

Health Elevations



A Quarterly Journal on
Health Policy in Colorado

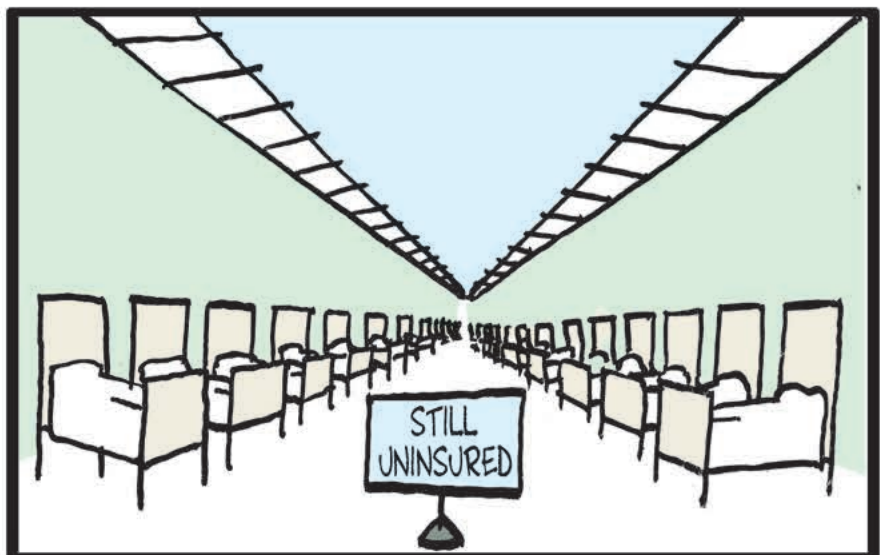
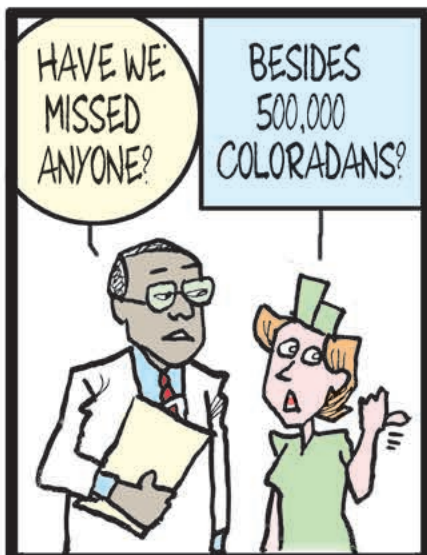
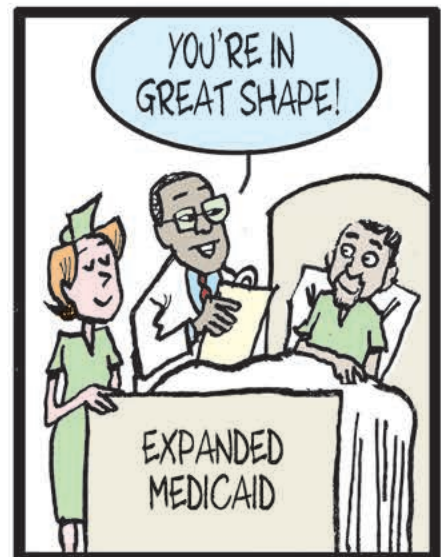
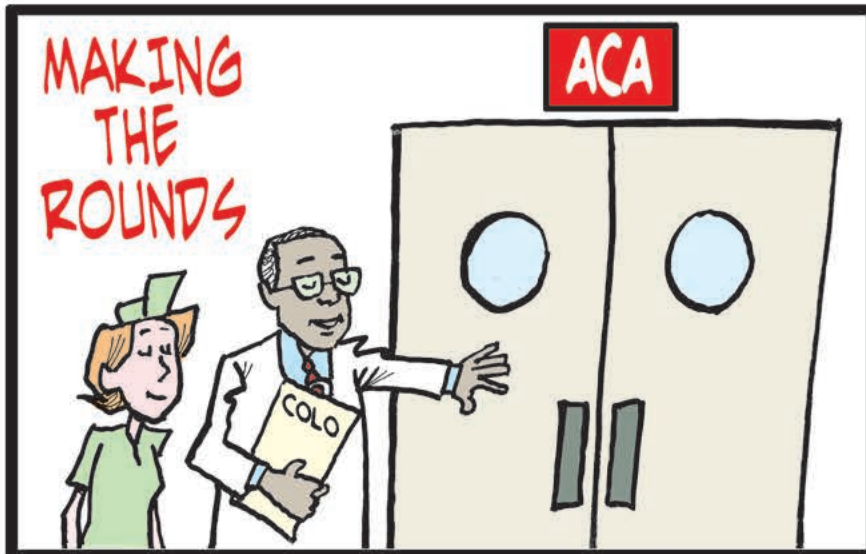
Summer 2015

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Health Elevations



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501 South Cherry Street, Suite 1100
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303.953.3600
www.ColoradoHealth.org

Summer 2015

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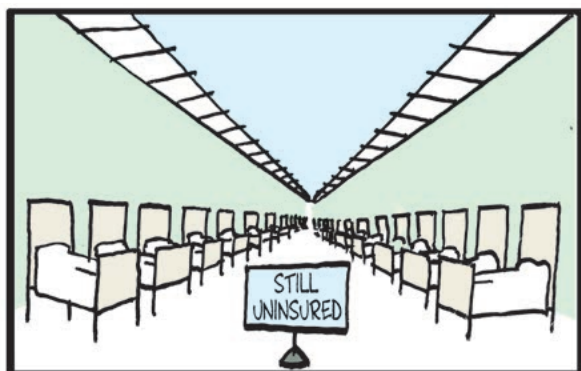
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- View animation by Mike Keefe reminding health reformers that the ACA didn't quite fix everything.
- Watch a father-daughter doctor team in Grand County talk about the ACA's impact on their practice.
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About the Colorado Health Foundation

HEALTH ELEVATIONS seeks to further the goals of the Colorado Health Foundation by highlighting problems that can be solved, illuminating the people who are making progress in solving them and provoking a new way of looking at complex health issues. The journal will report on and synthesize a variety of sources to provide information that can further the work of policymakers, grantees, providers and the engaged public in advancing better health care, health coverage and healthier living. Useful information presented in a memorable way is indispensable to the complex field of health policy.

THE COLORADO HEALTH FOUNDATION works to make Colorado the healthiest state in the nation by ensuring that all Colorado kids are fit and healthy, and that all Coloradans achieve stable, affordable and adequate health coverage to improve their health with support from a network of primary health care and community services. To advance our mission, the Foundation engages the community through grantmaking, public policy, investing in evaluation, private sector initiatives and strategic communications. For more information, please visit www.ColoradoHealth.org.

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The Colorado Health Foundation
RAHN PORTER

Editor in Chief
MICHAEL BOOTH

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KINDLE FAHLENKAMP-MORELL

Copy Editor
CAROL ROLLAND

Advisors
The Colorado Health Foundation
TANYA WEINBERG, AMY LATHAM

Creative Team
WELCH CREATIVE GROUP, INC.

Photographer/Videographer
JAMES CHANCE

Illustrators
KEVIN SEITZ, ROGER TIMONO, ALICIA VARGA

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Walking the Talk

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Five Years of the ACA

Undeniable Success and Lingering Challenges

Following the trail of the Affordable Care Act is a long, rugged journey.

But did we ever expect it to be easy? Health coverage and care are an emotional and financial core of family lives. Health spending makes up nearly 20 percent of the U.S. economy. Medicine has become wonderfully capable at the same time the medical and insurance bureaucracies have become maddeningly complex.

There was no way that radically overhauling the way we cover and treat many Americans was ever going to be a cakewalk.

In this issue of *Health Elevations*, a team of journalists fans out across Colorado to assess how more than five years of the ACA has transformed the health coverage and care landscape. From the far reaches of the San Luis Valley to the vital urban heartbeat of Denver Health, we sought to step around politics for a moment and see how far we've come.

We also wanted to remind readers that the national ACA movement was a natural extension of hard bipartisan work that had gone on for years prior in Colorado. Before there was the ACA, getting signed into law by the president in 2010, there was the Colorado Health Care Affordability Act of 2009, launching a provider fee and bolstering Medicaid in the state for decades to come.

Any honest scrutiny of the ACA will reveal plenty of flaws worth debating. It imposed mandates, expanded government's role in the safety net, added new taxes and did not quite expand the umbrella of health coverage to all. Yet the bottom line, quite easy to return to over and over again, is that

hundreds of thousands of Coloradans now have reliable health insurance coverage that they lacked before, and an avenue to life-changing care. Health costs are more predictable, and dozens of experiments in payment and delivery models show great promise to further transform the balky U.S. health care system.

I'm proud of the Colorado Health Foundation's role in supporting assistance sites and many other efforts to bring health coverage to more Coloradans. Even in its still-imperfect state, the expanded umbrella of coverage and care is far better than the previous system that left so many out.

Other stories in this edition highlight work left to do: The medical workforce must adapt faster to the demands of a population closer to full coverage; Doctors need more reason and reinforcement to employ complex Electronic Health Record systems; our leaders in government must prepare for an inevitable future recession and the resulting competing demands on public revenue.

The Colorado Health Foundation will strive to do its part, and help shape a future where the Affordable Care Act is an indispensable support for more and more Coloradans.



Rahn Porter, Interim CEO
The Colorado Health Foundation



The ACA Issue

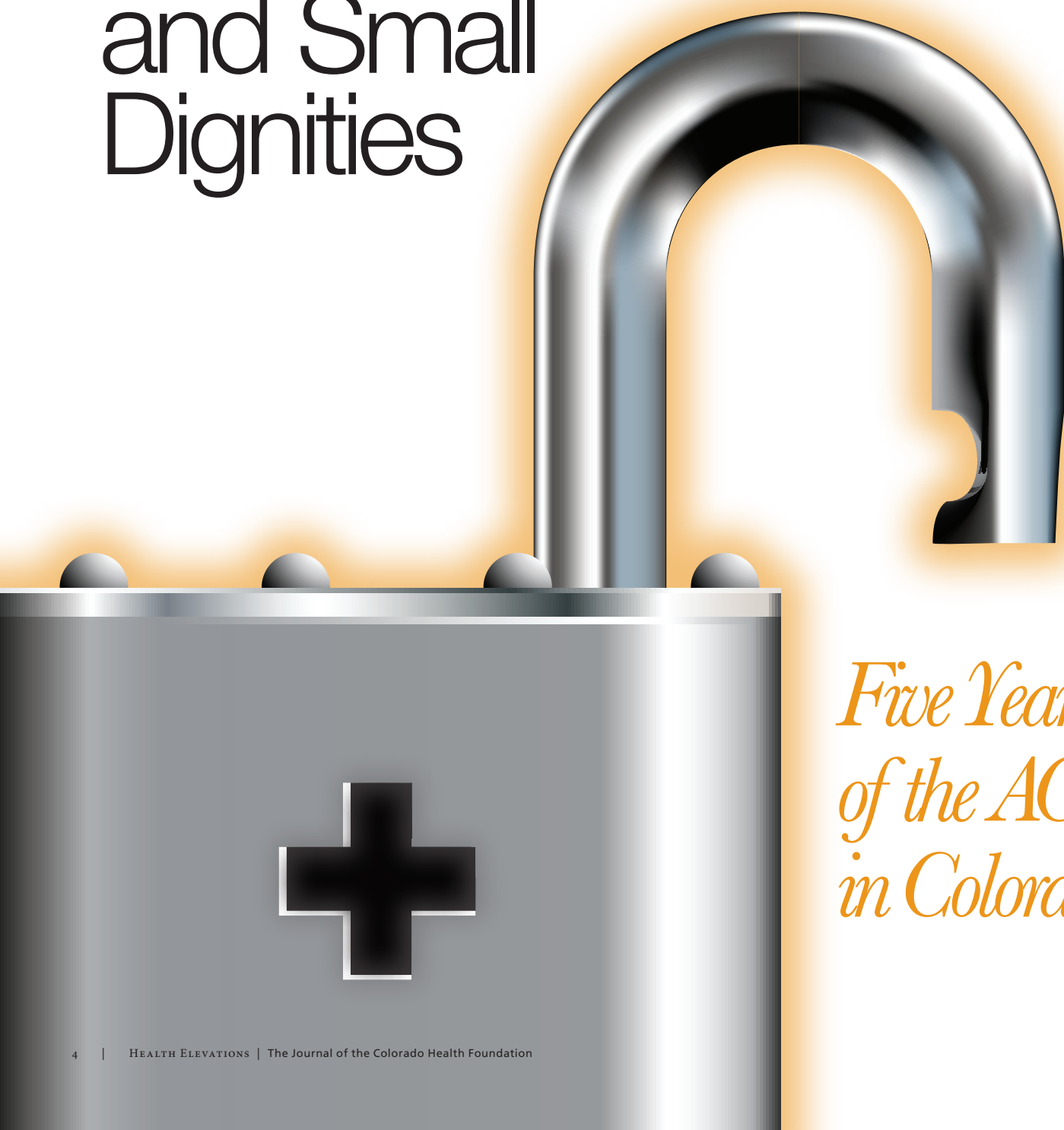
With more than five years of big changes in Colorado from the landmark Affordable Care Act, *Health Elevations* weighs in on the successes, the looming challenges, the people left out, seldom-considered economic threats and other timely issues. Journalists interviewed reformers, skeptics and many who are just busy getting the ACA "done" to frame how the biggest policy changes to health care in 50 years are leaving their mark in the Rocky Mountains.

Please send your thoughts on this issue via Twitter to @COHealthFDN or @MBoothDenver.

Big Numbers

and Small Dignities

By Michael Booth, Editor in Chief
Photography by James Chance



*Five Years
of the ACA
in Colorado*

It's not trivial. To proudly show up and say, 'I have coverage.' It's a human dignity issue.

Jandel Allen-Davis, MD, vice president of government and external relations, Kaiser Permanente of Colorado

The numbers have indeed changed in five turbulent years: The totals of uninsured dropping by the millions. Leaping insurance premiums, for now, calming to relatively tame levels. The government's predicted health insurance costs plummeting by the hundreds of billions.

And yet what may have changed most in the five years since the signing of the Affordable Care Act is not the big numbers, but a simple expectation: a sense of how life should feel, expanded from a luckier few to those who have spent much of their lives feeling less than lucky.

"It's not trivial," is the way Jandel Allen-Davis, MD, finally puts it, after an hour of reflection. "To proudly show up and say, 'I have coverage.' It's a human dignity issue," says the Kaiser Permanente Colorado vice president for government and external relations. "There's enough toxic shame out there without that. Is the ACA always pretty? No. But are we better off? Absolutely."

That humane expectation – that access to health care is more a right for the many than a privilege for the fortunate – has been embedded in Colorado's collective psyche as much as it has been codified into state and federal law.

It's in the hundreds of thousands of state residents who had no health insurance coverage on December 31, 2013, and now do. It's in the gleaming additions to safety net clinics across the state, expanded to better serve the insured and uninsured alike. It's in the persistent progressive movement to extend coverage to the 500,000 Coloradans still left out after years of reform. It's in the mindset even of politicians who ideologically opposed health reforms but now feel compelled to mend reform's faults before scrapping them altogether. And it's in a health delivery system come to accept the fact the great majority now walk in with coverage, quickly pivoting to the equally hard questions of cutting the cost and bureaucracy of delivering quality care.

Despite glitches, negative headlines, political acrimony and skepticism about

a growing role for government, the main change of recent years is that access to care and coverage for the average citizen is "the new normal," said Adam Fox, director of strategic engagement at the Colorado Consumer Health Initiative.

Small-business owner Truman Bradley could likely count himself among the "young invincibles" who no one was sure would sign up for ACA coverage. Yet he's a big fan of the robust, ACA-enhanced Kaiser policy he buys for himself through the Connect for Health Colorado exchange.

"People in their 20s feel immortal, but I've seen freaky things happen," said Bradley. "People are compelled to get the coverage they need now, and that's perfect. I know the number of uninsured has gone way down, and that's a really good thing."

Bradley recalled an emergency room visit, pre-ACA, from a time when he could only afford catastrophic coverage. They treated an eye infection from a backpacking trip with a pain pill, a bottle of saline and a pat on the back – along with a \$900 bill. "That's the kind of system we had before the ACA," Bradley said. "I know I was paying for a lot of underinsured and uninsured people. We are a sophisticated society and we should take steps to ensure people have the coverage they need."

The "new normal" is far from "ideal," though, and supporters of progressive health coverage and care policies in Colorado face a new set of challenges in coming months to smooth the consumer experience and then attack the core problems of too-high health care costs.

In the fifth year of major changes from a successful health reform push that had eluded U.S. supporters in previous decades, the looming hurdles include:

- Rebuilding the operations, image and funding of the Connect for Health Colorado insurance marketplace into a sustainable and consumer-friendly agency. This includes a long-overdue heavy lean from state leaders on Medicaid and Connect for Health Colorado to align their computers and fund

marketplace operations. It also includes a renewed push for largely ignored Small Business Health Options Program (SHOP) tax credits for providing insurance.

- Redoubling efforts to bring roughly 500,000 Coloradans left out of health insurance coverage – by immigration law, personal choice or lack of information – under the umbrella of a health care policy, or at the least, regular access to care.

- Attacking unnecessary high costs for procedures and drugs, the underlying and persistent health inflation that helped lead to 2010's ACA passage in the first place. A combination of a state cost control commission, new pushes for consumer transparency, ongoing payment reform efforts and other measures will seek inroads into the complex cost puzzle.

- Absorbing the June U.S. Supreme Court decision confirming the legality of subsidies in the 36 state exchanges run by the federal government. Many believe the decision cemented the future of the ACA for dozens of states, but opponents of the reforms may regroup and seek other legal strategies to overturn provisions of the law.

- Preserving health reform gains in a future recession – an economic downturn that is as unpredictable as it is inevitable. This hurdle adds a wild card few policymakers want to address. A major recession would put severe pressure on federal contributions to expanded Medicaid and the exchange subsidies, while even Colorado's smaller portion of expansion costs will appear more onerous in the next state budget crisis.

- Addressing waivers to current ACA rules open to states in 2017. There is growing Colorado sentiment to fashion alternatives to various regulations that would better fit needs in the Rocky Mountain state. The state could seek changes to minimum benefit mandates that make some individual policies unaffordable, alter how Medicaid is run or change the structure of the exchange marketplace.

As has always been the case in health reform, every knowledgeable actor has his own favorite part in need of rewriting.

“The cost question still seems so insurmountable,” said Tammy Niederman, a leader in the Colorado broker community who has supported the state marketplace while working to preserve access to private insurance. “One of the biggest challenges with the ACA is that it did not address the cost of care. It did not address why it’s not affordable for a majority of middle-class Americans. So you attack one smaller thing at a time.”

“The Supreme Court decision is a very big piece of it,” said state Rep. Lois Landgraf, a Republican representing Fountain and other areas south of Colorado Springs. “How much do you put into any of this when it could all go away? I know there’s a push to end the exchange; what I’d like to see is if we can look into these waivers. How could we do this better?”

This edition of *Health Elevations* explores not just five years of Colorado changes since the 2010 signing of the ACA, but goes deeper into the past of previous state-sponsored reforms and further into the future of pending challenges. Is Colorado better off in the five years since diving into the changes made possible by the ACA? Can the state improve on the ACA and guarantee its future? Was the ACA a start at making health care make sense in the U.S. or only a false start? And can the dream of near-universal care survive the inevitable roller coaster of the broader economy?

In other articles in this edition, we take a close look at individual pieces of the health care and policy community since the ACA:

Are Colorado hospitals meeting their required community benefit spending? How has Denver Health transformed in a city that now has near-universal health coverage? Can



The ACA has rolled into the San Luis Valley, above, and the heart of Denver Health, right, with big changes to coverage, patient care, hospital and clinic finances and many other issues.

rural hospitals hang on with help from the ACA or are too many still threatened? How has a doctor’s practice changed under the ACA revolution? And what has happened to the private insurance market, public advocacy groups and other key players in the last five years?

First, a quick trip in the time machine to 2008 and 2009, when the national atmosphere over health insurance and health care was bitter, tumultuous and all-consuming. Presidential candidates staked their fortunes on passing or blocking the first major federal reform since Medicare in the 1960s. Congressional hearings spotlighted sick patients cruelly canceled by allegedly

• • •
One of the biggest challenges with the ACA is that it did not address the cost of care. It did not address why it’s not affordable for a majority of middle-class Americans. So you attack one smaller thing at a time.

Tammy Niederman, a leader in the Colorado broker community

greedy insurers (the word “rescission” quickly became part of the political and social lexicon); Americans stuck in the turbulent individual insurance market grew used to premium hikes of 40 percent or more.

“We had a big ol’ target on our chests,” said Allen-Davis, referring to Kaiser and other high-profile insurance companies. “Some of those practices need to change.” The Commonwealth

Fund said in 2009 that 36 percent of those who tried to buy individual insurance plans faced some form of discrimination because of a pre-existing condition.

Colorado was ahead of some reforms, having long before added protections in the small group market such as guaranteed issue and “business groups of 1” to help small-business owners. A state tobacco tax in 2004 expanded Medicaid coverage, and the hospital provider fee in 2009 further expanded eligibility while shoring up state Medicaid’s long-term financing. Commissions and legislation from the Gov. Bill Ritter administration forward pushed advocacy, business and political interests together to craft bipartisan health solutions.

Yet, reflecting the problem of the uninsured in the rest of the U.S., 800,000 to 900,000 Coloradans – out of a population of about 5 million – were without insurance coverage and had limited access to health care. That mix included adults between jobs who didn’t qualify for Medicaid, workers whose employers didn’t provide coverage, undocumented immigrants barred from state benefits and those who might afford insurance who simply declined to buy it. The health system shifted costs for that group to employer-based insurance and anyone else who could pay; state residents avoided necessary care because they couldn’t afford it; premiums jumped to the double digits, and federal Medicare costs for the growing elderly population soared. Health costs rose to 17 percent of the U.S. gross domestic product and threatened to consume an ever-higher portion of public resources.

Enter the ACA, signed into law in March of 2010. The major provisions include:

- No lifetime limits on many insurance benefits, an end to “rescission,” coverage



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Local outreach centers for the Connect for Health Colorado insurance exchange and for Medicaid's expansion, including this one in the San Luis Valley, have been key to lowering the uninsured rate.

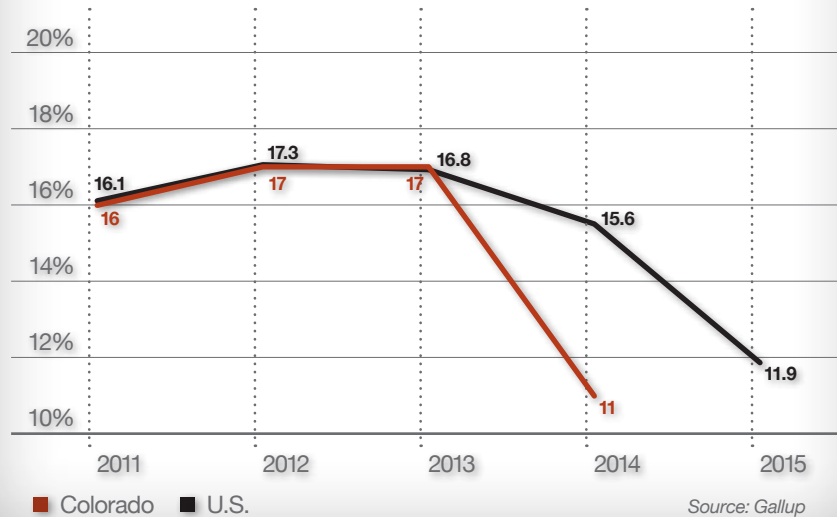
**Both sides
need to come
together more
than they have.
The blame
game has got
to stop.**

*Lorez Meinhold,
former top health advisor
to Gov. John Hickenlooper*

for kids on private insurance up to age 26 and free preventive care, beginning in the fall of 2010.

- Planning grants for states wanting to set up their own insurance marketplaces to channel subsidies and increase private competition for individual plans, beginning in 2011.
- Launching of the state exchanges in fall of 2013, with coverage to begin in 2014.
- Expansion of Medicaid to cover all people with incomes up to 133 percent of the federal poverty level, with coverage beginning in 2014. “I find all the discussions of the exchanges to be ironic,” said Adam Atherly, a professor and health care policy expert at the University of Colorado Denver’s School of Public Policy. “The core of the ACA is a major expansion of Medicaid, and that seems to be the state secret.”
- A mandate that all individuals who can afford it buy insurance coverage in exchange for a mandate that insurance companies issue policies even to those with pre-existing medical conditions, beginning in 2014.
- A pool of federal funds to promote experimentation in health cost and health delivery, including support for the Colorado HealthOP insurance plan, shared savings deals with Medicare providers, grants for electronic health records and integration of mental health care.
- Multimillion-dollar federal grants to safety net and community health clinics

Percentage Uninsured in Colorado and the U.S.



Local outreach centers for the Connect for Health Colorado insurance exchange and for Medicaid’s expansion, including this one in the San Luis Valley, have been key to lowering the uninsured rate.

to better serve the expanded Medicaid population, and to improve sliding-scale payment care to those still left uninsured after the ACA implementation. Clinica Family Health Services, for example, got \$3.8 million to expand in Thornton, while Metro Care Provider Network got \$10.2 million to replace its Jefferson County family health center. (Both clinics also received private grants from the Colorado Health Foundation to aid the expansions.)

Bottom Line for Change

And what has been the net effect of the ACA for Coloradans in the past five years?

For those who favored health care reforms to help the uninsured, the most important number is the total of new Medicaid expansion clients and individuals who bought insurance through Connect for Health Colorado who did not previously have policies. The state Department of Health Care Policy and Financing, which runs Medicaid with state and federal funds, estimates more than 352,000 of its current 1.2 million clients were newly eligible in the January 1, 2014, expansion. Though Connect for Health Colorado has not done its own survey, national surveys would indicate that about 37 percent of the 140,000 exchange customers did not previously have insurance.

Lisa Marie Meyer of Westminster is among the many Coloradans who feel the extension of health coverage and care to the greater public has been a life-saving umbrella.

Meyer, 47, was scraping out a living delivering flowers to shops at hospitals and other institutions when imaging recommended by a chiropractor revealed large shadows of tumor-like masses in her midsection. She’d never had insurance coverage, not even as a child. University of Colorado Health helped her sign up for Colorado’s indigent care program, but using those minimal benefits for expensive surgeries is often a battle.

Clinica, and in particular a nurse practitioner named Ruth Garcia, finally walked Meyer through the process of signing up for expanded Medicaid. Surgery removed growths that were massive but benign; Garcia and pharmacists helped her find the right medication for lifelong migraines; Clinica handed her to in-house counseling and group therapy for a difficult divorce and other issues.

“I am living proof” about the reach of the ACA, Meyer said. “I absolutely could have died. When I didn’t have insurance, it was a constant fear. Now I don’t have to look over my shoulder for that giant shadow.”

Nationally, a RAND Corp. study released in May reported a net gain of 17 million health insurance consumers since 2013, in line with other estimates. Gallup polls in recent months have indicated the Colorado rate of uninsured had dropped from 17 percent to 11.2 percent by 2014; some state health leaders believe that with continuing Medicaid sign-ups, the rate might be closer to 10 percent.



Dr. Dennard Ellison talks with Antonia Lopez at San Luis Valley Health, one of many Colorado rural communities adapting to the ACA.

On the big marks, including signing up 300,000 new Coloradans for coverage and care, reversing the cost shift, supporting community hospitals, and promoting innovative care models, the ACA scores well, said Joe Sammen, executive director of the Colorado Coalition for the Medically Underserved. “The ACA has really changed the culture of how we cover health care and deliver it in this country,” he said.

The exchange marketplace has landed sign-ups within its early range of predictions, but has been severely undercut by computer glitches that leave thousands waiting for answers and by high costs of call centers sorting out problems with the Medicaid/exchange interface. Heavy turnover of top personnel, infighting on the exchange board and a failure to cooperate fully and early with Medicaid further damaged the operation and the image.

“Both sides need to come together more than they have. The blame game has got to stop,” said Lorez Meinhold, the former top health care advisor to Gov. John Hickenlooper and a key architect of early adoptions of the ACA format in Colorado. Meinhold is now a health expert with Keystone Policy Center in Denver. “Now we need to learn from other states” that have worked together more seamlessly, including Kentucky, Meinhold said. The Washington Post in early May estimated nearly half of the 17 local exchanges in states and the District of Columbia were struggling financially, many reporting the same technology problems and lack of long-term operational financing troubling Colorado.

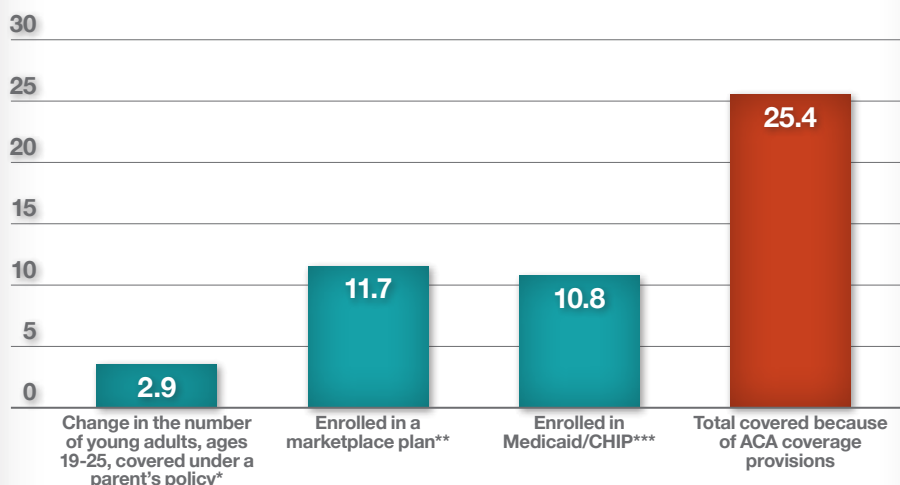
One of Colorado’s unique and most visible ACA crises was the soaring rates of exchange premiums in the mountain resort counties, an exaggeration of a long-standing cost differential for remote-yet-popular

locations. A benchmark silver-level plan on the exchange for Summit County, packed with ski resort workers needing coverage, shot to \$484 a month. The state Division of Insurance responded with a widening of the geographic rating system, spreading the risk among a larger population, and the next year’s silver plan for Summit dropped to \$266. Mountain counties are likely to enjoy even more price competition starting in January of 2016, when Kaiser, often one of the lower-priced plans because of its HMO network control, opens offices in Summit and Eagle counties.

Supporters of the ACA and some independent analysts say the main goal of health reform has been achieved.

“The Affordable Care Act has greatly expanded health insurance coverage, but it has caused little change in the way most previously covered Americans are getting

Over 25 Million Nationwide Gained Coverage Under the Provisions of the Affordable Care Act (as of March 2015)



* Change in number of young adults, ages 19-25, covered under a parent's policy from 2010-2014.
 ** Number of Americans that have selected or been automatically enrolled into a 2015 health insurance plan through the Health Insurance Marketplace (11/15/14-2/15/15), including Special Enrollment Period activity reported through Feb. 22, 2015.
 *** Increase in Medicaid and CHIP enrollment between October 2013 and December 2014.

Source: The Commonwealth Fund

Reformers agree that the main goal of the ACA was getting more people covered by health insurance; by that standard, the numbers are encouraging.

health insurance coverage,” said economist Katherine Carman, the lead author of the RAND study who was quoted in The Hill.

Critics of the ACA said its various mandates might ruin health insurance for the majority of working Americans who get private insurance through their employer by raising costs and encouraging business to dump employees into the exchanges. But Colorado’s private insurance rates have reported lower annual increases in recent years than in the worst years of the early and mid-2000s, when double-digit hikes were the norm.

A recent estimate by the Congressional Budget Office lowered the net federal cost of implementing the ACA by \$142 billion for the years 2016 to 2026. Federal costs will be 29 percent lower from 2015 to 2019 than originally projected in 2010, according to the Commonwealth Fund report.

Still, for those looking at a bigger picture than signing up the uninsured, the overall evaluation of the ACA still ranks as “to be determined.”

“We don’t have enough information to know if it’s benefiting society overall,” said Bill Lindsay, president of the benefits group

at Lockton Companies, a consultant for employers who also led the Blue Ribbon Commission recommending Colorado health reforms under the Ritter administration. “The benefits are primarily the insurance reform that’s taken place. It was necessary and very important to people. Now if you

• • •
**I’ve seen the difference.
 I feel like [health care] access
 for my community is better.**

Lorena Osorio, neighborhood activist

• • •
 need insurance, you can get it. The rest of the changes – the expanded Medicaid population, the consolidation of the hospitals, the doctors being purchased by hospitals, all those changes that are occurring in the delivery system – the question is what is the value of that? That’s still an open question.”

And those who remain opposed to the ACA’s expansion of government responsibility, especially the mandate to buy coverage, want to hear more about the ACA’s negative impacts on middle-class insurance buyers. Those individuals are required to buy coverage for minimum benefits they may never use, have seen their provider networks

narrowed after thinking they could keep their doctors and pay sky-high deductibles before their insurance ever kicks in, critics said.

“The constituents I hear from are those who had insurance and now pay twice as much as they used to pay,” said Landgraf, the legislator. “They attribute that to the ACA, as do I. A person who wants basic coverage can no longer get just a basic coverage plan.”

The widely varying assessments of the ACA put a spotlight on one of the act’s most progressive constructs – the idea that much of the reform’s impact would be felt soonest by underserved communities whose gains might be subsidized by the nation as a whole. That fact was not always the chosen political message, even among supporters. But its power is felt in places not prominent on cable news.

“I’ve seen the difference,” said Lorena Osorio, a neighborhood activist in largely Hispanic and modest-income ZIP codes in Westminster and south Adams County. The local safety net clinics have built additions, hired bilingual providers and staff, reduced their sliding-scale prices for the uninsured and added integrated care like nutrition classes and mental health, Osorio said through an interpreter. They can take more patients, and they do.

“I feel like access for my community is better,” she said. •



A 'flash mob' was called in front of Denver's renovated Union Station this spring as part of the kickoff for a petition drive to create a universal coverage and care system for Colorado, by reformers who say the ACA has not gone far enough.

Improving the ACA: A Delicate Dance

By Michael Booth
Photograph by James Chance

The Affordable Care Act has survived more than five years of nonstop challenges nearly intact. Yet even those inclined to endorse its sweeping benefits point out the act's internal structure and external economics make it resemble a sand sculpture just above high tide far more than an immutable Stonehenge.

Deep recession. Big employers itching to get out of providing insurance. The elephant in the room of baby boomer retirements swelling Medicare costs beyond budget limits. All promise to alter what we at the moment consider the most important features of the ACA.

Adam Atherly, a professor and health care policy expert at the University of Colorado Denver, noted that when the Health Insurance Portability and Accountability Act passed in 1996, it was touted as a way for workers to keep their coverage while switching to a new job. Years later, the public perceives it as a firewall to protecting their electronic medical records from prying eyes.

"The privacy issue is what we talk about 20 years later," Atherly said. "I have a feeling that what we will talk about in 20 years with the ACA, we don't know yet."

Most immediately, now that the U.S. Supreme Court has weighed in favor of federal subsidies in its crucial June decision, is a need to fix the Connect for Health Colorado insurance marketplace before all public and political confidence is lost, state experts agree. The exchange covers only about 140,000 people with individual policies compared with millions on employer-sponsored insurance plans, but its cost and its tenuous existence as a quasi-state agency give it outsized attention.

"It's fair to say we do have a slight hit to the brand," said interim exchange CEO Kevin Patterson, who as a longtime aide to Gov. John Hickenlooper is seen as a potential bridge between the exchange's operations and what should be a close ally – state Medicaid. "When you only talk about problems, people think all you have are problems. When we look at the places where people get stuck, it's less than 10 percent of those folks. The problem is, they are really, really stuck, and it's frustrating as all get out. And you're trying to make one of the most important purchases for your family. We've got to figure out a way to solve that problem."

That answer won't come until deep into the fall, when consumers trying to use the system learn whether the exchange and Medicaid interface was fixed, or whether ongoing problems continue to jam the costly call centers with time-consuming queries.

Consumers will also be learning about another deep worry of health insurance-watchers: what premiums will look like for 2016 policies in an atmosphere where newly insured clients may be using a lot of expensive services and driving up underwriting costs. In late spring of 2015, other states saw new rate filings in the high double digits, just like the "bad old days" of 2008 and 2009 before the ACA's signing.

The Colorado Consumer Health Initiative, which watches rate filings and sometimes protests increases, said Colorado may be in a unique situation: The state has a high number of insurers competing in the marketplace, which tends to rein in rates, and some of the insurers have high surplus loss reserves they could use to keep rates low even if claims move higher.

Advocacy and analysis groups will turn slightly from promoting coverage – which a great many eligible Coloradans now have – to seeking better access to actual care for those now covered. Many areas of the state outside the large Front Range cities force Medicaid patients into long waits when they seek specialty appointments, noted Jandel Allen-Davis, MD, vice president of government and external relations for Kaiser Permanente Colorado. (Kaiser has about 52,000 of the state's Medicaid clientele

...
Specialty access is virtually impossible in some parts of the state. You don't need just an insurance card – you need care.

Jandel Allen-Davis, MD, vice president of government and external relations, Kaiser Permanente Colorado

and sometimes has to cap further growth for financial and access reasons.)

“Specialty access is virtually impossible in some parts of the state,” she said. Medicaid officials will have to alter their reimbursement for specialty care if they want to break those logjams. “You don’t need just an insurance card – you need care.”

In Aspen late this spring, news surfaced that Pitkin County officials were searching hard for area providers who would take Medicaid, with some of the thousands of poverty-level residents having to go 70 miles to Rifle for care.

“You have to be careful where you assign blame for some issues,” said Joe Sammen, executive director of the Colorado Coalition for the Medically Underserved. “Specialty care access is a decades-long rural issue, not something necessarily that’s wrong with the law.”

Reform advocates see opportunity to broaden ACA benefits and win over new supporters by improving the performance of SHOP, the small employer insurance program meant to be promoted through the state marketplaces. SHOP lets the marketplaces channel federal tax credits to businesses or nonprofits with up to 50 employees who sign up for health coverage, but take up has been extremely slow.

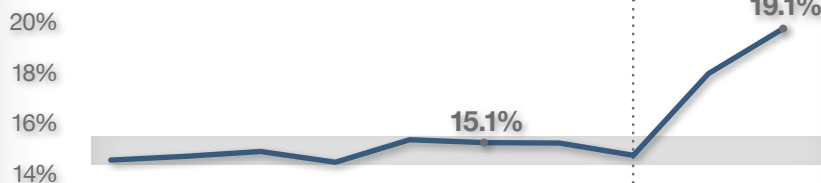
“We didn’t come close on enrollment targets in Colorado,” said Tim Gaudette, Colorado’s director of the Small Business Majority, an advocacy group. “It’s the second child, and it never saw the push and the emphasis.”

Without a mandate requiring small businesses to cover employees, it was too easy for employers to stay away when they heard of exchange glitches, Gaudette said. Brokers, meanwhile, did not find it a lucrative source of potential business. That could change, he added, when SHOP eligibility expands to 51 to 99 employees.

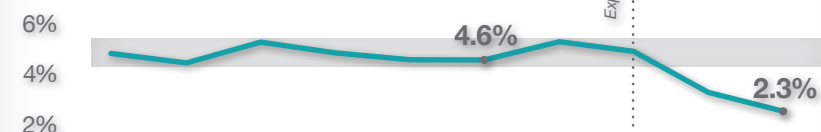
“It’s not a slam dunk,” he said. “If it was easy, it would have been done a long time ago.”

Changes in Hospital Finances in Medicaid Expansion States Since ACA

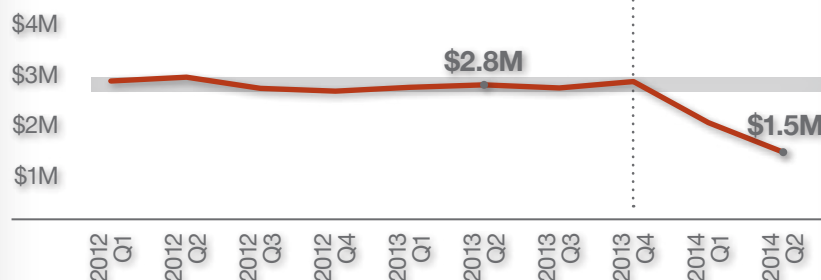
Percentage Medicaid Charges



Percentage Self-Pay Charges



Average Charity Care Per Hospital



■ Normal range of variation for 2012-2013

Source: The Commonwealth Fund

Hospitals that serve lower-income residents have felt big changes from the ACA, with an increase in Medicaid revenue directly affecting the drop in self-pay and the need for charity care.

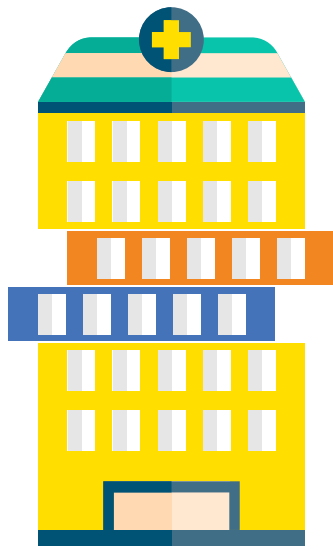
The biggest wild card for health reformers – and the one mentioned least – is the certitude of a future recession that could threaten the coverage gains made possible by the ACA. The latest deep recession officially ended in June of 2009, and with recent recessions hitting every five to 10 years, the U.S. would be due for a downturn by the end of this decade.

“Absolutely another recession will happen,” Atherly said. When it does, states like Colorado with tight restrictions on raising taxes or shifting budget burdens will seek relief in health costs, now making up about a third of general fund spending in many states through the growth of Medicaid programs. (Traditionally Medicaid is half funded by the federal government, and for now, Medicaid expansion is paid 100 percent by federal funds. The federal share for those new clients drops to 90 percent in coming years.)

Colorado’s hospital provider fee offers some cushion in a recession to pay for the state’s portion of Medicaid. And ACA rules about the Medicaid expansion include a bar on states cutting back eligibility once they have accepted the expansion. But other health costs can still be attacked, including Medicaid reimbursement rates to hospitals and other providers, Atherly noted. In one recession, he said, Hawaii started limiting inpatient hospital days. “A lot of states will try to do some pretty radical things,” he said.

Nationally, a recession would cut into tax collections and put pressure on Congress to cut the Medicaid expansion, alter Medicare and slash marketplace insurance subsidies, among other moves.

“I’d say no, the system’s not prepared for another recession,” Sammen said. “But is any system?” ●



Are Colorado Hospitals Building ACA's 'Community Benefit' Floors?

Reports are In, But Interpretation is Tricky

By Nancy Watzman

First, the good news. Thanks to the Affordable Care Act and regulatory changes made in recent years by the Internal Revenue Service, a greater wealth of information is available to the public than ever before about how nonprofit hospitals are meeting their obligations to the communities surrounding them.

Now, the bad: You need the digging skills of an investigative journalist, the know-how of a statistician and a background in hospital management to make heads or tails of that data.

"There has been a lot of progress made in improving transparency. Unfortunately, it is still not very consumer-friendly," said Adela Flores-Brennan, executive director of the Colorado Consumer Health Initiative. "It is challenging and time-consuming to track down all of the information that would give a comprehensive picture of community benefits."

The underlying idea behind disclosure is that because nonprofit hospitals enjoy enormous benefits from the public, they are both obligated to serve the public – that's the community benefit part – and to be transparent about how they are doing it. The value of the tax exemptions that the nation's 2,900 public hospitals enjoy is enormous: an estimated \$8.5 billion to \$21 billion, according to the Hilltop Institute at the University of Maryland, Baltimore County. The Joint Committee on Taxation estimated such benefits to be \$12.6 billion in 2002.

Thirty-one states require some sort of reporting of community benefits by nonprofit hospitals to state agencies; Colorado is not one of them, according to data gathered by the Hilltop Institute.

However, Colorado nonprofit hospitals must meet federal reporting requirements. Since 2009, following congressional hearings that highlighted problems and abuses, the IRS has required nonprofit hospitals to report the "community benefits" they provide. These are divided into six broad categories, ranging from amount spent on uncompensated care to training for medical students to the somewhat amorphous category of "community health improvement."

The ACA added some new requirements. In 2012 nonprofit hospitals became obligated to conduct community health needs assessments every three years. And they must produce written financial assistance policies along with plans to publicize those policies in the communities they serve. Both of these documents must be made "widely available" on a website. The IRS only issued final rules on these requirements in December 2014, nearly five years after passage of the ACA.

Understanding the Numbers

Finding all this information, however, is not only a chore, it's difficult for a layperson to interpret. Nonprofit hospitals report their spending on different categories of community benefits on a tax form known as Schedule H, which is appended to the 990s they file as charitable organizations, which often run more than 100 pages. Hospitals file these forms at the system level, not by individual hospital.

While a community member may ask a hospital to produce these 990s, they are also accessible through online search sites such as the Foundation Center and GuideStar. So, for example, it's possible to see that Children's Hospital Colorado, on the high end, reported spending 21.3 percent of its total expenses on community benefits in 2013, while PorterCare Adventist Health System reported spending 5.9 percent.

One big wrinkle: Government-run hospitals, such as Denver Health and the University of Colorado hospitals, are not required to file 990s and the Schedule H forms.

Furthermore, these figures can be misleading, caution experts. First, sometimes there are discrepancies between what hospitals report in a given community benefit category and what they report about their financial status elsewhere on the 990 form. In a comprehensive analysis of community benefits reported by nonprofit hospitals in 2009, published in the *New England Journal of Medicine* in 2013, researchers found such errors, although they were able to correct them with some digging from other data sources.

Another problem might be underreporting in some categories. Because the IRS has left gray what can be counted in the "community health improvement" category, hospitals may not include all the activities that they do for fear that the IRS won't allow it. Increasingly, hospital systems are defining health broadly and may get involved in issues not traditionally thought of in the health care category.

In April, the American Hospital Association and the Catholic Health Association of the United States, seeking some clarity, wrote the IRS requesting that the agency "formally acknowledge that support for improved housing to enhance the health of a hospital's community is a community benefit and should be recognized on ... Schedule H."

Charity Care Reporting

Meanwhile, community benefit reporting rules need to catch up with the new landscape after passage of the ACA. The percentage of uncompensated care provided, or charity care, is typically the largest that nonprofit hospitals report. For example, among five Colorado nonprofit hospital systems, the charity care percentage reported ranged from 7.58 to 15.33 percent. In the other categories, the reported percentages were all 1 percent or lower.

However, charity care levels “tell us more about the neighborhoods being serviced by the hospital” than a full picture of community benefits, said Phillip Gonzalez, program director of Community Catalyst, a national consumer health nonprofit organization.

In addition, in states such as Colorado, which implemented Medicaid expansion following passage of the ACA, hospitals are reporting lower charity care levels as people gain insurance. Nationwide, states that expanded their Medicaid programs saw a 29 percent increase in participation, a 30 percent decrease in charity care patients and a 25 percent decrease in self-pay patients, according to a Colorado Hospital Association analysis of 2014 first quarter data.

In this new world, it’s important to watch a growing category of people: the underinsured, said Gonzalez. “What does it matter if you have coverage but your deductible is \$10,000 or \$15,000? Are you going to behave as if you are insured or uninsured?”

Beyond the reporting of community benefits on Schedule H, consumers can also look at the community health needs assessments conducted by hospitals. For example, Children’s Hospital Colorado makes available online its 2012 analysis of community health needs. The survey identified four areas as priorities: access to health care, obesity, injuries and mental health.

Evaluating how well a given hospital system has conducted its community health needs assessments, however, is somewhat subjective since they all follow different formats; it is not a simple number that can be put in a spreadsheet. Community Catalyst recommends looking at who was involved in the assessment, who was left out and who should be included; how data were gathered and presented to the community; and the program’s impact.

As for new financial assistance policies required by the ACA – due by the end of this year – there may be some overlap with the Hospital Payment Assistance Program. Approved by the Colorado Legislature in 2012, this new law requires hospitals to create and publicize financial assistance policies. It also limits charges for certain patients – uninsured Coloradans making under a certain income level – to that of an insured patient. A 2014 law, S.B. 14-50, set up a committee of consumer and hospital representatives to clarify how the law should be enforced.

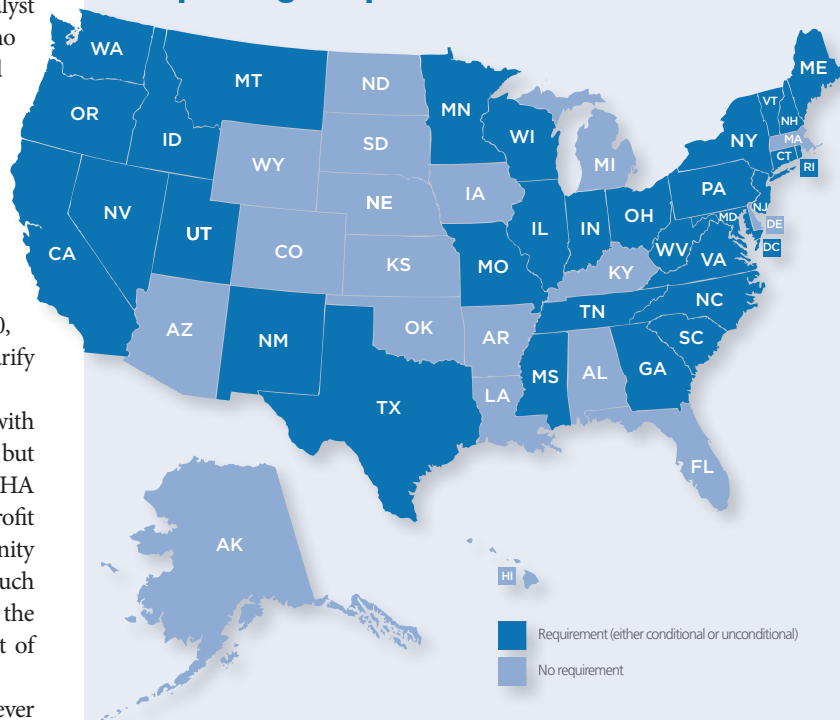
Hospitals recognize that providing the public information with the community benefits they offer is not only a requirement, but an important tool for gaining support. In September, the CHA launched its first survey of state hospitals – private and nonprofit alike – to gather not just information, but stories about community benefits programs. However, the association did not receive as much participation as it would have liked and so hopes to expand the project in this coming year, said Kevin Downey, vice president of communications and media relations at the CHA.

Unfortunately, while more information is available than ever before about hospital community benefits, it is far from complete. And gathering and interpreting it remain largely the province of experts. •

Key Transparency Requirements for Hospitals

- All nonprofit hospitals are required to report community benefits to the IRS on Schedule H of 990 tax forms. These are filed annually.
- In addition, the ACA requires nonprofit hospitals to conduct Community Health Needs Assessments (CHNAs) and financial assistance policies and make them “widely available” on a website.
- Government hospitals are not required to file 990 tax forms. However, they are required to conduct CHNAs and post financial assistance policies.
- The state of Colorado has no separate requirements for nonprofit hospitals to report community benefits, nor do 18 other states as shown in map below. At least one national study showed that nonprofits in states with a local reporting requirement – in addition to the federal rules – tend to spend more on community benefits.
- However, a 2012 Colorado law, the Hospital Payment Assistance Program, and 2014 follow-up legislation, do establish requirements for financial assistance and require both private and nonprofit hospitals to publicize these policies in the communities.

Community Benefit Reporting Requirement



An ACA Infusion for Denver Health



By Kelly Pate Dwyer
Photography by James Chance

Denver Health's scraped-and-rebuilt Lowry Family Health Center is one of the more visible signs of changes to patient care made possible by the ACA.

Denver Health was operating at a \$4.6 million annual deficit in 2013 when its leaders took a calculated risk: to expand rather than cut their way to stability.

They recruited 18 medical, dental, specialty and behavioral health professionals for Denver Health's primary care clinics to prepare for an anticipated surge of insured patients in 2014, when the Affordable Care Act expanded Medicaid services.

That planning, along with other innovations in prevention and coordinated, patient-based care delivery, is paying off in many ways.

The hospital and its network of community health centers and specialty clinics posted an operating margin of \$36 million last year, most of which comes from Medicaid expansion payments. About 70,000 Denver County residents have signed up for Medicaid coverage (12,500 through the Medicaid plan administered by Denver Health) since the end of 2013, pushing the total number of insured Denver residents to 94 percent and hitting a 2018 community goal three years early, said Bill Burman, MD, an infectious disease specialist and director of Denver Public Health. With only 6 percent of residents uninsured, one of the largest cities in the West is now seeing the results of near-universal health coverage.

Many of Denver's newly insured are choosing Denver Health – and not necessarily for trauma and emergencies. Primary care visits at community clinics have increased by 25 percent, and behavioral health visits have more than doubled since late 2013. Altogether, Denver Health community centers care for one-third of Denver County residents and 40 percent of its children, Burman said. Meanwhile, emergency room visits are flat, which is relatively good news compared with the majority of U.S. hospitals where ER visits are on the rise.

Two of the three big reform goals – expanding coverage and access to care – are happening in Denver, Burman said. As for the third, improving health across the population, “we’re not there yet,” he said. “Is it an audacious goal? I think it’s starting to happen. Realizing the full ACA potential depends on developing self-sustaining care models that provide the right care by the right clinical staff member at the right time and place.”

Denver Health has introduced and continues to develop those models.

While health care reform affects Denver Health in mostly positive ways, challenges abound. Denver Health jumped into the

commercial market with individual plans sold on the Connect for Health Colorado insurance marketplace that did not attract as many customers as officials had hoped. More significantly, should a piece of ACA law move forward that cuts Disproportionate Share Hospital (DSH) payments – funding to hospitals that serve large proportions of Medicaid and uninsured patients – that “would severely negatively impact operations,” Burman said.

Patient-Centered Care

The traditional care model that gives most patients a 20-minute time slot doesn't make sense, Burman explained. A healthy child in need of one vaccination can be handled in a few minutes. But a high-risk patient with multiple co-morbidities requires care from multiple providers over an extended time to positively affect that patient's health and well-being and to keep hospitalization costs down.

To that end, Denver Health has stratified care delivery to meet individual patient needs. The primary care clinics are geared toward health prevention and maintenance for all patients, insured or uninsured, including patients managing chronic conditions. Patient navigators at each clinic help patients get what they need. Services include pediatric and women's health, dental, eye and behavioral health. Denver Health also operates numerous school-based clinics.

By contrast, high-risk adults may be referred to the Intensive Outpatient Clinic, on the main campus, where a typical initial visit involves meeting with multiple providers over the course of a few hours. Since this clinic opened in 2013, hospitalizations among high-risk adults have declined 15 percent, Burman said. (Since more hospital patients are insured, he said, it is easier to arrange for follow-up and specialty care.)

Denver Health also provides services for children with special health needs and, through a partnership with the Mental Health Center of Denver, services for adults with significant mental health diagnoses.

Treating the whole patient, Burman explained, means not only providing integrated and coordinated medical and behavioral care, but connecting patients with community-based services such as housing, employment and drug treatment that support their overall well-being and can lead to better health outcomes.

Reform Drives and Threatens Funding Stream

Payments from newly covered Medicaid patients are fueling Denver Health's efforts in primary and specialty care clinics. Denver Health has also spent most of a \$20 million 21st Century Care grant from the Center for Medicare & Medicaid Innovation, which was established as part of the ACA, on hiring (45 full-time providers since 2013) and information technology infrastructure to support stratified, coordinated care, and on developing metrics and reporting methods that measure how these approaches are working and inform necessary changes.

In May 2014, Denver Health raised \$84.8 million in a bond sale to fund expansion and remodeling in some clinics, construction of a new clinic in southwest Denver and some inpatient services.

“Denver Health is doing a tremendous job managing finances and operations,” said Bill Lindsay, president of the benefits group at Lockton Companies. “So few hospitals remain independent. Most people shake their heads and say, ‘I don't know how these guys do it.’ They've been very effective navigating the complicated health care system and finding a way to survive and serve their patients. It's remarkable.”

While Denver Health forges ahead with cutting-edge innovations, it continues to wrestle with the expenses of serving a relatively high volume of uninsured patients, which cost \$256 million in 2014.

ACA proponents had expected, or at least hoped, that expanding coverage via Medicaid and affordable commercial plans would reduce hospital admissions and ER visits by encouraging nonemergent patients to seek primary care instead. In fact, three-quarters of ER doctors have reported increases in ER volume, 17 percent have reported no change and only 5 percent have witnessed decreases in patient volume since Medicaid expanded January 1, 2014, according to a recent survey by the American College of Emergency Physicians.

On a national scale, experts point to several causes for ER volumes, including shortages in primary care providers, providers who don't accept Medicaid, the 24/7 convenience of the ER and pent-up demand among patients who don't have a traditional doctor relationship. At Denver Health, flat numbers likely reflect a decrease in patients using the ER, who are visiting clinics instead, and an increase in population. The number of people living in downtown Denver and the immediate surrounding neighborhoods has increased by about 9,000 people in the last five years, according to U.S. Census data and research by Claritas.

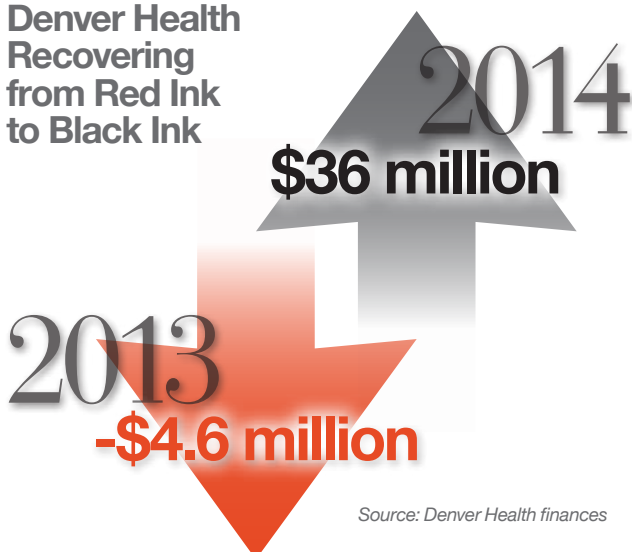
Nationally, the lackluster performance of some commercial plans on the exchanges is especially troubling to hospitals. The Obama administration was counting on enrolling enough commercially insured patients to generate sufficient revenue for hospitals like Denver Health that they would no longer need Disproportionate Share Hospital funds, Lindsay said. Under the ACA, that program is slated to phase out but is now under review.

If Disproportionate Share Hospital payments are completely eliminated, Denver Health would take a \$54 million hit, Burman said, in effect negating revenue from newly covered Medicaid patients. Those proposed cuts have now been delayed until 2017, giving Denver Health and other safety net hospitals more time to prepare for a revenue drop.

Insurance Market Full of Unknowns

At the same time Denver Health has patched its financing for the key role as the city's social safety net, other agencies under the Denver Health umbrella are trying to extend the brand into a more mainstream role of coverage-and-care home to all residents.

**Denver Health
Recovering
from Red Ink
to Black Ink**



Source: Denver Health finances

Denver Health's insurance arm, for example – Denver Health Medical Plan – now understands firsthand how commercial plans are faring on the exchanges. DHMP introduced seven plans under the brand “Elevate” on Connect for Health Colorado last year.

“The Elevate plans aren't doing as well as we had hoped,” said Laurie Goss, director of managed care marketing for DHMP's commercial products. Without much claims experience in this new market, Denver Health has taken a conservative approach in pricing premiums in the middle range, she said.

Plans with the lowest premiums are commanding the greatest market share, said Louise Norris, a local insurance broker who writes for The Colorado Health Insurance Insider.

Goss suspects some uninsured people haven't signed up for insurance because the penalty for lack of coverage is small and the Colorado Indigent Care Program continues to offer discounts to some uninsured people. Most members of Elevate plans are people who previously had been denied for pre-existing conditions and people “who know Denver Health, have gotten care at Denver Health and want to continue to see one of the doctors there, she added.”

By contrast, DHMP's Medicaid Managed Care plan has experienced 22.5 percent growth – to 68,000 members – since late 2013. That growth equated to \$150 million in Medicaid payments to Denver Health in 2014, an increase of \$18 million from 2013.

DHMP also offers Medicare and Child Health Plan Plus (CHP+) plans as well as large group health plans for Denver Health employees, Denver police and other city employees and retirees. Goss said that about 6 percent of Denver's city employees are enrolled in one of the Denver Health group plans. DHMP hopes to increase membership in 2016 with its HighPoint plan, which, for all its large group plans, will extend in-network coverage to providers at Children's Hospital Colorado and University Hospital as well as Denver Health.

Survival and Growth

In an environment of rapid consolidation, Denver Health stands out as an independent. Yet its continued success comes both from innovation and a multifaceted reach.

Denver Health partners with other hospitals and clinics to provide care, operates an urban family medicine residency program and is building a primary care residency for nurse and physician assistant



training. It also partners with the University of Colorado Denver on a mentoring program that pairs physicians with minority students, and with Denver Public Schools on a Medical Careers Pathways program for high school students.

Burman said he already sees evidence of improved health across the local population: “In Denver, the ACA has led to historic rates of health coverage, increased access to care and expansion in the care system for low-income persons.”

He looks forward to the pending release of the Colorado Health Access Survey to help assess whether patients are getting the care their insurance covers. In the coming years, he expects Denver will experience similar improvements as those in Massachusetts, where smoking declined, mental health care improved, and personal and family bankruptcy (from health care costs) declined following expanded coverage and access.

Lindsay sees opportunity for Denver Health as more middle-class suburbanites return to city living. “They have an opportunity to appeal to that new market segment,” he said, but the challenge for the hospital is competing with Rose Medical Center and St. Joseph Hospital for patients. Many people respect Denver Health as the ER to go to for severe trauma, but do not think of it first when their young child has a fever at two in the morning.

“I think they're working hard to change that image,” Lindsay said. “What they're doing is the right thing, but the market hasn't responded yet.” ●



The rebuilt Lowry Family Health Center, left, and a young patient, above, on the eastern edge of Denver, is one example of Denver Health trying to become a health plan and care option for everyone, beyond its traditional image as a safety net. At right, Susana Rodriguez weighs and measures 5-year-old Abdirahman Mohamed during his appointment.



ACA Leads to More Robust Care in San Luis Valley

By Buffy Gilfoil
Photography by James Chance

For decades, residents of the vast San Luis Valley have found their way to basic health care services. No one was turned away. But many left emergency rooms and doctors' offices with no means to fill a prescription, no plan for handling a chronic illness or no way to pay for desperately needed specialty care.

In the wide and sometimes unforgiving landscape between the San Juan and the Sangre de Cristo mountains, the Affordable Care Act has deepened the health care experience for many.

"We're not caring for more patients, but we're giving more care for patients," said Gregory McAuliffe, MD, chief medical officer at San Luis Valley Health.

Integrated care, the provider fee and the ACA have combined to bring about changes that improve patient care. "All those pieces have made health care more robust than it was 10 years ago," McAuliffe said.

San Luis Valley Health employs about 650 and serves more than 46,000 people living in a six-county, 8,192-square-mile agricultural plain (nearly as large as New Jersey).

The flagship campus is a 49-bed hospital in Alamosa that provides medical/surgical intensive care, intensive care and obstetrical services. The emergency department sees more than 12,000 patients a year, and paramedic-staffed ambulance crews respond to approximately 2,400 calls annually.

In recent years, San Luis Valley Health expanded beyond the main campus to include Conejos County Hospital in La Jara, and five primary and specialty care clinics throughout the valley.

The partnership with Conejos County Hospital was a lifeline for the 17-bed, critical-care hospital, which, like many rural hospitals across the nation, was in a fragile financial position. Elsewhere in Colorado, small hospitals in remote places from Leadville to Holyoke struggle to shore up crumbling buildings or attract medical professionals. Some Colorado rural hospitals see up to 80 percent of their revenue from Medicare and Medicaid, which pay bare-bones reimbursement with no margin for error, according to the Colorado Hospital Association.

The American Hospital Association reports that nearly 40 percent of critical access hospitals – a designation for many isolated rural facilities – have negative operating revenue.

"(Conejos County Hospital was) smaller and their financials were much more vulnerable. They were facing significant change or closure," said Konnie Martin, CEO at San Luis Valley Health. The merger also helped the regional medical center, she said, because it helped provided a bigger, integrated network.

Similarly, the inclusion of clinics helped both the center and the clinics. "We didn't lose all of the providers and have to start over," Martin said.

Improving the Bottom Line

With many services under one umbrella as well as an affiliation with Centura for advanced

care, San Luis Valley Health readily provides integrated care that is conveniently located and relatively seamless for patients.

In addition, since the various facilities qualify for different types of payments, the organization benefits from a broad base of reimbursement formulas.

"We have a prospective-payment hospital (fee for service), a critical access hospital, provider-based clinics, provider-based rural health clinics and traditional fee for service," Martin said. "We are using every opportunity to build the best business model for our community to preserve care and build services."

While integrated care benefits delivery of care and the organization's finances, the provider fee allows for more comprehensive services to Medicaid patients. For example, a patient who would have received care only for an acute incident before the provider fee may now be eligible for follow-up and specialty care as well as prescriptions. Among the many changes brought by the ACA was expansion of preventive care and of health care insurance availability.



Continuous eligibility for Medicaid is now more common. In the past, Medicaid and insurance eligibility, and therefore coverage, went on and off. The situation was bad for both patients and the system. “Interrupted health care results in no health care,” McAuliffe said.

Over the past five years, San Luis Valley Regional Medical Center added specialty care in cardiology, oncology and neurology. In addition, services have been expanded in obstetrics and gynecology, pediatrics and orthopedics. Units that provide preventive services, such as mammography, are busier.

“We’re able to finance and provide services in a sustainable fashion for the patients,” McAuliffe said. Previously, he explained, “it was hit and miss. It was financially impossible to support those specialty services.

“On the other end, we had fewer people who had Medicaid who were able to access the services. It helped on both sides – both on the provider side and on the patient side,” he added.

Creating a Sustainable System

While integration of services, the provider fee and the ACA have allowed San Luis Valley Health to expand services, these changes have also brought challenges.

“The health care system itself is complex and the Affordable Care Act didn’t simplify it at all,” Martin said. “For the average consumer, regardless of what expertise they bring in the door, it’s hard to understand the system and get through it.”

To help ensure that valley residents receive appropriate health care coverage, Connect for Health Colorado selected the center to host a certified assistance site where residents can register in person for coverage, including potential eligibility for private insurance subsidies or Medicaid.

The site has been busiest, of course, during open season. It helped 1,179 applicants register for coverage in the first enrollment and 1,219 in the second. But even at other times assistance is available to help with problems.

Donna Wehe, San Luis Valley Health patient access manager, is painfully aware of a range of problems, including what she calls the “family glitch,” where a wife, for example, has coverage through an employer, but the expense of adding her husband would be prohibitive. The availability of the expensive coverage, however, prevents the husband from qualifying for low-cost coverage through the marketplace.

Some residents need help understanding that an increase in income may also mean

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The health care system itself is complex and the Affordable Care Act didn’t simplify it at all.

For the average consumer, regardless of what expertise they bring in the door, it’s hard to understand the system and get through it.

Konnie Martin, CEO, San Luis Valley Health

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an increase in premiums or a bigger tax bill. Some need advice when they receive calls throughout the year urging them to switch their plans in the next open season. College students and unmarried couples expecting children present challenges, too.

“We really want to educate our patients,” Wehe said.

The ACA has also brought complications for professionals. Some well-intentioned technology requirements waste time and money, even going so far as distracting doctors “from what they’re trying to do: care for patients,” McAuliffe said.

San Luis Valley institutions have to merge, improvise and otherwise stay creative to keep financially afloat, even with the ACA’s help. Above left, John Reyes of Baca, Colo., takes advantage of some lobby time while waiting for an appointment at San Luis Valley Health.





The payer mix has improved in the valley, but it is still challenging. The vast majority of patients who recently became eligible for health care coverage qualified for Medicaid instead of commercial insurance. For every patient who received private coverage through the exchange marketplace, 10 patients qualified for Medicaid, officials said.

“Medicaid is a far better payer than no payer,” Martin said. “But compared to our peers in urban areas, there’s a pretty drastic difference.”

According to Martin, the organization needs a bottom line, even if it is modest. “Even though we’re only talking about usually single-digit margins, they matter,” she said.

One reason for a balanced budget with a margin is the need to maintain and replace equipment and facilities. Failure to have a balanced budget with a margin for an extended time has contributed to the fragile finances of many rural critical access hospitals. “You get to a point where you don’t have anything left,” she said.

Another reason is that a sustainable budget is needed to recruit and train professionals. “We have to be able to demonstrate and give them confidence that we’re here for the long haul,” Martin said. Pay in the valley is competitive with that in urban areas, she added.



Integrated care, the provider fee and ACA help San Luis Valley Health maintain a modest return back into infrastructure and investment, according to Martin.

“My outlook for our organization and our community is a positive one,” she said. “We are strongly committed. We feel very invested in making sure the community has health care.” ●

Making the ACA work in rural Colorado means patient care from doctors like Dennard Ellison, above. But it also means connecting people to coverage to bolster a hospital’s finances. In top photo, “Hub” manager Donna Wehe works on staff training with Shirley Garcia, including changes to the Connect for Health Colorado site.

Doctors & the ACA

More Time with Patients, If They are Lucky Enough to Get in the Door

By Elise Oberliesen
Photography by James Chance

For all the complex debate about health reform policies, the massive changes to health coverage provided by the Affordable Care Act still pay off in their most tangible form at the simple moment when a provider sits down with a patient.

Many health care professionals in Colorado say that viewed through that standard, the ACA brought some positive changes to the health care system. Yet many in the same group also have a laundry list of improvements.

More and more health encounters are paid through systems that reward primary visits, preventive care, longer conversations and whole-life assistance which don't always come with a traditional billing code.

At the same time, many Colorado primary and specialty offices are buried in demand, raising questions of how much true change coverage can bring if it doesn't result in access to actual care.

"Now providers can focus on quality rather than volume," said David Watson, MD, chief medical officer with Centura Health Physician Group, which represents a network of nearly 500 medical providers employed directly by Centura, the largest hospital system in Colorado.

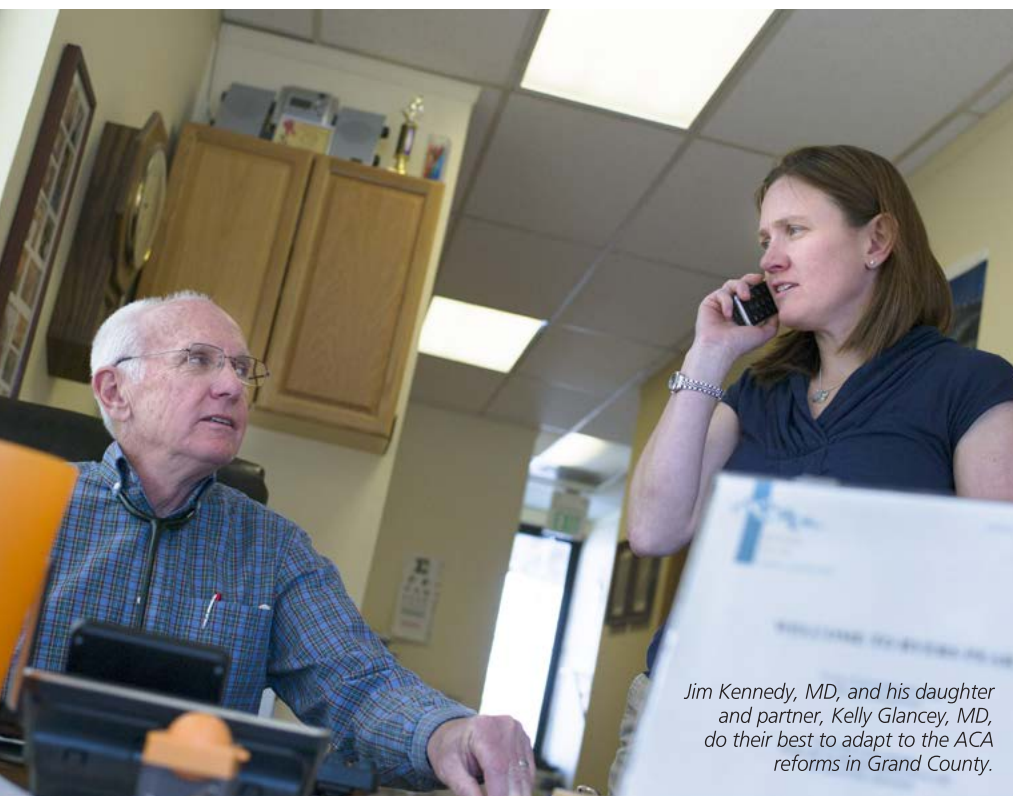
More than ever, a doctor's performance is measured from a patient-centered perspective.

"The way that processes are starting to be incentivized is by rewarding for outcomes based on value, effectiveness, satisfaction, convenience, rather than how fast you can keep running on the treadmill," Watson said.

Those new relationships can certainly benefit the patients who get in the door, said Liz Stark, RN BSN, executive director with Community Health Services, a nonprofit that collaborates with the Colorado Department of Public Health and Environment, Pitkin County and the City of Aspen.



Physicians are one of the health care groups who are not yet ready to pledge perfect allegiance to everything ACA. While reforms mean better care coordination at clinic groups like New West Physicians, above, some doctors also hit an overload of paperwork, and expensive EHR systems that don't really talk to each other. New Medicaid patients may have trouble finding a doctor to take them.



Jim Kennedy, MD, and his daughter and partner, Kelly Glancey, MD, do their best to adapt to the ACA reforms in Grand County.

Communities in Need

Demand and supply issues in Colorado change as fast as the elevated terrain. While Aspen is a charming mountain community to outsiders, on the interior, Stark said, both primary care and specialty care physicians are in short supply. The typical tourist experience of health care is radically different than that of residents who make the local service economy run. In Pitkin County, with the exception of one pediatric practice, none of the primary care or specialty doctors provide services for people on Medicaid.

Many workers travel about 20 miles outside of town to Mountain Family Health Center, a federally qualified health center that takes both Medicaid and private insurance. MFHC provides medical, dental and behavioral health services.

Aspen and the Roaring Fork Valley do have a public transit network supporting both ski tourists and employees; still, for elderly people or young families with small children, Stark said, trekking up and down the valley by bus is no easy feat.

That's one reason why she'd like to see a satellite health center built within city limits – a solution she said would increase access to care. The health board will review such considerations later this summer, she adds.

MFHC is “at capacity. They need more space and more funds to meet demand,” said Stark, an assessment echoed by MFHC officials.

Stark says the demand at MFHC has increased as a result of the Affordable Care Act providing insurance to more people, through both the exchange marketplace and expanded Medicaid. And that's a welcome change, she noted. But the coverage will not make a big difference in peoples' lives, she added, if provider scarcity makes it impossible to either land an appointment or travel to it.

The Always-Future Promise of EHR

One bedrock promise of health care reform has been a transition to electronic health records, bringing the vast paper warehouses of patient files and doctors' notes into the digital era. The ACA and the HITECH Act provided bonuses to offices setting up electronic records, and a second round of payments to systems that managed to communicate smoothly with each other.

Four in 10 hospitals are still not using even a basic EHR system, Vox health writer Sarah Kliff said in May; only 14 percent of doctors nationally said they could transmit medical records outside their own practice or organization.

Those practices that do set up EHRs are not guaranteed entry into a cohesive system, either. Physician Health Partners, a management group for a wide network of Front Range practices, said its various offices are working on 18 different EHR platforms.

New West spent \$3 million on a comprehensive digital record system before the ACA was fully implemented, and still considers the switch a good decision.

The ACA is a “good start,” Stark said, and has been especially helpful for people who previously had no insurance coverage – people who were excluded from so-called things like “free” wellness checks.

But the word “affordable” in the ACA still does not apply in every patient case, she added.

“We need some regularity regarding affordability because a lot of people still cannot afford [insurance].”

That's true whether you use Medicaid or qualify for a health plan under the ACA, said Ken Cohen, MD, chief medical officer with New West Physicians, one of the largest private practices on the Front Range.

People who end up with Medicaid, which could be an employed single mom working at the deli counter or a struggling family where dad works seasonal jobs, see their options translate into fewer choices, Cohen said.

“So if physicians are not taking Medicaid, a lot of patients don't have access to a large subset of physicians,” he said, adding that patients aren't usually thrilled when their provider pool shrinks.

“Our practices are pretty full, so we made the decision that any of our patients that end up on Medicaid as a function of signing up on the exchange, we would continue to care for them in our practices,” he said.

However, the practice is not able to accept new Medicaid patients – something Cohen said could cause future access to care issues for patients.

“There's an even greater issue ... for Medicaid patients at the specialty care level,” he said.

If someone needs surgery to mend a broken wrist, from, say, a snowboarding accident, Cohen said finding a surgeon who takes Medicaid patients may present challenges.

The dollar figure is less, but the difficulties greater, in smaller doctor offices across Colorado. Jim Kennedy, MD, and his daughter, Kelley Glancey, MD, who together are the sole providers for their Byers Peak Family Practice in Grand County. Kennedy said it costs about \$7,000 per year to have a patient portal, electronic prescribing, and electronic filing maintenance. The sheer cost of EHR can hurt any practice, said Kennedy, but it tends to hurt a smaller practice out of proportion.

Kennedy said a recent breakdown in his practice's system lasted two weeks. Even on a normal day, the demands for vast amounts of information inputs, and lingering questions over how all that information gets used, still trouble him, he said.

Projects with Purpose

One lesser-known ACA tool helping some providers broaden and deepen their services is the Comprehensive Primary Care initiative, a four-year demo project created by the Centers for Medicare and Medicaid, under provisions in the ACA. Primary care practices are given tools and incentives to keep better tabs on patients with chronic diseases like diabetes – one of the most costly diseases. Translation: Better disease management equals cost savings.

The aim of CPC is to select various primary care practices within seven regions of the United States, and offer innovative payment reform options that help providers deliver high-quality care at lower costs. The program uses a multipayer approach that includes both private and state health plans.

Banner Medical Group in Northern Colorado operates nine locations under the CPC initiative, said J.P. Valin, MD, chief medical officer of Clinical Practice and Western Region for the group.

"The biggest benefit of CPC: It pays a case management fee, a per member/per month payment to our practices for CPC patients in the clinic," he said.

The extra money allows providers to apply those funds to staff who then work with patients in a coordination of care role – which includes helping with referrals, setting up follow-up appointments and basically "navigating the health care system," said Valin.

"We've embedded clinical pharmacists into our clinics which allow patients on multiple medications to navigate complex medication regimens," he said.

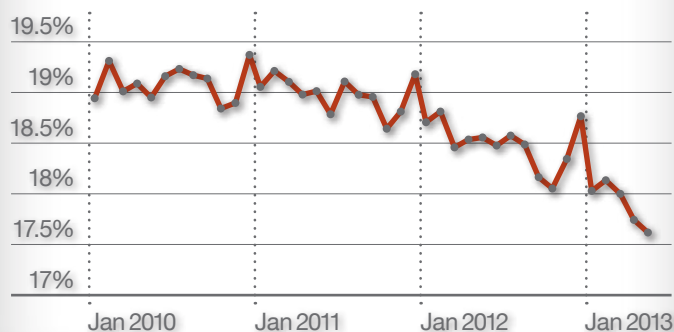
And in some cases, the pharmacist has minimized duplicative medications, he added.

But not all practices have extra support staff. At their Grand County practice, Kennedy and Glancey do it all, from scheduling an appointment to diagnosing a swollen appendix.

Kennedy referred to CPC as a "blended payment model," where physicians operate as a fee-for-service provider but also get reimbursed separately for add-on services that treat chronic diseases. Essentially, add-on services stretch beyond typical doctor visits, said Kennedy. It's this kind of coordination of care that he said would not typically be covered in a traditional fee-for-service model. Even without extra staff, the CPC model allows Byers Peak to improve the patient experience.

"You get paid to treat someone with a broken leg, but also you are rewarded for your efforts when tracking down patients with chronic disease who need repeated refills to help manage a chronic condition like diabetes," Kennedy said.

All Cause, 30-Day Hospital Readmission Rate



Source: The Commonwealth Fund

Another major success of the ACA has been to encourage communications between hospitals and a patient's medical home and doctor, thus reducing dangerous and expensive readmissions for the same illness.

Also, under CPC, providers can more easily stay in contact with their patients. And when they make the no-show list, as patients often do, Glancey picks up the phone to reschedule the missed appointment.

Do Physicians Feel Passed Over by ACA?

There is a sense in talking with some physicians that while they recognize the ACA has made some improvements to the overall health system, they do not see it as a piece of social reform that greatly impacts their practice of medicine. More patients come with at least minimal insurance coverage, but that may only add to the paperwork burden of most practices; EHRs have been costly, time-consuming and isolated rather than integrated; case workers can help patients navigate the system, but the doctor's time always manages to get filled back up.

Cohen, for one, is not holding his breath that the 2016 presidential election will change the direction of national health policy.

"The only thing that will allow meaningful reformation of our health care system is campaign finance reform," Cohen said.

"Because as long as special interest groups can write legislation, things are not going to move in a direction that helps patients." •

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You get paid to treat someone with a broken leg, but also you are rewarded for your efforts when tracking down patients with chronic disease who need repeated refills to help manage a chronic condition like diabetes.

Jim Kennedy, MD, Byers Peak Family Practice

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THE COLORADO HEALTH FOUNDATION
501 South Cherry Street, Suite 1100
Denver, Colorado 80246
303.953.3600
www.ColoradoHealth.org

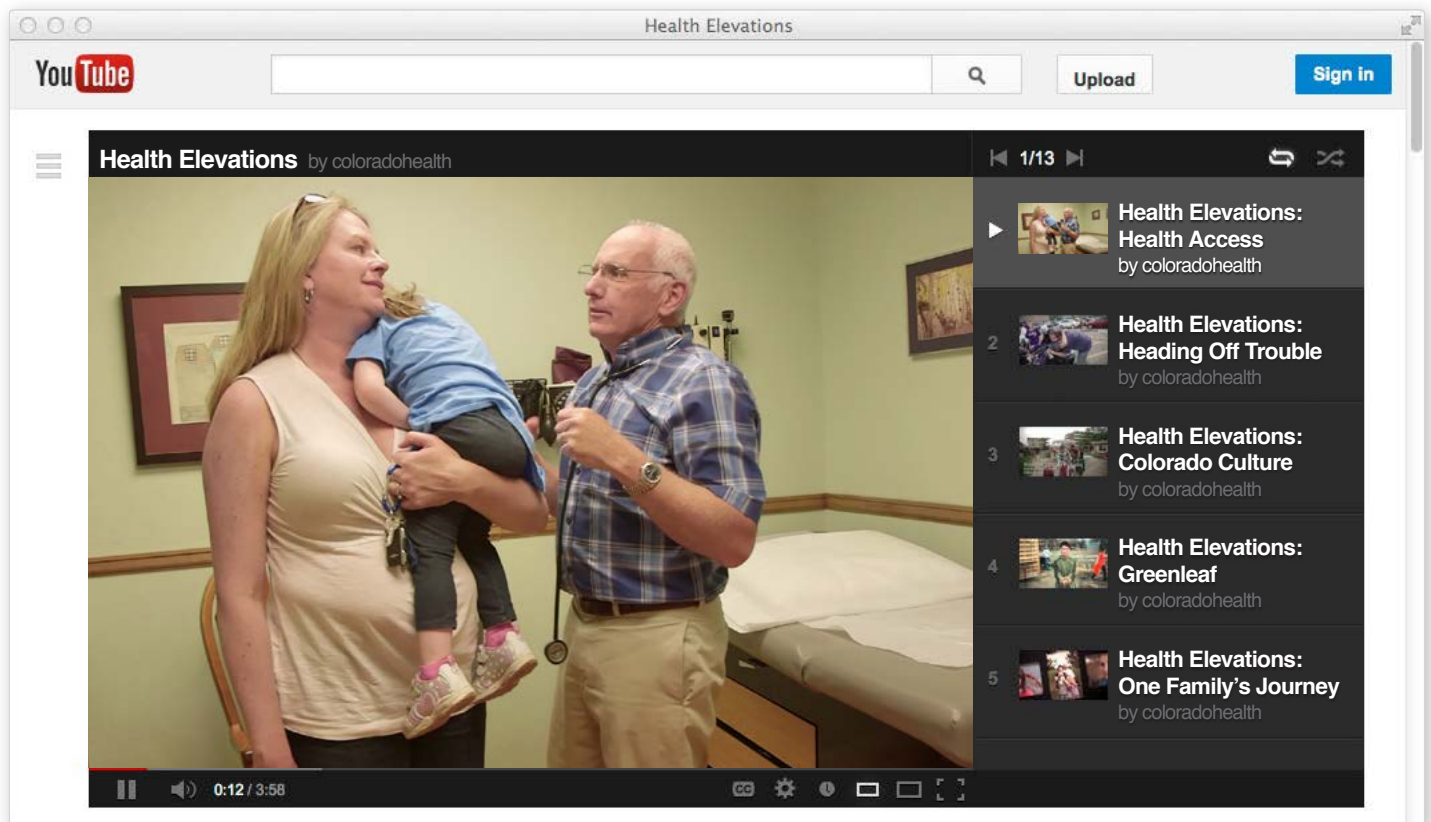
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The ACA in the Exam Room

For our five-year review of the Affordable Care Act in Colorado, we asked doctors to tell us how their practices and payers have changed as a result of the comprehensive law. Meet one father-daughter practice in rural Grand County in our video story, at www.ColoradoHealth.org/journal.

Exclusive Online Video Content



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