Health Plan Benefits and Qualifications Advisory Committee Meeting

February 16, 2017

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Agenda

A. Call to Order and Introductions

B. Public Comment

C. Vote: February 3, 2017 Meeting Minutes

D. 2018 Plan Offerings

E. Certification Requirements for Consideration: 2018

F. Next Steps

G. Adjournment

➢2018 Plan Offerings: Standardized/Non-Standard Plan Submissions

Standardized/Non-Standard Plan Submissions

Number of QHPs for Submission by Carrier: Standard & Non-Standard

Current guidelines, as approved by AHCT BOD, are outlined in the table below:

Number of Plans Permitted per Carrier				
	Individual Market*		Small Group Market	
	Standardized	Non-Standard	Standardized	Non-Standard
Platinum	1 (Optional)	2	1	2
Gold	1	3	1	3
Silver	1	3	2	3
Bronze	2	3	2	3
Catastrophic	N/A	1	N/A	N/A
Total	4 Required / 1 Optional	12 Optional	6 Required	11 Optional
Maximum	17		17	

2017 Available Plan Offerings

19 in Individual market (two carriers):

- 8 standard plans (no Platinum)
- Non-standard plans: 2 Gold, 5 Silver, 2 Bronze and 2 Catastrophic

8 in Small Group market (one carrier):

- 6 standard plans
- Non-standard plans: 1 Gold, 1 Bronze

**Additionally, plan variants are required for submission in the Individual Market*

➢2018 Plan Offerings: Small Group

AHCT SHOP: Additional Platinum Standardized Plan

	2017/2018 Standardized Platinum	2018 Additional Platinum Option
Combined Medical & Rx Deductible	$100	$0
Coinsurance	20%	0%
Out-of-pocket Maximum	$2,000	$2,600
Primary Care	$15	$30
Specialist Care	$35	$50 *
Urgent Care	$50	$75
Emergency Room	$100	$200
Inpatient Hospital	$300 per day (after ded., $600 max. per admission)	$500 per day ($1,500 max. per admission)
Outpatient Hospital	$300 (after ded.)	$300
Advanced Radiology (CT/PET Scan, MRI)	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 *	$0
Laboratory Services	$10 *	$0
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum	$15	$30 *
Chiropractic Care 20 visit calendar maximum	$30	$50
All Other Medical	20%	0%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $25 / $40 / 20% ($100 max per spec. script)	$5 / $50 / 50% / 50% ($500 max. per non-preferred brand or spec. script)
2017 AVC Results	**90.49%**	**N/A**
2018 AVC Results	**89.97%**	**88.15%**
Difference	-0.51%	-2.34%
Estimated Premium Impact	0.33%	-0.04%

Actuarial Value Calculator (AVC) results provided by Wakely Consulting Group

Represents In-Network Cost Sharing;
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

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AHCT SHOP: Additional Platinum Standardized Plan

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan Deductible				
Individual	$100	$2,000	$0	$2,000
Family	$200	$4,000	$0	$4,000
Out-of-Pocket Maximum*				
Individual	$2,000	$4,000	$2,600	$5,200
Family	$4,000	$8,000	$5,200	$10,400
*Includes deductible, copayments and coinsurance				
Provider Office Visits				
Adult Preventive Visit	$0 copay per visit	20% coinsurance per visit	$0 copay per visit	30% coinsurance per visit after OON plan deductible is met
Infant / Pediatric Preventive Visit	$0 copay per visit	20% coinsurance per visit	$0 copay per visit	30% coinsurance per visit after OON plan deductible is met
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$35 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met

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AHCT SHOP: Additional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Outpatient Diagnostic Services				
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	20% coinsurance per service after OON plan deductible is met	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	30% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service	20% coinsurance per service after OON plan deductible is met	$0 copayment per service	30% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service	20% coinsurance per service after OON plan deductible is met	$0 copayment per service	30% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$20 copayment per service	20% coinsurance per service after OON plan deductible is met	$20 copayment per service	30% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy (30 day supply per prescription)				
Tier 1	$5 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	$5 copayment per prescription	50% coinsurance per prescription
Tier 2	$25 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	$50 copayment per prescription	50% coinsurance per prescription
Tier 3	$40 copayment per prescription	20% coinsurance per prescription after OON plan deductible is met	50% coinsurance up to a maximum of $500 per prescription	50% coinsurance per prescription
Tier 4	20% coinsurance up to a maximum of $100 per prescription	20% coinsurance per prescription after OON plan deductible is met	50% coinsurance up to a maximum of $500 per prescription	50% coinsurance per prescription

AHCT SHOP: Additional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Outpatient Rehabilitative and Habilitative Services				
Speech Therapy *(40 visits per plan year limit combined for Rehabilitative PT/OT/ST; separate 40 visitsper plan year combined for Habilitative PT/OT/ST)*	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy *(40 visits per plan year limit combined for Rehabilitative PT/OT/ST; separate 40 visitsper plan year combined for Habilitative PT/OT/ST)*	$15 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$30 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Other Services				
Chiropractic Services *(up to 20 visits per plan year)*	$35 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply	20% coinsurance per equipment/supply after OON plan deductible is met	50% coinsurance per equipment/supply	50% coinsurance per visit after OON plan deductible is met
Durable Medical Equipment (DME)	20% coinsurance per equipment/supply	20% coinsurance per equipment/supply after OON plan deductible is met	50% coinsurance per equipment/supply	50% coinsurance per visit after OON plan deductible is met
Home Health Care Services *(up to 100 visits per plan year)*	$0 copay per visit	20% coinsurance per visit after $50 deductible is met	$25 copay per visit	25% coinsurance per visit after $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	$300 copayment after INET plan deductible is met	20% coinsurance per visit after OON plan deductible is met	$200 copayment per visit	30% coinsurance per visit after OON plan deductible is met

AHCT SHOP: Additional Platinum Standardized Plan, cont'd

	CURRENT PLATINUM PLAN		ADDITIONAL PLATINUM PLAN	
Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Inpatient Hospital Services				
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) **(skilled nursing facility stay is limited to 90 days per plan year)*	$300 copayment per day to a maximum of $600 per admission after INET plan deductible is met	20% coinsurance per visit after OON plan deductible is met	$500 copayment per day to a maximum of $1,500 per admission	30% coinsurance per visit after OON plan deductible is met
Emergency and Urgent Care				
Ambulance Services	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Room	$100 copayment per visit	$100 copayment per visit	$200 copayment per visit	$200 copayment per visit
Urgent Care Centers	$50 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$75 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 19)				
Diagnostic & Preventive	$0 copay per visit	50% coinsurance per visit after OON plan deductible is met	$0 copay per visit	50% coinsurance per visit after OON plan deductible is met
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services *(medically necessary only)*	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 19)				
Prescription Eye Glasses *(one pair of frames and lenses or contact lens per plan year)*	$0 copay for Lenses; $0 copay for Collection frame; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered	$0 copay for Lenses; $0 copay for Collection frame; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist *(one exam per plan year)*	$35 copayment per visit	20% coinsurance per visit after OON plan deductible is met	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met

➢2018 Plan Offerings: Stand-Alone Dental Plan (SADP)

SADP – Actuarial Value (AV) Overview

- ACA Compliant plans must conform with either a "High" or "Low" Actuarial Value
  - AV pertains ONLY to pediatric portion of plan, as adult dental is not considered an Essential Health Benefit per ACA regulations
  - High plan = 85% AV: consumer, on average, pays 15% of cost sharing for covered pediatric benefits
  - Low plan = 70% AV: consumer, on average, pays 30% of cost sharing for covered pediatric benefits
- No prescribed tool provided by CMS to perform analysis
  - Actuarial Certification is required
  - Plus/Minus 2 point 'de minimis' range is permitted
- AHCT standardized SADP is certified as a "High" AV plan
  - No cost sharing changes are required for 2018 to current SADP, as plan continues to meet High AV
  - CMS final 2018 Payment Notice confirms no change in maximum out-of-pocket (MOOP) for SADP
    - $350 for one child / $700 for two or more children in a family

AHCT 2017 Standardized SADP Plan Design

Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible *(Does not apply to Preventive & Diagnostic Services for In-Network Services)*	$60 per member, up to 3 family members	$60 per member, up to 3 family members
Out-of-Pocket Maximum *for children under age 19 only* For one child Two or more children	 $350 $700	Not Applicable
Diagnostic & Preventive Services		
Oral Exams / X-Rays / Cleanings	$0	20% after OON deductible is met
Basic Services		
Filings / Simple Extractions	20% after INET deductible is met	40% after OON deductible is met
Major Services		
Surgical Extractions, Endodontic Therapy, Periodontal Therapy, Crowns, Prosthodontics	40% after INET deductible is met	50% after OON deductible is met
Other Services *(for children under age 19)*		
Medically-Necessary Orthodontic Services	50% after INET deductible is met	50% after OON deductible is met
Waiting Periods and Plan Maximums (*for adults aged 19 and older only*)		
Applicable Waiting Period for Benefit		
Diagnostic and Preventive Services	no waiting period	
Basic Services	6 months	
Major Services	12 months	
Plan Maximum	$2,000 per adult member age 19 and over (combined In-Network and Out-of-Network Services)	

Actuarial Value (AV): "High" (85%) Pertains to Pediatric Benefits *only*

No CMS prescribed AV Calculator for SADPs

Maximum Out-of-Pocket: $350/$700

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➢ *Certification Requirements for Consideration: 2018*

Tobacco Use Surcharge: ACA Regulations/CT Statute

45 C.F.R §147.102	• **Tobacco surcharge permitted, but may not vary by more than 1.5:1 compared to premium rate for non-smokers; may only be applied for those who may legally use tobacco under federal and state law** • **Tobacco use is defined as consumption of tobacco on average four or more times per week (within no longer than the past 6 months) & includes all tobacco products, except religious/ceremonial use** • **Tobacco use must also be defined in terms of when a tobacco product was last used**
26 C.F.R §1.36B-3(e)	• **The premium tax credit amount may not include any adjustments for tobacco use**
Connecticut General Statute §38a-567	• **Tobacco use is not an allowed case characteristic & is therefore not applicable in the small employer market in Connecticut**

C.F.R. = Code of Federal Regulations

Tobacco Use Facts & Figures

- Per the Centers for Disease Control and Prevention website*
  - 36.5% of adults with any mental illness reported current use** of tobacco in 2013 compared to 25.3% of adults with no mental illness
  - People living below the poverty level and people having lower levels of educational attainment have higher rates of cigarette smoking than the general population
    - Among people having only a GED certificate, smoking prevalence is more than 40%
  - 29.8% of African American adults reported current use** of tobacco in 2013.
  - 20.9% of Hispanic/Latino adults reported current use** of tobacco in 2013.
- A Kaiser Health News article from May 2016 indicated that smokers may be avoiding the surcharge in states that include it by not reporting tobacco use status appropriately, citing the following:
  - Idaho: per federal survey, 17% of adults smoke regularly, but < 3% who bought coverage in 2016 on the state's insurance exchange paid the surcharge.
  - Kentucky: over 25% of adults smoke regularly, but 11% paid the tobacco surcharge.
  - Minnesota: 18% of adults smoke, but < 5% paid the tobacco surcharge.

* https://www.cdc.gov/tobacco/disparities/index.htm

*** "Current Use" per CDC website was defined as self-reported consumption of cigarettes, cigars, smokeless tobacco, and pipe tobacco in the past year and past month (at the time of survey)*

Formulary Requirements: ACA Regulation/CID Guidance

45 C.F.R §156.122

- Under Marketplace regulations a health plan does not provide essential health benefits unless it covers at least the greater of one drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB-benchmark plan; and
- Submits its formulary drug list to the Exchange, the State or the federal Office of Personnel Management, and
- Beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P&T) committee that meets specified standards

Connecticut Insurance Department (CID) Bulletin No. HC-113

- Published June 22, 2016
- Carriers are required "to file their prescription drug formularies for all plans, whether or not such plans are subject to the ACA, to ensure consistency and transparency in the marketplace."
- CID will obtain information via a survey to perform an annual evaluation

Formulary: AHCT Certification Standard

AHCT Standard
As approved by AHCT BOD in April 2014, the current certification standard pertaining to formulary review is: **"To require a QHP Issuer for the Standard Plan designs to provide a prescription drug formulary that offers the highest benefit level, whether it meets one of the standards set forth in 45 C.F.R. 156.122** **Or** **is equal in number and type to the formulary in the plan with the highest enrollment (representing a similar product) offered outside of the Marketplace."**

Network Adequacy Requirements: Regulations & Guidance

45 C.F.R §156.230	• Each QHP issuer that uses a provider network must ensure that the network (consisting of in-network providers) made available to all enrollees: • Includes essential community providers; • Maintains a network that is sufficient in number & types of providers, including mental health and substance abuse providers, to assure that all services will be accessible without unreasonable delay; and, • Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Services (PHS) Act.
Connecticut Public Act 16-205	• The Act specifies that, effective January 1, 2017, carriers are to maintain a network of providers consistent with the National Committee for Quality Assurance (NCQA) network adequacy requirements or URAC's provider network access/availability standards
CID Bulletin No. HC-117 (10/25/16)	• Outlines how the requirements of Public Act 16-205 are to be implemented • Requires health carriers to file each new network and access plan within 30 days prior to the date any new network will be offered, and complete the Network Adequacy Survey as its filing submission; Annual survey submissions for networks effective on and after January 1, 2018 to be included as part of the annual form filing process

Provider Network Adequacy Certification Standards

Federally Facilitated Exchanges	AHCT
• CMS will assess provider networks using a "reasonable access" standard in order to identify networks that fail to provide access without unreasonable delay • CMS will use time & distance criteria for certain types of providers to assess whether an issuer is meeting this standard* • CMS will review issuers' network adequacy templates that are submitted as part of the certification process to ensure that the plan provides access to at least one provider for each provider type for at least 90 percent of enrollees	AHCT's current requirement to assess network adequacy, as approved by AHCT BOD in April 2014 is: "To require Qualified Health Plan (QHP) Issuers to develop and maintain provider networks for the standard plan designs offered for sale in the Marketplace that include at least 85% of those unique providers and unique entities that comprise the network of the most popular plan, of a similar type, actively sold by the Issuer or the Issuer's affiliate if such affiliate has a larger provider network."

Essential Community Providers (ECPs): ACA Regulation

45 C.F.R. §156.235

- **"A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards."**

Essential Community Providers (ECPs) Defined

- Providers serving predominantly low-income, medically underserved individuals
- Providers described in section 340B of Public Health Service (PHS) Act & section 1927(c)(1)(D)(i)(IV) of Social Security Act
- Include not-for-profit / State-owned providers as described in section 340B of PHS Act *that don't participate in the 340B Program*
- Not-for-profit or governmental family planning service sites that don't receive a grant under Title X of the PHS Act
- Indian health care providers

Category	Types of Entities
HOSPITALS	**Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals**
FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)	**FQHCs and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations**
INDIAN HEALTH CARE PROVIDERS	**IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations**
RYAN WHITE PROVIDERS	**Ryan White HIV/AIDS Program Providers**
FAMILY PLANNING PROVIDERS	**Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics**
OTHER ECPs	**STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals**

ECP Certification Standards

Federally Facilitated Exchanges	AHCT
MEDICAL PLANS: • Contract with at least 30 percent of available ECPs in each QHP's service area • Offers contracts in good faith to all available Indian health care providers in the service area • Offers contracts in good faith to at least one ECP in each ECP category in each county in the service area (where an ECP is available)	AHCT's current standard for ECP contracting was approved by the AHCT BOD in November 2012 & updated/approved in June 2013 • QHPs are required to have contracts with at least 90% of FQHCs or "look alike" health centers in Connecticut, and by January 1, 2015, 75% of all other designated ECPs • Due to the potential challenges of implementation and contracting with this subset of providers, consideration is given for carriers that demonstrate good faith effort to accomplish these standards NOTE: This same standard has been applied to both QHPs and SADPs
STAND-ALONE DENTAL PLANS (SADPs): • Offers a contract in good faith to at least 30 percent of available ECPs in each plan's service area • Offers a contract in good faith to all available Indian health care providers in the service area	
ECP list supplied by CMS to carriers as a source to use in ECP contracting efforts • List is based on data CMS maintains as well as data received directly from providers through an 'ECP petition process'	ECP list supplied by AHCT to carriers as a source to use in ECP contracting efforts • List is based on data AHCT maintains

AHCT ECP - Contracting Information

Carrier Contracting Results as of December 2016 Submission		
	Carrier 1	**Carrier 2**
FQHCs	**12 of 16: 75%***	**10 of 16: 62.5%****
Non-FQHCs	**542 of 660: 82.12%**	**505 of 660: 76.5%**
Notes	***Partially contracted with each of the other 4 FQHCs 473 of 497 available services at 227 FQHC locations are contracted (95%)**	****Partially contracted with each of the other 6 FQHCs 462 of 497 available services at 227 FQHC locations are contracted (93%)**

➢Next Steps

➢ *Appendix*

AHCT Individual Enrollment: Standardized/Non-Standard Plans

	Enrollment as of:			
	3/11/2014	2/3/2015	2/2/2016	1/10/2017
Platinum Non-Standard	0	0	0	0
Platinum Standardized	0	840	1,561	0
TOTAL	0	840	1,561	0
Gold Non-Standard	2,734	4,354	4,670	2,108
Gold Standardized	10,492	11,413	9,340	8,001
TOTAL	13,226	15,767	14,010	10,109
Silver Non-Standard	7,132	9,990	9,052	10,325
Silver Standardized	29,121	47,732	62,299	56,941
TOTAL	36,253	57,722	71,351	67,266
Bronze Non-Standard	7,830	12,947	16,475	3,109
Bronze Standardized	2,027	6,635	10,564	22,651
TOTAL	9,857	19,582	27,039	25,760
Catastrophic Non-Standard	1,397	1,531	2,063	1,724
N/A	0	0	0	0
TOTAL	1,397	1,531	2,063	1,724
Combined Non-Standard	19,093	28,822	32,260	17,266
Combined Standardized	41,640	66,620	83,764	87,593
TOTAL	60,733	95,442	116,024	104,859

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AHCT ECP List Composition

Composition of AHCT ECP Listing				
	Federally Qualified Health Centers (FQHCs)			
Number of:	**1/22/16**	**6/2/16**	**8/26/16**	**11/15/16**
Entities	**16**	**16**	**16**	**16**
Locations	**161**	**217**	**224**	**227**
Services	**315**	**450**	**471**	**497**
	AHCT standard for QHPs is that they have contracts with at least 90% of FQHCs or "look alike" health centers in Connecticut*			
	Non-FQHCs			
Number of:	**1/22/16**	**6/2/16**	**8/26/16**	**11/15/16**
Entities	**198**	**186**	**181**	**180**
Locations	**617**	**619**	**639**	**660**
Services	**945**	**954**	**999**	**1045**
	AHCT standard for QHPs is that they have contracts with at least 75% of all other designated ECPs (i.e., 'Non-FQHCs')*			

AHCT considers the ECP contracting standard for FQHCs to be met when every service at every location is contracted for 15 of the 16 available FQHCs

AHCT considers the ECP contracting standard for non-FQHCs to be met when 75% of all locations are contracted (with all services available at a location included in the contract)

**Consideration is given for carriers that demonstrate good faith effort to accomplish these standards due to the potential challenges of implementation and contracting*

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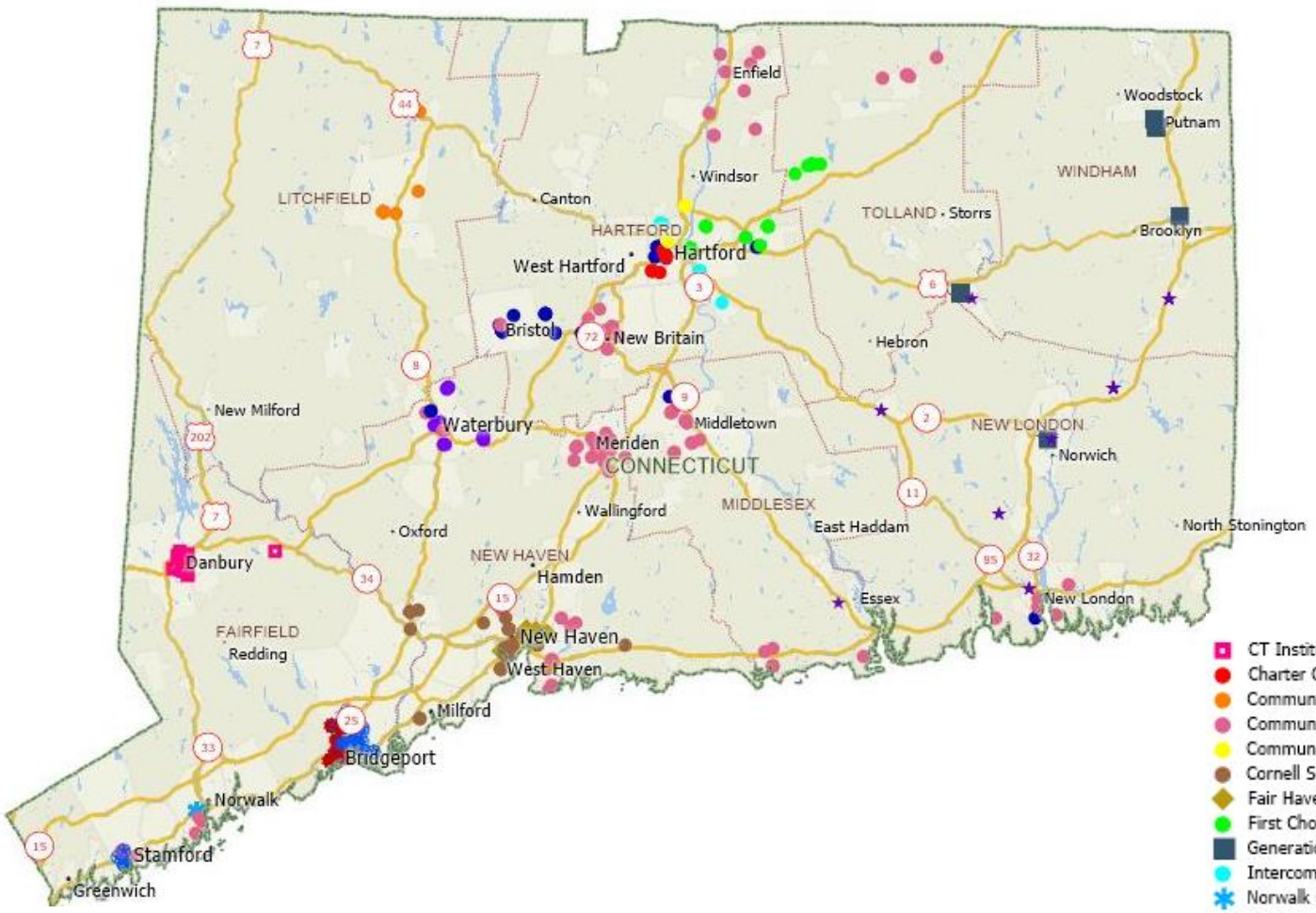
AHCT ECP Listing: Locations of Services at FQHCs in CT



LEGEND

- CT Institute for Communities, Inc.
- Charter Oak Health Center, Inc.
- Community Health & Wellness Center of Greater Torrington, Inc.
- Community Health Center, Inc.
- Community Health Services, Inc.
- Cornell Scott - Hill Health Corporation
- Fair Haven Community Health Center
- First Choice Health Center, Inc. (formerly E. Hartford HealthCare)
- Generations Family Health Center, Inc.
- Intercommunity, Inc.
- Norwalk Community Health Center, Inc.
- Optimus Health Care, Inc.
- Southwest Community Health Center, Inc.
- Staywell Health Care, Inc.
- United Community & Family Services, Inc.
- Wheeler Clinic, Inc.