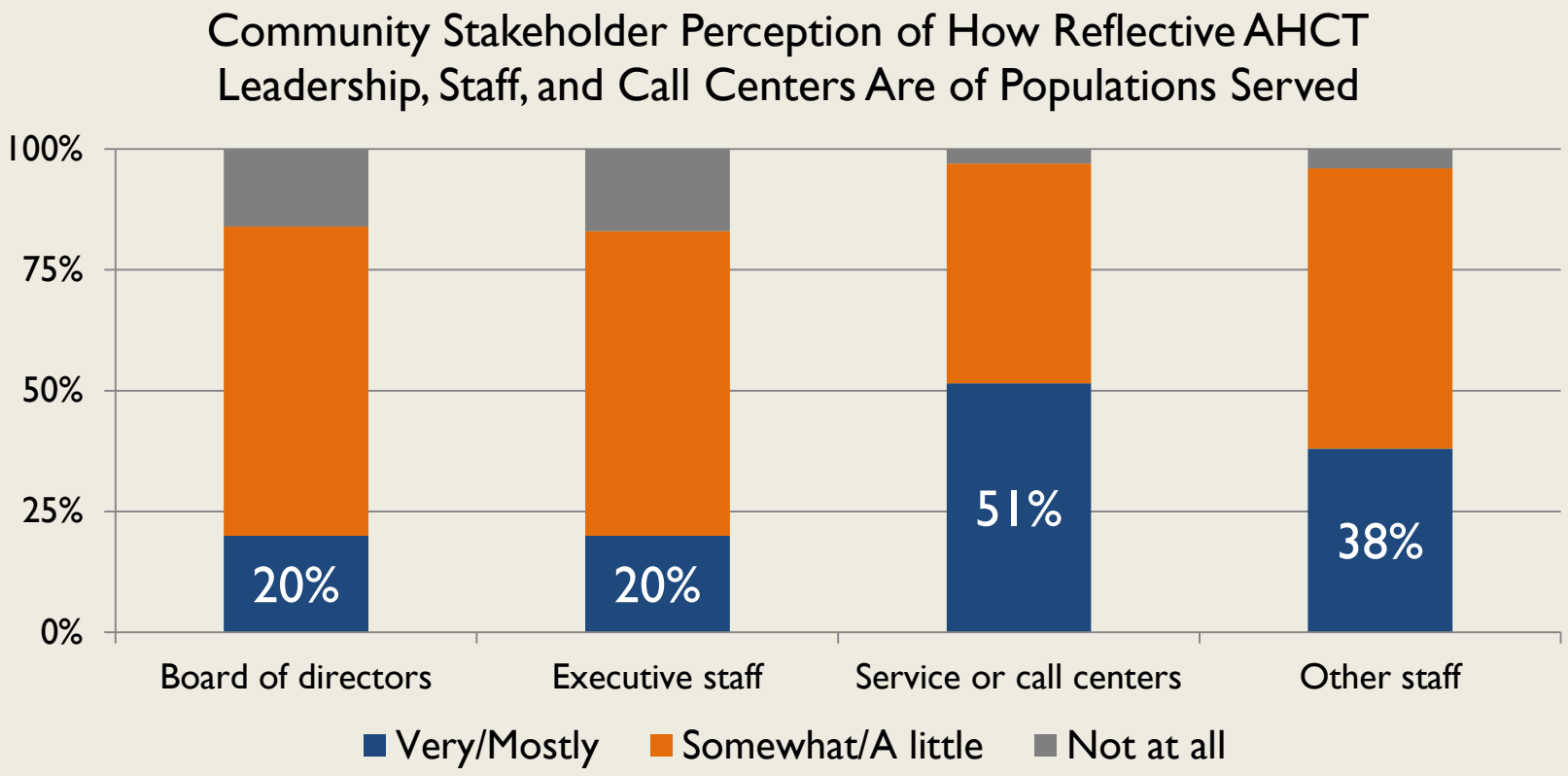
Community Stakeholder Knowledge of AHCT's Commitment to Health Equity



Community Stakeholder Perception of How Well AHCT's Health Equity Commitment Has Been Communicated



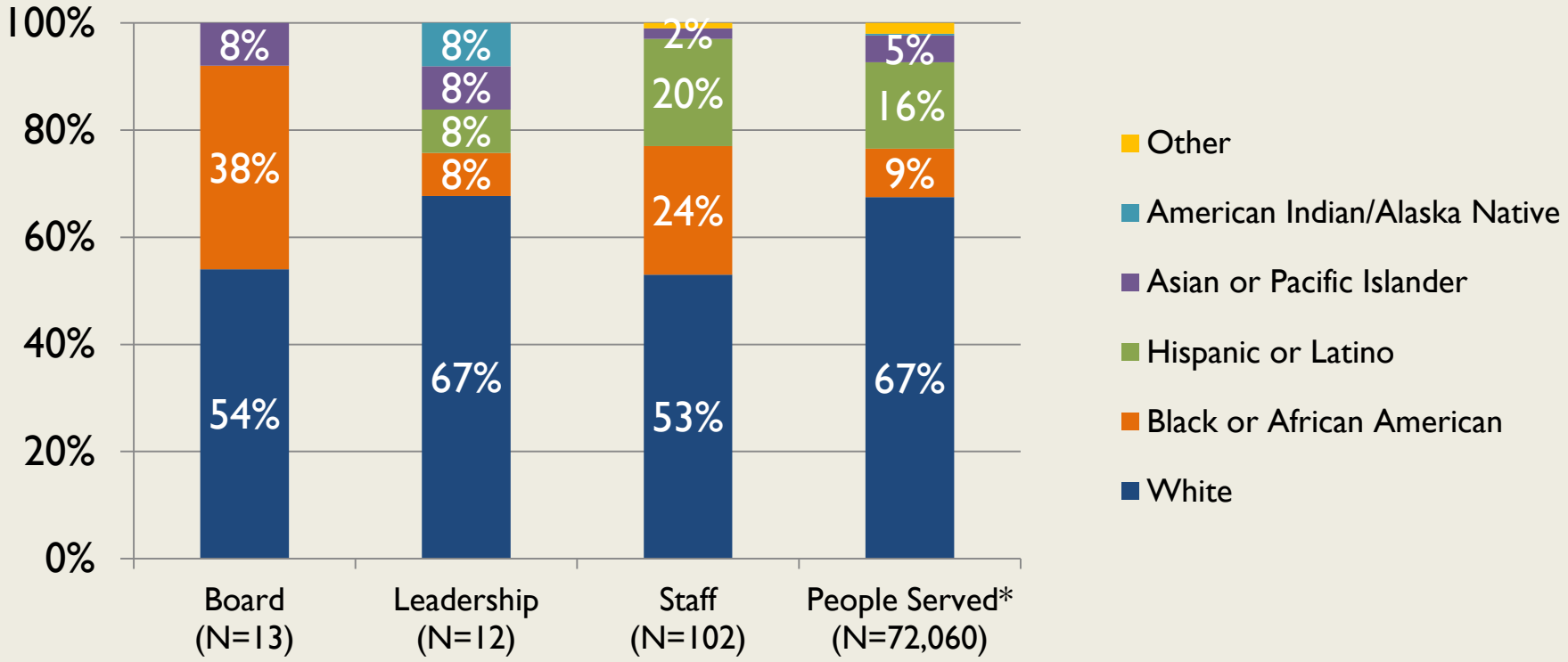
ORGANIZATIONAL DIVERSITY: COMMUNITY STAKEHOLDER PERCEPTIONS



When asked to report how diversity in the marketplace has changed, 33% report that they feel it has grown.

ORGANIZATIONAL AND AHCT MEMBER DIVERSITY

Racial/Ethnic Composition of AHCT Board of Directors, Executive Leadership, Staff, and Primary Applicants, (as of January, 2016)

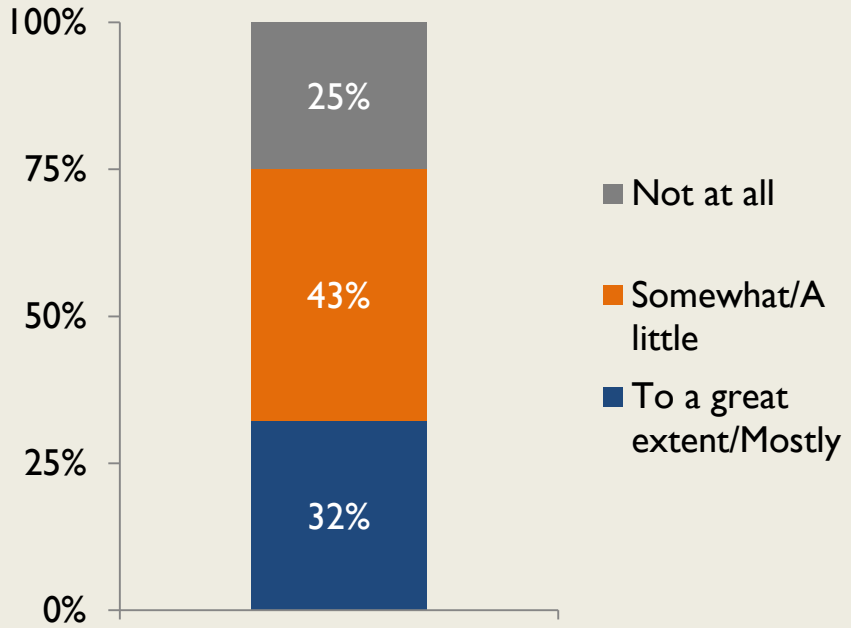


*Note: Diversity by Race/Ethnicity data for People Served is reported for primary applicant respondents.

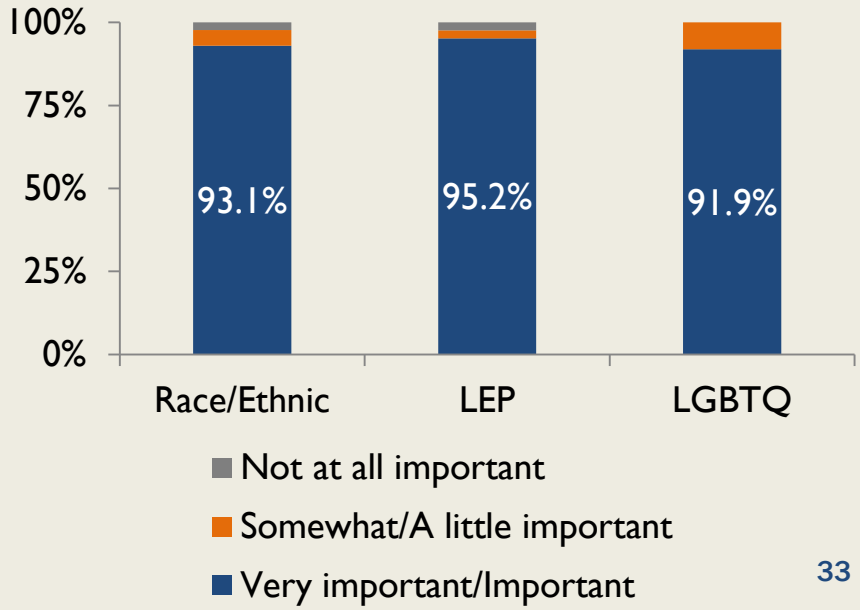
FINANCIAL COMMITMENT TO HEALTH EQUITY

- AHCT's annual budget for OE3 was $32 million (QHP budget excluding Medicaid allocation). As equity/diversity activities were spread across AHCT's functions, it is difficult to tease out exact spending for this priority. Nonetheless, community stakeholders identify financial commitment and allocation to diverse populations as being important to reaching this group.

Community Stakeholder Perception of AHCT's Financial Commitment to Health Equity Objectives

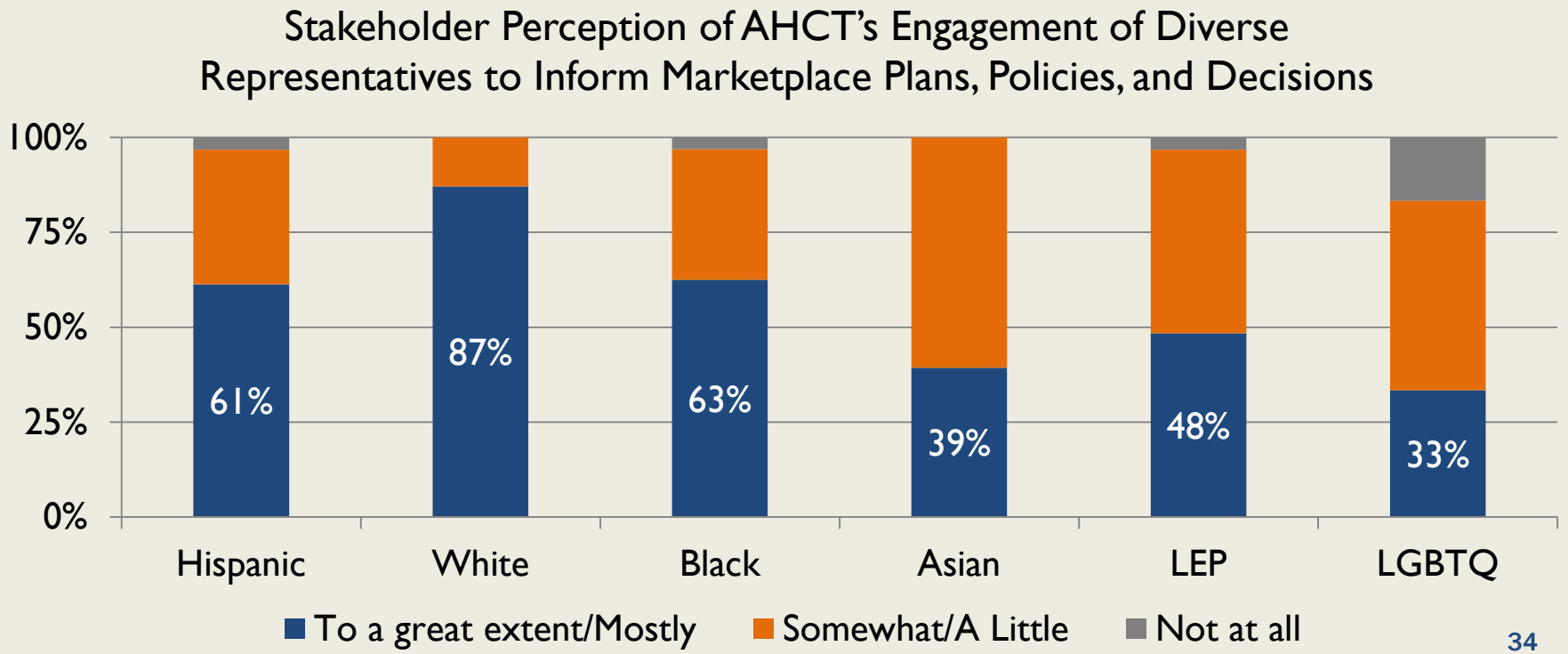


Community Stakeholder Opinion About Importance of Financial Allocation by Populations of Concern



COMMUNITY ENGAGEMENT: COMMUNITY STAKEHOLDER PERCEPTIONS

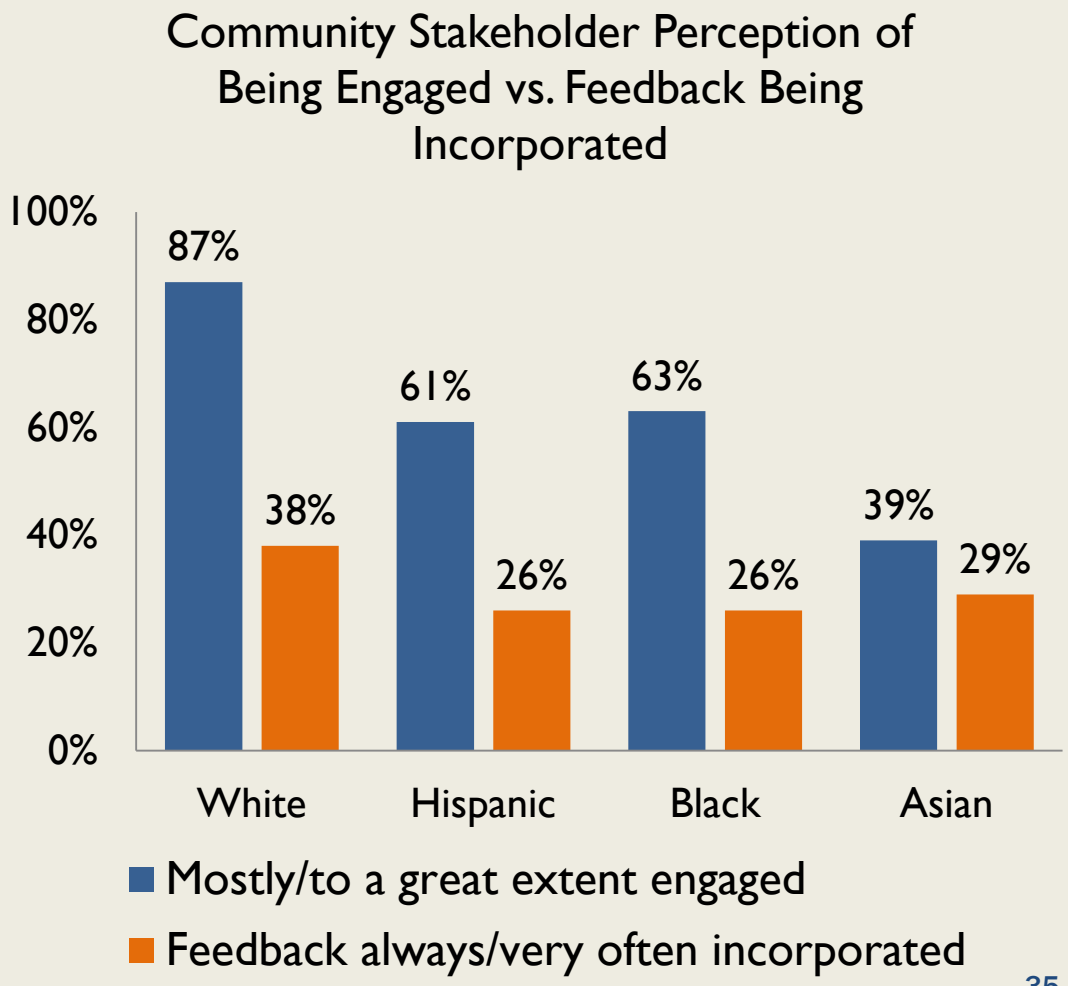
AHCT reports that it very often engages community partners representing diverse racial, ethnic, and linguistic populations. While stakeholders agree this occurs at least somewhat or a little, they feel that engagement varies by racial/ethnic population.



ENGAGEMENT VS. INCORPORATING FEEDBACK: COMMUNITY STAKEHOLDER PERCEPTIONS

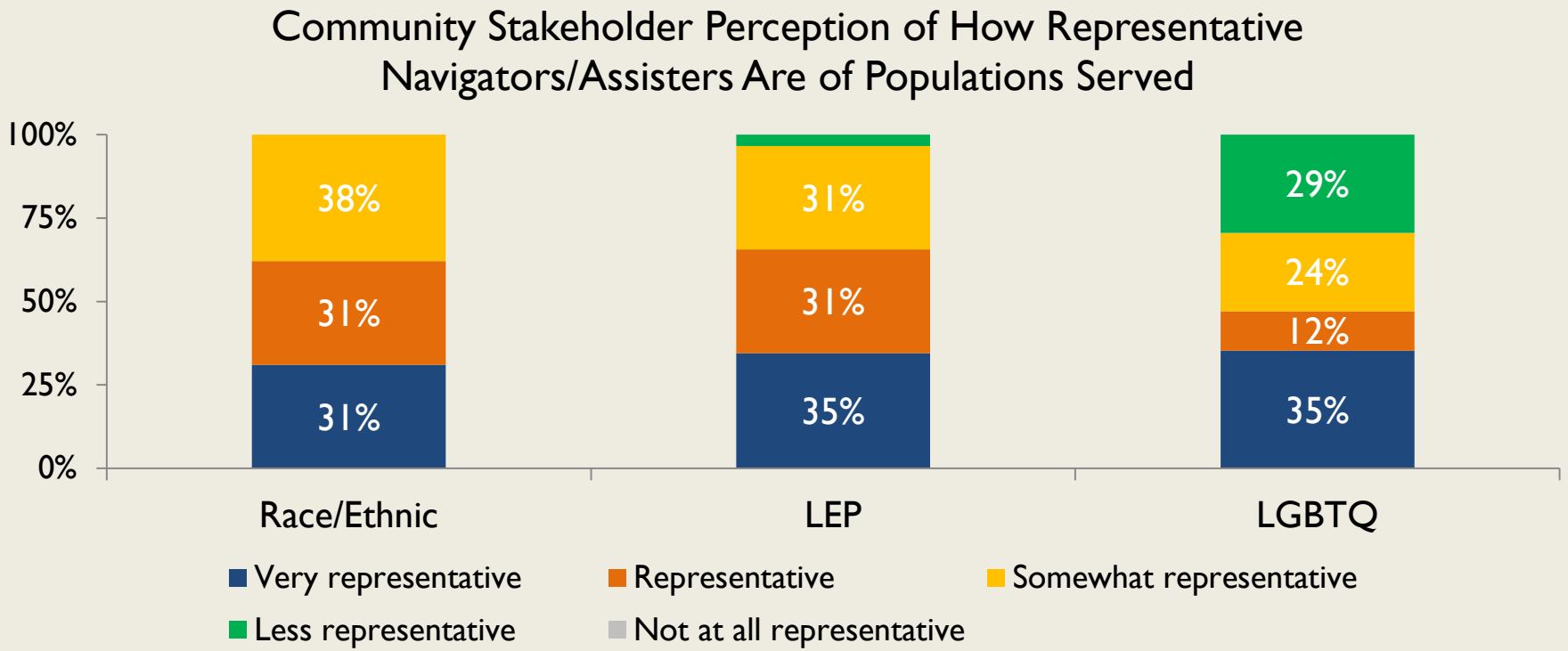
Overall stakeholder perception of community engagement and incorporation of feedback varies by race/ethnicity.

In addition, stakeholders feel that engagement does not always translate to incorporation of feedback.



NAVIGATOR AND IN-PERSON ASSISTERS*: COMMUNITY STAKEHOLDER PERCEPTIONS

- AHCT reports that navigators/assisters are very representative of the AHCT eligible populations. Generally most stakeholders agreed that navigators/assisters were at least somewhat representative.

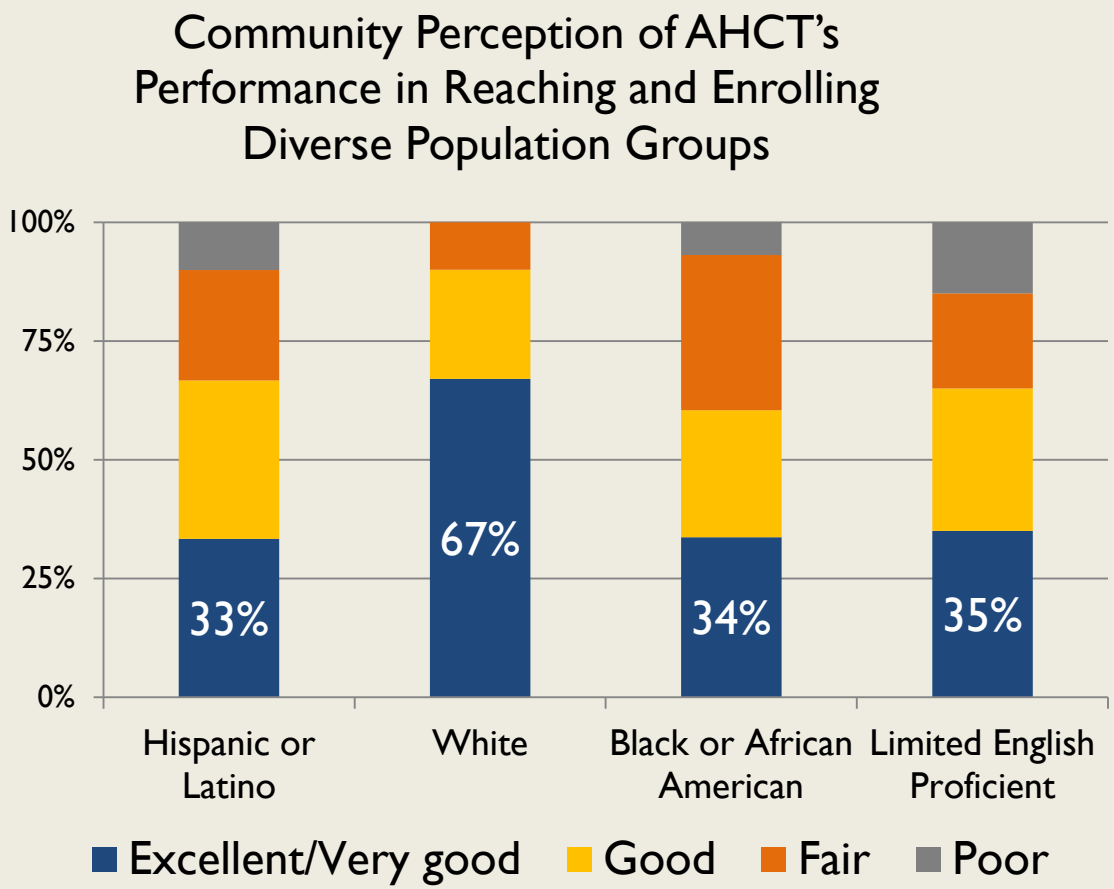


*AHCT no longer has in-person assisters, this changed since OE1.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

- AHCT reported that in the past OEs it has worked to advance CLAS. Through support from Connecticut Health Foundation and CMS, AHCT has developed programs to assure that language assistance, interpreter services, and other consumer support are provided "year round." However, only 50% of stakeholders report knowing about AHCT's year round CLAS efforts.

ENROLLMENT OUTCOMES & COMMUNITY PERCEPTION OF PERFORMANCE



Over 116,000 Enrolled in AHCT in 2016

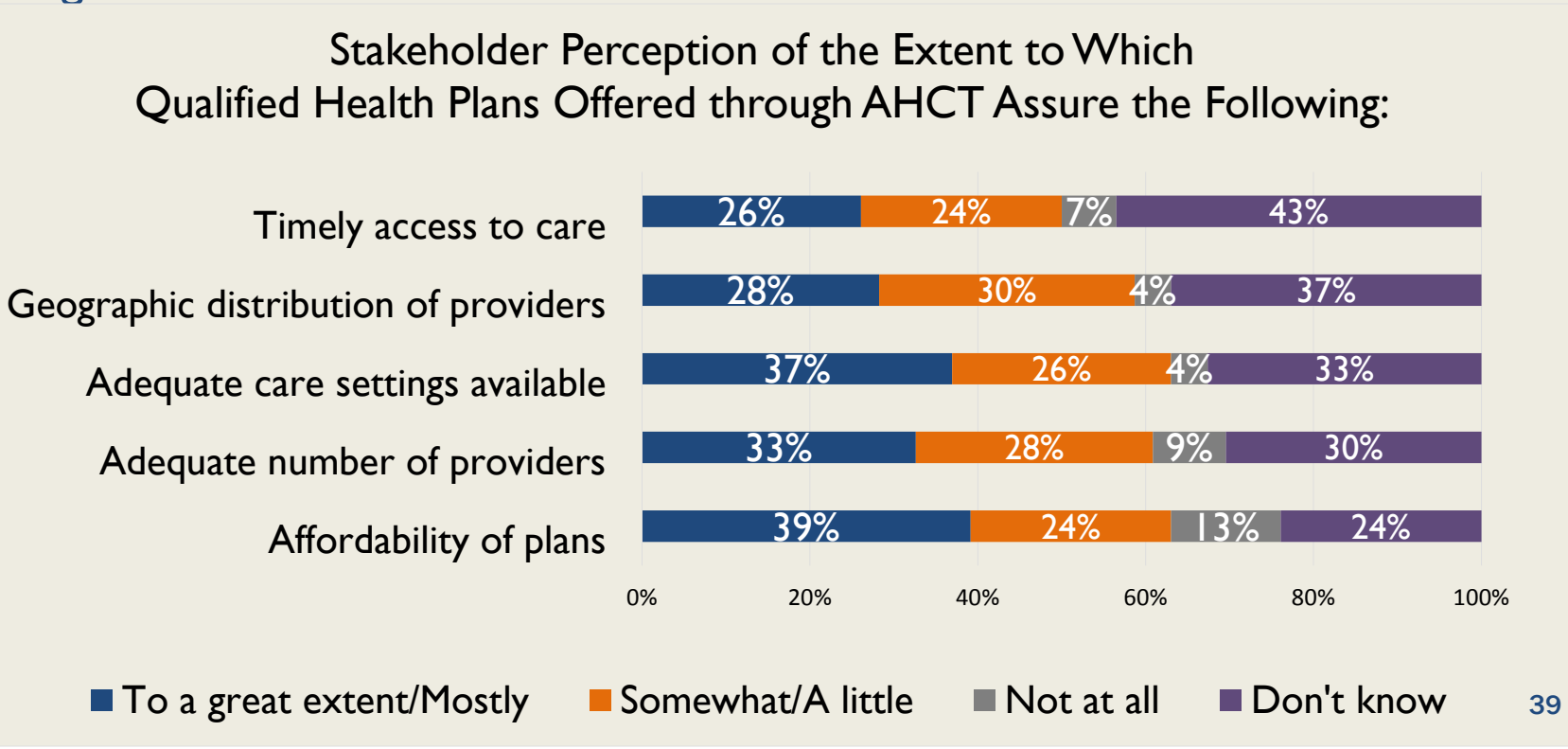
	% Enrolled in OE3
White	66.0%
Hispanic	16.8%
Black	8.2%
Asian	6.4%
AI/AN	0.3%
Other	2.3%

Source: Calculations based on data provided by AHCT, May 2016. Note 35% of individuals not reporting race/ethnicity not included in denominator of percent calculation.

Asian populations not reported due to data collection error.

ACCESS TO CARE & NETWORK ADEQUACY

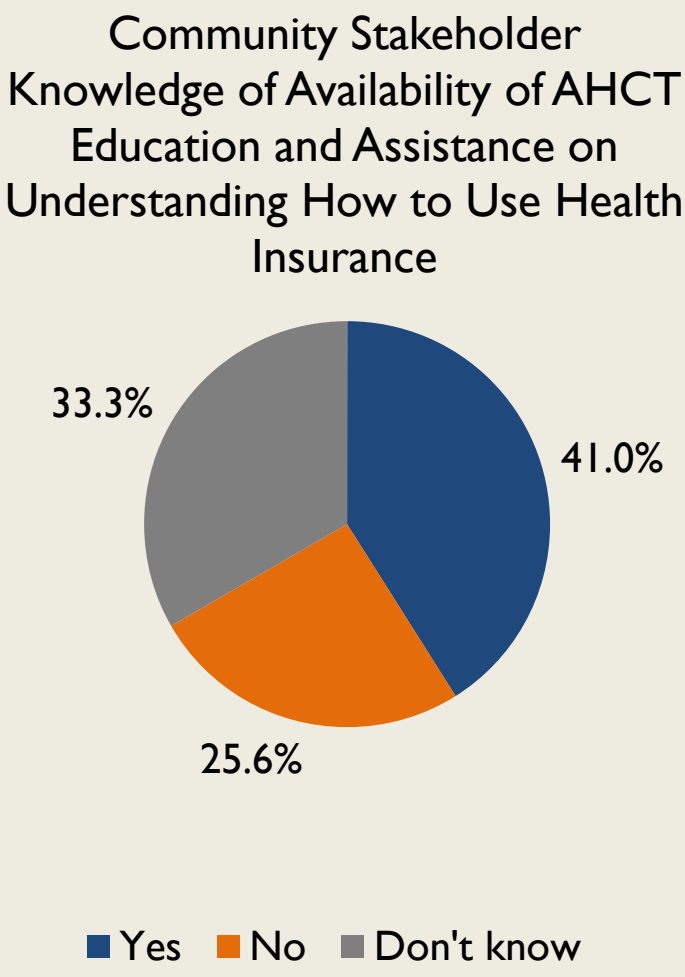
- AHCT reports that it works to wholly assure network adequacy, including adequate number and type of providers in QHPs. Nearly 40% of stakeholders mostly or to a great extent agree with this.



HEALTH INSURANCE LITERACY EDUCATION AND ASSISTANCE

- AHCT provides education and assistance to individuals to help them understand how to use health insurance. This includes outreach efforts, educational webinars, community chats, educational collateral, and other resources. Additional support is also provided in English, Spanish, and 100+ languages over the phone.

- However, only 41% of community stakeholders are aware of such education and assistance.



MOVING FORWARD: POINTS FOR CONSIDERATION

THANK YOU

Research Team

Dennis P. Andrulis, PhD, MPH
Senior Research Scientist, Texas Health Institute
Associate Professor, University of Texas School of Public Health
dandrulis@texashealthinstitute.org

Nadia J. Siddiqui, MPH
Director of Health Equity Programs
Texas Health Institute
nsiddiqui@texashealthinstitute.org

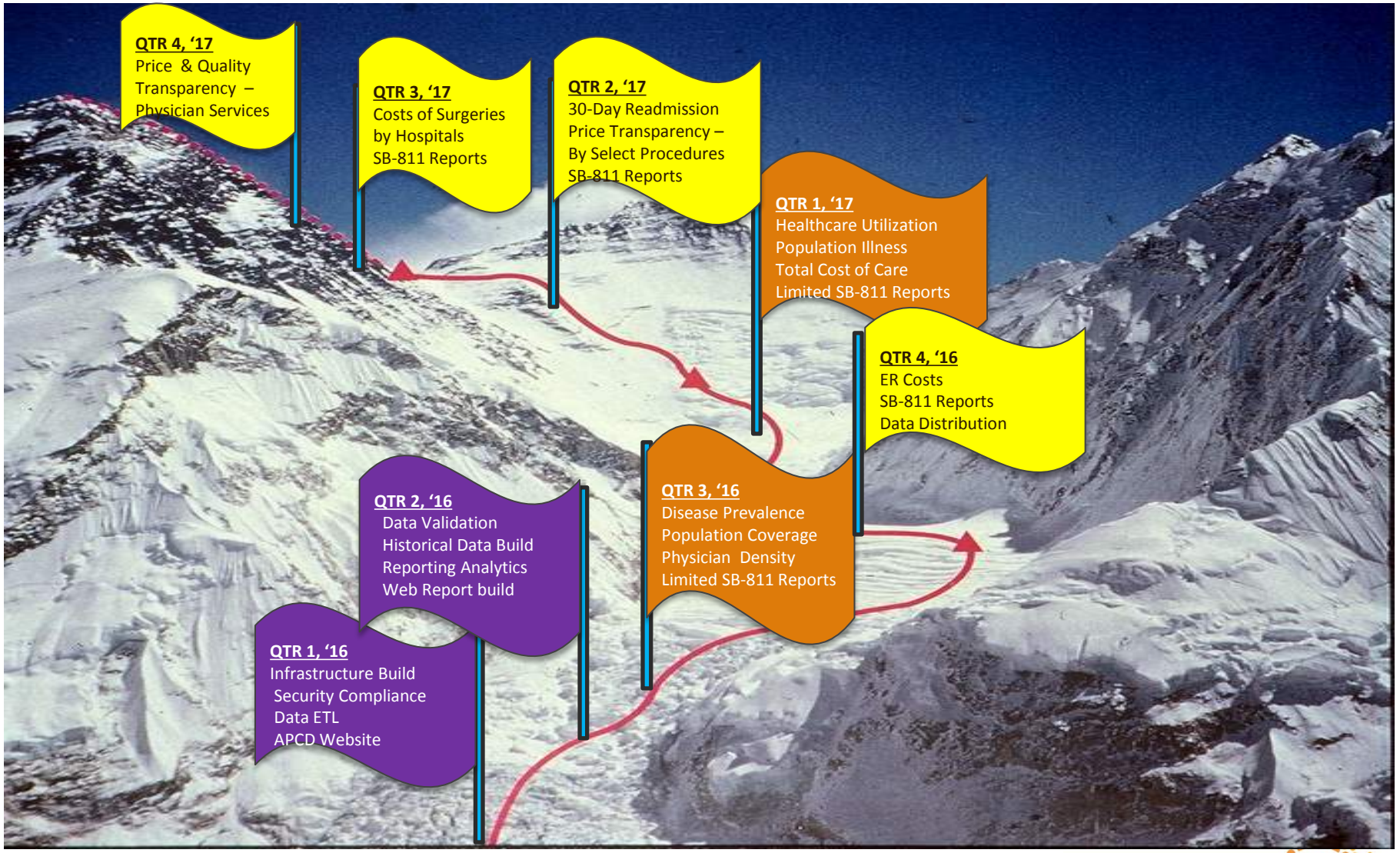
Anna Stelter, MPH, MSSW
Policy Analyst
Texas Health Institute

Matthew Turner, PhD, MPH
Senior Analyst
Texas Health Institute

All Payer Claims Database (APCD) Update

May 19, 2016

APCD Implementation Timeline



access health CT

APCD Data Submission Status

- APCD Data Collection Plan - Data collection is ongoing although data quality validation has been very slow for some of the submitting entities. Two (2) carriers (Aetna and Anthem) have stopped data submissions until they filter ASO data from their files.
- We are targeting roughly 850,000 lives by mid-May 2016
- Received confirmation from CMS that our APCD will be considered as eligible to receive Research Identifiable Files (RIF) data under the CMMI funded SIM program category of data request
- National Association of Health Data Organization (NAHDO) has also approached U.S. Department of Labor (DOL) with the idea of collecting uniform data from various states as a remedy to ERISA restrictions. NAHDO also has developed a uniform data lay out detail. CT's APCD is evaluating the proposed uniform data lay out standard currently. This is a promising approach.

APCD Data Submission Status

- Total population in CT was 3.58 million in 2015*
- Total estimated population in APCD in the future (even without ERISA plans) is approximately 3.02 million lives

Payer Types	Total (Million Lives)	Collectible (Million Lives)
Commercial		
Non-ERISA Plans	1.43	1.43
ERISA Plans	0.42	-
Medicare	-	-
Medicare Advantage (Part C)	0.20	0.20
Medicare FFS (Parts A & B)	0.63	0.63
Medicaid / CHIP	0.76	0.76
Uninsured	0.14	-
TOTAL	**3.58**	**3.02**

** Estimates for commercial plans are derived from APCD data submissions; Medicaid and Medicare estimates are from Kaiser State Health Facts (http://kff.org/statedata/) and uninsured rate at 3.8% from AHCT 2015 Member Census*

APCD Data Grouping Approaches

- In an effort to prepare readiness to address disparities in care, which is currently part of our organization's important strategy, we consider APCD as an important instrument in addressing it. To that objective, we have sought inputs from various stakeholders in the state regarding how we approach it.
- Reality is that we may not have good race and ethnicity data in our claims/eligibility files.
- Researched various approaches to measuring disparities in care – identifying surrogate measures (groupers) like Health Reference Groups (HRG), The Five Connecticuts, Opportunity Index, Planning Regions, Educational Reference Groups (ERG), District Reference Groups (DRG), Racially Concentrated Areas of Poverty (RCAP)

APCD Data Collection Status Update – Race Data Completion

- AI/AN
- Asian
- Black/African
- American Native Hawaiian or Pacific Islander
- White
- Other Race
- Unknown/Not – Specified
- Hispanic

Submitters	Race Information Completion Rate	Population Weights
Aetna	32.6%	19.8%
Anthem	0.3%	24.4%
Cigna	0.0%	9.4%
ConnectiCare	3.2%	17.3%
Harvard Pilgrim	5.2%	0.3%
United Health Group	0.1%	27.8%
Well Care	49.4%	0.9%
OVERALL	**7.6%**	

Note: *Based on test data for year 2012; current completion rate may be different.*

Combining Connecticut's APCD with DPH Birth Records

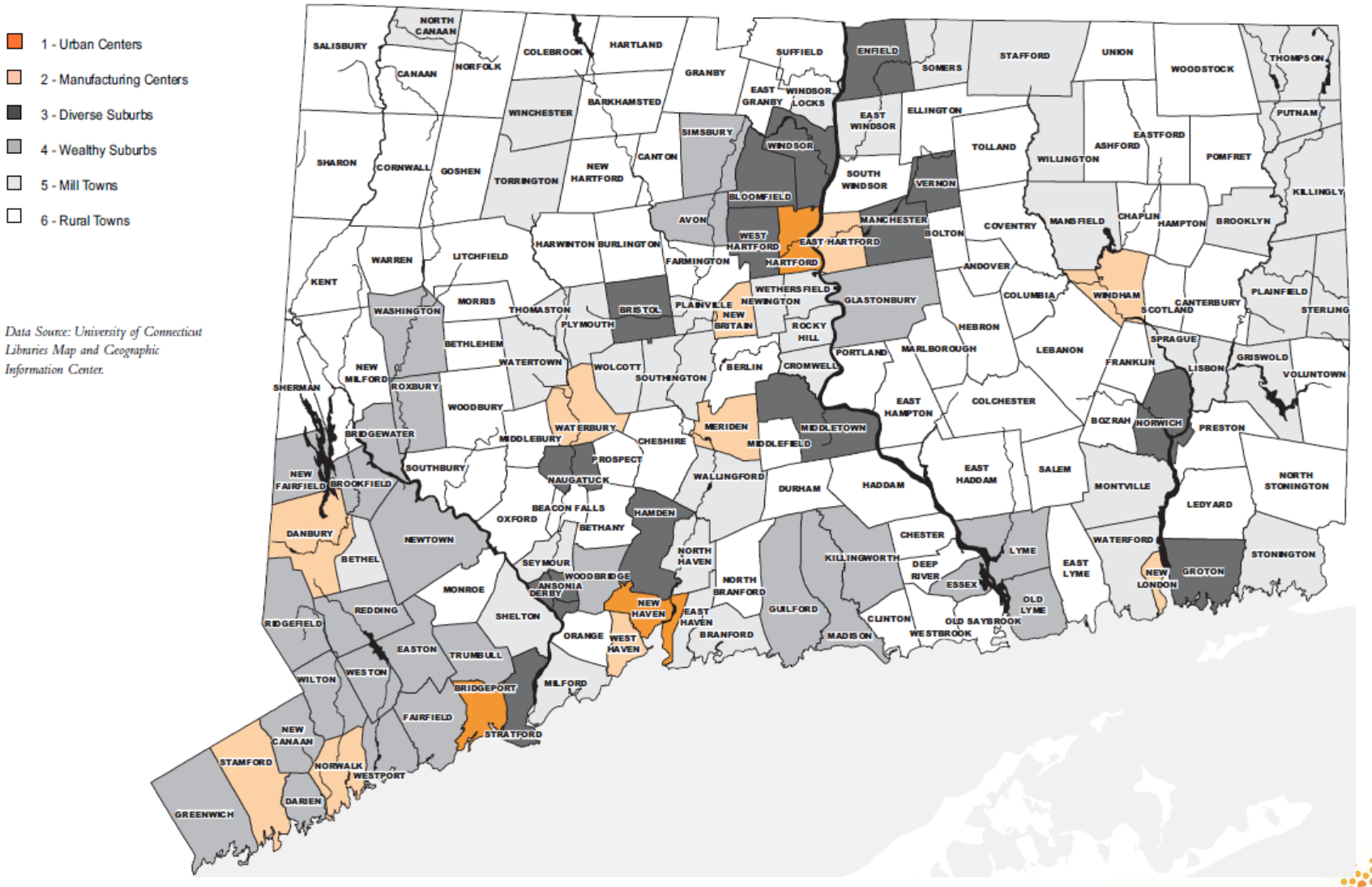
- Collaboration involving UConn, Access Health CT, DPH, Onpoint, CSMS
- Two step process:
  1. Merge birth records with APCD member file
     - ~ 60% of CT residents born in CT; have child in CT (?)
  2. Use multiple imputation to impute race and ethnicity for patients not in birth records
     - Uses patient demographics (address, name, age etc.) to build a predictive model for patients race/ethnicity
- Results included in APCD files

Source: Slide from Dr. Robert Aseltine's presentation to the APCD Advisory Group on 2/11/2016

APCD Data Grouping Approaches – Health Reference Group (HRG)

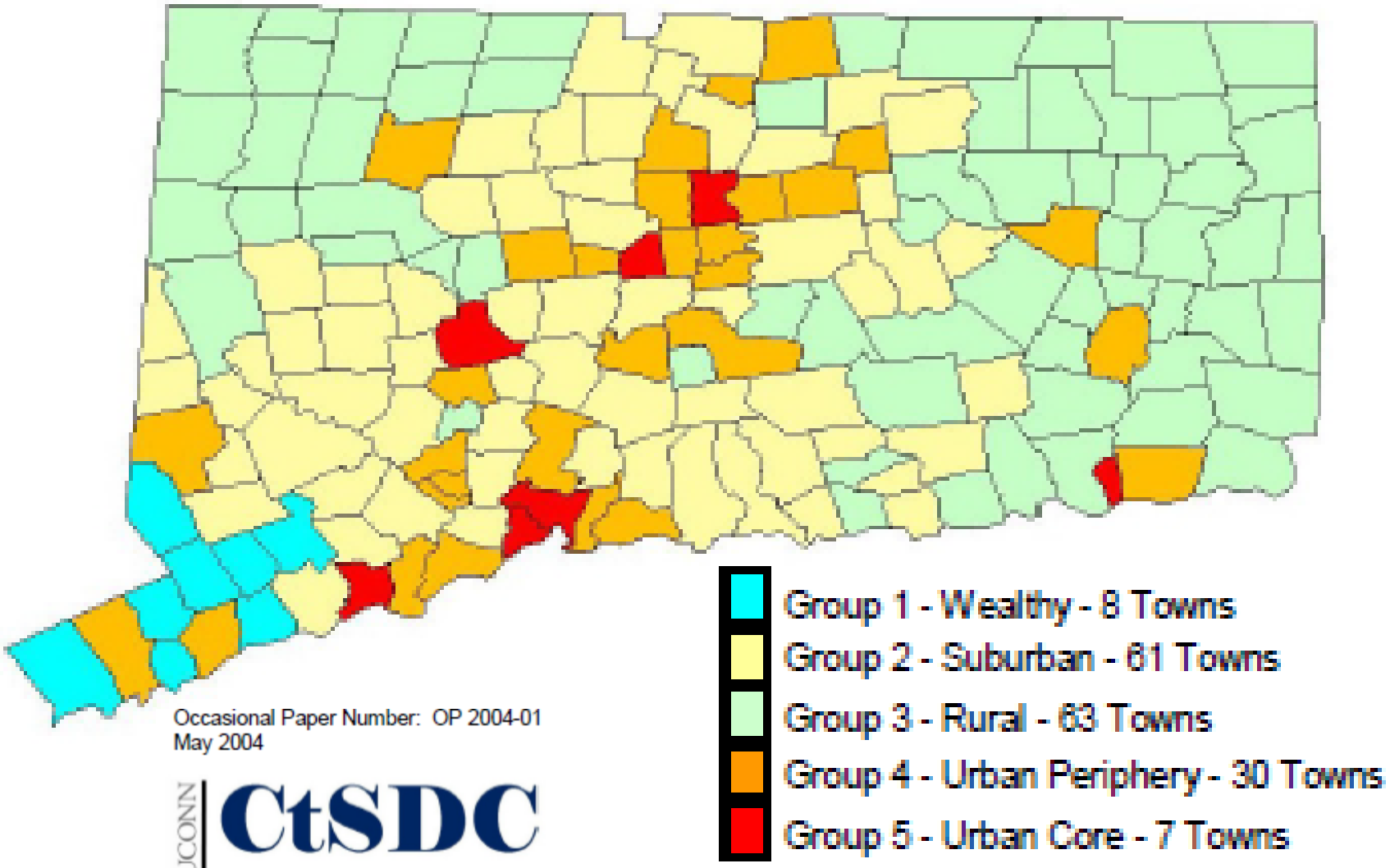
HEALTH REFERENCE GROUP DESCRIPTIVE TOTALS AND AVERAGES	1 Urban Centers (UC)	2 Manufacturing Centers (MC)	3 Diverse Suburbs (DS)	4 Wealthy Suburbs (WS)	5 Mill Towns (MT)	6 Rural Towns (RT)
Number of Cities/Towns	3	10	15	27	39	75
Total Population	384,733	662,398	587,504	487,620	698,517	584,793
Percent of Total Property Valuation that is Residential	51.7	66.7	72.8	88.8	74.1	84.7
Residential Property Valuation Per Capita	$11,989	$26,216	$28,459	$106,0665	$32,688	$51,197
Average Town Population	128,244	66,240	39,167	18,060	17,911	7,797
Percent of Family Households Headed by Single Females with Children Under 18	32.3	17.2	12.4	4.6	8.7	5.9
Percent Black-alone Not Hispanic Population	33.6	12.2	11.2	0.8	1.8	1.0
Percent Hispanic Population	31.2	18.9	5.4	2.0	2.7	1.7
Population Density Per Square Mile	7,435	3,315	1,830	649	821	277
Percent College Graduates Among Residents 25 and Over	17.2	21.9	26.3	56.2	23.8	34.5
Percent Below Poverty Criteria	46.9	28.7	18.7	7.2	15.8	10.9

APCD Data Grouping Approaches – Health Reference Group (HRG)



access health CT

APCD Data Grouping Approaches – The Five Connecticuts



Occasional Paper Number: OP 2004-01
May 2004

UCONN CtSDC
Connecticut State Data Center

access health CT

APCD Data Grouping Approaches – Opportunity Index

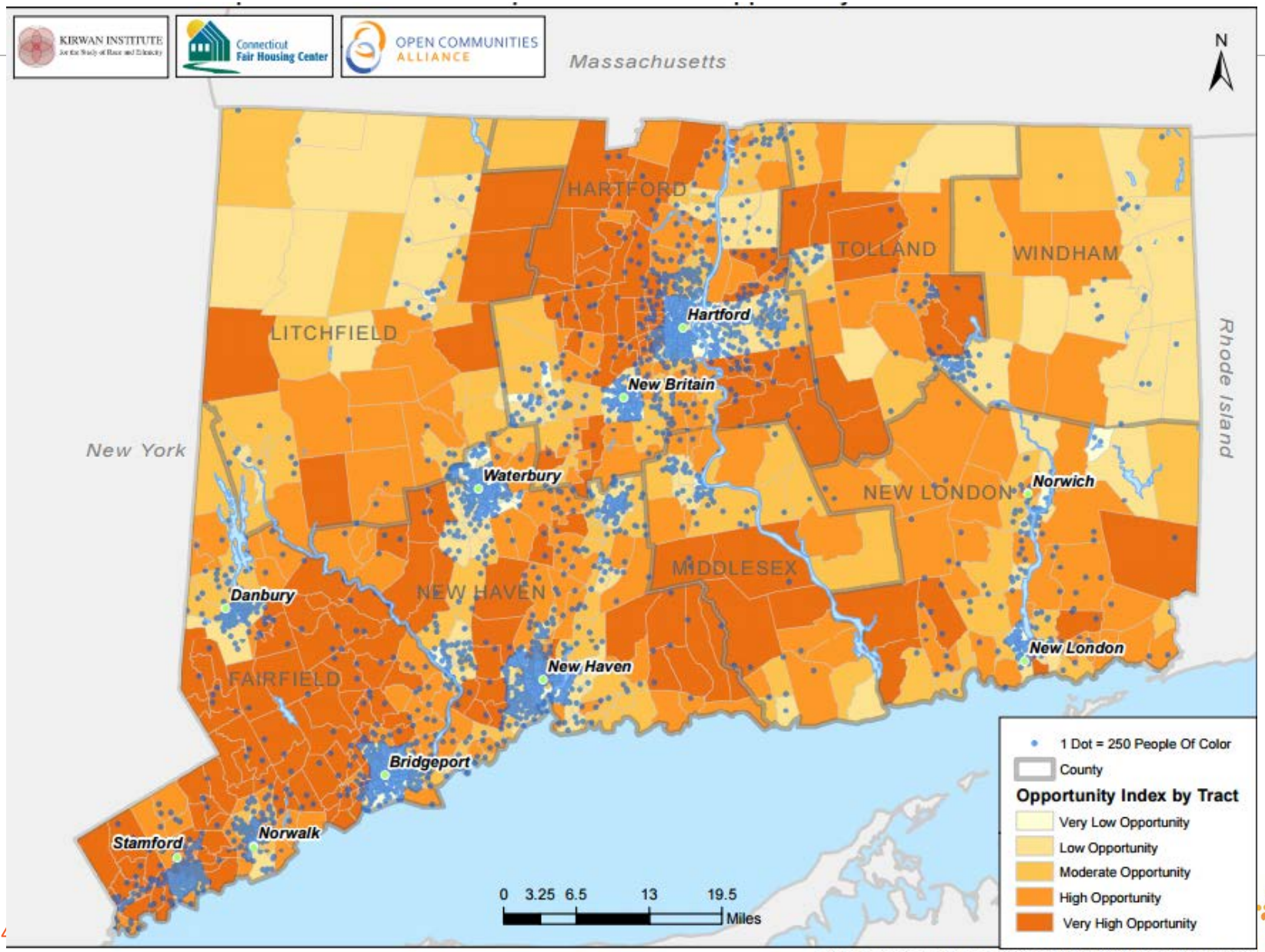
Opportunity mapping is an analytical tool that deepens our understanding of "opportunity" dynamics within regions. The goal of opportunity mapping is to identify opportunity-rich and opportunity-isolated communities.

Opportunity mapping indicators

Educational Indicators	Economic Indicators	Neighborhood/Housing Quality Indicators
Students Passing Math Test scores	Unemployment Rates	Neighborhood Vacancy
Students Passing Reading Test scores	Population on Public Assistance	Crime Rate
Educational Attainment	Job Growth	Neighborhood Poverty Rate
	Employment Access	Homeownership Rate
	Job Diversity	

Source: http://www.ctoca.org/introduction_to_opportunity_mapping

APCD Data Grouping Approaches – Opportunity Index



APCD Data Grouping Approaches – Opportunity Index

	Very Low Opportunity	Low Opportunity	Moderate Opportunity	High Opportunity	Very high Opportunity
Black (non-Hispanic)	48.98%	24.29%	13.07%	9.19%	4.47%
Hispanic (any race)	46.85%	25.86%	11.82%	9.07%	6.41%
Asian (non-Hispanic)	12.16%	23.43%	19.74%	22.38%	22.30%
White (non-Hispanic)	7.00%	18.94%	22.44%	25.00%	26.62%

Adjournment

access health CT