Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING

May 1, 2018
4:00 pm

Health District of Northern Larimer County
120 Bristlecone Drive
Fort Collins, CO

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING
May 1, 2018
4:00 pm
Health District, 1st Floor Conference Room

AGENDA

4:00 p.m. **Board Dinner**

4:05 p.m. **CALL TO ORDER; Introductions; Approval of Agenda** ..... Michael Liggett

4:10 p.m. **PUBLIC COMMENT**
Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

4:15 p.m. **FAREWELL TO OUTGOING BOARD MEMBERS**

4:20 p.m. **DISCUSSION & ACTIONS**

- Policy ..... Alyson Williams
  - Federal Issues: Farm Bill, Late Breaking Issues
  - Colorado: Update on Previous Bills; Any Late Breaking Issues
  - New Bills
    - HB18-1357 – Behavioral Health Ombudsperson Office
    - HB18-1384 – Study Health Care Options
    - HB18-1392 – State Innovation Waiver for Reinsurance Program
    - SB18-272 and HB18-1416 – Crisis and Suicide Prevention Grant Programs
- Approval for Vendor Expense: Toolbox Creative ..... Lin Wilder

5:00 p.m. **UPDATES & REPORTS**

- Fourth Quarter Report and other Executive Director Updates ..... Carol Plock
- Other Updates
- UCHealth-North/PVHS Board Liaison Report ..... Tess Heffernan

5:15 p.m. **PUBLIC COMMENT (2nd opportunity) See Note above.**

5:20 p.m. **CONSENT AGENDA**

- Approval of the April 10 Board Meeting Minutes
- Approval of the March 2018 Financials

5:25 p.m. **DECISION**

- Approval of the March 27, 2018 Board Meeting Minutes (one absence)

5:30 p.m. **ANNOUNCEMENTS**

- May 16, SUD Kick-Off Events – Rethinking Addiction: Using Science to Build an Ecosystem of Treatment and Recovery
  - 8:00 am – 10:00 am – Physician and Behavioral Health Provider Breakfast, Fort Collins Senior Center
  - 7:00 pm – 8:30 pm – Lincoln Center, Magnolia Theater

6:00 p.m. **EXECUTIVE SESSION**
For the purpose of discussion pertaining to personnel issues pursuant to §24-6-402(4)(f) of the C.R.S.
(Executive Director review)

6:30 p.m. **ADJOURN**

■ MISSION ■

The Mission of the Health District of Northern Larimer County is to enhance the health of our community.

■ VISION ■

- District residents will live long and well.

- Our community will excel in health assessment, access, promotion and policy development.
  - Our practice of **assessment** will enable individuals and organizations to make informed decisions regarding health practices.
  - All Health District residents will have timely **access** to basic health services.
  - Our community will embrace the **promotion** of responsible, healthy lifestyles, detection of treatable disease, and the **prevention** of injury, disability and early death.
  - Citizens and leaders will be engaged in the creation and implementation of ongoing **systems and health policy development** at local, state, and national levels.
  - Like-minded communities across the country will emulate our successes.

■ STRATEGY ■

The Health District will take a leadership role to:

- Provide exceptional health services that address unmet needs and opportunities in our community,
- Systematically assess the health of our community, noting areas of highest priority for improvement,
- Facilitate community-wide planning and implementation of comprehensive programs,
- Educate the community and individuals about health issues,
- Use Health District funds and resources to leverage other funds and resources for prioritized projects, and avoid unnecessary duplication of services,
- Promote health policy and system improvements at the local, state and national level,
- Continuously evaluate its programs and services for quality, value, and impact on the health of the community,
- Share our approaches, strategies, and results, and
- Oversee and maintain the agreements between Poudre Valley Health System, University of Colorado Health and the Health District on behalf of the community.

■ VALUES ■

- Dignity and respect for all people
- Emphasis on innovation, prevention and education
- Shared responsibility and focused collaborative action to improve health
- Information-driven and evidence-based decision making
- Fiscal responsibility/stewardship
- An informed community makes better decisions concerning health

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. If you choose to make comments about any agenda item or about any other topic not on the agenda, please use the following guidelines.

- **Before you begin your comments please:** Identify yourself – spell your name – state your address. Tell us whether you are addressing an agenda item, or another topic.
- **Limit your comments to five (5) minutes.**

Revised 1/26/2016

Health District
OF NORTHERN LARIMER COUNTY

April 23, 2018

The Honorable Alex Azar
Secretary, Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mr. David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Short-Term, Limited Duration Insurance, CMS-9924-P

Dear Administrator Verma, Secretary Azar, Acting Commissioner Kautter, and Assistant Secretary Rutledge,

The Board of Directors of the Health District of Northern Larimer County appreciates the opportunity to comment in response to the proposed rule regarding short-term, limited duration insurance (STLDI). The Health District is a special tax district — like a school, fire or water district — that was created by voters in 1960 to serve the health needs of our community. It is local government, operating under special district laws of the State of Colorado.

The Health District is very concerned about the impact that the proposed federal rules on STLDI could have on the insurance market and consumers. **We strongly recommend that the proposed rule be rescinded in its entirety**. This proposed rule removes critically important consumer protections and should not be implemented.

However, if Centers for Medicare and Medicaid Studies (CMS) and the Departments plan on finalizing and implementing the proposed rule the **effective date should be after open enrollment for plan year 2019**. If this becomes final rule **the duration of STLDI plans should remain at 3 months**. A notice that is required to be disclosed in the contract and any application materials should be included in the final rule. **The notice should be worded to be understandable by those with low health literacy, and should add language educating applicants on the availability of subsidies for individual health plans and the differences between STLDI and plans purchased through the Marketplace**. Furthermore, the notice should **include explicit language about the potential risks for a person or family that purchases a STLDI plan** (i.e. denial for pre-existing conditions, risk of cancellation, which essential health benefits are not included, lifetime limits, etc.)

Effective Date

Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market. Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. **Delaying implementation until 2020 will give insurers time to adjust** to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow

states time to respond, through legislative or regulatory changes, to the impact of expanded availability of STLDI plans on their markets.

Duration of Plans

Short-term, limited-duration insurance is intended to provide temporary insurance during unexpected coverage gaps. **We oppose allowing short-term coverage for any period lasting longer than three months.** By allowing short-term coverage to be sold for 12 months some consumers may believe that they are enrolling in comprehensive health insurance, that falls under the requirements set forth by the Affordable Care Act. The duration of 12 months too closely mimics the typical duration of comprehensive insurance to distinguish STLDI plans from those plans being sold in the individual marketplace. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." If one year a consumer purchases a STLDI plan outside the period of open enrollment and expects to renew the plan the following year but becomes "uninsurable" in the interim they may not qualify for a special enrollment period to access coverage through the individual market. This could leave the person uninsured, which could leave them with increased costs.

With the proposed alterations to the duration of STLDI plans, they will no longer be "short-term" as they can provide coverage for essentially a year and be renewed indefinitely or until the consumer becomes "uninsurable" according to the insurer. **We strongly oppose the proposed changes in the duration of STLDI plans at §54.9801-2 / §2590.701-2 / §144.103.**

Notice Requirement

We commend the Departments and CMS for acknowledging that allowing STLDI plans to be issued for 12 months of coverage could prove confusing to consumers. The proposed regulation includes a required notice to applicants and purchasers that states that the policy is not required to comply with federal health insurance requirements and for them to check the policy to understand what is covered. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We strongly recommend, however, that the notice must to be clearer to be more easily understood by consumers, be available in multiple languages, and address all the potential risks to the consumer if they purchase a STLDI plan. The final rule should add language to the notice for STLDI coverage that educates the applicant on the availability of subsidies for persons who are not eligible for group health insurance. Since many purchasers of STLDI have recently lost their employer based coverage some would potentially be eligible for financial assistance. Coming from employer based coverage, these individuals may not be aware of the availability of subsidies and cost-sharing reductions, or their financial eligibility for these programs. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does NOT trigger a special enrollment period. **We urge that an amended notice be included in the final regulation that is explicit, has information critical to consumer interests, and is provided in multiple languages.**

Market and Consumer Impacts

Under current law, if an individual enrolls in a STLDI plan in excess of three months, they may be subject to the individual mandate penalty. This penalty may encourage individuals to enroll in ACA-compliant plans rather than STLDI. Since this incentive will no longer be in place once the penalty ends in 2019,

this proposed rule increases the risk of market segmentation. The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[1] As enrollment in STDLI plans tends to skew younger and healthier, the sale of these plans can have serious impact on the overall individual market risk pool. The sale of these STLDI plans could lead to higher premiums in the traditional individual market, as healthier consumers exit the market to enroll in short-term coverage. This adverse selection contributes to instability in the individual market and raises the cost of coverage for people who have health conditions. **The American Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums in the ACA-compliant market.** Income-related premium subsidies in the individual market tends to offset the cost differential to help correct for the adverse selection. Lower-income people would be protected by these premium subsidies, but middle-income people not eligible for subsidies who buy ACA-compliant plans would likely see premium increases if this proposed rule were to be enacted. Relative to current law in 2018, premiums would increase by up to $69 per month, which would result in federal outlays for advance premium tax credits that would increase by up to $3.048 billion.[2] All of this would be compounded as individual market insurers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market. This would further reduce choices or leave more counties without an insurer and increase costs for those consumers remaining in the individual market.

Unlike ACA-compliant plans, STLDI plans do not have the same consumer protections. Because short-term plans are exempt from the ACA's pre-existing condition protections, plans deny coverage altogether or deny coverage of specific services based on health status and medical history. In addition to being able to exclude coverage for pre-existing conditions, these plans should NOT be allowed to categorically exclude certain benefits, such as routine maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation.

Short-term plans also impose lifetime and annual limits. An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact to individuals and families could be financially devastating and leave them without coverage. Additionally, STLDI plans can include fine print in contracts that may be not be apparent to the consumer at the time they enroll in the plan. For example, a child breaks their leg during a soccer game and the parent takes them to the hospital because the policy covers hospital care. However in the fine print the policy excludes "treatment of injury resulting from participation in organized sports," so the trip to the facility is not covered by insurance and the family ends up having to pay out-of-pocket. Because of the lack of consumer protections in STDLI, individuals and families will not have comprehensive health coverage and they could bear the brunt of uncompensated care.

We urge CMS and the Departments to consider these detrimental impacts of STLDI to consumers and the insurance market while finalizing the rule and opt to rescind this proposed rule altogether.

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[1] Blumberg, L., Buettgens, M., Wang, R. (February 2018). The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. Retrieved 26 March, 2018), from https://edit.urban.org/sites/default/files/publication/96781/2001727_0.pdf

[2] Keith, K. (Feb. 20, 2018). Administration Moves to Liberalize Rules on Short-Term, Non-ACA-Compliant Coverage. *Health Affairs Blog.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180220.69087/full/

Thank you for this opportunity to comment in response to the proposed rule on Short-Term, Limited Duration Insurance (CMS-9924-P). If you have any questions or concerns about our recommendations, please contact Alyson Williams at awilliams@healthdistrict.org or (970)224-5209.

Sincerely,

The Board of Directors of the Health District of Northern Larimer County

Date: April 27, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

HB18-1357: BEHAVIORAL HEALTH CARE OMBUDSPERSON PARITY REPORTS

Concerning access to behavioral health care services, and, in connection therewith, establishing an ombudsperson for behavioral health access to care to assist consumers in accessing care and requiring health insurers and the commissioner of insurance to report on compliance with mental health parity laws.

Details

Bill Sponsors: House–*Michaelson Jenet (D)*
Senate – *Gardner (R) and Williams A (D),* Jahn (U)
Committee: House Public Health Care & Human Services
Bill History: 4/4/2018- Introduced in House- Assigned to Public Health Care & Human Services
4/17/2018- House Committee on Public Health Care & Human Services Refer Amended to Appropriations
Next Action: Hearing in House Committee on Appropriations

Bill Summary

This bill establishes the office for behavioral health access to care as an independent office in the Department of Human Services (DHS) to assist Coloradans in accessing behavioral health care. The bill also requires health insurers and the commissioner of the Division of Insurance (DOI) to report on issues related to mental health parity requirements.

Issue Summary

Federal Law/Regulation

The Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) requires that certain health insurers provide mental health or substance use disorder benefits comparable to medical and surgical benefits.[1] The MHPAEA originally applied only to group health plans, but after the enactment of Affordable Care Act (ACA) the coverage was extended to individual health insurance coverage. The Parity Act does not include enforcement provisions to ensure that health plans and carriers are complying.[2]

The 21st Century Cures Act (Cures Act) was enacted in 2016 and incorporated the Helping Families in Mental Health Crisis Reform Act of 2016. The Cures Act included provisions in Title XIII to attempt to create guidance and standards to determine compliance (by payers and providers) with the parity requirements enacted in the Parity Act.[2] Compliance with the Parity Act has been recognized as being based on a subjective interpretation of the application of non-quantifiable treatment limitations (i.e. prior authorization, medical necessity, formulary content, etc.) for mental health and substance use disorder coverage by health plans and insurers.[2] The Cures Act requires the Assistant Secretary for Mental Health and Substance Use within the Department of Health and Human Services (HHS) to consult with the Secretaries of Labor and

[1] The Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services (n.d.) *The Mental Health Parity and Addiction Equity Act (MHPAEA).* Retrieved from https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html

[2] Kolsrud, R & Moore, G. (Jan. 4, 2017). *The 21st Century Cures Act- Mental Health Parity.* Retrieved from https://www.healthlawyers.org/Members/PracticeGroups/TaskForces/BH/alerts/Pages/The_21st_Century_Cures_Act_Mental_Health_Parity.aspx

Treasury to devise a compliance program and create a guidance document. Compliance with the Parity Act and Cures Act is only briefly mentioned and allows health insurers to get four "free" violations, with the fifth violation sparking an audit of a plan or insurer the year following this violation.[2]

In April 2018, U.S. Senators from the Health, Education, Labor, and Pensions Committee sent a letter to HHS to inquire about the enforcement of the parity laws and the other provisions included in the Cures Act.[3] The Senators have set a deadline for answers of May 1, 2018.

Colorado Law/Regulation

Colorado statute includes a parity provision that states, "Every health benefit plan […], must provide coverage for the treatment of biologically based mental illness and mental disorders that is no less extensive than the coverage provided for a physical illness."[4] These health benefit plans do not include: accident only, credit, dental, vision, Medicare supplements, disability income insurance, liability insurance.[5]

The Division of Insurance (DOI) mandates that carriers offering individual and small group health benefit plans (on or off the Exchange) must include the essential health benefits package of 13 categories.[6] The regulation includes a category of mental health, substance use disorders, and behavioral health treatment services. Under this category plans must provide benefits for treatment of alcohol and drug dependency and mental health services (including partial hospitalization and/or inpatient treatment outside of a hospital) to the extent provided under the medical or surgical benefit.

Mental Health Parity

The National Alliance on Mental Illness released a report in 2017 that delineated there are still barriers to mental health care after the Parity Act of 2008.[7] The report found that of those respondents with private insurance, nearly 35 percent had difficulties finding any mental health therapist that accepted their insurance. Additionally, out-of-pocket costs that exceeded $200 were 1.5 times more frequent for mental health therapists and psychiatric prescribers that for medical specialty care.

The 2017 Colorado Health Access Survey by the Colorado Health Institute found that 7.6 percent of Coloradans, or about 382,000 people, needed mental health care or counseling services in the past year but did not get them.[8] Additionally, approximately 67,000 Coloradans reported needing substance use disorder care in the past year but did not get it; most respondents did not access this care because they were concerned about the cost (54%) or did not think their health insurance would cover it (53%).

The Health District of Northern Larimer County's 2016 Community Health Survey found that it is not always easy to access mental health care in Larimer County.[9] Of those respondents with a mental health problem, 16 percent reported their access to health care whenever they need it is less than good (i.e. fair, poor, or very poor). Additionally, the majority (54%) of this population has put off mental health care in the past 2

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[3] Hellmann, J. (April 17, 2018). *Senators press administration on mental health parity.* Retrieved from http://thehill.com/policy/healthcare/383518-senators-press-administration-on-mental-health-parity

[4] § 10-16-104

[5] § 10-16-102(32)(b)

[6] CCR 702-4 Series 4-2

[7] National Alliance on Mental Illness (Nov. 30, 2017) *NAMI Releases Parity Report Which Finds Insurance Companies Still Discriminate Against Mental Health Care*. Retrieved from https://www.nami.org/Press-Media/Press-Releases/2017/NAMI-Releases-Parity-Report-Which-Finds-Insurance

[8] Colorado Health Institute. (2017). *Data.* Retrieved from https://www.coloradohealthinstitute.org/data

[9] Health District of Northern Larimer County (2016). *2016 Community Health Assessment.* Retrieved from https://www.healthdistrict.org/2016-community-health-assessment

years due to cost. This delay in care can have a detrimental impact on individuals; of the respondents who put off care due to cost, 22 percent considered suicide in the past year.

This Legislation

This bill creates the office of the ombudsperson for behavioral health access to care within the office of the Executive Director of the Department of Human Services. By January 1, 2019, the governor must designate an ombudsperson. The ombudsperson is to serve as a neutral party to help consumers (uninsured, publicly insured, privately insured, or insured by coverage not subject to state regulation) and providers (acting on their own behalf, a consumer's behalf, or a group of behavioral health provider's behalf) navigate and resolve issues that are related to accessing mental health care and substance use disorder care. The duties of the ombudsperson include:

- Interacting with consumers and providers that have concerns or complaints to resolve access and coverage issues;
- Identifying, tracking, and reporting concerns, complaints, and potential violations of state and federal law/regulations to the appropriate agency;
- Receiving and reporting concerns and complaints relating to inappropriate care, an emergency hold, and certifications for short-term and long-term treatment;
- Providing appropriate information to aid consumers in obtaining care;
- Developing appropriate points of contact for referrals to state and federal agencies;
- Providing appropriate information to help consumers or providers file appeals or complaints with the appropriate entity (i.e. insurers, state agencies, federal agencies).

The Commissioner of Insurance and the Executive Director of DHS are to appoint a liaison to the office of the ombudsperson to receive reports of concerns, complaints, and potential violations.

The ombudsperson must prepare and submit a report by September 1, 2020 and each September 1 thereafter, that includes information from the preceding fiscal year concerning actions taken by the ombudsperson that relate to the duties of the position detailed above. The report must be submitted to the Governor, Executive Director of DHS, Commissioner of Insurance, Senate Committee on Health and Human Services, House Committee on Health, Insurance, and Environment and House Committee on Public Health Care and Human Services.

Any carrier that offers a health benefit plan that is subject to the parity provision in state statute (§10-16-104(5.5)) must submit a report to the Commissioner of Insurance by January 1, 2019, then every January 1 thereafter. This report is mandated to include a variety of information regarding mental health and substance use disorder benefits. A description of the process used to develop or select the medical necessity criteria used in determining benefits for treatment of behavioral health, mental health, or substance use disorders and medical/surgical benefits must be provided in the report. The report must identify all of the nonquantitative treatment limitations that are put on benefits for both behavioral health benefits and medical/surgical benefits. A description of how the insurance carrier complies with the requirement of maintaining an adequate network of behavioral, mental health, and substance use disorder providers. The carriers must conduct analyses and report the results regarding the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health treatment compared to those for medical/surgical benefits. The report on the results of the analyses must include the factors used to determine whether a nonquantitative treatment limitation will apply to a benefit and the evidentiary standards used to define those factors. The carrier must provide the comparative analyses and the results that were performed.

Finally, the report must disclose the findings of and conclusions drawn from the analyses that indicate that each plan offered by the carrier complies with state and federal laws and regulations.

The Commissioner of Insurance may allow carriers to submit analyses for only a select number of nonquantitative treatment limitations to relieve carriers from the burden of performing analyses on every limitation for every plan. By March 1, 2019, and every March 1 thereafter, the Commissioner of Insurance must submit a report and present that report to the General Assembly. This report must be written in plain language and posted to the Division of Insurance's website. This report and presentation must include:

- The methodology used to verify that carriers are complying with state and federal parity regulations and laws;
- The market conduct examinations initiated, conducted, or completed in the previous year regarding compliance with state and federal parity regulations and laws;
- Any educational or corrective actions that have been taken to ensure carrier compliance.

Reasons to Support

An ombudsperson would mean that consumers have a resource on their side when they are having trouble accessing behavioral health services, scheduling an appointment, locating a provider, or they have a concern regarding coverage of behavioral health services. Currently, the process for remedying concerns, complaints, or possible violations is not always apparent to the consumer or the provider. Having a central source to aid in this process will ensure that the intent of state and federal regulations and laws is followed. This office would also allow the state to document the issues that are occurring in regards to parity and perhaps, in the future, address issues that are found through regulatory or statutory frameworks.

Supporters

- Colorado Behavioral Healthcare Council
- Colorado Hospital Association
- Colorado Psychiatric Society
- Denver Human Services
- Jefferson County Human Services
- Mental Health Colorado
- National Alliance on Mental Illness

Reasons to Oppose

The cost of the office is expected to increase state expenditures by $147,000 in FY2018-2019 and $194,000 thereafter. As the Federal government is working on compliance with the 2008 Parity Act through the provisions in the 21st Century Cures Act, the state could await action to determine the best course of action to avoid expending unnecessary funds for an issue that may be addressed at the federal level. The U.S. Department of Health and Human Services has recently updated their parity help website, which now guides users to the appropriate resource to voice concerns, complaints, and possible violations.[10] Carriers might also claim that the reporting requirements are burdensome.

Opponents

- No opposition has been made public at this time.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and

[10] U.S. Department of Health and Human Services (2018). *Mental Health and Addiction Insurance Help*. Retrieved from https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html

governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

Date: April 27, 2018 **Staff:** Devin Nelson and Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

HB18-1384: STUDY HEALTH CARE COVERAGE OPTIONS

Concerning a study to identify affordable, competitive health care coverage options for Colorado

Details

Bill Sponsors:	House – *Roberts (D) and Catlin (R)*, Wilson (R) Senate – *Coram (R) and Donovan (D)*
Committee:	House Health, Insurance, & Environment
Bill History:	4/12/2018- Introduced in House- Assigned to Health, Insurance, & Environment 4/17/2018- House Committee on Health, Insurance, & Environment Refer Unamended to Appropriations 4/23/2018- House Committee on Appropriations Refer Amended to House Committee of the Whole 4/25/2018- House Third Reading Passed - No Amendments 4/25/2018- Introduced in Senate- Assigned to State, Veterans, & Military Affairs
Next Action:	5/3/2018- Hearing in Senate Committee on State, Veterans, & Military Affairs

Bill Summary

This bill requires the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance (DOI) in the Department of Regulatory Agencies to conduct a study and submit a report the General Assembly concerning the cost benefits, and feasibility of implementing a Medicaid buy-in option, a public-private partnership option, or a community or regionally based option for health care coverage. The report would contain a detailed analysis of the advantages and disadvantages of each option and must identify the most feasible option based on objectives and criteria described in the bill.

Issue Summary

The Affordable Care Act (ACA) prohibits insurers from charging higher prices based on preexisting health conditions or gender; however, it does allow them to adjust their prices based on age, tobacco use and geography.[1] Currently, the state of Colorado is comprised of nine geographic rating areas for health insurance coverage options and costs. Colorado currently faces a huge disparity in healthcare costs and options, with the Colorado mountain regions facing some of the highest healthcare costs in the country. In 2014, claims for commercial insurers' (that participate in the All-Payer Claims Database) cost per member per year ranged from $4,073 in Boulder to $5,532 the Western region creating a difference of 36 percent these geographic rating regions.[2] The rates approved by the DOI for a 'silver' plan for plan year 2018 had great variability between regions. Only one company on the exchange, HMO Colorado, served all nine of the rating areas in plan year 2018.[3] The lowest approved silver plan premium for this carrier on the marketplace was in Rating Area 7 (Pueblo), set at $443.65-$524.91 and the highest was in Rating Area 9 (West), set at $622.90-$818.69.[5] In Colorado, the average annual percent growth in private health insurance spending from

[1] The Colorado Health Institute (2014). *Coloradans are willing to pay for insurance, but not that much*. Retrieved from https://www.coloradohealthinstitute.org/research/coloradans-are-willing-pay-insurance-not-much

[2] Scanlon, W. (2017). Steamboat Today. *Active Lives, few providers push up medical costs in Colorado Mountains,* Retrieved from https://www.steamboattoday.com/news/active-lives-few-providers-push-up-medical-costs-in-colorado-mountains/

[3] Colorado Department of Regulatory Agencies, Division of Insurance (Oct. 18, 2017). *2018 Medical Individual Premiums- All Types.* Retrieved from https://drive.google.com/file/d/0BwguXutc4vbpbkNSUW50azFMSWs/view?usp=sharing

2001-2014 was 6.6 percent, greater than the United States average of 5.3 percent.[4] Three potential options have been identified by this bill for needing further analysis to determine their potential to bring down health care costs in these regions and impact on the entire state.

Medicaid Buy-In Programs

It has been identified that two different policies can be described as Medicaid buy-in programs. The first would create a new eligibility category for direct purchase of Medicaid by individuals with all of the associated rights, obligations, and services that flow through the current Medicaid program. This version of Medicaid buy-in requires modifications to state plan amendments of the program and likely would require an 1115 waiver.

The other policy approach would use the framework of Medicaid managed care contracts and networks to create metal plans for purchase on the Marketplace.[5] This concept may not include every Medicaid benefit currently available at every level of metal plan. For example. The Medicaid "buy-in" at the 'gold' level may include more optional services than the 'bronze' level.

There are many details that would have to be considered with either approach. For example, Colorado currently offers other benefits through Medicaid other than the required ten essential health benefits, such as adult dental care. The State of Colorado would have to determine whether a buy-in program would be more or less generous that the current Medicaid benefit package. Further, in setting up a Medicaid buy-in option, it will have to be determined how to designate the cost, such as the amount of cost-sharing required of the enrollee as well as how these plans will be funded (i.e. a combination premium payments and federal funds).[6] Another consideration is who would be eligible to buy-in to such a program. It is possible that it could be open to any Coloradan or only those at a designated income level. Designers of such a buy-in program would need to determine if health care providers would get the same reimbursement as a traditional Medicaid program or if it would be increased. There also must be consideration of how a buy-in program would affect Federally Qualified Health Centers and other entities that typically treat those on Medicaid, are underinsured, or are uninsured.

Public/Private Partnership

According to the World Health Organization, "public-private partnerships are seen as an effective way to capitalize on the relative strengths of the public and private sectors to address problems that neither could tackle adequately on its own." [7] In this case in particular, research regarding private-public partnerships would most likely explore allowing a private insurance company to bid on providing an insurance option that utilizes Medicaid's existing infrastructure. Further, it would most likely be a managed care program (rather than fee-for-service) and would be managed by a private insurance company.[8]

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[4] Henry J. Kaiser Family Foundation (2018). *Average Annual Percent Growth in Private Health Insurance Spending by State.* Retrieved from https://www.kff.org/private-insurance/state-indicator/average-annual-percent-growth-in-private-health-insurance-spending-by-state/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] Anderson, D & Sandoe, E. (2018). Health Affairs. *A Framework for Evaluating Medicaid Buy-In Proposals.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180320.297250/full/

[6] Holahan, J & Blumberg, L. (2018). Robert Wood Johnson Foundation. *The Implications of a Medicaid Buy-in Proposal.* Retrieved from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2018/rwjf442774

[7] World Bank Group. (2016). *Public-Private Partnerships in Health.* Retrieved from https://ieg.worldbankgroup.org/evaluations/public-private-partnerships-health

[8] Jorgensen, H. (2018). Healthier Colorado. *Finding a Colorado Solution to the Skyrocketing Cost of our Health Care.* Retrieved from https://healthiercolorado.org/blog-post/finding-colorado-solution-skyrocketing-cost-health-care/

A primary example of this type of program in the state of Colorado would be the Children's Health Plan Plus (CHP+ or Colorado's CHIP program). CHIP is a federally funded public, low-cost health insurance plan (with sliding scale annual fees) offered to children and pregnant women throughout the United States. For the majority of service areas in Colorado, CHP+ is contracted out to Colorado Access, a private non-profit organization. Colorado Access provides claim payment services, provider service and contract administration, and utilization management for members of the statewide CHP+ State Managed Care Network and CHP+ Prenatal Care Program. [9] A public private partnership would potentially be modeled after a system such as this.

Regional Co-Op Plan

Numerous types of cooperatives exist including consumer cooperatives, purchasing/shared services cooperatives, and worker cooperatives. Each works though different methods:

- *Consumer cooperatives* are "owned by the people who buy the goods or use the services of the cooperative. They employ physicians and own health care facilities." [10]
- *Purchasing/shared services cooperatives* are 'owned and governed by independent business owners, small municipalities and, in some cases, state governments that band together to enhance their purchasing power with the goal to lower costs, improve competitiveness, and increase their ability to provide quality services. They often are referred to as "exchanges," "connectors," "alliances," or "purchasing pools."'[5]
- *Worker cooperatives* are "owned and governed by the employees of the business. They operate in all sectors of the economy and provide workers with both employment and ownership opportunities." [5]

Based on the wording in this legislation it is suggested that purchasing/shared services cooperatives may be of interest; however, it was not highlighted specifically what type of cooperative legislators would be interested in researching for these areas.

It is important to note that the majority of cooperatives that have been in existence have failed. The Affordable Care Act created the Consumer Operated and Oriented Plan which was meant to foster the creation of cooperative health plans; however, only 11 of the original 23 CO-OPs are still operational and only 4 offered plans in 2018.[11] For example, Colorado HealthOP was forced to close by the Division of Insurance in 2015 as it was unable to meet the state regulatory requirements for capital and surplus due to the unanticipated decrease in Federal reimbursement in the risk corridor program.[12] A key element of the ACA was the risk corridor program, which mitigated an insurance company's risks of having high-cost consumers in its covered groups by cushioning insurers from extreme losses. Simply, plans with lower than expected claims were charged and funds were paid to those insurers with higher than expected claims.[13] However, Congress declined to provide funding to the program, which made it particularly hard for Co-Ops who were trying to keep costs down for consumers and counted on the program for their financial viability. One of the most well-known cooperatives, Group Health, recently failed in February 2017. Group Health Cooperative was a Washington/Idaho based health plan that served upwards of 650,000 members, and it

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[9] Colorado Access. (n.d.).Retrieved from http://www.coaccess.com/chp-state-managed-care-network-smcn

[10] https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/insurance/ES-HealthCareCooperativesDefinitionsandStateExamples-032311.pdf

[11] Norris, L. (2017). Health Insurance. *CO-OP Health Plans: Patients Interests First.* Retrieved from https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/

[12] Division of Insurance (Dec. 2015). *Why did the Division of Insurance take action against the Colorado HealthOP?* Retrieved from https://drive.google.com/file/d/0BwguXutc4vbpcHVWYjhaVlB1ajg/view

[13] Cox, C., Semanskee, A., Claxton, G., & Levitt, L. (Aug. 17, 2016). *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors.* Retrieved from https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/

was acquired by Kaiser Permanente in 2016. Furthermore, a significant portion of purchasing/shared services fail due to poor participation from employers and health plans. [5]

This Legislation

The legislation tasks HCPF and DOI with studying the feasibility and cost of implementing various healthcare coverage options that leverage existing state infrastructure, increase competition, improve quality, and provide stable access to affordable health insurance to enable policy makers to determine whether there are innovative health insurance options that would be beneficial for Colorado. They will be required to complete the study and submit a report on or before February 15, 2019. The study must evaluate the following three options for health care coverage: Medicaid Buy-In Option, Public-Private Partnership, and a Community or Regionally Based Cooperative Health Plan affiliated with a private carrier. The report must identify the most feasible option based on affordability to consumers at different income levels, administrative and financial burden to the state, ease of implementation, and likelihood of success.

Furthermore, in completing the study HCPF shall conduct actuarial research to identify the potential cost of premiums and cost-sharing to pay claims in an essential health benefit compliant plan; evaluate provider rates necessary to incentivize participation and encourage high-quality healthcare delivery; evaluate eligibility criteria for individuals to participate; determine the impacts on state budget, the individual market, the Colorado Health Benefit Exchange, the Colorado Medical Assistance Program and the Children's Basic Health Plan; investigate the feasibility of establishing a pilot program for those areas of the state with limited consumer choice and where premiums are unaffordable; investigate funding options, including state funds and federal funds secured through available waivers; and evaluate the feasibility, legality, and scope of any federal waivers.

Lastly, stakeholders shall be engaged in the process including public and private health insurance experts, as well as consumers, consumer advocates, providers, and carriers.

HCPF is appropriated $225,000 and the DOI is appropriated $135,141 for the 2018-2019 fiscal year from the General Fund.

Reasons to Support

This bill could provide more information and offer ideas regarding how to tackle sky-rocketing health coverage costs in Colorado's mountain and rural regions. A report on potential health coverage options tailored to building off of current Colorado health care infrastructure could better inform policy makers on the future of potential steps and legislation that could help improve healthcare access and increase coverage. Furthermore, there is currently uncertainty at the federal level surrounding health coverage and access, as well as increasing marketplace instability. It does not appear as if Congress will take action to stabilize the market anytime in the near future. Coloradans may continue to see their health coverage costs rise rapidly. This bill provides the state of Colorado with the opportunity to research other health coverage options, and may uncover options that could provide residents with stability, increased coverage, and improved access.

Supporters

- Asian Pacific Development Center
- Bell Policy Institute
- Chronic Care Collaborative
- Colorado Association for School-Based Health Care
- Colorado Center on Law and Policy
- Colorado Coalition for the Homeless
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition

- Colorado Ovarian Cancer Alliance
- Counties and Commissioners Acting Together
- Healthier Colorado
- Mental Health Colorado
- National Association of Insurance and Financial Advisors
- The Arc of Arapahoe Douglas
- The Arc of Southwest Colorado

Reasons to Oppose

This bill would result in administrative costs for conducting the research and developing the report. Specifically, $360,976 would be required from the general fund for HCPF and the DOI to contract with consultants to perform this research. [14] Furthermore, this bill does not tackle the underlying issues behind high costs in the state of Colorado. A *Total Cost of Care Multi-State Analysis* by the Center for Improving Value in Health Care (CIVHC) found that the primary reason that total costs were high in Colorado was due to higher prices of services (6 percent above average) and greater utilization of services (11 percent above average).[15] In particular, high costs in eastern Colorado are driven by both higher prices and greater utilization, while high costs in the western and mountain regions were driven primarily by higher prices. [11] While expanding affordable coverage is important, this bill does not research the underlying issues that may cause costs to continue to increase.

Opponents

- No opposition has been made public at this time.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

[14] Colorado Legislative Information. (2018). *House Bill 18-1384 Fiscal Note*. Retrieved from http://leg.colorado.gov/sites/default/files/documents/2018A/bills/fn/2018a_hb1384_00.pdf

[15] Center for Improving Value in Health Care. (2018). *Total Cost of Care Multi-State Analysis.* Retrieved from http://www.civhc.org/wp-content/uploads/2018/02/Total-Cost-of-Care-Spot-Analysis.pdf

Date: April 27, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

HB18-1392: STATE INNOVATION WAIVER REINSURANCE PROGRAM

Concerning the creation of the Colorado reinsurance program to provide reinsurance payments to health insurers to aid in paying high-cost insurance claims, and, in connection therewith, authorizing the commissioner of insurance to seek approval from the federal government to waive applicable federal requirements, provide federal funds, or both to enable the state to implement the reinsurance program and making the program contingent upon waiver or funding approval, and making an appropriation.

Details

Bill Sponsors: House–*Michaelson Jenet (D)*
Senate – *Gardner (R) and Williams A (D),* Jahn (U)

Committee: House Public Health Care & Human Services

Bill History: 4/13/2018- Introduced in House- Assigned to Health, Insurance, & Environment
4/19/2018- House Committee on Health, Insurance, & Environment Refer Amended to Finance
4/23/2018- House Committee on Finance Refer Amended to Appropriations
4/27/2018- House Committee on Appropriations Refer Amended to House Committee of the Whole

Next Action:

Bill Summary

This bill authorizes the Commissioner of Insurance to apply for a State Innovation Waiver (Section 1332) from the United States Department of Health and Human Services for the waiver, funding, or both, to allow Colorado to implement and operate a reinsurance program to assist health insurers in paying high-cost insurance claims. The program cannot be established without the approval of the federal government. The reinsurance program is created within the Division of Insurance (DOI).

Issue Summary

Insurance in Colorado

Each of the 64 counties in Colorado currently has at least one carrier providing insurance. According to the 2017 Colorado Health Access Survey (CHAS), 93.5 percent are Coloradans are insured.[1] In Larimer County, 59 percent of residents reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.[2] Only 4 percent of residents within the boundaries of the Health District of Northern Larimer County reported having no health insurance in 2016. [3] Additionally, 86 percent of Health District residents reported having continual health insurance during the preceding 3 years in the same survey.[3] However, cost is an issue that is at the forefront of consumer's minds. For those that are uninsured, 78.4 percent cited that the cost of the insurance was a barrier to purchasing coverage.[1] In

[1] Colorado Health Institute (2017). *Colorado's New Normal: Findings from the 2017 Colorado Health Access Survey.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

[2] Larimer Health Tracker (2016). Retrieved from www.larimerhealthtracker.org

[3] 2016 Community Health Survey; note: 5 percent reported that they did not know if they had health insurance or not.

2018, health insurance rates increased an average of 32.2 percent in the individual market in Colorado.[4] The mountain resort region of Summit, Pitkin, Eagle, and Garfield counties in Colorado were found in 2014 to be the most expensive for insurance in the entire United States.[5]

Uncertainty at the National Level

The Trump administration has proposed two regulations that could have a destabilizing effect on the individual market. The first proposed rule was promulgated in January 2018 and would expand association health plans (AHPs).[6] This would expand the opportunity for unlicensed entities to operate in competition with state-licensed insurers and exempt AHPs from many standards and consumer protections that would apply if the coverage was offered in the traditional state-regulated individual and small-group markets. Over time the plans may draw healthy people out of the marketplace and into AHPs, leading to adverse selection, which could have a deleterious effect on premiums for those remaining in the marketplace.[7] The second proposed rule, issued in February 2018, changes the regulations of short-term, limited duration health insurance policies.[8] This proposed rule would change the allowed duration of short-term insurance from 3 months to 364 days. The Urban Institute estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[9] As enrollment in short-term plans tends to skew younger and healthier, the sale of these plans can have serious implications for the health of the overall individual market risk pool. The sale of these short-term plans could lead to higher premiums in the traditional individual market, as healthier consumers exit the market to enroll in short-term coverage. Overall, both of these agencies' proposed regulations could destabilize Colorado's individual health insurance market.

Section 1332 Waivers

Within the Affordable Care Act (ACA), section 1332 allows for states to implement elements of the ACA in alternative manners. Section 1332 waivers are limited as these novel approaches must be as successful in providing affordable, quality health coverage and must cost the federal government either the same amount or less than the standard implementation. There are four specific limitations for this waiver, known colloquially as "guardrails." The innovation must:

1. Provide coverage that is the same or more comprehensive than the original;
2. Provide coverage that is at least as affordable;
3. Provide coverage for the same amount or more people; **and**
4. Not add to the federal deficit.

These guardrails were set forth in the statutory language, but can be interpreted differently by each administration. The Centers for Medicare and Medicaid Services (CMS) has created a detailed page guiding states through the 1332 waiver process. In the final submission, the state must include a variety of critical documents. Some of these documents include: an actuarial analysis, a 10-year budget demonstrating

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[4] Colorado Health Institute (April 2018). *Insurance Prices.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2018%20Final%20Rate%20Analysis.pdf

[5] Rau, J. (Feb. 2 2014) *The 10 Most Expensive Insurance Markets in the United States.* Kaiser Health News. Retrieved from https://khn.org/news/most-expensive-insurance-markets-obamacare/.

[6] U.S. Department of Labor (Jan. 4, 2018). *US Department of Labor Announces Proposal to Expand Access to Healthcare through Small Business Health Plans.* Retrieved from https://www.dol.gov/newsroom/releases/ebsa/ebsa20180104

[7] American Academy of Actuaries. (Feb. 2017). *Issue Brief: Association Health Plans.* Retrieved from https://www.actuary.org/content/association-health-plans-0

[8] Centers for Medicare & Medicaid Services (Feb. 20, 2018). *Fact Sheet: Short-Term, Limited Duration Insurance Proposed Rule.* Retrieved from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-20.html

[9] Blumberg, L., Buettgens, M., Wang, R. (February 2018). The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. Retrieved 26 March, 2018), from https://edit.urban.org/sites/default/files/publication/96781/2001727_0.pdf

federal budget neutrality, any data or assumptions that help demonstrate satisfaction of the guardrails, and many other requirements for the innovative plan.[10]

Reinsurance

Reinsurance was designed as a way to cut the cost for insurance companies by paying a portion of the claims of their most expensive customers in the individual market, with the intent that the insurance companies can then lower insurance costs for their customers.[11] The simplest way to put it is that reinsurance is insurance for insurers. A reinsurance program and high-cost coverage can be designed in many ways. A traditional reinsurance program provides payments to insurers for high-cost claims.[11] In this type of program, eligibility can be based on either threshold of the total of all claims or a threshold per each individual enrollee. Another way is to design a reinsurance program that creates a segregated group for certain conditions that are known to be high-cost to the insurers, this is known as a traditional high-risk pool.[12] This type of program is typically prospective, or looks into the future to expect a certain outcome, and separates customers into a high-risk pool based on being diagnosed with one of several identified conditions and provides insurers with a set amount of reinsurance payments based on the typical costs of a patient with that condition. Finally, a hybrid/invisible pool type design can either be retrospective (i.e. look into the past) or prospective and the individuals can either be in a single or separated risk pool.

For a claims-based reinsurance program the 'attachment point' is the amount of a consumer's annual claims that trigger payments from a reinsurance program. The reinsurance's 'coinsurance rate' is the percentage of claims costs above the attachment point that the reinsurance program pays to the insurer. Then the 'reinsurance cap' is the maximum amount of annual claims that the reinsurance would make payments on to the insurer per high-cost consumer.

Reinsurance is being considered in state and national conversations because it provides a possible method for decreasing the risk for insurers. By doing so, this allows insurers to decrease premium costs for consumers as there is less uncertainty about how they will pay for all of their customer's claims in a given benefit year. Additionally, it may entice reluctant insurers into markets from which they had previously withdrawn due to high claims costs.

Cover Colorado

Before the enactment of the ACA, the state had a program called Cover Colorado, which was a high-risk pool that operated from 1991 to 2013.[11] Each year there were approximately 13,700 individuals in the program with total claims of more than $117 million. The program was funded through monthly premium fees (50%), assessments on state regulated plans including stop loss and reinsurance (25%), and unclaimed property funds (25%). One of the issues with this high-risk pool program was that premiums were much higher than traditional insurance. A consumer could get insurance even with a preexisting condition but only if they could afford they high costs. Due to the fact that this program was sunset in 2014, new legislation is required to create a reinsurance program and construct the waiver to apply for federal funds.

Reinsurance Analysis for Colorado

Senate Bill (S.B.) 17-300 mandated that the Division of Insurance conduct a study of the different methods of providing health coverage to high-risk individuals and reducing premiums in the individual market. The

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[10] Centers for Medicare & Medicaid Services (2017). *Section 1332: State Innovation Waivers.* Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

[11] Colorado Health Institute (April 2018). *A Game-Changer for High Insurance Prices?: Reinsurance Presents an Option to Aid a Troubled Market.* Retrieved from https://www.coloradohealthinstitute.org/research/game-changer-high-insurance-prices

[12] Division of Insurance, Colorado Department of Regulatory Agencies (Oct. 2, 2017). *A Report Regarding SB17-300: Colorado High-Risk Health Coverage Study.* Retrieved from https://leg.colorado.gov/sites/default/files/images/doi_sb17-300_study_final_report.pdf

study was contracted out to a company, Milliman, who analyzed 25 different reinsurance scenarios.[13] The following chart demonstrates the projections that the actuarial analysis found in three scenarios for a reinsurance program.[8]

State of Colorado 2018 Illustrative Reinsurance Scenarios – Estimated Market Impact and Funding Requirements			
	High	**Medium**	**Low**
Reinsurance Fund Size ($ Millions)	$296	$177	$59
Individual Market Premium Rate Reduction	-21%	-12%	-4%
Federal Pass-Through Percentage with Margin	40%	40%	40%
Federal Pass Through-Funding ($ Millions)	$119	$71	$24
State-Based Revenue Requirement ($ Millions)	$177	$106	$35

The analysis found that there would be at least two beneficial impacts of Colorado implementing a reinsurance program. First, it will likely decrease prices for those in the individual market that are not receiving subsidies from the Federal government. Also, the analysis asserts that the morbidity of the individual market risk pool may ameliorate with additional enrollment from those who do not receive subsidies and may have otherwise forgone coverage.

Other States with Reinsurance Programs

Alaska was the first state to be approved to operate a reinsurance program in July 2017. The Alaska reinsurance program utilizes a prospective, hybrid condition-based model, under which 30 high-cost conditions are covered. This program is funded with 81 percent federal funds and the remaining is appropriated state funds.[11] Minnesota, on the other hand, had their waiver approved in September 2017 for a retrospective, hybrid claims-base model, which is funded with a combination of state and federal funds. Minnesota's program has an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000.[11] The state funding of this program comes from the state's General Funds and a health access fund.[11] Oregon's request for federal funding to finance the Oregon Reinsurance Program was approved in October 2017.[14] This program has a coinsurance rate of 50 percent between the attachment point (yet to be determined) and a cap of approximately $1 million.[12]

This Legislation

This bill imparts all powers necessary to implement the Colorado Reinsurance Program to the Commissioner of Insurance and is specifically given authorization to:

- Enter into contracts to carry out the reinsurance program
- Take legal action to avoid payment of improper claims
- Establish procedures for the operation of the program
- Establish procedures for carriers to submit claims to the program
- Establish and adjust the payment parameters for each benefit year
- Assess special fees against insurers for the operation of the program

[13] Milliman, Inc. (Nov. 22, 2017). *Actuarial Report to the Colorado High-Risk Health Care Coverage Task Force, Final Report.*
[14] Kaiser Family Foundation. (April 19, 2018). *Tracking Section 1332 State Innovation Waivers*. Retrieved from https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

- Apply for a state innovation waiver, federal funds, or both for the program
- Apply for and expend gifts, grants, donations, and any federal funds that become available
- Adopt rules that are necessary to implement, administer, and enforce the program

The reinsurance program is created within the Division of Insurance (DOI). The implementation and operation of the program is contingent upon approval of the state innovation waiver or federal funding. The program is to constitute an enterprise for the purposes of the Taxpayers Bill of Rights (TABOR).[15] The Commissioner will collect or access data from an eligible carrier[16] to determine reinsurance payments. On a quarterly basis during an applicable benefit year, eligible carriers shall report claims costs that exceed the attachment point and each insurer that is subject to the special fees shall report on its collected assessments. The Commissioner is to notify eligible carriers of reinsurance payments to be made for the benefit year no later than June 30 of the year following the benefit year. Then, by August 15 of the year after the benefit year, the Commissioner will disburse the reinsurance payments to eligible carriers.

In order to calculate eligibility and reinsurance payments for the 2019 benefit year, the commissioner shall set the attachment point, coinsurance rate, and reinsurance cap at points to meet specified goals. This amount is to achieve a reduction in claims costs between 30-35 percent in geographic rating regions 5 (Grand Junction) and 9 (West). Further, these points are to result in a reduction in claims costs between 20-25 percent in geographic rating regions 4 (Fort Collins), 6 (Greeley), 7 (Pueblo), and 8 (East). Finally, for the other geographic rating regions in state (1 [Boulder], 2 [Colorado Springs], and 3 [Denver]) these amounts are to achieve a reduction in claims costs between 15-20 percent.

For the 2020 benefit year, and each year thereafter, the Commissioner shall conduct a stakeholder process then establish and publish the payment parameters for the benefit year by the March 15 of the year immediately preceding the benefit year in question. When setting the rates for 2020 and after, the following factors for each rating region shall be considered: carrier participation and competition in the individual market, enrollment and morbidity in the individual market, participation and competition by providers, and rates in the individual market. If there is ever inadequate funds in the program to meet the payment parameters, then the Commissioner shall establish new payment parameters within the available funds. Additionally, if these circumstances occur, the Commissioner is to allow carriers to revise applicable rate filings for the next benefit year.

An eligible carrier must make requests for reinsurance payments in accordance with requirements that are set by the Commissioner. By April 30 following the benefit year for which reinsurance payments are requested, carriers must provide the Commissioner with access to the data, under applicable Federal laws.[17] Eligible carriers shall keep enough documents and records that can substantiate their requests for reinsurance payments for at least 6 years. The documents and records shall be available upon request of the Commissioner for verification, investigation, audit, or other review of reinsurance payments. The Commissioner will calculate reinsurance payments based off of an eligible carrier's incurred claims costs for a covered person's benefits in the benefit year. The Commissioner is to ensure that reinsurance payments to eligible carriers do not exceed the total amount paid by the carrier for any eligible claim.[18] The carrier is

[15] Section 20 of Article X of the Colorado State Constitution

[16] A carrier that offers individual health benefit plans that are compliant with the ACA and incurs claims costs for a covered person's covered benefits in the applicable benefit year.

[17] Federal Risk Adjustment Program; 42 U.S.C. Sec. 18063

[18] The total amount paid by the eligible carrier means the amount paid by the carrier based on the allowed amount minus any deductible, coinsurance, or copayment.

allowed to request reconsideration of the Commissioner's decision of payments within 30 days of the original decision.

For each benefit year, the Commissioner is to maintain accounting regarding the money appropriated for reinsurance payments, operational/administrative costs, requests for reinsurance payments from carriers, reinsurance payments made to carriers, and administrative/operational expenses incurred for the program. By November 1 of the year following the benefit year or 60 days after the final disbursement of reinsurance payments for that benefit year (whichever is later), the Commissioner will summarize the program's operations for that benefit year in a public report. The bill specifies that the reinsurance program is subject to audit by the state auditor.

The Reinsurance Program Cash Fund is created in the treasury that consists of any federal funding, special fees, and gifts, grants, or donations. All money that is deposited or paid into the program cash fund (including interest or income earned through investment) is continuously available and appropriated to the DOI to be expended for the program's reinsurance payments of the operating and administrative expenses of the program.

For the 2019 benefit year, special fees are to be assessed against insurers to provide funding for the program. The fees are based on the amount necessary to reduce the claims costs by the amounts previously outlined. However, the fees cannot exceed 2 percent of the premiums collected by an insurer that provides group or individual health benefit plans that are subject to state regulation (excludes Medicaid and the Children's Health Insurance Plan) and the fees cannot be greater than 8 percent of the premiums collected by entities that directly or indirectly provide stop-loss or excess loss insurance to a self-insured group health plan. For the 2020 benefit year and every year thereafter, the special fees must not exceed these thresholds and are to be based on the claims submitted, the administrative/operating costs of the reinsurance program in the immediate preceding benefit year, and the expected annual growth of the program. Rules are to be promulgated to implement the special fees including the time periods for billing and collection of the fees, procedures for the approval, deferral or abatement of the fees, and the assessment amount of the fees. If an insurer fails to pay a special fee in the established time period, the Commissioner may use all available powers to enforce payment.

The Commissioner is to apply to the U.S. Department of Health and Human Services for a waiver, federal funds, or both to implement and operate the reinsurance program for plan years starting on or after January 1, 2019. Any application must state that the operation of the program is contingent on approval of the request. The waiver application should ensure that it is done in accordance with Section 1332 of the ACA and include a request for a pass-through of federal funding. The Commissioner is to notify the Joint Budget Committee, Senate Committee on Health and Human Services, House Committee on Health, Insurance, and Environment, and House Committee on Public Health Care and Human Services regarding any federal actions on the waiver application. All of the provisions in this bill are repealed if the waiver is denied.

For the 2018-2019 fiscal year, $15,000 is appropriated to the Department of Regulatory Agencies for use by the DOI.

How This Legislation May Look

Figure 1 from the Colorado Health Institute illustrates how the bill envisions the state's reinsurance program to be funded.[9] Table 2 demonstrates the projected special fees on the three types of insurers subjected to such fees in the legislation.[9] For those consumers of the individual market they will expectedly either see their premiums decrease or stay the same. Consumers in the group market may see their premiums rise between $18 and $96 per year.

FIGURE 1. How a Reinsurance Program Works

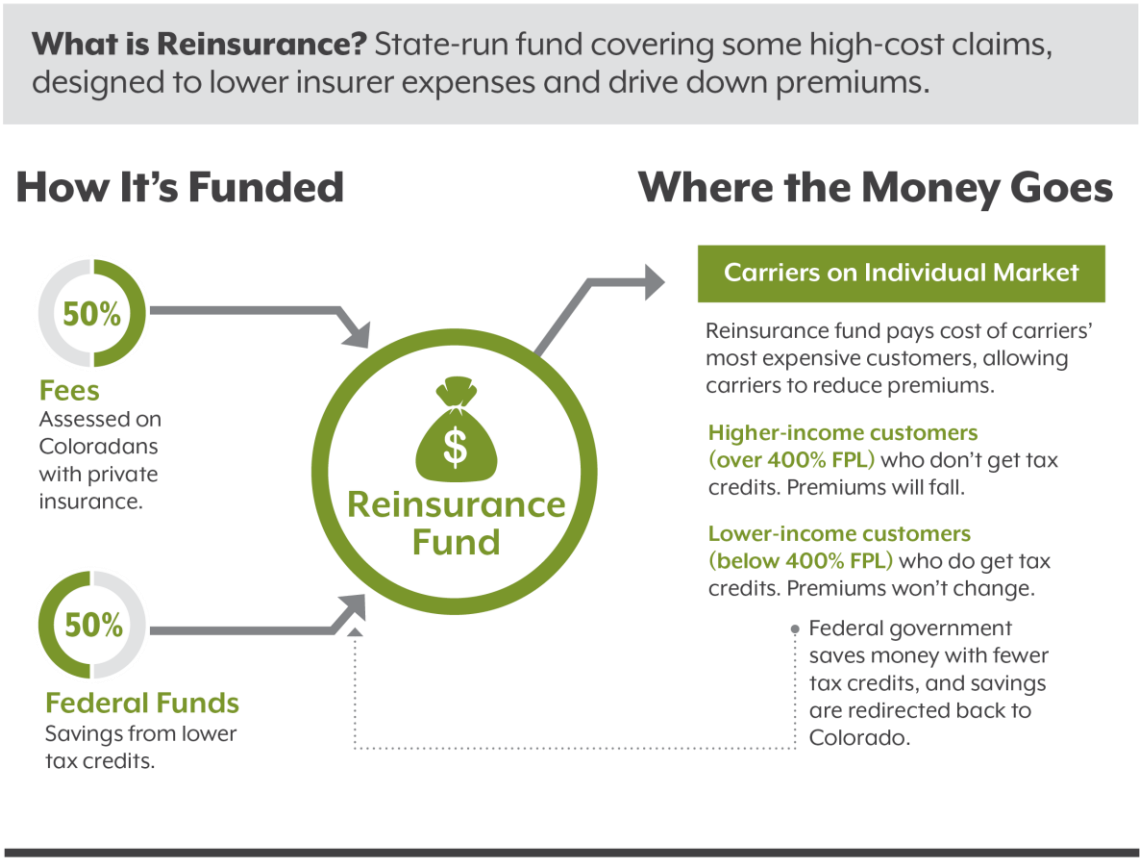

TABLE 2. Projected Fees to Run a Reinsurance Program

Health Insurance Plans Subject to Fee	Number of People Subject to the Fee	Fee per person per year		
		Small Reinsurance Fund (5% Claims Impact)	Moderate Reinsurance Fund (15% Claims Impact)	Large Reinsurance Fund (25% Claims Impact)
Fully insured group plans, Individual plans, Stop-loss plans*	2.0 million	$18	$54	$96

* HB 1392 proposes a large reinsurance fund with fees on these three types of plans.

Reasons to Support

The program could provide substantial relief to the 124,000 people who buy coverage on the individual market but do not receive the federal Advance Premium Tax Credits. The approximately two million covered people who would pay new fees would get the indirect benefit of a healthier insurance market. A healthier market could ultimately have a positive effect on the amount of their premiums. As the individual market becomes so destabilized prices for all tend to go up, and if it fails then prices will skyrocket for everyone in the state.

If prices in the individual market decrease, it could spur some of the uninsured to gain coverage. Most of those that are foregoing insurance are reporting that they are doing so due to cost. It is likely that the removal of the individual mandate from the federal government coupled with increasing costs for health insurance in the individual market will increase the amount of Coloradans that are uninsured. Addressing the cost of premiums in the individual market could keep these people in the market, which could avert uncompensated care costs associated with increased uninsurance rates.

Introducing a reinsurance program would help with the stabilization of the individual market, which most in the state assert is at a crisis point. State stabilization is particularly important since it is uncertain what policies regarding health care will be made at the federal level. Although reinsurance does not solve the problem of affordability, it provides a better anticipated outcome than the status quo. Decreased premiums on the individual market would allow more individuals and families that do not qualify for subsidies to be able to afford health insurance while being able to pay for food and utilities, repay student loans, and/or contribute to retirement plans.

Reinsurance could also help keep carriers in the market as the program removes some of the financial risk from the entities. Keeping these carriers in the market improves competition in the market. Improved competition results in increased choice for consumers.

Supporters

- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Connect for Health Colorado
- Division of Insurance
- Friday Health Plans
- Garfield County Commissioners
- Grand County Commissioners
- Healthier Colorado
- National Association of Insurance and Financial Advisors
- Summit County Chamber of Commerce
- Summit County Commissioners

Reasons to Oppose

Reinsurance does not solve the problem of affordability in health care. A recent study has demonstrated that Colorado spends drastically more (17 percent more than the average for comparable populations) than many other states.[19] Some are concerned about the funding mechanism for the reinsurance program, since placing fees on other types of plans might penalize those who do not get their coverage through the individual market and employers who provide employer-sponsored insurance, if their costs do not ultimately go down. Other states have appropriated funds from their budget to create and administer such a program, some think this a more appropriate funding mechanism for such a program. Additionally, some believe that how the program is currently modeled will exacerbate costs for the rest of the health insurance market.

[19] Network for Regional Healthcare Improvement. (2018). *Healthcare Affordability: Untangling Cost Drivers*. Retrieved from http://www.nrhi.org/uploads/benchmark_report_final_web.pdf

Opponents

- Colorado Competitive Council
- Colorado State Chamber of Commerce
- Kaiser Permanente HMO
- National Federation of Independent Business

Other Considerations

It is uncertain how much the cost of premiums will rise in 2019 without reinsurance due to the repeal of the individual mandate and other actions at the federal level. Therefore, the price reductions due to a reinsurance program could go unnoticed by the consumer. The reinsurance program could prevent a larger premium increase than what would occur at the status quo, but if consumers are expecting premiums to decrease in plan year 2019 they may be disappointed.

The Milliman actuarial study only examined the impacts of a reinsurance program for one year, 2019. Therefore, the longer-term impacts are largely unknown. Furthermore, the analysis is based on many assumptions, including how much carriers are able to decrease their premiums and how much money the Federal government will contribute to the program under a waiver.

Reinsurance must weigh the benefits for approximately 124,000 Coloradans against the costs for the 2 million Coloradans paying fees. The following chart from the report by the Colorado Health Institute demonstrates the pros and cons for different groups affected by a reinsurance program.[9]

Who Gets What from Reinsurance

Middle-class Individual Market Customers: This group would benefit the most. The ACA offers no financial help for people who earn more than four times the federal poverty level, so they suffered the most under the recent dramatic price increases. They would see the most relief from a reinsurance program.

Subsidized individual market customers: This group would see little change. The ACA offers subsidies to cushion the effects of price hikes. A reinsurance program would use some of those subsidies to lower premium prices, so the result probably would be a wash for this group.

Other health insurance enrollees: Customers of small- and large-group health insurance plans and individual market plans could face fees of $11 to $185 a year, according to an estimate.

Insurance companies: Carriers that sell plans on the individual market would likely come out ahead with more predictable markets. But they may also be assessed fees to help finance the reinsurance program.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

Health District
OF NORTHERN LARIMER COUNTY

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: April 27, 2018

Re: Staff Recommendation for 5/1/2018 Board Meeting Bill Positions

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HB18-1357: Behavioral Health Care Ombudsperson Parity Reports

Staff recommends that the Board of Directors support HB18-1357.

HB18-1384: Study Health Care Coverage Options

Staff recommends that the Board of Directors support HB18-1384.

HB18-1392: State Innovation Waiver Reinsurance Program

Staff recommends that the Board of Directors support HB18-1392.

Date: April 27, 2018 Staff: Alyson Williams	**MEMO** TO THE BOARD OF DIRECTORS ***BOARD ACTION REQUESTED***	Health District OF NORTHERN LARIMER COUNTY

SB18-272: CRISIS AND SUICIDE PREVENTION TRAINING GRANT PROGRAM

Policy Issue Summary

The bill creates the crisis and suicide prevention training grant program in the Colorado Department of Public Health and Environment (CDPHE). The purpose of the grant program is to provide financial assistance to schools in providing crisis and suicide prevention training to schools. Priority is given to those schools that have previously not received such training, but if there is money remaining grants may be awarded to schools that have offered trainings in the past. The grant program may authorize up to $400,000 in grants per year in varying amounts and no more than 3 percent of the funding may be used for administrative expenses. The Office of Suicide prevention and the School Safety Resource Center shall work collaboratively with CDPHE to develop guidelines and criteria for the grant program. Grant recipients are required to report on their activities using grant money.

The crisis and suicide prevention training grant program fund is created and authorized to accept appropriations from the General Assembly, as well as gifts, grants, and donations.

Reason for Involvement by the Health District of Northern Larimer County

The Health District has a strong interest in the prevention of suicides among Larimer County youth. In 2015, Colorado ranked ninth for the highest suicide rate in the United States and is consistently among the top ten states with the highest suicide rates nationally.[1] Among youth and young adults ages 10 to 24, suicide remained the leading cause of death in Colorado[1]. The 2015 Healthy Kids Colorado Survey found that nearly 17.5 percent of high school aged youth reported considering suicide and 7.8 percent reported making one or more suicide attempts in the previous year.[1] In 2016, 83 people completed suicide in Larimer County.[3] Of these 83 cases, 4 were under the age of 18, with the youngest being 15 years of age.[2]

As the Poudre School District has already conducted suicide prevention training with members of their staff they may not be eligible for grant funds unless funds remained after priority grants were awarded.

Staff Recommendation

Staff recommends the Board of Directors does not take a position on SB18-272 in favor of supporting HB18-1416 as it provides opportunities for all schools regardless of previous suicide prevention efforts and has required training/education for school staff, students, and parents.

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[1] Brummett, S., Fine, E., Hindman, J., & Myers, L. (2017). *Office of Suicide Prevention Annual Report 2016-2017*. Department of Public Health and Environment. Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf

[2] Wilkerson, J. (2017). *2016 Annual Report*. Loveland: Office of the Larimer Counter Coroner. Retrieved from https://www.larimer.org/sites/default/files/uploads/2017/2016-annual-report.pdf

Date: April 27, 2018 **Staff:** Alyson Williams	**MEMO** **TO THE BOARD OF DIRECTORS** ***BOARD ACTION REQUESTED***	Health District OF NORTHERN LARIMER COUNTY

HB18-1416: STUDENT SUICIDE PREVENTION GRANT PROGRAM

Policy Issue Summary

The bill creates the student suicide prevention grant program for schools within the Department of Public Health and Environment (CDPHE). The purpose of the grant program is to provide financial assistance to school districts, schools of a school district, including charter schools, and institute charter schools to develop and implement student suicide prevention policies and training programs. The bill specifies the minimum requirements for the policies and training programs. At a minimum, the suicide prevention training for staff must include: identifying at-risk students and adults and practices for referring identified individuals to assistance. The grantee must also have a training for students to learn effective practices to increase protective factors (i.e. problem-solving, social support, resiliency, self-awareness, and positive mental/emotional health). The final required aspect for grantees is education for parents about suicide prevention.

CDPHE is required to work with the Office of Suicide Prevention and the School Safety Resource Center in the Department of Public Safety in implementing the grant program. The State Board of Health is directed to adopt rules to implement the grant program, including criteria that the department must take into consideration in awarding grants. Grants must range from $5,000 to $10,000, and no more than 10 percent of the funding (total of $400,000 for fiscal year 2018-2019) may be used for administrative expenses.

Each grant recipient is required to submit information concerning the use of the grant money to CDPHE, and CDPHE is required to submit an annual report concerning implementation of the grant program to the State Board of Health and to the Senate Committee on Health and Human Services and the House Committee on Public Health Care and Human Services. CDPHE is required to post on its website available evidence-based best practices and other resources for persons involved in student suicide prevention.

Reason for Involvement by the Health District of Northern Larimer County

The Health District has a strong interest in the prevention of suicides among Larimer County youth. In 2015, Colorado ranked ninth for the highest suicide rate in the United States and is consistently among the top ten states with the highest suicide rates nationally.[1] Among youth and young adults ages 10 to 24, suicide remained the leading cause of death in Colorado[1]. The 2015 Healthy Kids Colorado Survey found that nearly 17.5 percent of high school aged youth reported considering suicide and 7.8 percent reported making one or more suicide attempts in the previous year.[1] In 2016, 83 people completed suicide in Larimer County.[3] Of these 83 cases, 4 were under the age of 18, with the youngest being 15 years of age.[2]

Staff Recommendation

Staff recommends the Board of Directors support the House Bill 18-1416.

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[1] Brummett, S., Fine, E., Hindman, J., & Myers, L. (2017). *Office of Suicide Prevention Annual Report 2016-2017*. Department of Public Health and Environment. Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf

[2] Wilkerson, J. (2017). *2016 Annual Report*. Loveland: Office of the Larimer Counter Coroner. Retrieved from https://www.larimer.org/sites/default/files/uploads/2017/2016-annual-report.pdf

LEGISpeak

Health District of N. Larimer County

Note that the "Summary" column reflects the bill as original introduced, unless otherwise noted as "Updated" to reflect major changes that occurred between introduction and passage. "Inactive" bills are those that were defeated in some manner other than the usual "Postponed Indefinitely." If you have questions, contact awilliams@healthdistrict.org.

Legislation in the 2018 Session

Updated Fri, 27 April, 2018

Passed/Signed into Law

Priority / Position	Summary	Sponsors	Status
1	**HB18-1172 - Money Allocated To Designated Managed Service Organization** The bill amends the 'Increasing Access to Effective Substance Use Disorder Services Act' to: • Clarify that a designated managed service organization (designated MSO) may use money allocated to it from the marijuana tax cash fund for expenditures for substance use disorder services and for any start-up costs or other expenses necessary to increase capacity to provide such services; • Permit a designated MSO to spend an unused allocation in the next state fiscal year after it has been received, but requires any unspent amount after that time to be returned to the department of human services (department); • Allow the appropriation of the money unspent by a designated MSO in the year it is received to roll forward to the next state fiscal year; • Require a designated MSO to submit an annual expenditure report to legislative committees in addition to the department, which is currently the only entity that receives this report; • Eliminate an annual mid-year expenditure report that a designated MSO is required to submit to the department and replaces it with a requirement that the designated MSO provide the department with information about expenditures as required by the department; • Eliminate the requirement that a departmental report about expenditures to legislative committees must continue after the first report is made; and • Require the department to report on outcomes related to the implementation of the act as part of its 'State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act' hearing. *(Note: This summary applies to this bill as introduced.)*	House: Young (D) Senate: Lambert (R)	Passed/Signed into Law 04/09/2018 - Governor Signed 04/03/2018 - Sent to the Governor 04/03/2018 - Signed by the President of the Senate

Priority / Position	Summary	Sponsors	Status
1 Neutral March 13, 2018	**SB18-136 - Health Insurance Producer Fees And Fee Disclosure** The bill allows an insurance producer or broker advising a client on individual health benefit plans to charge the client a fee if the producer or broker does not receive a commission related to the individual health benefit plan selected by the client and if the producer or broker discloses in writing the fee to the client. The commissioner of insurance shall promulgate rules regarding how the producer or broker must provide the fee disclosure. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Kraft-Tharp (D) Sias (R) Senate: Neville (R)	Passed/Signed into Law 04/12/2018 - Governor Signed 04/11/2018 - Sent to the Governor 04/11/2018 - Signed by the Speaker of the House
1 Strongly Support February 13, 2018	**SB18-146 - Freestanding Emergency Departments Required Consumer Notices** The bill requires a freestanding emergency department (FSED), whether operated by a hospital at a separate, off-campus location or operating independently of a hospital system, to provide any individual that enters the FSED seeking treatment a written statement of patient information, which an FSED staff member or health care provider must explain orally and which must indicate that: • The facility is an emergency medical facility that treats emergency medical conditions; • For FSEDs that do not include an urgent care clinic on site, the facility is not an urgent care center or primary care provider; • For FSEDs that includes an urgent care clinic on site, the facility contains an urgent care center and operates at specified hours; • The FSED will screen and treat the individual regardless of ability to pay; • The individual has a right to ask questions about treatment options and costs and to receive prompt and reasonable responses; • The individual has a right to reject treatment; • The FSED encourages the individual to defer questions until after being screened for an emergency medical condition; and • The facility will provide the patient a more comprehensive statement of patient's rights after initial screening or treatment, as applicable. The state board of health is authorized to update the patient information statement contents, by rule, as necessary. Additionally, an FSED must post a sign that states 'This is an emergency medical facility that treats emergency medical conditions.' The sign must also indicate whether the facility contains an urgent care clinic. After conducting an initial screening and determining that a patient does not have an emergency medical condition or after treatment has been provided to stabilize an emergency medical condition, the FSED must provide the patient a written disclosure that: • Specifies whether the facility accepts patients enrolled in medicaid, medicare, the children's basic health plan, or TRICARE; • Lists the particular health insurance provider networks and carriers with which the FSED participates or states that the FSED is not a participating provider in any provider networks; • Specifies the price listed on the FSED's chargemaster or other fee schedule for the 25 most common health care services it provides; • Contains the price listed on the FSED's chargemaster or other fee schedule for the facility fees associated with the 25 most common health care services the FSED provides; • Contains a statement specifying that the price listed on the chargemaster or fee schedule for any given health care service is the maximum charge that	House: Sias (R) Singer (D) Senate: Kefalas (D) Smallwood (R)	Passed/Signed into Law 04/25/2018 - Governor Signed 04/18/2018 - Sent to the Governor 04/18/2018 - Signed by the Speaker of the House

Priority / Position	Summary	Sponsors	Status
	any patient will be billed and that the actual charge for a health care service may be lower based on health insurance benefits and the availability of discounts and financial assistance; • Contains a statement urging a person covered by health insurance to contact his or her health insurer for information about his or her financial responsibility and a person who is uninsured to contact the FSED's financial services office to discuss payment options and the availability of financial assistance prior to receiving health care services; • Contains information about the facility fees that the FSED charges; and • Includes the FSED's website address where the disclosure may be located. The FSED must also post the information in the written disclosure on its website and update the written and web-based disclosure at least once every 6 months. Additionally, the FSED must provide all information in a clear and understandable manner and in languages appropriate to the communities and patients it serves. The state board of health is authorized to adopt rules to implement and enforce the requirements of the bill. $34,725 is appropriated from the health facilities general licensure cash fund to the health facilities and emergency medical services division in the department of public health and environment for administration and operations. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*		
2 SDA Support	**HB18-1039 - Change Date Of Regular Special District Elections** Currently, regular special district elections are held on the Tuesday immediately succeeding the first Monday of May in every even-numbered year. Commencing in 2023, the bill moves such elections to the Tuesday following the first Monday of May in odd-numbered years. In order to implement the new date on which regular special district elections will be held, **section 4** of the bill provides that the directors elected at the special district elections held in 2020 and 2022 will serve 3-year terms. **Section 5** makes a conforming amendment to the 'Rail District Act of 1982', which uses the same election schedule as provided for special district directors. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Ransom (R) Senate: Gardner (R)	Passed/Signed into Law 03/15/2018 - Governor Signed 03/09/2018 - Sent to the Governor 03/08/2018 - Signed by the President of the Senate
2	**HB18-1086 - Community College Bachelor Science Degree Nursing** The bill allows, with board approval, a community college that is part of the state system of community and technical colleges (community college) to offer a bachelor of science degree in nursing as a completion degree (nursing degree). In considering a request from a community college to offer a nursing degree, the board shall consider student and workforce demand, cost effectiveness for students, and accreditation and licensing requirements. At least 90 days prior to requesting board approval to offer a nursing degree, a community college shall provide notice of its request to all state institutions of higher education. A reporting requirement is added providing that each state-supported institution of higher education that offers a nursing degree provide the department of higher education with an annual report concerning its nursing degree program. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Buckner (D) Lundeen (R) Senate: Neville (R) Aguilar (D)	Passed/Signed into Law 03/24/2018 - Governor Became Law 03/13/2018 - Sent to the Governor 03/13/2018 - Signed by the President of the Senate

Priority / Position	Summary	Sponsors	Status
2	**HB18-1112 - Pharmacist Health Care Services Coverage** The bill requires a health benefit plan to provide coverage for health care services provided by a pharmacist if: • The services are provided within a health professional shortage area; and • The health benefit plan provides coverage for the same services provided by a licensed physician or advanced practice nurse. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Becker (R) Esgar (D) Senate: Crowder (R)	Passed/Signed into Law 04/09/2018 - Governor Signed 04/02/2018 - Sent to the Governor 04/02/2018 - Signed by the President of the Senate
2	**HB18-1148 - Stage Four Advanced Metastatic Cancer Step Therapy** The bill prohibits a carrier that issues a health benefit plan that covers treatment for stage four advanced metastatic cancer from requiring a cancer patient to undergo step therapy prior to receiving a drug approved by the United States food and drug administration if use of the approved drug is consistent with best practices for treatment of the cancer and as long as the drug is on the carrier's prescription drug formulary. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Michaelson Jenet (D) Senate: Crowder (R)	Passed/Signed into Law 04/09/2018 - Governor Signed 04/04/2018 - Sent to the Governor 04/04/2018 - Signed by the President of the Senate
2	**HB18-1162 - Supplemental Appropriation - Department Of Human Services** Supplemental appropriations are made to the department of human services. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Hamner (D) Senate: Lambert (R)	Passed/Signed into Law 03/01/2018 - Governor Signed 02/27/2018 - Sent to the Governor 02/27/2018 - Signed by the President of the Senate
2 2/3	**HB18-1196 - Applications For Aid To The Needy Disabled Program** Under current law, in order to receive assistance under the aid to the needy disabled program, an applicant must be examined by a physician, physician assistant, advanced practice nurse, or registered nurse. The bill adds to the list of persons authorized to perform an examination a licensed or certified psychologist, a licensed social worker, a licensed professional counselor, or any other qualified personnel the department of human services deems appropriate. Any person who performs an examination is required to certify the diagnosis, prognosis, and other relevant medical or mental factors relating to the applicant's disability. *(Note: This summary applies to this bill as introduced.)*	House: Exum (D) Senate: Todd (D)	Passed/Signed into Law 03/29/2018 - Governor Signed 03/21/2018 - Sent to the Governor 03/21/2018 - Signed by the President of the Senate

Priority / Position	Summary	Sponsors	Status
2	**HB18-1282 - Health Care Provider Unique Identification Per Site Or Service** **Section 2** of the bill requires an off-campus location of a hospital to apply for, obtain, and use on claims for reimbursement for health care services provided at the off-campus location a unique national provider identifier, commonly referred to as 'NPI'. The off-campus location's NPI must be used on all claims related to health care services provided at that location, regardless of whether the claim is filed through the hospital's central billing or claims department or through a health care clearinghouse. **Section 3** requires all medicaid providers that are entities to obtain and use a unique NPI for each site at which they deliver services and for each provider type that the department of health care policy and financing has specified. Entity medicaid providers must use on all claims the unique NPI that identifies both the site where the services were provided and the provider type rendering the services, regardless of whether the claim is filed through the entity's central billing or claims department or through a health care clearinghouse. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Lontine (D) Sias (R) Senate: Smallwood (R) Kefalas (D)	Passed/Signed into Law 04/25/2018 - Governor Signed 04/19/2018 - Sent to the Governor 04/19/2018 - Signed by the President of the Senate
2	**SB18-020 - Registered Psychotherapists Auricular Acudetox** Current law allows licensed mental health care professionals and level III certified addiction counselors who have documented that they have undergone auricular acudetox training to perform auricular acudetox. The bill allows registered psychotherapists who have documented that they have undergone the same training requirements to also perform auricular acudetox. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Esgar (D) Senate: Garcia (D)	Passed/Signed into Law 03/22/2018 - Governor Signed 03/12/2018 - Sent to the Governor 03/12/2018 - Signed by the Speaker of the House
2	**SB18-050 - Free-standing Emergency Facility As Safe Haven** The bill expands Colorado's safe haven laws to include staff members of community clinic emergency centers as persons allowed to take temporary physical custody of infants 72 hours old or younger when the infant is voluntarily surrendered by its parent or parents. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Coleman (D) Catlin (R) Senate: Smallwood (R)	Passed/Signed into Law 03/07/2018 - Governor Signed 03/02/2018 - Sent to the Governor 03/01/2018 - Signed by the Speaker of the House
2	**SB18-054 - Cap Fee Increases Assisted Living Residences** Under current law, the state board of health (board) is authorized to establish a schedule of fees for health facilities, including assisted living residences, which fees must be sufficient to meet the department of public health and environment's direct and indirect costs in regulating health facilities. With regard to most department-regulated health facilities, the board cannot increase fees by more than the inflation rate. However, the inflation rate limitation does not apply to the fees assessed by the department against assisted living residences. Starting August 1, 2019, the bill imposes the inflation rate limitation on fees assessed against assisted living residences. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Liston (R) Senate: Crowder (R)	Passed/Signed into Law 03/01/2018 - Governor Signed 02/27/2018 - Sent to the Governor 02/27/2018 - Signed by the Speaker of the House

Postponed Indefinitely

Priority / Position	Summary	Sponsors	Status
1 SDA Oppose	**HB18-1036 - Reduce Business Personal Property Taxes** There is currently an exemption from property tax for business personal property that would otherwise be listed on a single personal property schedule that is equal to $7,400 for the current property tax year cycle. The bill raises the exemption to $50,000 commencing in tax year 2018, and continues to adjust it for inflation for subsequent property tax cycles, so that businesses with personal property under $50,000, or the inflation adjusted amount, would not have to file the business personal property tax forms nor pay the corresponding tax. The bill also raises the value of business personal property that qualifies for an exemption for consumable property from $350, which is the value set by the property tax administrator, to $500. *(Note: This summary applies to this bill as introduced.)*	House: Leonard (R) Senate: Neville (R)	Postponed Indefinitely 02/01/2018 - House Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/10/2018 - Introduced In House - Assigned to State, Veterans, & Military Affairs
1 Neutral	**HB18-1097 - Patient Choice Of Pharmacy** The bill prohibits a carrier that offers or issues a health benefit plan that covers pharmaceutical services, including prescription drug coverage, or a pharmacy benefit management firm managing those benefits for a carrier, from: • Limiting or restricting a covered person's ability to select a pharmacy or pharmacist of the covered person's choice if certain conditions are met; • Imposing a copayment, fee, or other cost-sharing requirement for selecting a pharmacy of the covered person's choosing; • Imposing other conditions on a covered person, pharmacist, or pharmacy that limit or restrict a covered person's ability to use a pharmacy of the covered person's choosing; or • Denying a pharmacy or pharmacist the right to participate in any of its pharmacy network contracts in this state or as a contracting provider in this state if the pharmacy or pharmacist has a valid license in Colorado and the pharmacy or pharmacist agrees to specified conditions. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Catlin (R) Danielson (D) Senate: Coram (R) Todd (D)	Postponed Indefinitely 03/19/2018 - Senate Committee on Business, Labor, & Technology Postpone Indefinitely 03/12/2018 - Introduced In Senate - Assigned to Business, Labor, & Technology 02/23/2018 - House Third Reading Passed - No Amendments
1 Support March 27, 2018	**HB18-1279 - Electronic Prescribing Controlled Substances** The bill requires podiatrists, physicians, physician assistants, advanced practice nurses, and optometrists, starting July 1, 2021, and dentists and practitioners serving rural communities or in a solo practice, starting July 1, 2022, to prescribe schedule II, III, or IV controlled substances only via a prescription that is electronically transmitted to a pharmacy unless a specified exception applies. Prescribers are required to indicate on license renewal questionnaires whether they have complied with the electronic prescribing requirement. Pharmacists need not verify the applicability of an exception to electronic prescribing when they receive an order for a controlled substance in writing, orally, or via facsimile transmission and may fill the order if otherwise valid under the law. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Esgar (D) Senate: Priola (R) Moreno (D)	Postponed Indefinitely 04/25/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 04/17/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/17/2018 - House Third Reading Passed - No Amendments

Priority / Position	Summary	Sponsors	Status
1 1/2	**HB18-1288 - Conflict-free Case Management** The bill implements conflict-free case management for individuals enrolled in home- and community-based services under Colorado's medicaid program. The definition of conflict-free case management is included in the bill and reflects the policy that case management services are provided to an individual who is enrolled in home- and community-based services by an agency that is not also providing the same individual services and supports. The bill defines and authorizes case management agencies that will provide case management services and contains provisions for the department of health care policy and financing's oversight of case management agencies. The medical services board shall promulgate rules upon the enactment of the bill for the certification and decertification of case management agencies, as well as rules that ensure that an individual enrolled in home- and community-based services has access to case management services and that there is a process for a person to select the case management agency of his or her choice. The bill authorizes the department of health care policy and financing to seek a federal exemption from conflict-free case management for rural single entry point agencies, as defined in the bill. The bill contains time frames for the implementation of conflict-free case management in Colorado, and includes a date by which all persons receiving home- and community-based services will be served through a system of conflict-free case management. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Young (D) Winter (D) Senate:	Postponed Indefinitely 04/24/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 04/17/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/17/2018 - House Third Reading Passed - No Amendments
1 Oppose April 10, 2018	**HB18-1311 - Single Geographic Rating Area Individual Health Plan** Under current law, health insurers are permitted to consider the geographic location of the policyholder when establishing health insurance rates for individual and group insurance plans. For an individual health plan issued, amended, or renewed on or after January 1, 2019, the bill prohibits a health insurer from considering the geographic location of the policyholder when establishing rates for the plan, thereby creating a single geographic rating area consisting of the entire state for purposes of all individual health benefit plans. *(Note: This summary applies to this bill as introduced.)*	House: Rankin (R) Hamner (D) Senate:	Postponed Indefinitely 04/19/2018 - House Committee on Health, Insurance, & Environment Postpone Indefinitely 03/21/2018 - Introduced In House - Assigned to Health, Insurance, & Environment + Finance + Appropriations

Priority / Position	Summary	Sponsors	Status
1	**HB18-1365 - Primary Care Infrastructure Creation** The bill establishes a primary care payment reform collaborative in the primary care office in the department of public health and environment. To facilitate the collaborative's work, the administrator of the all-payer health claims database is to report data on primary care spending by private health insurers, insurers providing state employee health benefit plans, and the department of health care policy and financing under the state medicaid program and the children's basic health plan. *(Note: This summary applies to this bill as introduced.)*	House: Ginal (D) Sias (R) Senate: Priola (R) Moreno (D)	Postponed Indefinitely 04/26/2018 - House Committee on Legislative Council Postpone Indefinitely 04/24/2018 - House Committee on Health, Insurance, & Environment Refer Amended to Legislative Council 04/05/2018 - Introduced In House - Assigned to Health, Insurance, & Environment
1 Took Positions on Components: Syringe Access in Hospitals-Strongly Support School Policies for Naloxone-Strongly Support Study of Penalties-Support February 13, 2018	**SB18-040 - Substance Use Disorder Harm Reduction** **Opioid and Other Substance Use Disorders Interim Study Committee.** The bill: • Specifies that hospitals may be used as clean syringe exchange sites (**section 1**); • Provides civil immunity for participants of a clean syringe exchange program (**section 1**); • Creates a supervised injection facility pilot program in the city and county of Denver and provides civil and criminal immunity for the approved supervised injection facility (**sections 2 through 4**); • Allows school districts and nonpublic schools to develop a policy by which schools are allowed to obtain a supply of opiate antagonists and school employees are trained to administer opiate antagonists to individuals at risk of experiencing a drug overdose (**sections 5 through 11**); and • Requires the commission on criminal and juvenile justice to study certain topics related to sentencing for opioid-related offenses (**section 12**). *(Note: This summary applies to this bill as introduced.)*	House: Singer (D) Senate: Lambert (R)	Postponed Indefinitely 02/14/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/10/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
1	**SB18-049 - Use Of Mobile Electronic Devices While Driving** Current law prohibits the use of wireless telephones while driving for individuals who are younger than 18 years of age. The bill: • Extends the prohibition to drivers of all ages; • Increases the penalty for minor drivers from $50 per violation to $300 per violation, to match the penalty that currently applies to adult drivers; • Extends the existing prohibition of the use of wireless telephones to include all mobile electronic devices; • Creates an exception to the prohibition of the use of mobile electronic devices for adult drivers who use a mobile electronic device through the use of a hands-free device; and • Repeals a sentence enhancement for a violation that causes a bodily injury or death. *(Note: This summary applies to this bill as introduced.)*	House: Melton (D) Senate: Court (D)	Postponed Indefinitely 01/24/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/10/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
1	**SB18-053 - Primary Offense For No Safety Belt** Current law requires every driver of and every front-seat passenger in a motor vehicle equipped with a safety belt system to wear a fastened safety belt while the motor vehicle is being operated. The bill extends this requirement to every passenger in a motor vehicle. Current law provides that a law enforcement officer may not cite a driver of a motor vehicle for a failure to wear a safety belt unless the driver was stopped for a different alleged traffic violation. The bill repeals this limitation, allowing a law enforcement officer to stop and cite a driver solely for a failure to wear a safety belt. *(Note: This summary applies to this bill as introduced.)*	House: Young (D) Senate: Court (D)	Postponed Indefinitely 01/24/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/10/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
1	**SB18-065 - Add Health Maintenance Organizations Life And Health Insurance Protection Association** The bill amends the 'Life and Health Insurance Protection Association Act' as follows: • Adds health maintenance organizations (HMOs) as members of the association and subjects HMOs to assessments from the association; • Allocates responsibility for long-term care insurance assessments between health insurance and life insurance association members; and • Requires member insurers that write health benefit plans in Colorado to collect a fee of up to $2 per month from each certificate holder, policyholder, or contract holder for each certificate, policy, or contract the member insurer issues, to be deposited into a fund for the purpose of defraying the costs of a health insurer insolvency. *(Note: This summary applies to this bill as introduced.)*	House: Kraft-Tharp (D) Senate: Gardner (R)	Postponed Indefinitely 02/16/2018 - Senate Committee on Business, Labor, & Technology Postpone Indefinitely 02/05/2018 - Senate Committee on Business, Labor, & Technology Committee Vote - Final Action Failed 01/31/2018 - Senate Committee on Business, Labor, & Technology Witness Testimony and/or Committee Discussion Only

Priority / Position	Summary	Sponsors	Status
1	**SB18-080 - Wholesale Canadian Drug Importation Program** The bill creates the 'Colorado Wholesale Importation of Prescription Drugs Act', under which the department of health care policy and financing (department) must design a program to import prescription pharmaceuticals from Canada for sale to Colorado consumers. The program design must ensure both drug safety and cost savings for Colorado consumers. The department must submit the program design to the secretary of the United States department of health and human services and request the secretary's approval of the program as meeting the requirements of federal law to import Canadian pharmaceutical products. If the secretary approves the program, the department must implement the program. The department must adopt a funding mechanism to cover the program's administrative costs, and the department must annually report on the program to the general assembly. *(Note: This summary applies to this bill as introduced.)*	House: Lontine (D) Senate: Aguilar (D)	Postponed Indefinitely 02/05/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/31/2018 - Senate Committee on State, Veterans, & Military Affairs Witness Testimony and/or Committee Discussion Only 01/12/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
1	**SB18-097 - Concealed Handgun Carry With No Permit** The bill allows a person who legally possesses a handgun under state and federal law to carry a concealed handgun in Colorado. A person who carries a concealed handgun under the authority created in the bill has the same carrying rights and is subject to the same limitations that apply to a person who holds a permit to carry a concealed handgun under current law, including the prohibition on the carrying of a concealed handgun on the grounds of a public elementary, middle, junior high, or high school. The bill reduces an appropriation. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Van Winkle (R) Senate: Neville (R)	Postponed Indefinitely 03/21/2018 - House Committee on State, Veterans, & Military Affairs Postpone Indefinitely 03/12/2018 - Introduced In House - Assigned to State, Veterans, & Military Affairs 03/08/2018 - Senate Third Reading Passed - No Amendments
1	**SB18-113 - Circle Substance Use Disorder Treatment Prog** The bill formally establishes in statute the circle program, a 90-day inpatient treatment program for persons with co-occurring mental health and substance use disorders. *(Note: This summary applies to this bill as introduced.)*	House: Esgar (D) Senate: Garcia (D)	Postponed Indefinitely 02/07/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/29/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
1	**SB18-114 - Suicide Prevention Enhance Student Life Skills** The bill encourages school districts, public schools, charter schools, and institute charter schools (schools) to develop and adopt a student suicide prevention policy (prevention policy) and to designate a staff person to serve as a student suicide prevention coordinator for the school. Each school may select the type of training and programs to use that best suit its individual needs, but schools are encouraged to include in prevention policies: • A tiered training approach for school personnel; • Life skills, social emotional learning, and resiliency training for students that is integrated throughout all areas of the curricula, to the extent possible; • Training for students to effectively educate their peers about suicide risk factors, signs, and symptoms, as well as the importance of reaching out to a trusted adult when needed; • Parent education about suicide; and • The use of curricula and professional development materials, training, and other resources from the office of suicide prevention (OSP) in the department of public health and environment (department), the school safety resource center in the department of public safety, and the Colorado parent and teacher association. The student suicide prevention grant program for schools (grant program) is created in the department, to be administered by the department. The purpose of the grant program is to provide financial assistance to schools in the development and implementation of prevention policies. The grant program may authorize up to 25 grants per year, ranging between $5,000 and $10,000. The state board of health shall promulgate rules concerning the guidelines and criteria for the grant program. An advisory board is created in the OSP to work in collaboration with the department to make recommendations concerning guidelines and criteria, assist with reviewing grant applications, and make recommendations concerning grant awards. The student suicide prevention grant program for schools fund is created and authorized to accept appropriations from the general assembly, as well as gifts, grants, and donations. The department is required to post on its website available evidence-based best practices and other resources for persons involved in student suicide prevention. The bill makes conforming amendments that authorize the existing office of suicide prevention in statute. *(Note: This summary applies to this bill as introduced.)*	House: McLachlan (D) Wilson (R) Senate: Todd (D)	Postponed Indefinitely 02/14/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 02/12/2018 - Senate Committee on State, Veterans, & Military Affairs Witness Testimony and/or Committee Discussion Only 01/29/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
1	**SB18-152 - Prohibit Price Gouging On Prescription Drugs** The bill: • Prohibits a pharmaceutical manufacturer or wholesaler from price gouging on sales of essential off-patent or generic drugs; • Makes the practice of price gouging a deceptive trade practice under the 'Colorado Consumer Protection Act'; and • Requires the state board of pharmacy and the executive director of the department of health care policy and financing to report suspected price gouging to the attorney general. The attorney general is authorized to seek subpoenas and file lawsuits with the appropriate district courts. *(Note: This summary applies to this bill as introduced.)*	House: Lontine (D) Senate: Aguilar (D)	Postponed Indefinitely 02/14/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/29/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
1	**SB18-153 - Behavioral Health Care Related To Suicide Ideation** The department is required to study and address gaps in suicide prevention issues and to collaborate with other offices and the community to evaluate best practices for suicide prevention and intervention and opioid abuse issues. The department is required to report findings to the general assembly. The bill requires the department of public health and environment (department) to work with Colorado hospitals to evaluate the Colorado suicide prevention plan. The department is also required to develop a health authorization release form to improve communication between behavioral health professionals regarding the person giving consent. A health care facility is required to have a plan for individuals transitioning from inpatient to outpatient care. *(Note: This summary applies to this bill as introduced.)*	House: Senate: Kefalas (D)	Postponed Indefinitely 02/14/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 02/12/2018 - Senate Committee on State, Veterans, & Military Affairs Witness Testimony and/or Committee Discussion Only 01/29/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
1	**SB18-211 - Marijuana Consumption Club License** The bill creates a marijuana consumption club (club) license. The license is subject to the same licensing requirements as other retail marijuana licenses. The license may be issued to a person who operates an establishment where retail marijuana or retail marijuana products may be sold and consumed. The club's sales are limited to the same limits as a retail marijuana store. The club may not serve food prepared on site or alcohol. Entry to the club is restricted to those persons at least 21 years of age. A club shall purchase its retail marijuana or retail marijuana products from a licensed marijuana business or get a cultivation license and sell its own marijuana. A club may not permit outside marijuana or marijuana products. All retail marijuana or retail marijuana products must be consumed or disposed of on site. A club and its employees shall successfully complete a responsible vendor program annually. A club has the same immunity to a lawsuit for an injury caused by a club patron that a bar enjoys. The bill allows a local government to permit clubs in its jurisdiction. If a local government permits clubs, it shall adopt an approval or licensing requirement. In order to operate as a club, the club must comply with the local and state licensing regulations. A club is exempt from the 'Colorado Clean Indoor Air Act' for marijuana consumption purposes if it is fully ventilated. Public display, consumption, or use of marijuana in a club is not a criminal offense. *(Note: This summary applies to this bill as introduced.)*	House: Melton (D) Senate: Marble (R)	Postponed Indefinitely 04/02/2018 - Senate Committee on Business, Labor, & Technology Postpone Indefinitely 03/19/2018 - Introduced In Senate - Assigned to Business, Labor, & Technology

Priority / Position	Summary	Sponsors	Status
1 Strongly Oppose March 27, 2018	**SB18-214 - Request Self-sufficiency Waiver Medicaid Program** The bill directs the department of health care policy and financing (department) to prepare and submit a waiver to the federal government requesting authority to implement certain self-sufficiency provisions as part of the Colorado medical assistance program (medicaid). The bill: • Requires able-bodied adults as a condition of eligibility for medicaid to become employed, actively seek employment, attend job or vocational training, or volunteer at a nonprofit organization; except that this requirement does not apply to certain persons specified in the bill; • Requires able-bodied adults to verify income monthly for determination of eligibility; • Authorizes the department to prohibit enrollment in medicaid if a person fails to report a change in family income or makes a false statement regarding compliance with the work requirement; • Establishes a lifetime limit on medicaid benefits of 5 years, and includes persons excepted from the limit; and • Authorizes the department to impose copayments to deter the use of emergency departments and ambulance services for nonemergency services and nonemergency transportation. The bill requires the department to report to the general assembly regarding the preparation, submission, approval, implementation, and outcome of the self-sufficiency waiver provisions. *(Note: This summary applies to this bill as introduced.)*	House: Beckman (R) Senate: Crowder (R)	Postponed Indefinitely 03/29/2018 - Senate Committee on Health & Human Services Postpone Indefinitely 03/19/2018 - Introduced In Senate - Assigned to Health & Human Services
1	**SB18-237 - Out-of-network Providers Carriers Required Notices** Under current law, when a health care provider who is not under a contract with a health insurer, and is therefore an out-of-network provider, renders health care services to a person covered under a health benefit plan at a facility that is part of the provider network under the plan (in-network facility), the health insurer is required to cover the services of the out-of-network provider at the in-network benefit level and at no greater cost to the covered person than if the services were provided by an in-network provider. The bill specifies that the in-network benefit level also applies to emergency services provided to a covered person by an out-of-network provider or at an out-of-network facility. The bill also requires health care facilities, providers, and health insurers to provide disclosures to consumers about the potential effects of receiving nonemergency services from an out-of-network provider or emergency services at an out-of-network facility. The commissioner of insurance, the director of the division of professions and occupations, and the state board of health are directed to adopt rules detailing the disclosure requirements imposed on carriers, providers, and health facilities. Additionally, if a covered person receives nonemergency services provided by an out-of-network provider at an in-network facility or emergency services provided by an out-of-network provider or at an out-of-network facility and pays the out-of-network provider or facility an amount in excess of the required cost-sharing amount, the out-of-network provider or facility must refund the overpayment and must pay interest on the overpayment if the provider or facility fails to timely refund the overpayment. *(Note: This summary applies to this bill as introduced.)*	House: Esgar (D) Senate: Gardner (R)	Postponed Indefinitely 04/18/2018 - Senate Committee on Health & Human Services Postpone Indefinitely 04/09/2018 - Introduced In Senate - Assigned to Health & Human Services

Priority / Position	Summary	Sponsors	Status
2	**HB18-1044 - Colorado Children's Trust Fund Act** The bill amends current statutory language in the 'Colorado Children's Trust Fund Act' to place a greater priority on preventing child maltreatment fatalities and continuing to prevent child maltreatment. This includes reducing the occurrence of prenatal drug exposure and drug endangerment and reducing the occurrence of other adverse childhood experiences. The current membership of the Colorado children's trust fund board (board) is increased from 9 members to 21 members, to reflect a broader approach to child maltreatment prevention issues. Duties and powers of the board are expanded to include: • Advising and making recommendations to the governor, state agencies, and other entities concerning child maltreatment prevention; • Developing strategies and monitoring efforts to decrease incidences of child maltreatment, child maltreatment fatalities, and other adverse childhood experiences; and • Monitoring and implementing, as appropriate, the ongoing development and implementation of programs and factors that affect work in the area of childhood maltreatment. The bill expands the accepted uses for grants from the Colorado children's trust fund to include programs working to reduce the incidence of child maltreatment fatalities, child maltreatment, and other adverse childhood experiences. The repeal date for the act is extended from July 1, 2022, to July 1, 2023. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Kraft-Tharp (D) Senate: Priola (R)	Postponed Indefinitely 02/26/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 02/21/2018 - Senate Committee on State, Veterans, & Military Affairs Witness Testimony and/or Committee Discussion Only 02/05/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs
2	**HB18-1071 - Regulate Oil Gas Operations Protect Public Safety** Current law declares that it is in the public interest to '[f]oster the responsible, balanced development, production, and utilization of the natural resources of oil and gas in the state of Colorado in a manner consistent with protection of public health, safety, and welfare, including protection of the environment and wildlife resources'. The Colorado court of appeals, in *Martinez v. Colo. Oil & Gas Conservation Comm'n* , 2017 COA 37, has construed this language to mean that oil and gas development is not balanced with the protection of public health, safety, and welfare, including protection of the environment and wildlife resources. Rather, that development must occur in a manner consistent with such protection. The bill codifies the result reached in *Martinez* . *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Salazar (D) Senate: Moreno (D)	Postponed Indefinitely 03/07/2018 - Senate Committee on Agriculture, Natural Resources, & Energy Postpone Indefinitely 02/12/2018 - Introduced In Senate - Assigned to Agriculture, Natural Resources, & Energy 02/09/2018 - House Third Reading Passed - No Amendments

Priority / Position	Summary	Sponsors	Status
2	**HB18-1114 - Require License Practice Genetic Counseling** The bill enacts the 'Genetic Counselor Licensure Act'. On and after June 1, 2019, a person cannot practice genetic counseling without being licensed by the director of the division of professions and occupations in the department of regulatory agencies. To be licensed, a person must have graduated with an appropriate genetic counseling degree and have been certified by a national body, except that the director may issue a provisional license to a candidate for certification pursuant to requirements established by rule. The bill gives title protection to genetic counselors and standard licensing, rule-making, and disciplinary powers to the director. Genetic counselors must have insurance unless the director, by rule, finds that insurance is not reasonably available. The bill repeals the act on September 1, 2025. Genetic counselors are subject to the mandatory disclosures of the 'Michael Skolnik Medical Transparency Act of 2010'. $22,677 is appropriated to the department of regulatory agencies from the division of professions and occupations cash fund to implement the act. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Ginal (D) Buckner (D) Senate: Todd (D)	Postponed Indefinitely 04/24/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 04/12/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/12/2018 - House Third Reading Passed - No Amendments
2	**HB18-1118 - Create Health Care Legislative Review Committee** The bill recreates the former health care task force, renamed as the statewide health care review committee, to study health care issues that affect Colorado residents throughout the state. The committee consists of the members of the house of representatives committees on health, insurance, and environment and on public health care and human services and the senate committee on health and human services. The committee is permitted to meet up to 2 times during the interim between legislative sessions, including 2 field trips. For the 2018-19 fiscal year, the bill appropriates $23,951 from the general fund to the legislative department to implement the bill. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Ginal (D) Beckman (R) Senate: Aguilar (D) Crowder (R)	Postponed Indefinitely 04/02/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 03/26/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 03/21/2018 - House Third Reading Passed - No Amendments
2 Support February 27, 2018	**HB18-1182 - Statewide System For Advance Directives** Not more than 30 days after receiving at least $750,000 in gifts, grants, and donations for the purpose of creating and administering a statewide electronic system (system) that allows medical professionals and individuals to upload and access advance directives, the department of public health and environment shall create such a system. 'Advance directive' means: • A declaration as to medical treatment; • A medical durable power of attorney; • A directive relating to cardiopulmonary resuscitation; • A medical orders for scope of treatment form; • A designated beneficiary agreement; or • Any legal form of these types that has been properly executed in another state in accordance with the laws of that state. The department shall contract with one or more health information organization networks for the administration and maintenance of the system during the next year.	House: Ginal (D) Landgraf (R) Senate: Court (D) Coram (R)	Postponed Indefinitely 03/29/2018 - House Committee on Health, Insurance, & Environment Postpone Indefinitely 02/02/2018 - Introduced In House - Assigned to Health, Insurance, & Environment

Priority / Position	Summary	Sponsors	Status
2	**HB18-1223 - Declare Autism Epidemic In Colorado** The bill directs the executive director of the department of public health and environment (director) to convene the governor's expert emergency epidemic response committee (committee) for the purpose of determining whether there is an autism epidemic in Colorado. The committee shall review autism data from 1990 to 2017 from every Colorado county and across all age groups. If the committee determines there is an autism epidemic, the director shall advise the governor to declare that an autism epidemic exists in Colorado; that reasonable and appropriate measures be taken to address the autism epidemic and protect the public health; that departments with publicly funded safety net programs update their plans to include the autism epidemic; and the percentage at which the state will contribute money to the autism epidemic. The committee shall prepare a report documenting its reasons for determining whether an autism epidemic exists and provide a copy of the report to the governor, the director, and each member of the general assembly.	House: Reyher (R) Senate: Crowder (R)	Postponed Indefinitely 04/26/2018 - House Committee on Health, Insurance, & Environment Postpone Indefinitely 02/05/2018 - Introduced In House - Assigned to Health, Insurance, & Environment
2	**SB18-006 - Recording Fee To Fund Attainable Housing** Currently, each county clerk and recorder collects a surcharge of one dollar for each document received for recording or filing in his or her office. The surcharge is in addition to any other fees permitted by statute. **Section 2** of the bill allows counties to impose an increased surcharge in the amount of $5 for documents received for recording or filing on or after January 1, 2019. In a county that has elected to collect the increased surcharge of $5, out of each $5 collected, the bill requires the clerk to retain one dollar to be used to defray the costs of an electronic or core filing system in accordance with existing law. The bill requires the clerk to transmit the other $4 collected to the state treasurer, who is to credit the same to the statewide attainable housing investment fund (fund). **Section 3** creates the fund in the Colorado housing and finance authority (authority). The bill specifies the source of money to be deposited into the fund and that the authority is to administer the fund. The bill directs that, of the money transmitted to the fund by the state treasurer, on an annual basis, not less than 25% of such amount must be expended for the purpose of supporting new or existing programs that provide financial assistance to persons in households with an income of up to 80% of the area median income for the purpose of allowing such persons to finance, purchase, or rehabilitate single family residential homes as well as to provide financial assistance to any nonprofit entity and political subdivision that makes loans to persons in such households to enable such persons to finance, purchase, or rehabilitate single family residential homes. Section 3 also requires the authority to submit a report, no later than June 1 of each year, specifying the use of the fund during the prior calendar year to the governor and to the senate and house finance committees. *(Note: This summary applies to this bill as introduced.)*	House: Winter (D) Senate: Zenzinger (D)	Postponed Indefinitely 02/05/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/31/2018 - Senate Committee on State, Veterans, & Military Affairs Witness Testimony and/or Committee Discussion Only 01/10/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
2	**SB18-018 - Colorado Commission On Criminal And Juvenile Justice Criminal Sentencing Study** **Sentencing in the Criminal Justice System Interim Study Committee.** The bill directs the Colorado commission on criminal and juvenile justice (commission) to contract for a study of the most effective criminal sentencing practices available. The commission must establish an advisory committee to review the study and make recommendations regarding changes to the Colorado sentencing scheme based on the study. *(Note: This summary applies to this bill as introduced.)*	House: Senate: Kagan (D)	Postponed Indefinitely 04/11/2018 - Senate Committee on Appropriations Postpone Indefinitely 01/22/2018 - Senate Committee on Judiciary Refer Amended to Appropriations 01/10/2018 - Introduced In Senate - Assigned to Judiciary
2	**SB18-023 - Promote Off-label Use Pharmaceutical Products** The bill allows a pharmaceutical manufacturer or its representative to promote the off-label use of a prescription drug, biological product, or device approved by the United States food and drug administration. *(Note: This summary applies to this bill as introduced.)*	House: Ginal (D) Senate:	Postponed Indefinitely 02/15/2018 - Senate Committee on Health & Human Services Postpone Indefinitely 01/10/2018 - Introduced In Senate - Assigned to Health & Human Services
2	**SB18-048 - Protect Act Local Government Authority Oil & Gas Facilities** **Section 1** of the bill specifies that the short title of the act is the 'Protect Act'. Current law specifies that local governments have powers, commonly called 'House Bill 1041' powers, which are a type of land use authority, over oil and gas mineral extraction areas only if the Colorado oil and gas conservation commission has designated a specific area as an area of state interest; **sections 3 and 4** repeal that limitation. **Section 5** includes specific authority to regulate the siting of oil and gas facilities in counties' existing land use authority. **Section 6** makes the same changes with regard to municipalities' existing land use authority. **Sections 7 and 8** specify that the Colorado oil and gas conservation commission's authority to regulate oil and gas operations, including the siting of oil and gas facilities, does not exempt an oil and gas facility from a local government's siting authority and that an oil and gas operator must ensure that the location of an oil and gas facility complies with city, town, county, or city and county siting regulations. Sections 5, 6, and 8 specify that, notwithstanding any other provision of law, the governing body of a municipality and a board of county commissioners may, in order to protect the public safety, health, and welfare of the citizens of the local government, plan, zone, and refuse to allow oil and gas operations. *(Note: This summary applies to this bill as introduced.)*	House: Foote (D) Senate: Jones (D)	Postponed Indefinitely 01/29/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/10/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
2	**SB18-155 - Hospital Community Benefits Reporting Requirements** The bill requires hospitals, other than critical access hospitals, that are exempt from state or local taxes to report information about the tax benefits they receive and the community benefits they provide. The bill creates a hospital community benefits advisory council within the department of health care policy and financing to accept and analyze hospital reports. The executive director of the department is required to adopt rules, in consultation with the advisory council, specifying when hospitals are to submit the reports, the form and manner of reporting the required data, the categories of community benefits they provide and the services that constitute a community benefit, and related matters. Upon analyzing hospital data, the advisory council is to: • Make recommendations to the executive director regarding any modifications needed to the hospital reporting requirements as specified in rules; and • Provide annual reports to specified legislative committees regarding the hospital data and any legislative recommendations. The advisory council and hospital reporting requirements are subject to sunset review in 2021, with repeal of the advisory council and hospital reporting requirements scheduled for September 1, 2022. *(Note: This summary applies to this bill as introduced.)*	House: Pettersen (D) Senate: Aguilar (D)	Postponed Indefinitely 02/14/2018 - Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely 01/29/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Active

Priority / Position	Summary	Sponsors	Status
1 Support February 13, 2018	**HB18-1003 - Opioid Misuse Prevention** **Opioid and Other Substance Use Disorders Interim Study Committee. Section 1** of the bill establishes in statute the opioid and other substance use disorders study committee, consisting of 5 senators and 5 representatives from the general assembly, to: • Study data and statistics on the scope of the substance use disorder problem in Colorado; • Study current prevention, intervention, harm reduction, treatment, and recovery resources available to Coloradans, as well as public and private insurance coverage and other sources of support for treatment and recovery resources; • Review the availability of medication-assisted treatment and the ability of pharmacists to prescribe those medications; • Examine measures that other states and countries use to address substance use disorders; • Identify the gaps in prevention, intervention, harm reduction, treatment, and recovery resources available to Coloradans and hurdles to accessing those resources; and • Identify possible legislative options to address gaps and hurdles to accessing prevention, intervention, harm reduction, treatment, and recovery resources. The committee is authorized to meet 6 times in a calendar year and may report up to 6 legislative measures to the legislative council, which bills are exempt from bill limitations and introduction deadlines. The committee is repealed on July 1, 2020. **Section 2** requires the governor to direct the Colorado consortium for prescription drug abuse prevention to: • Create a process to develop a plan that addresses the full continuum of recovery services; • Develop a definition for recovery residences and recommend whether the residences should be licensed; and • Report recommendations to the general assembly.	House: Pettersen (D) Senate: Priola (R)	Active 04/26/2018 - Senate Committee on Legislative Council Refer Unamended to Appropriations 04/25/2018 - Senate Committee on State, Veterans, & Military Affairs Refer Amended to Legislative Council 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
	Section 3 specifies school-based health care centers may apply for grants from the school-based health center grant program to expand behavioral health services to include treatment for opioid and other substance use disorders and requires the department of public health and environment to prioritize funding to the centers that serve communities with high-risk factors. **Section 4** directs the department of health care policy and financing, starting July 1, 2018, to award grants to organizations to operate a substance abuse screening, brief intervention, and referral program. **Section 5** creates the Charlie Hughes and Nathan Gauna opioid prevention pilot program in the Tony Grampsas youth services program for preventing opioid use among the youth population and supporting youth whose family members experience addiction. The Tony Grampsas youth services board shall oversee a grant process for the pilot program using specific criteria. The Tony Grampsas youth services program shall award the grants on or before October 1, 2018. The bill creates a fund for the direct and indirect costs associated with the program. The department of human services is required to work with the grant recipients and submit a report to the general assembly on or before January 1, 2021, regarding the progress of the grant recipients. **Section 6** directs the center for research into substance use disorder prevention, treatment, and recovery to develop and implement continuing medical education activities to help prescribers of pain medication to safely and effectively manage patients with chronic pain, and when appropriate, prescribe opioids. Sections 3 through 6 also direct the general assembly to appropriate money to implement those sections. **Section 7** appropriates: • $675,00 to the department of health care policy and financing from the marijuana tax cash fund to implement the bill; • $750,000 to the department of higher education from the marijuana tax cash fund for research purposes; • $1,500,000 to the youth opioid and substance use prevention fund from the marijuana tax cash fund; • $500,000 to the department of human services from reappropriated funds for use by the division of child welfare; • $90,928 to the department of humans services from the marijuana tax cash fund for use by the division of child welfare; • $39,249 to the legislative department from the general fund; and • $775,00 to the department of public health and environment from the marijuana tax cash fund for use by the prevention services division. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*		

Priority / Position	Summary	Sponsors	Status
1 Support March 13, 2018	**HB18-1007 - Substance Use Disorder Payment And Coverage** **Opioid and Other Substance Use Disorders Interim Study Committee.** The bill requires all individual and group health benefit plans to provide coverage without prior authorization for a five-day supply of at least one of the federal food and drug administration-approved drugs for the treatment of opioid dependence for a first request within a 12-month period. The bill prohibits carriers from taking adverse action against a provider or from providing financial incentives or disincentives to a provider based solely on a patient satisfaction survey relating to the patient's satisfaction with pain treatment. The bill clarifies that an 'urgent prior authorization request' to a carrier includes a request for authorization of medication-assisted treatment for substance use disorders. The bill permits a pharmacy that has entered into a collaborative pharmacy practice agreement with one or more physicians to administer injectable antagonist medication for substance use disorders and receive an enhanced dispensing fee for the administration. The bill requires the Colorado medical assistance program to authorize reimbursement for at least one federal food and drug administration-approved ready-to-use opioid overdose reversal drug without prior authorization. The bill permits a pharmacy that has entered into a collaborative pharmacy practice agreement with one or more physicians to administer injectable opioid antagonist medication for substance use disorders and receive an enhanced dispensing fee under the Colorado medical assistance program for the administration. The bill requires the department of health care policy and financing and the office of behavioral health in the department of human services to establish rules that standardize utilization management authority timelines for the nonpharmaceutical components of medication-assisted treatment for substance use disorders. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Kennedy () Singer (D) Senate: Lambert (R)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee, Floor
1	**HB18-1009 - Diabetes Drug Pricing Transparency Act 2018** The bill creates the 'Diabetes Drug Pricing Transparency Act of 2018'. The state board of health is responsible for implementing the act. Drug manufacturers, pharmacy benefit managers, insurers, and pharmacies must submit annual reports to the state board regarding prescription insulin drugs used to treat diabetes. The state board analyzes the submitted information and publishes a report. The state board may impose penalties on drug manufacturers or pharmacy benefit managers who do not comply with reporting requirements. Nonprofit organizations advocating for patients with diabetes or funding diabetes medical research that receive contributions from certain diabetes drug manufacturers must annually report those contributions. $287,602 is appropriated from the general fund to the department of public health and environment to implement the act. $10,656 of this amount is reappropriated to the department of law for legal services to the department of public health and environment. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Roberts (D) Senate: Donovan (D)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
1	**HB18-1094 - Children And Youth Mental Health Treatment Act** The bill extends indefinitely the 'Child Mental Health Treatment Act' and renames it the 'Children and Youth Mental Health Treatment Act' (act). Significant changes to the act include: • Continuing the ability of a parent or guardian of a non-medicaid eligible child or youth to receive mental health services for the child or youth without unwarranted child welfare involvement; • When evaluating a child or youth for eligibility for mental health treatment services (services), the evaluating mental health agency shall use a standardized risk stratification tool; • Establishing a new definition of 'mental health agency' to capture a larger set of behavioral health services providers; • Reporting requirements for the department of health care policy and financing and mental health agencies that provide services for children and youth are updated and clarified; • Requiring the department of human services to maintain and update a list of providers on its website, as well as post information from various reports required by the act, excluding any personal health information; and • Revising the membership of the advisory board that assists and advises the executive director of the department of human services with the development of service standards and rules for the provision of services. The bill makes conforming amendments. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Herod (D) Wist (R) Senate: Moreno (D)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee
1 Strongly Support February 13, 2018	**HB18-1136 - Substance Use Disorder Treatment** **Opioid and Other Substance Use Disorders Interim Study Committee.** The bill adds residential and inpatient substance use disorder services and medical detoxification services to the Colorado medical assistance program. The benefit is limited to persons who meet nationally recognized, evidence-based level of care criteria for residential and inpatient substance use disorder treatment. The benefit will not be effective until the department of health care policy and financing (department) seeks and receives any federal authorization necessary to secure federal financial participation in the program. Prior to seeking federal approval, the department shall seek input from stakeholders regarding decisions relating to the benefit. The department shall prepare and submit a performance review report to committees of the general assembly concerning services provided under the benefit and the effectiveness of those services. After considering the performance review report, the general assembly may enact legislation modifying or repealing the benefit. If an enhanced residential and inpatient substance use disorder treatment and medical detoxification services benefit becomes available, managed care organizations shall reprioritize the use of money allocated from the marijuana tax cash fund to assist in providing treatment, including residential treatment, to persons who are not otherwise covered by public or private insurance. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Pettersen (D) Senate: Priola (R)	Active 04/25/2018 - Senate Committee on State, Veterans, & Military Affairs Refer Amended to Appropriations 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments

Priority / Position	Summary	Sponsors	Status
1 Support-Suicide Prevention Training Programs and Awareness Neutral-Decrease of Mental Health Consent Age for Outpatient Treatment February 27, 2018	**HB18-1177 - Youth Suicide Prevention** The bill requires the office of suicide prevention (office) in the department of public health and environment (department) to work with appropriate entities to develop and implement a plan to provide access to training programs related to youth suicide prevention for people who regularly interact with youth but who are not in a profession that typically provides such training opportunities, such as camp counselors, recreation center employees, youth group leaders, clergy, and parents. The office is required to approve at least 3 nonprofit organizations statewide to participate in a coordinated program of youth suicide prevention training. Classes and programs offered by the approved nonprofit organizations must be free to the public, and the department shall reimburse the approved nonprofit organization for any direct or indirect costs associated with such classes and programs. The bill further directs the department to coordinate efforts to create and implement a statewide awareness campaign about suicide and youth suicide prevention, as well as awareness of the suicide prevention hotline. The awareness campaign may include, but is not limited to, the use of written, electronic, radio, and television media. The age of consent for a minor to seek and obtain outpatient psychotherapy services is lowered from 15 years of age or older to 12 years of age and older. The licensed mental health provider is immune from civil or criminal liability for providing outpatient psychotherapy services unless he or she acts negligently or outside the scope of his or her practice. The bill clarifies that the age of consent for a minor seeking inpatient psychotherapy or other inpatient mental health services without the consent of a parent or legal guardian remains 15 years of age or older. *(Note: This summary applies to this bill as introduced.)*	House: Michaelson Jenet (D) Senate: Fenberg (D) Coram (R)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee
1	**HB18-1179 - Prohibit Price Gouging On Prescription Drugs** • Prohibits a pharmaceutical manufacturer or wholesaler from price gouging on sales of essential off-patent or generic drugs; • Makes the practice of price gouging a deceptive trade practice under the 'Colorado Consumer Protection Act'; and • Requires the state board of pharmacy and the executive director of the department of health care policy and financing to report suspected price gouging to the attorney general. The attorney general is authorized to seek subpoenas and file lawsuits with the appropriate district courts. *(Note: This summary applies to this bill as introduced.)*	House: Salazar (D) Senate:	Active 04/25/2018 - House Second Reading Laid Over to 04/27/2018 - No Amendments 04/24/2018 - House Second Reading Laid Over to 04/26/2018 - No Amendments 04/23/2018 - House Second Reading Laid Over to 04/25/2018 - No Amendments

Priority / Position	Summary	Sponsors	Status
1	**HB18-1181 - Nonresident Electors And Special Districts** **Section 1** of the bill expands the definition of 'eligible elector', as used in reference of persons voting in special district elections, to include a person who owns, or whose spouse or civil union partner owns, taxable real or personal property situated within the boundaries of the special district or the area to be included in the special district and who has satisfied all other requirements in the bill for registering to vote in an election of a special district but who is not a resident of the state. **Section 2** prohibits a person from voting in a special district election unless that person is an eligible elector as defined by the bill. The section also requires any person desiring to vote at any election as an eligible elector to sign a self-affirmation that the person is an elector of the special district. The bill specifies the form the affirmation must take. **Section 3** specifies procedures by which the eligible elector becomes registered to be able to vote in the special district election. This section also contains an affirmation to be executed by the voter upon completing his or her application for registration. **Section 4** authorizes each special district board to select, in an exercise of its own discretion and by majority vote of the board's voting members, one or more additional board members, each of whom shall serve as a nonvoting member of the board. A member of the board appointed for this purpose must be a person who is a nonresident of the state of Colorado but is otherwise eligible to cast a ballot in elections of the special district in accordance with the bill. A board with 5 members may appoint no more than 2 nonvoting members of the board. The term of such board members is 4 years subject to renewal of one or more additional 4-year terms in the discretion of a majority of the voting members of the board. Any board member appointed for this purpose may be removed for cause at any time by a majority of the voting members of the board. *(Note: This summary applies to this bill as introduced.)*	House: Liston (R) Senate:	Active 04/26/2018 - House Considered Senate Amendments - Result was to Concur - Repass 04/24/2018 - House Considered Senate Amendments - Result was to Laid Over Daily 04/24/2018 - Senate Third Reading Passed - No Amendments
1 Support February 27, 2018	**HB18-1212 - Freestanding Emergency Departments Licensure** The bill creates a new license, referred to as a 'freestanding emergency department license', for the department of public health and environment (CDPHE) to issue on or after July 1, 2021, to a health facility that offers emergency care, that may offer primary and urgent care services, and that is either: • Owned or operated by, or affiliated with, a hospital or hospital system and is located more than 250 yards from the main campus of the hospital; or • Independent from and not operated by or affiliated with a hospital or hospital system and is not attached to or situated within 250 yards of, or contained within, a hospital. The state board of health is to adopt rules regarding the new license, including rules to set licensure requirements and fees, safety and care standards, and staffing requirements. A health facility with a freestanding emergency department license is limited in the amount of facility fees the facility can charge patients. CDPHE may fine or take action on the license of a freestanding emergency department that charges facility fees in violation of the limits established in the bill.	House: Kennedy () Landgraf (R) Senate: Kefalas (D)	Active 04/24/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/24/2018 - House Third Reading Passed - No Amendments 04/23/2018 - House Third Reading Laid Over Daily - No Amendments

Priority / Position	Summary	Sponsors	Status
1 Support Supported as concept of 1/9/2018 draft bill on 2/13/2018.	**HB18-1260 - Prescription Drug Price Transparency** The bill enacts the 'Colorado Prescription Drug Price Transparency Act of 2018', which requires: • Health insurers, starting in 2021, to submit to the commissioner of insurance (commissioner), as part of the health care cost reporting requirement, information regarding prescription drugs covered under their health insurance plans that were dispensed in the preceding calendar year; • Prescription drug manufacturers to notify state purchasers, health insurers, and pharmacy benefit management firms when the manufacturer, on or after July 1, 2020, increases the price of certain prescription drugs by more than 10% or introduces a new specialty drug in the commercial market; and • Prescription drug manufacturers, within 15 days after the end of each calendar quarter that starts on or after July 1, 2020, to provide specified information to the commissioner regarding the drugs about which manufacturers are required to notify purchasers of a drug price increase or new specialty drug on the market. The commissioner is required to post the information received from prescription drug manufacturers on the division of insurance website. Additionally, the commissioner, or a disinterested third-party contractor, is to analyze the data submitted by health insurers and prescription drug manufacturers and other relevant information to determine the effect of prescription drug costs on health insurance premiums. The commissioner is to publish a report each year, submit the report to specified legislative committees, and present the report during annual 'State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act' hearings. The commissioner is authorized to adopt rules as necessary to implement the requirements of the act. A prescription drug manufacturer that fails to notify purchasers or fails to report required data to the commissioner is subject to discipline by the state board of pharmacy, including a penalty of $1,000 per day for each day the manufacturer fails to comply with the notice or reporting requirements. The commissioner is to report manufacturer violations to the state board of pharmacy. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Ginal (D) Jackson (D) Senate: Moreno (D)	Active 04/17/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/17/2018 - House Third Reading Passed - No Amendments 04/16/2018 - House Third Reading Laid Over to 04/17/2018 - No Amendments
1 Support March 27, 2018	**HB18-1284 - Disclosure Of Prescription Costs At Pharmacies** The bill enacts the 'Patient Drug Costs Savings Act' (act). The act prohibits a carrier that has a contract with a pharmacy or pharmacist, or a pharmacy benefit management firm acting on behalf of a carrier, from: • Prohibiting a pharmacy or pharmacist from, or penalizing a pharmacy or pharmacist for, providing a covered person information on the amount of the covered person's cost share for the covered person's prescription drug and the clinical efficacy of any more affordable alternative drugs that are therapeutically equivalent; or • Requiring a pharmacy to charge or collect a copayment from a covered person that exceeds the total submitted charges by the network pharmacy. The act requires the commissioner of insurance to act when the commissioner determines that a carrier or pharmacy benefit management firm has not complied with the above prohibitions. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Buckner (D) Wilson (R) Senate: Kefalas (D)	Active 04/26/2018 - Sent to the Governor 04/26/2018 - Signed by the President of the Senate 04/26/2018 - Signed by the Speaker of the House

Priority / Position	Summary	Sponsors	Status
1	**HB18-1292 - Pilot Program Assistance Person Experiencing Homelessness** The bill establishes the state access to resources and training grant program for persons experiencing homelessness (START grant program) in the department of local affairs (department). The purpose of the START grant program is to make grant money available to public safety, social services, or nonprofit agencies that have contact with persons experiencing homelessness. A grant recipient shall use grant money only to provide personnel and resources to persons experiencing homelessness. The START grant program is also designed to develop and institute community-centered programs with proactive solutions to provide assistance to persons experiencing homelessness and may include, but need not be limited to, training, work programs, housing vouchers, transportation, counseling or therapy, and food assistance. The department is responsible for establishing procedures, timelines, and criteria for the START grant program. A public safety, social services, or nonprofit agency may apply for a grant, provided it clearly demonstrates a plan for collaboration with municipal or county courts, local law enforcement, local human or social services agencies, and nonprofit agencies that have contact with persons experiencing homelessness. The general assembly is authorized to make an appropriation from the marijuana tax cash fund to fund the START grant program. Each START grant recipient is required to provide a report to the department on activities and outcomes related to the START grant, and the department is required to provide a summary of the outcomes of the START grant program in its annual report to the general assembly. The bill establishes the state access to resources and training grant program for persons experiencing homelessness (START grant program) in the department of local affairs (department). The purpose of the START grant program is to make grant money available to public safety, social services, or nonprofit agencies that have contact with persons experiencing homelessness. A grant recipient shall use grant money only to provide personnel and resources to persons experiencing homelessness. The START grant program is also designed to develop and institute community-centered programs with proactive solutions to provide assistance to persons experiencing homelessness and may include, but need not be limited to, training, work programs, housing vouchers, transportation, counseling or therapy, and food assistance. The department is responsible for establishing procedures, timelines, and criteria for the START grant program. A public safety, social services, or nonprofit agency may apply for a grant, provided it clearly demonstrates a plan for collaboration with municipal or county courts, local law enforcement, local human or social services agencies, and nonprofit agencies that have contact with persons experiencing homelessness. The general assembly is authorized to make an appropriation from the marijuana tax cash fund to fund the START grant program. Each START grant recipient is required to provide a report to the department on activities and outcomes related to the START grant, and the department is required to provide a summary of the outcomes of the START grant program in its annual report to the general assembly. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: McKean (R) Rosenthal (D) Senate: Court (D) Priola (R)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
1	**HB18-1307 - Limit Access To Products With Dextromethorphan** The bill states that it is unlawful for a seller, retailer, or vendor to knowingly or willfully dispense, sell, or distribute a finished drug product containing any quantity of dextromethorphan to a person less than 18 years of age. A seller, retailer, or vendor making a retail sale of a finished drug product containing any quantity of dextromethorphan must require and obtain proof of age from the purchaser before completing the sale unless the seller, retailer, or vendor reasonably presumes from the purchaser's outward appearance that the purchaser is at least 25 years of age. A seller, retailer, or vendor who violates the prohibition or who fails to obtain proof of age when required to do so commits an unclassified petty offense and, upon conviction thereof, shall be punished as follows: • For a first offense, the court shall warn the seller, retailer, or vendor in writing; and • For a second or subsequent offense, the seller, retailer, or vendor shall pay a fine of not more than $200. The prohibition does not apply to a medication containing dextromethorphan, which medication is sold pursuant to a valid prescription. It is an affirmative defense if the seller, retailer, or vendor is an employer and trains its employees concerning the bill's restrictions on the distribution of medications containing dextromethorphan. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Singer (D) Lee (D) Senate: Gardner (R) Cooke (R)	Active 04/26/2018 - Senate Third Reading Passed - No Amendments 04/25/2018 - Senate Second Reading Special Order - Passed - No Amendments 04/23/2018 - Senate Committee on Judiciary Refer Unamended - Consent Calendar to Senate Committee of the Whole
1 Support April 10, 2018	**HB18-1313 - Pharmacists To Serve As Practitioners** The bill clarifies that a licensed and qualified pharmacist may serve as a practitioner and prescribe over-the-counter medication under the 'Colorado Medical Assistance Act' and a statewide drug therapy protocol pursuant to a collaborative pharmacy practice agreement. *(Note: This summary applies to this bill as introduced.)*	House: Ginal (D) Becker (R) Senate: Aguilar (D) Priola (R)	Active 04/25/2018 - Senate Committee on Health & Human Services Refer Unamended to Senate Committee of the Whole 04/17/2018 - Introduced In Senate - Assigned to Health & Human Services 04/17/2018 - House Third Reading Passed - No Amendments
1	**HB18-1321 - Efficient Administration Medicaid Transportation** The bill requires the department of health care policy and financing (department) to create and implement a method for meeting urgent transportation needs within the existing nonemergency medical transportation benefit under the medical assistance program. The method created by the department must provide medical service provider and facility access to approved providers who can meet urgent transportation needs, and include an efficient method for obtaining and paying for the transportation services. The department shall annually report to certain committees of the general assembly on the implementation and effectiveness of the process. The bill includes an appropriation to implement the bill. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: McKean (R) Senate: Moreno (D)	Active 04/25/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/25/2018 - House Third Reading Passed - No Amendments 04/24/2018 - House Second Reading Special Order - Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
1	**HB18-1322 - 2018-19 Long Appropriation Act** Provides for the payment of expenses of the executive, legislative, and judicial departments of the state of Colorado, and of its agencies and institutions, for and during the fiscal year beginning July 1, 2018, except as otherwise noted. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Hamner (D) Senate: Lambert (R)	Active 04/12/2018 - House Consideration of First Conference Committee Report result was to Adopt Committee Report - Repass 04/12/2018 - Senate Consideration of First Conference Committee Report result was to Adopt Committee Report - Repass 04/11/2018 - First Conference Committee Result was to Adopt Rerevised w/ Amendments
1 Support The Board of Directors voted to support the funding of the All-Payer Claims Database, whether that occurs through the budgetary or legislative process. January 23, 2018	**HB18-1327 - All-payer Health Claims Database** **Joint Budget Committee.** The bill authorizes the general assembly to appropriate general fund money to the department of health care policy and financing (department) to pay for expenses related to the all-payer health claims database (database). The bill also establishes a grant program to assist nonprofit organizations and governmental entities, other than the department, in accessing the database to conduct research. The bill authorizes the advisory committee to oversee the database, review grant applications, and recommend to the department which grant applications to fund and the amount of each grant. The department is authorized to develop and review grant applications and determine which grant applications to fund and the amount of each grant. The medical services board is authorized to adopt rules governing the grant program. The bill appropriates money to the department to pay for the database and the grant program. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Young (D) Senate: Moreno (D)	Active 04/17/2018 - Sent to the Governor 04/16/2018 - Signed by the President of the Senate 04/16/2018 - Signed by the Speaker of the House
1	**HB18-1357 - Behavioral Health Care Ombudsperson Parity Reports** **Section 1** of the bill establishes an office of the ombudsperson for behavioral health access to care as an independent office within the office of the executive director of the department of human services to assist Coloradans in accessing behavioral health care. **Section 3** requires health insurers and the commissioner of insurance to report on issues related to mental health parity requirements. *(Note: This summary applies to this bill as introduced.)*	House: Michaelson Jenet (D) Senate: Gardner (R) Williams (D)	Active 04/17/2018 - House Committee on Public Health Care & Human Services Refer Amended to Appropriations 04/04/2018 - Introduced In House - Assigned to Public Health Care & Human Services

Priority / Position	Summary	Sponsors	Status
1	**HB18-1358 - Health Care Charges Billing Required Disclosures** The bill imposes requirements on health care facilities, health care providers, pharmacies, and health insurers, starting January 1, 2019, to disclose information about health care charges. Specifically, **section 2** of the bill enacts the 'Comprehensive Health Care Billing Transparency Act' (act), which requires health care facilities, including hospitals, ambulatory surgical centers, community clinics, and physician practice groups, to: • Publish their fee schedules or other lists of charges the facilities bill for specific health care services before applying any discounts, rebates, or other charge adjustment mechanisms; • Include in every bill sent to a patient an itemized detail of each health care service provided, the charge for the service, how any payment or adjustment by the patient's health insurer was applied to each line item in the bill, and, for hospitals, the amount of the healthcare affordability and sustainability fee the hospital is charged; and • In situations where an individual provides health insurance information to the facility or a provider in a facility setting, disclose whether the facility or provider participates in the individual's health insurance plan; whether the services the facility or provider will render will be covered as an in-network or out-of-network benefit; and whether the individual will receive a service from an out-of-network provider at an in-network facility. For an individual health care provider who provides health care services at a health care facility, has a separate fee schedule for the services the provider delivers in the facility setting, and whose fees for those services are not included in the facility's published fee schedule, the provider must provide a fee schedule to the facility for posting on the facility's website. Section 2 also prohibits a facility or provider from billing a patient or third-party payer an amount in excess of the lower of any established self-pay rate or the lowest rate negotiated with or reimbursed by any third-party payer, including the federal centers for medicare and medicaid services in the United States department of health and human services, for the particular health care services rendered to the patient if the facility or provider has failed to publish or provide its fee schedule. Additionally, section 2 requires a pharmacy to publish a list of its retail drug prices, which is a list of the charges the pharmacy charges to an insured or uninsured person for prescription drugs it administers or dispenses, before any rebates, discounts, or other price adjustment mechanisms are applied. **Section 4** specifies that failure to comply with the requirements to publish retail drug prices constitutes grounds for the state board of pharmacy to discipline a pharmacist. Health insurers, facilities, and providers are prohibited from including any provision in a contract between the parties issued, amended, or renewed on or after January 1, 2019, that restricts the ability of a provider, facility, or health insurer to provide patients with the charge information required to be published. Section 2 also directs the state board of pharmacy to adopt rules necessary to implement the provisions of the act that are applicable to pharmacies and the executive director of the department of public health and environment to adopt any other rules necessary to implement and administer the act. **Section 3** requires health insurers to publish information about contract terms, cost-sharing arrangements, and prescription drug prices. The commissioner of insurance is directed to adopt rules to implement and administer these requirements and is authorized to use enforcement powers under current law to enforce the requirements on health insurers. *(Note: This summary applies to this bill as introduced.)*	House: Foote (D) Beckman (R) Senate: Lundberg (R) Aguilar (D)	Active 04/04/2018 - Introduced In House - Assigned to Health, Insurance, & Environment

Priority / Position	Summary	Sponsors	Status
1	**HB18-1370 - Drug Coverage Health Plan** The bill prohibits a health insurance carrier from excluding or limiting a drug under a health benefit plan and from moving the drug to a disadvantaged tier in the plan formulary if the drug was covered at the time the covered person enrolled in the plan. A carrier may not increase the amount that a covered person pays for a copayment, coinsurance, or deductible or set limits while the covered person is covered by the health benefit plan for drugs that were covered when the person became covered under the plan. If a carrier uses a tiered plan, the carrier may not move a drug to a disadvantaged tier under specified circumstances. A carrier may limit coverage for a drug or biosimilar product if a provider prescribes a generic drug or biosimilar product to treat the covered person's medical condition instead of the originally-prescribed drug and the covered person agrees. *(Note: This summary applies to this bill as introduced.)*	House: Esgar (D) Singer (D) Senate:	Active 04/09/2018 - Introduced In House - Assigned to Health, Insurance, & Environment
1	**HB18-1384 - Study Health Care Coverage Options** The bill requires the department of health care policy and financing and the division of insurance in the department of regulatory agencies (departments) to conduct a study and to prepare and submit a report to certain committees of the general assembly concerning the costs, benefits, and feasibility of implementing a medicaid buy-in option, a public-private partnership option, or a community- or regionally based option for health care coverage. The report must contain a detailed analysis of the advantages and disadvantages of each option and must identify the most feasible option based on objectives and criteria described in the bill. In conducting the study, the departments shall engage in a stakeholder process that includes public and private health insurance experts, consumers, consumer advocates, providers, and carriers. The bill includes an appropriation. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Roberts (D) Catlin (R) Senate: Coram (R) Donovan (D)	Active 04/25/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/25/2018 - House Third Reading Passed - No Amendments 04/24/2018 - House Second Reading Special Order - Passed with Amendments - Committee
1	**HB18-1392 - State Innovation Waiver Reinsurance Program** The bill authorizes the commissioner of insurance to apply to the secretary of the United States department of health and human services for a state innovation waiver, for federal funding, or both to allow the state to implement and operate a reinsurance program to assist health insurers in paying high-cost insurance claims. The state cannot implement the program absent waiver or funding approval from the secretary. The program is established as an enterprise for purposes of section 20 of article X of the state constitution. *(Note: This summary applies to this bill as introduced.)*	House: Kennedy () Rankin (R) Senate: Coram (R) Donovan (D)	Active 04/23/2018 - House Committee on Finance Refer Amended to Appropriations 04/19/2018 - House Committee on Health, Insurance, & Environment Refer Amended to Finance 04/13/2018 - Introduced In House - Assigned to Health, Insurance, & Environment

Priority / Position	Summary	Sponsors	Status
1	**HB18-1416 - Student Suicide Prevention Grant Program** The bill creates the student suicide prevention grant program for schools (grant program) in the department of public health and environment (department) to be administered by the department. The purpose of the grant program is to provide financial assistance to school districts, schools of a school district, including charter schools, and institute charter schools to develop and implement student suicide prevention policies and training programs. The bill specifies the minimum requirements for the policies and training programs. The department is required to work with the office of suicide prevention in the department and the school safety resource center in the department of public safety in implementing the grant program. The state board of health (state board) is directed to adopt rules to implement the grant program, including criteria that the department must take into consideration in awarding grants. Each grant recipient is required to submit information concerning the use of the grant money to the department, and the department is required to submit an annual report concerning implementation of the grant program to the state board and to the health and human services committee of the senate and the public health care and human services committee of the house of representatives. The department is required to post on its website available evidence-based best practices and other resources for persons involved in student suicide prevention. The grant program is funded by money appropriated from the school safety resource center cash fund. The bill authorizes the existing office of suicide prevention in statute. *(Note: This summary applies to this bill as introduced.)*	House: McLachlan (D) Carver (R) Senate: Todd (D) Coram (R)	Active 04/26/2018 - House Committee on Education Refer Amended to Appropriations 04/20/2018 - Introduced In House - Assigned to Education
1	**HJR18-1012 - Medicaid Eligibility Detained Individuals** Summary in Progress	House: Benavidez (D) Michaelson Jenet (D) Senate: Crowder (R) Fields (D)	Active 04/25/2018 - Senate Third Reading Passed - No Amendments 04/24/2018 - Senate Third Reading Laid Over Daily - No Amendments 04/24/2018 - Introduced In Senate - Assigned to

Priority / Position	Summary	Sponsors	Status
1 Support March 13, 2018	**SB18-022 - Clinical Practice For Opioid Prescribing** **Opioid and Other Substance Use Disorders Interim Study Committee.** The bill restricts the number of opioid pills that a health care practitioner, including physicians, physician assistants, advanced practice nurses, dentists, optometrists, podiatrists, and veterinarians, may prescribe for an initial prescription to a seven-day supply and allows each health care practitioner to exercise discretion to include a second fill for a seven-day supply, unless, in the judgment of the practitioner, the patient: • Has chronic pain that typically lasts longer than 90 days or past the time of normal healing, as determined by the podiatrist, or following transfer of care from another podiatrist who prescribed an opioid to the patient; • Has been diagnosed with cancer and is experiencing cancer-related pain; or • Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days. Additionally, an advanced practice nurse may prescribe a refill if the patient is undergoing palliative or hospice care. The restrictions repeal on September 1, 2021. Current law allows health care practitioners and other individuals to query the prescription drug monitoring program (program). The bill requires health care practitioners to indicate his or her specialty or practice area upon the initial query and to query the program prior to prescribing the second fill for an opioid unless the person receiving the prescription meets certain requirements. The bill requires the department of public health and environment to report to the general assembly its findings from studies regarding the prescription drug monitoring program conducted pursuant to a federal grant program. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Pettersen (D) Kennedy () Senate: Aguilar (D)	Active 02/23/2018 - Introduced In House - Assigned to Health, Insurance, & Environment 02/22/2018 - Senate Third Reading Passed - No Amendments 02/21/2018 - Senate Second Reading Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
1 1/2	**SB18-024 - Expand Access Behavioral Health Care Providers** **Opioid and Other Substance Use Disorders Interim Study Committee.** The bill modifies the Colorado health service corps program administered by the primary care office in the department of public health and environment as follows: • For purposes of determining areas in the state in which there is a shortage of health care professionals and behavioral health care providers to meet the needs of the community, allows the primary care office, under guidance adopted by the state board of health, to develop and administer state health professional shortage areas using state-specific methodologies; • Allows behavioral health care providers, which include licensed and certified addiction counselors, licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychologists, licensed physician assistants with specific training in substance use disorders, advanced practice nurses, and physicians certified or trained in addiction medicine, pain management, or psychiatry, and candidates for licensure as an addiction counselor, professional counselor, clinical social worker, marriage and family therapist, or psychologist, to participate in the loan repayment program on the condition of committing to provide behavioral health care services in health professional shortage areas for a specified period; • Directs the advisory council to prioritize loan repayment and scholarships for those behavioral health care providers, candidates for licensure, or addiction counselors who provide behavioral health care services in nonprofit or public employer settings but permits consideration of applicants practicing in a private setting that serves underserved populations; • Establishes a scholarship program to help defray the education and training costs associated with obtaining certification as an addiction counselor or with progressing to a higher level of certification; • Adds 2 members to the advisory council that reviews program applications, which members include a representative of an organization representing substance use disorder treatment providers and a licensed or certified addiction counselor who has experience in rural health, safety net clinics, or health equity; • Modifies program reporting requirements and requires annual reporting that coincides with required SMART Act reporting by the department; and • Requires the general assembly to annually appropriate $2.5 million from the marijuana tax cash fund to the primary care office to provide loan repayment for behavioral health care providers and candidates for licensure participating in the Colorado health service corps and to award scholarships to addiction counselors participating in the scholarship program. The bill appropriates $2.5 million from the marijuana tax cash fund to the department of public health and environment for use by the primary care office in the prevention services division to implement the bill. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Singer (D) Senate:	Active 04/20/2018 - Introduced In House - Assigned to Public Health Care & Human Services 04/17/2018 - Senate Third Reading Passed - No Amendments 04/16/2018 - Senate Second Reading Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
1 Support iDrive Campaign January 23, 2018	**SB18-108 - Eligibility Colorado Road And Community Safety Act** Currently, a person who is not lawfully present in the United States may obtain a driver's license or identification card if certain requirements are met. One of the requirements is that the person present a taxpayer identification card. The bill allows a person to present a social security number as an alternative to a taxpayer identification card. The bill allows the license or identification card to be reissued or renewed in accordance with the process used for other licenses and identification cards. A person whose license is lost or stolen may obtain a replacement without renewing the license. $108,992 is appropriated to the department of revenue from the licensing services cash fund to implement the bill. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Singer (D) Singer (D) Senate: Crowder (R) Coram (R)	Active 04/26/2018 - House Considered Senate Adherence - Result was to Recede 04/19/2018 - Senate Considered House Amendments - Result was to Adhere 04/18/2018 - House Third Reading Passed - No Amendments
1 Oppose Strongly Oppose Position- February 13, 2018 Oppose Position- February 27, 2018	**SB18-132 - 1332 State Waiver Catastrophic Health Plans** The bill requires the commissioner of insurance to conduct an actuarial analysis to determine if the sale of catastrophic health plans to Colorado residents 30 years of age and older and not meeting a hardship requirement would result in a reduction in advanced premium tax credits received by Colorado residents or increase the average premiums of individual health plans. If the actuarial analysis demonstrates that there would not be a reduction in advanced premiums tax credits or an increase in average premiums of individual health plans, the commissioner shall apply to the secretary of the United States department of health and human services for a 5-year waiver of the federal law restricting catastrophic health plans offered through the Colorado health benefit exchange. The waiver, if approved, would permit the offering of catastrophic health plans to any individual residing in Colorado rather than only individuals under the age of 30 or meeting a hardship requirement. Catastrophic health plans under the waiver must only be sold through the health benefit exchange and would not be eligible for advanced premium tax credits. If the waiver is denied, the statutory section is repealed. The bill appropriates $9,200 to the department of regulatory agencies for use by the division of insurance for personal services. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Kennedy () Senate: Smallwood (R)	Active 04/26/2018 - Sent to the Governor 04/26/2018 - Signed by the Speaker of the House 04/25/2018 - Signed by the President of the Senate
1 Support March 13, 2018	**SB18-168 - Medication-assisted Treatment Through Pharmacies** The bill requires extended-release opioid antagonists for use in medication-assisted treatment to be included as a pharmacy benefit under the medical assistance program. The bill permits a pharmacist who has entered into a collaborative pharmacy practice agreement with one or more prescribers to administer injectable medication-assisted treatment for substance use disorders and receive an enhanced dispensing fee under the Colorado medical assistance program for the administration. *(Note: This summary applies to this bill as introduced.)*	House: Senate:	Active 02/21/2018 - Introduced In Senate - Assigned to Business, Labor, & Technology

Priority / Position	Summary	Sponsors	Status
1	**SB18-249 - Redirection Criminal Justice Behavioral Health** The bill directs the chief judge of each judicial district in the state or the chief judge of Denver county court, or their designees (chief judge), to work with interested stakeholders to develop alternative programs that are unique to the judicial district that redirect individuals with low-level criminal behavior with a behavioral health condition to community resources and treatment rather than continued criminal justice involvement (program). Interested stakeholders must include law enforcement, jail officials, district attorneys, public defenders, judges, pretrial service providers when available, and local community mental and behavioral health providers within the judicial district. The chief judges shall convene stakeholder meetings to design and develop programs, contract with local community behavioral health providers to assist in accomplishing the goals of the programs, and administer the programs after implementation. Each program must include a standardized, evidence-based screening tool to be used by jail personnel to preliminarily identify individuals in custody who might be eligible for redirection through the program. Each program must identify existing programs and resources available for individuals with behavioral health conditions. After the prescreening, designated jail personnel shall refer individuals who might potentially be eligible for the program to a redirection specialist in the judicial district who shall, within 48 hours after arrest, evaluate the individual for eligibility based on established criteria. Upon completion of the evaluation, the redirection specialist shall notify the court and all other required parties, as determined by the program, of the evaluation results and the redirection specialist's recommendation for redirection. Information collected from or about the individual during either the prescreening or evaluation must be kept confidential as required by law. The court shall make a determination about redirecting an individual into the community behavioral health system. If the court orders the individual into redirection and behavioral health treatment, the criminal charges against the individual must be dismissed. Each judicial district shall establish procedures and agreements concerning how to track such individual's progress. Local community behavioral health providers are responsible for complying with any reporting and communication requirements of the program as established by the stakeholders. The state court administrator is responsible for overall program administration, including ensuring that, on or before January 1, 2019, each judicial district implements its own unique program. *(Note: This summary applies to this bill as introduced.)*	House: Lee (D) Young (D) Senate: Gardner (R) Lambert (R)	Active 04/17/2018 - Introduced In Senate - Assigned to Judiciary

Priority / Position	Summary	Sponsors	Status
1	**SB18-250 - Jail-based Behavioral Health Services** The bill continues to allow the correctional treatment cash fund to be used to provide treatment for persons with mental and behavioral health disorders who are being served through the jail-based behavioral health services program (program). The program is housed in the office of behavioral health. The purpose of the program is to provide adequate staff to complete competency screenings, prescribe psychiatric medications as necessary, and provide mental health counseling and transitional care coordination; train jail staff on behavioral health disorders and best practices in working with individuals with mental health, substance use, and co-occurring disorders; and fund administrative costs to jails participating in the program. Jails that are participating in the program shall, at a minimum: • Screen individuals who are being booked into the facility for various behavioral health issues; • Provide adequate and appropriate access to health care and medications; • Coordinate services with community mental health providers prior to the release of an inmate to ensure continuity of care following his or her release from the jail facility; and • Track performance outcome measures for individuals affected by the program. *(Note: This summary applies to this bill as introduced.)*	House: Lee (D) Young (D) Senate: Gardner (R) Lambert (R)	Active 04/17/2018 - Introduced In Senate - Assigned to Judiciary
1	**SB18-251 - Statewide Behavioral Health Court Liaison Program** The bill establishes in the office of the state court administrator (office) a statewide behavioral health court liaison program (program). The purpose of the program is to identify and dedicate local behavioral health professionals as court liaisons (court liaisons) in each state judicial district to facilitate communication and collaboration among judicial, health care, and behavioral health systems. The office shall administer the program and establish procedures, timelines, and funding guidelines for the program. Program funding must be allocated to judicial districts based on case volume, geographical complexity, and density of need. Specific duties of the court liaisons are outlined, as well as reporting requirements. *(Note: This summary applies to this bill as introduced.)*	House: Lee (D) Young (D) Senate: Gardner (R) Lambert (R)	Active 04/17/2018 - Introduced In Senate - Assigned to Judiciary
1	**SB18-263 - Pilot Program Court Approval Treatment Medications In Jails** The bill creates a pilot program in the department of human services (department) to establish the safety and effectiveness of allowing a licensed psychiatrist to petition the court for authority to administer medications in a jail over the objection of a respondent. The advisory board to the department (advisory board) shall approve any applying jail for participation in the pilot program if it has established a contract with a facility designated by the department and also meets the minimum criteria established in the bill. The advisory board shall only authorize a maximum of 5 jails to participate in the pilot program. The pilot program will be monitored by the office of behavioral health. The office of behavioral health and the sheriff or appropriate law enforcement for a jail applying to participate in the pilot program shall collaboratively develop requirements for a participating jail. Requirements for information and affirmations are to be included in the petition to the court. The department is required to report on the pilot program on or before December 31, 2021. The pilot program is repealed, effective September 1, 2022. Language is clarified concerning hearings and jurisdiction in cases brought to the court for mental health proceedings, including involuntary administration of medications and certifications. If such a case is presented to a jury, the jury shall only hear evidence on the issue of whether the person has a mental health disorder and, as a result of such mental health disorder, is a danger to others or to himself or herself or is gravely disabled. *(Note: This summary applies to this bill as introduced.)*	House: Singer (D) Senate:	Active 04/20/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
1	**SB18-266 - Controlling Medicaid Costs** **Joint Budget Committee.** The bill directs the department of health care policy and financing (department) to provide information to providers participating in the accountable care collaborative regarding: • Cost and quality of medical services provided by hospitals and other medicaid providers; and • Cost and quality of available pharmaceuticals prescribed by medicaid providers. The department may make the same information available to other medicaid providers. The department shall automatically review claims to identify and correct improper coding prior to payment and may obtain commercial technology to conduct the reviews. The department is authorized to pursue cost-control strategies, value-based payments, and other approaches to reduce the rate of expenditure growth in the medicaid program. The department shall allow recipients, providers, and stakeholders an opportunity to comment and shall report to the joint budget committee prior to implementing any strategies or measures. The department is required to contract for an independent evaluation of any measures pursued and to provide reports to the joint budget committee on the evaluations. Subject to federal approval, the department is also directed to design and implement an evidence-based hospital review program to ensure that utilization of hospital services is based on a recipient's need for care. Prior to implementing any changes, the department shall allow recipients, providers, and stakeholders an opportunity to comment and shall report to the joint budget committee. The department shall also report to the joint budget committee on the estimated savings from the changes. *(Note: This summary applies to this bill as introduced.)*	House: Young (D) Senate: Lundberg (R)	Active 04/26/2018 - Senate Second Reading Laid Over Daily - No Amendments 04/24/2018 - Senate Committee on Appropriations Refer Unamended to Senate Committee of the Whole 04/20/2018 - Introduced In Senate - Assigned to Appropriations
1	**SB18-270 - Behavioral Health Crisis Transition Referral Program** The bill establishes the community transition specialist program (program) in the office of behavioral health (office) in the department of human services (department). The program coordinates referrals of high-risk individuals to transition specialists by certain behavioral health facilities and programs. High-risk individuals are under an emergency or involuntary hold, have a significant mental health or substance use disorder, and are not in consistent behavioral health treatment. Transition specialists provide services related to housing, program placement, access to behavioral health treatment or benefits, advocacy, and other supportive services. The department is required to adopt rules to implement the program. The bill requires the office to collect data and make recommendations to the department, and the department is required to include program information in the department's annual SMART act report. *(Note: This summary applies to this bill as introduced.)*	House: Pettersen (D) Wist (R) Senate: Neville (R)	Active 04/20/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Priority / Position	Summary	Sponsors	Status
1	**SB18-272 - Crisis And Suicide Prevention Training Grant Program** The bill creates the crisis and suicide prevention training grant program (grant program) in the department of public health and environment (department). The purpose of the grant program is to provide financial assistance to schools in providing crisis and suicide prevention training to schools, with priority given to those schools that have previously not received such training. The grant program may authorize up to $400,000 in grants per year in varying amounts. The office of suicide prevention and the school safety resource center shall work collaboratively with the department to develop guidelines and criteria for the grant program. Grant recipients are required to report on their activities using grant money. The crisis and suicide prevention training grant program fund is created and authorized to accept appropriations from the general assembly, as well as gifts, grants, and donations. The bill makes conforming amendments that authorize the existing office of suicide prevention in statute. *(Note: This summary applies to this bill as introduced.)*	House: Carver (R) McLachlan (D) Senate: Todd (D)	Active 04/25/2018 - Senate Committee on Health & Human Services Refer Unamended to Appropriations 04/20/2018 - Introduced In Senate - Assigned to Health & Human Services
2	**HB18-1001 - FAMLI Family Medical Leave Insurance Program** The bill creates the family and medical leave insurance (FAMLI) program in the division of family and medical leave insurance (division) in the department of labor and employment to provide partial wage-replacement benefits to an eligible individual who takes leave from work to care for a new child or a family member with a serious health condition or who is unable to work due to the individual's own serious health condition. Each employee in the state will pay a premium determined by the director of the division by rule, which premium is based on a percentage of the employee's yearly wages and must not initially exceed .99%. The premiums are deposited into the family and medical leave insurance fund from which family and medical leave benefits are paid to eligible individuals. The director may also impose a solvency surcharge by rule if determined necessary to ensure the soundness of the fund. The division is established as an enterprise, and premiums paid into the fund are not considered state revenues for purposes of the taxpayer's bill of rights (TABOR). *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Winter (D) Gray (D) Senate: Donovan (D) Fields (D)	Active 04/20/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/16/2018 - House Third Reading Passed - No Amendments 04/09/2018 - House Third Reading Laid Over to 04/16/2018 - No Amendments
2	**HB18-1040 - Inmate Treatment Incentive Plans** **Legislative Oversight Committee Concerning the Treatment of Persons with Mental Health Disorders in the Criminal and Juvenile Justice Systems.** The bill requires the department of corrections to: • Monitor the number of inmates who need sex offender treatment or services and the number who are not receiving such treatment or services; • Develop an incentive plan to contract for more mental health professionals to provide sex offender treatment or services in difficult-to-serve geographic areas; and • Report to the joint budget committee the number of inmates needing treatment or services, the number not receiving the treatment or services, and the impact of the incentive plan. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Benavidez (D) Senate: Fields (D)	Active 04/26/2018 - Sent to the Governor 04/26/2018 - Signed by the President of the Senate 04/26/2018 - Signed by the Speaker of the House

Priority / Position	Summary	Sponsors	Status
2	**HB18-1207 - Hospital Financial Transparency Measures** The bill requires the department of health care policy and financing (department), in consultation with the Colorado healthcare affordability and sustainability enterprise board, to develop and prepare an annual report detailing uncompensated hospital costs and the different categories of expenditures made by general hospitals in the state (hospital expenditure report). In compiling the hospital expenditure report, the department shall use publicly available data sources whenever possible. Each general hospital in the state is required to make available to the department certain information, including: • Hospital cost reports submitted to the federal centers for medicare and medicaid services; • Annual audited financial statements; except that, if a hospital is part of a consolidated or combined group, the hospital may submit a consolidated or combined financial statement if the group's statement separately identifies the information for each of the group's licensed hospitals; • Utilization and staffing information and standard units of measure; and • Information accessed through a secure, online data collection and reporting system that provides a central location for the collection and analysis of hospital utilization and financial data. • The hospital expenditure report must include, but not be limited to: A description of the methods of analysis and definitions of report components by payer group; • Uncompensated care costs by payer group; and • The percentage that different categories of expenses contribute to overall expenses of hospitals. The department is required to submit the hospital expenditure report to the governor, specified committees of the general assembly, and the medical services board in the department. The department is also directed to post the hospital expenditure report on the department's website.	House: Kennedy () Rankin (R) Senate: Moreno (D) Smallwood (R)	Active 04/18/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 03/14/2018 - House Third Reading Passed - No Amendments 03/13/2018 - House Second Reading Passed - No Amendments
2	**HB18-1208 - Expand Child Care Expenses Income Tax Credit** Currently, a resident individual with a federal adjusted gross income of $60,000 or less is allowed a state income tax credit (state credit) for child care expenses that is a percentage of a similar federal income tax credit claimed (federal credit). The amount of the state credit depends on the individual's adjusted gross income (AGI). If the individual's AGI is: • $25,000 or less, then the state credit is 50% of the federal credit; • $25,001 to $35,000, then the state credit is 30% of the federal credit; and • $35,001 to $60,000, then the state credit is 10% of the federal credit. The bill expands the state credit by allowing a resident individual with an AGI that is less than or equal to $150,000 to claim a credit that is equal to 80% of the individual's federal credit. *(Note: This summary applies to this bill as introduced.)*	House: Duran (D) Winter (D) Senate:	Active 04/26/2018 - House Second Reading Special Order - Passed with Amendments - Committee 04/25/2018 - House Committee on Appropriations Refer Amended to House Committee of the Whole 03/12/2018 - House Committee on Finance Refer Amended to Appropriations

Priority / Position	Summary	Sponsors	Status
2	**HB18-1268 - Recall Petition Election Special District Director** The bill establishes procedures to govern the recall of a director of a special district. **Section 4** of the bill requires the court as defined for the special district to appoint a designated election official (DEO) to oversee the recall election. The director and the director's spouse or civil union partner cannot serve as the DEO. The bill requires that recall petitions must be approved as to form by the DEO before being circulated. To be approved, a petition must designate a committee to represent the signers, must name only one director, and must include a brief statement of the grounds for the recall. It must also provide certain warnings to electors concerning their eligibility to sign. **Section 5** requires that signed petitions be filed with the DEO within 60 days after their form has been approved. Signed petitions must include a signed and notarized affidavit from the circulator attesting to the circulator's compliance with the requirements of the law. Once a signed petition is filed, the DEO is required to review the petition and issue a written determination that the petition is sufficient or not sufficient within 5 business days, unless a protest is filed before that date. An eligible elector may file a protest of a recall petition within 15 days after a petition is filed. In the case of a protest, a hearing is required and the DEO is the hearing officer. The hearing officer is required to issue a determination that the petition is sufficient or not sufficient within 15 days after the conclusion of the hearing. If a petition is determined not sufficient, the committee representing the electors may withdraw, amend, and refile it within 15 days. A petition can only be withdrawn and refiled once. A determination that a petition is sufficient or not sufficient is subject to judicial review on request by the director, the director's representative, or a majority of the committee representing the electors, but judicial review cannot include the statement of the grounds on which the recall is sought. If a petition is determined sufficient, the board of the special district must set a date for the recall election, and determine whether the election will take place at the polling place or by mail ballot. If a regular special district election is to be held within 180 days after the date on which the board orders the recall election, the recall election must be held as part of the regular election. If the director is seeking reelection at that regular election, only the question of his or her reelection appears on the ballot. If the director's successor is to be chosen at that regular election, and the director is not seeking reelection, only the selection of the successor appears on the ballot. The recall election may also be held as part of a coordinated election if the information required for the ballot is determined within the deadline, and the county clerk and recorder agrees. **Section 6** provides that if the director resigns in writing prior to the election, the recall proceedings are terminated and the office is filled as a vacancy. The ballot for a recall election must include the statement of grounds for the recall that was included in the petition. The director may file a statement in support of his or her retention, which must also be included on the ballot if it is timely filed. The ballot must also include the names of candidates nominated to fill the office if the director is recalled. If an incumbent is not recalled, or if a recall petition is deemed not sufficient, **section 7** authorizes the special district to reimburse the director for reasonable expenses. Under **section 10** , the special district must pay the costs of the county clerk and recorder and the DEO for the recall election. **Section 8** provides that after one recall election that does not recall the director, any subsequent recall petition must be signed by more than 50% of the eligible electors to be sufficient. **Section 11** makes a conforming amendment to the 'Uniform Election Code of 1992'. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Gray (D) Senate: Gardner (R)	Active 04/26/2018 - Sent to the Governor 04/26/2018 - Signed by the President of the Senate 04/26/2018 - Signed by the Speaker of the House

Priority / Position	Summary	Sponsors	Status
2	**HB18-1294 - Sunset Continue Regulation Nursing Home Administrators** **Sunset Process - House Health, Insurance, and Environment Committee.** The bill implements the recommendations of the department of regulatory agencies, as contained in the department's sunset review of nursing home administrators, as follows: • Continues the regulation of nursing home administrators by the board of examiners of nursing home administrators in the division of professions and occupations for 7 years, until September 1, 2025 (**sections 1 and 2**); and • Changes the membership of the 5-member board of examiners from 3 practicing nursing home administrators and 2 members representing the public to 2 practicing nursing home administrators and 3 members representing the public. The board membership change applies to appointments made on or after July 1, 2018 (**section 3**). The bill requires a nursing home administrator to report to law enforcement possible felony conduct by an employee. If the employee holds a state license, the administrator must also report the conduct to the appropriate occupational board or the director of the division of professions and occupations. Failure to report is grounds for discipline. *(Note: This summary applies to this bill as introduced.)*	House: Lontine (D) Buckner (D) Senate: Crowder (R)	Active 04/26/2018 - House Second Reading Special Order - Passed with Amendments - Committee 04/25/2018 - House Committee on Appropriations Refer Amended to House Committee of the Whole 04/23/2018 - House Committee on Finance Refer Amended to Appropriations
2	**HB18-1298 - Colorado Secure Savings Plan** The bill establishes the Colorado secure savings plan (plan), which is a retirement savings plan for private-sector employees in the form of an automatic enrollment payroll deduction individual retirement account. Employers with a specified number of employees in the state are required to participate in the plan, but any employer may choose to participate in the plan. The Colorado secure savings plan board of trustees (board) is created and consists of the state controller, the director of the governor's office of state planning and budgeting, and 7 additional trustees with certain experience who are appointed by the governor and confirmed by the senate. The trustees on the board have a fiduciary duty to the plan's enrollees and beneficiaries and are required to: • Establish investment options that offer employees returns on contributions without incurring debt or liabilities to the state; • Establish the process for allocating investment earnings and losses to individual plan accounts on a pro rata basis; • Make and enter into contracts and hire staff as necessary for the administration of the plan; • Conduct a periodic review of the performance of any investment vendors; • Cause money in the Colorado secure savings plan fund (fund) to be invested with the intent to achieve cost savings through efficiencies and economies of scale; • Establish the process for an enrollee to contribute a portion of his or her wages to the plan for automatic deposit and establish the process by which the participating employer forwards those contributions to the plan; • Establish the process for enrollment in the plan including the process by which an employee can opt not to participate in the plan; • Accept gifts, grants, and donations from specified entities and pursue options for bank loans or a line of credit to cover the start-up costs of the plan; • Procure, as needed, insurance against loss in connection with the property, assets, or activities of the plan; • Allocate administrative fees to individual retirement accounts in the plan on a pro rata basis; • Set minimum and maximum contribution levels; • Facilitate education and outreach to employers and employees; • Ensure that the plan complies with all applicable state and federal laws;	House: Pettersen (D) Bridges (D) Senate: Donovan (D) Todd (D)	Active 04/25/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/25/2018 - House Third Reading Passed - No Amendments 04/24/2018 - House Second Reading Special Order - Passed with Amendments - Committee

Priority / Position	Summary	Sponsors	Status
	• Deposit all gifts, grants, donations, fees, and earnings from investment of money in the fund into the fund and pay the administrative costs and expenses for the creation, management, and operation of the plan from money in the fund; • Determine any nominal and reasonable assistance that may be provided to businesses to offset the initial costs of enrolling employees in the plan and complying with audits and plan implementation; • Prepare or cause to be prepared certain annual audits and annual reports regarding the plan; • Develop a process to ensure that employers are in compliance with the requirements of the plan and develop a penalty structure for employers who fail, without reasonable cause, to enroll employees in the plan; • Conduct or cause to be conducted a financial feasibility study to ensure that the plan will be self-sustaining; and • Conduct an analysis of relevant consumer protections available under federal law and make recommendations to the general assembly regarding additional necessary consumer protections that should be included in legislation implementing the plan. The bill specifies the process by which the board is required to engage an investment manager to invest the assets of the plan and specifies the investment options that the board is required to create. The bill creates the fund as a trust outside of the state treasury, specifies that the fund will include the individual retirement accounts of enrollees in the plan, and allows the board to use a certain percentage of money in the fund for the administrative expenses of the plan. The money in the fund is not property of the state and cannot be commingled with state money. The board must design and disseminate employer and employee information packets regarding the plan and the options for employee participation in the plan to all employers that participate in the plan. If, based on the required financial feasibility study, the board determines that the plan will be self-sustaining and would promote greater retirement savings for private-sector employees, the board must recommend to the general assembly that the plan be implemented. The board may not implement the plan unless the general assembly, acting by bill, directs the board to implement the plan. The bill dictates the timing for the board to implement the plan, if directed to do so by the general assembly, and a time frame for employers to establish a system by which enrollees in the plan can remit payroll deduction contributions to the plan. Employers must automatically enroll employees in the plan unless an employee has opted out of participation in the plan. Enrollees may select an investment option and contribution level or use the default investment option and contribution amount established by the board. The bill specifies that the state and employers do not have any duty or liability to any party for the payments of any retirement savings benefits accrued by any individual through the plan. *(Note: This summary applies to this bill as introduced.)*		

Priority / Position	Summary	Sponsors	Status
2	**HB18-1300 - Bachelor Nursing Completion Degree Local District College** The bill allows a local district college (college), such as Aims community college, to offer a bachelor of science degree in nursing program as a completion degree in nursing to students who have or are pursuing an associate degree in nursing, provided that the college's board of trustees determines it is appropriate to address the needs of the communities within its service area, as approved by the Colorado commission on higher education based on existing criteria. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Young (D) Buck (R) Senate: Marble (R) Cooke (R)	Active 04/26/2018 - House Considered Senate Amendments - Result was to Concur - Repass 04/19/2018 - House Considered Senate Amendments - Result was to Laid Over Daily 04/19/2018 - Senate Third Reading Passed - No Amendments
2	**HB18-1319 - Services Successful Adulthood Former Foster Youth** The bill allows county departments of human or social services to extend the provision of certain services for a successful adulthood to foster care youth between the ages of 18 and 21 who have exited the foster care system (former foster care youth), including assistance with employment, housing, education, financial management, mental health care, and substance abuse treatment (services for a successful adulthood). The bill also tasks the state department of human services with establishing a former foster care youth steering committee. The purpose of the steering committee is to develop recommendations for an implementation plan that supports the long-term provision of services for a successful adulthood for former foster care youth. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Singer (D) Young (D) Senate: Gardner (R)	Active 04/23/2018 - Introduced In Senate - Assigned to State, Veterans, & Military Affairs 04/20/2018 - House Third Reading Passed - No Amendments 04/19/2018 - House Second Reading Special Order - Passed with Amendments - Committee
2	**HB18-1326 - Support For Transition From Institutional Settings** **Joint Budget Committee.** The bill directs the department of health care policy and financing (department) to provide community transition services and supports to persons who are in an institutional setting, who are eligible for medicaid, and who desire to transition to a home- or community-based setting (eligible persons). The services and supports must be available to eligible persons who transitioned from an institutional setting for up to one year. The bill requires the department to submit an annual report to specified committees of the general assembly on the effectiveness of providing the services and supports. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Young (D) Senate: Lambert (R)	Active 04/19/2018 - Sent to the Governor 04/19/2018 - Signed by the President of the Senate 04/17/2018 - Signed by the Speaker of the House

Priority / Position	Summary	Sponsors	Status
2	**HB18-1335 - County Child Care Assistance Program Block Grants** **Joint Budget Committee.** For providers under the Colorado child care assistance program (CCCAP), the bill requires the state department of human services (department), in consultation with the counties, annually to contract for a market rate study of provider rates for each county. Based on the market rate study and each county's percentage of the total number of children eligible to participate in CCCAP, the department establishes the amount of each county's block grant. The bill allows the department to adjust a county's block grant amount based upon rules promulgated by the department. Under current law, a county is permitted to determine the percentage of the federal poverty level for eligibility in CCCAP for that county. The bill sets the federal poverty level for all counties at 185% but allows the state board of human services to adjust the percentage by rule if required by federal law. The bill adjusts certain periods of eligibility and removes references to preconditions that have been previously met. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Young (D) Senate: Lundberg (R)	Active 04/26/2018 - House Considered Senate Amendments - Result was to Concur - Repass 04/23/2018 - House Considered Senate Amendments - Result was to Laid Over Daily 04/23/2018 - Senate Third Reading Passed with Amendments - Floor

Priority / Position	Summary	Sponsors	Status
2	**HB18-1394 - Update Colorado Disaster Emergency Act** The bill updates the Colorado disaster emergency act to include provisions related specifically to recovery, mitigation, and resiliency and to establish the roles and responsibilities of state and local agencies at all stages of emergency management. **Section 3** of the bill adds language defining the stages of response and recovery, as well as definitions of emergency, resiliency, and mitigation. **Section 4** allows the governor to convene a disaster policy group to coordinate the response and recovery from disaster emergencies. If the governor convenes the policy group, the governor is required to appoint a chair and to delegate to the chair the authority to manage cross-departmental and interjurisdictional coordination of recovery efforts. **Sections 5 and 21** repeal and relocate existing language establishing the governor's expert emergency epidemic response committee, update the language to reflect amendments throughout the bill, and add the executive director of the department of local affairs or his or her designee to the committee. The bill creates the Colorado resiliency office in the division of local government within the department of local affairs in **sections 17 and 18.** The office is required to develop a resiliency and community recovery program for the state that must address coordination among state and local agencies and risk and vulnerability reduction. The office is required to consult with other state agencies and stakeholders in developing the program. **Sections 6, 8, 9, 10, 12, 13, and 14** amend existing statutes concerning disaster planning and response at the state and local level to include references to recovery, mitigation, and preparedness. The requirement for a state disaster plan is amended to require a comprehensive emergency management program that addresses preparation, prevention, mitigation, response, and recovery from emergencies and disasters. Local and interjurisdictional disaster agencies are renamed as emergency management agencies. The emergency management agencies are required to develop a local or interjurisdictional plan that includes provisions for preparation, prevention, mitigation, response, and recovery from emergencies and disasters. Agencies may incorporate by reference existing locally adopted plans, plans approved by the office of emergency management or the federal emergency management agency, and other relevant plans. **Section 15** amends a requirement in existing law that the governor consider steps that could be taken on a continuing basis to prevent and reduce the harmful consequences of disasters and adds language requiring the governor to also consider mitigation and recovery from disasters. **Sections 16, 19, and 20** make conforming amendments. *(Note: This summary applies to this bill as introduced.)*	House: Singer (D) McKean (R) Senate: Kefalas (D)	Active 04/26/2018 - House Second Reading Special Order - Passed with Amendments - Committee 04/26/2018 - House Committee on Appropriations Refer Unamended to House Committee of the Whole 04/19/2018 - House Committee on Local Government Refer Amended to Appropriations
2	**SB18-013 - Expand Child Nutrition School Lunch Protection Act** Current law creates an annual appropriation to provide lunches at no charge to children in state-subsidized early childhood education programs administered by public schools or in kindergarten through fifth grade who would otherwise have to pay for a reduced-price lunch. The bill extends the grade of eligibility to eighth grade in schools that elect to participate in the expanded program. The bill authorizes an annual appropriation, including a cap on the amount of the annual appropriation, to cover the expanded grades of eligible children. *(Note: This summary applies to this bill as introduced.)*	House: Michaelson Jenet (D) Senate: Fields (D) Gardner (R)	Active 01/25/2018 - Senate Committee on Education Refer Unamended to Appropriations 01/10/2018 - Introduced In Senate - Assigned to Education

Priority / Position	Summary	Sponsors	Status
2	**SB18-071 - Extend Substance Abuse Trend And Response Task Force** The state substance abuse trend and response task force is scheduled to be repealed effective July 1, 2018. The bill extends the repeal for 10 years to September 1, 2028. The bill appropriates $3,000 from the substance abuse prevention, intervention, and treatment cash fund to pay for expenses of the task force. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Esgar (D) Senate: Crowder (R)	Active 04/20/2018 - Sent to the Governor 04/20/2018 - Signed by the Speaker of the House 04/19/2018 - Signed by the President of the Senate
2 2/3	**SB18-126 - Traditional And Large Premium Cigars Tax Definition** The bill defines a traditional large and premium cigar, which is a type of tobacco product, for purposes of the excise tax on tobacco products. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Pabon (D) Van Winkle (R) Senate: Grantham (R) Guzman (D)	Active 04/03/2018 - House Third Reading Lost - No Amendments 04/02/2018 - House Second Reading Passed - No Amendments 03/29/2018 - House Second Reading Laid Over to 04/02/2018 - No Amendments
2 2/3	**SB18-179 - Extend Credit For Out-of-state Tobacco Sales** Currently and until September 1, 2018, a distributor can claim a credit for taxes paid on tobacco products that are shipped or transported by the distributor to a consumer outside of the state. The bill makes the credit permanent and requires the distributor to maintain certain records related to the out-of-state sales to consumers. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*	House: Hooton (D) Pabon (D) Senate: Hill (R) Williams (D)	Active 04/11/2018 - Senate Considered House Amendments - Result was to Not Concur - Request Conference Committee 04/10/2018 - Senate Considered House Amendments - Result was to Laid Over Daily 04/09/2018 - House Third Reading Passed - No Amendments

CSV

memo

To: Health District Board members

From: Lin Wilder, Director, Community Impact Team

Date: April 27, 2018

Re: Request for general approval of Toolbox Creative contract

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At an earlier Board meeting in 2018, Community Impact Team staff provided the Board with a brief overview of our planned public awareness campaign around substance use disorders, and indicated that we had identified a vendor to help us with this project.

As a reminder, the following is a brief description of this project:

> This is a three-year social marketing campaign with a goal to transform public perceptions of addiction and substance use in Larimer County and promote public understanding that: 1) addiction is a chronic disease requiring adequate levels and quality of treatment; 2) treatment works and recovery is possible; and 3) recovery has significant benefits for individuals, families and the community. The first phase of the campaign is planned for release in the summer of 2018.

We recently realized that we did not ask the Board for an actual vote to approve the contract in the amount of $65,000 for Toolbox Creative. We are, therefore, bringing this issue to your attention now, and asking for that approval. Note that this $65,000 is in the existing budget. $20,000 of the cost is funded from the MHSU Alliance members' contributions, and $45,000 is funded from Health District Reserve dollars ($25,000 from the SUD Transformation Project line item, and $20,000 from other MHSU-related reserves).

We apologize for this error, and appreciate your consideration of this request.

Health District
OF NORTHERN LARIMER COUNTY

QUARTERLY SERVICE REPORT
FOR THE QUARTER ENDING
DECEMBER 2017

DENTAL SERVICES

I. DENTAL CLINIC

The theme of the fourth quarter was continued focus on the dedicated outreach and marketing efforts aimed at informing the community about the dental services offered at the Health District, which began in earnest in the third quarter. These activities included continued marketing efforts in print advertising in the Coloradoan and Compass newsletter, as well as online on the social media platforms Facebook and Instagram. The second wave of direct mailing outreach was sent in December to 3,000 Medicaid members living in northern Larimer County as part of a partnership with the Larimer County Department of Human Services.

Head Start and Project Smile school year screenings continued into October and kept both dental and hygiene providers very busy visiting local schools. Client visits continued to marginally rebound slightly from the previous quarter. Funding for the third year of the Senior Dental Program (which began on July 1) was nearing exhaustion as the fourth quarter came to a close, significant because many senior patients put off care when these funds from the state run out. Additionally, the money that the Family Dental Clinic has been awarded by the Larimer County Office on Aging (LCOA) to aid seniors with the cost of their dental care for the 2017/18 funding period was frozen by staff at LCOA due to federal budget delays.

In the fourth quarter of 2017, the Family Dental Clinic was over target for the number of clients served, and under target in regards to the number of dental visits and the amount of RVUs produced overall. The staff provided care to 1,490 clients, 350 (31%) above the target of 1,140. The growth in number of clients seen is partially attributed to the number of children seen at school screenings (465) but it also demonstrated stabilization in the number of clients being seen at the clinic, which may have been related to the continued marketing and outreach efforts. The clinic was below the quarterly target for RVU (relative value unit) production. Staff produced 10,041 RVUs during the quarter compared to a target of 12,375 (2,334, or 19%, less than anticipated), and experienced 2,846 dental visits compared to a target of 3,042 (196 less visits, or 6% less than anticipated). In total, 8% of the providers' FTE in the fourth quarter was shifted from clinic hours to school screenings. Overall in 2017, the Family Dental Clinic served 4,159 unduplicated clients (401 fewer clients, or 9% under target), completed 11,280 dental visits (890 or 7% less visits than anticipated, and produced 38,890 RVUs (19% under target). While these metrics are under target, the quarter by quarter trends started to show improvement as 2017 progressed.

> ***Case Example:*** I had the opportunity to experience a "reunion" with a 60 year old woman who first started coming to the dental clinic in 2013. When she first presented to the clinic, she had an extreme fear of dental treatment and a significant amount of dental treatment needed. Over several months, we were able to work through the anxiety, gain her trust, and complete her dental treatment. After we completed her treatment plan, she "disappeared" from the clinic for more than 4 years. Recently, she came back into the clinic and shared that for the past 4 years she had suffered from severe depression, lost her job, moved out of the state, and experienced homelessness and had been living out of her car. She knew that she had neglected her general health and her dental health since we had last seen her. Unfortunately, over the span of 4 years her teeth had become non-restorable. We are in the process of extracting all of her teeth and fabricating complete dentures. She was in tears expressing her gratitude for being back in Fort Collins and being able to come back to the Health District dental clinic to take care of her dental needs. It has been a great experience to reconnect with her and to be a part of helping her reconstruct her life.
>
> ***Case Example:*** A patient of mine has had a very difficult few years. He has had many health problems, spending quite a few days and nights in the hospital. He also has mild dementia. His wife takes care of his day-to-day needs, including scheduling his dental appointments. Recently, his wife wound up in the hospital for almost a month, leaving the patient on his own to manage his affairs. He had teeth breaking and they needed to be pulled and his partial denture no longer fit, making eating very difficult. He was already in a tough position in all other areas of his life so everyone (including the front office who made sure he had his appointments scheduled and knew when to come in) pulled together to get his teeth removed, add new teeth to his partial denture, and make sure that it fit. The patient was very happy with the final result. With everything else going on, we wanted to make sure he could at least eat and smile and he was very grateful.

II. DENTAL CONNECTIONS

During the fourth quarter 2017, staff placed 12 clients with Dental Care Access ("DCA") volunteer providers, 9 clients below the quarterly target of 21 (43% below the quarterly target). Volunteer providers completed 25 appointments resulting in 39 completed dental procedures for individuals who would not otherwise have been able to afford dental care. The estimated market value of these services is $9,437. Although there are no targets for Dental Connections' information and referral services, during the fourth quarter, program staff took 155 total resources and referral calls, 74 of which were unduplicated individuals. Overall in 2017, 51 clients were placed with DCA providers (39% under the goal of 84, largely because the Dental Clinic had capacity to serve people instead of sending them out, and increased its eligibility level to 250%) for a total of 84 appointments resulting in 166 completed dental procedures valued at approximately $46,989.

General Anesthesia Program (GAP)

Six patients participating in the Dental Care Under General Anesthesia Program (GAP) received care at the Harmony Surgery Center in the fourth quarter, two patients short of the quarterly target of 8 patients (25% below the quarterly target). This number represents surgery dates for October and November only because historically we not see clients through GAP in the month of December. For fourth quarter 2017, a total of 65 procedures were completed, for an estimated $8,152 billed to Health First Colorado (Colorado's Medicaid Program). Procedures were not billed by the Health District, but rather by our participating GAP providers. Overall in 2017, 27 medically fragile individuals were able to access the specialized dental care provided through the GAP (just 3 fewer than the 30 anticipated), and a total of 242 procedures were completed over the course of the year. An estimated $27,936 was billed to Medicaid for these services.

> ***Case Examples***: Since its inception in 2011, Dental Connections has become a valued resource for mental health professionals, case managers and medical office staff to call when they want to help their clients but simply don't know where to turn for information on available dental options. With outreach efforts and through word of mouth, Dental Connections has gained a reputation in our local community as a place to call for dental care and a resource to get other dental benefit answers.
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> Recently a case manager called Dental Connections regarding her 53 year old client Matthew (not his real name). Matthew receives Social Security Disability Income and carries Medicare for his medical benefits. Having the Medicare benefit usually precludes an individual from being eligible for the Health First Colorado (Colorado's Medicaid program) benefit. However, there are certain state waiver programs that allow qualifying disabled or medically compromised individuals additional long term care medical care. Essentially these individuals qualify for both Medicare and full Medicaid benefits. Knowing only the basic eligibility parameters, Dental Connections staff recommended the case manager contact Larimer County Department of Human Services to apply for this waiver. Matthew did qualify for the waiver program, and now he has access to the full slate of Medicaid benefits, including dental. Thanks to his new Medicaid dental coverage, Matthew was able to get his remaining extractions completed and once adequate healing takes place, he will receive his new dentures and be on the road to a restored sense of self that will come with his new smile!

HEALTH CARE ACCESS

I. LARIMER HEALTH CONNECT

During the fourth quarter of 2017, staff provided assistance to 1,109 households through 1,770 encounters (in-person or intensive phone follow up) (254% or 1,270 above the target of 500) resulting in at least 887 people enrolled in coverage (356 Medicaid/CHP+, 531 Marketplace plans).

The program greatly exceeded targets during this quarter primarily due to the start of Open Enrollment for 2018 coverage, which began on November 1st. Marketing efforts were stepped up to assure people were aware of the shortened open enrollment period (and how it was different from the federal marketplace), demystify myths surrounding availability of cost sharing reductions and to raise awareness about the availability of the financial assistance. Strategies included a robust social media outreach with Facebook and Twitter, an updated special insert on Health Insurance in the 2017 Fall Compass, and a special 4-page direct mail piece distributed to over 135,000 households in targeted zip codes throughout the county.

Staff provided extended office hours, with appointment availability from 8 am – 8 pm select days during the week and were open two Saturdays each month during Open Enrollment. The extended hours and increased staffing during the OE period allowed us to serve more clients during the same period as compared to last year. Staff regularly fielded concerns from clients about the uncertain future of their ability to retain health insurance.

For the year, staff achieved 138% of the projected target of providing intensive assistance in 2000 in person, phone, or email encounters, instead providing over twice as many encounters, at 4,759.

Client Stories: A self-employed family of 5, with three young boys, came in for assistance. The family ended up with mixed-eligibility status, with the kids eligible for CHP+ and the parents qualifying for tax credits. The parents have been coming in since the first open enrollment, since being self-employed and having mixed eligibility leads to a higher likelihood of running into trouble with re-enrollment. The customers reported their appreciation that the staff takes the time to sit and fill out applications with them. Staff have had to facilitate 3-way calls with Connect for Health and CHP+ and have diligently helped them troubleshoot issues. "We never felt like we were a burden to anyone … it is very hard to find this kind of help these days… We joke -- our dog once had better coverage than us! She had 96% coverage! And we are human beings! It means a lot to be able to go in and not worry if your child needs care. It means a lot when you are a one-income family and self-employed. I think it will help us as our business continues to grow. These programs (CHP+ and financial assistance through the marketplace) help people get on their feet and support them until things improve and become more stable. I hope that next year it will continue."

II. PRESCRIPTION ASSISTANCE

During the 4rd quarter, staff provided prescription assistance services to 69 clients (8% below the target of 75), through 119 client service contacts. While slightly under the target for the number of unduplicated clients, the level of assistance needed per client was high as the program was over targets for Vouchers, RX Outreach and MPAPs. A total of 79 voucher units were issued and completed (27% over the target of 62), 108 RX Outreach Units were initiated (23% over the target of 88), and 225 MPAP units were initiated (20% above the target of 188). For the year, the program served 193 unduplicated clients compared to a target of 300 (36% under target), but exceeded targets for the number of vouchers units issued and completed by 13%, and the number of RX Outreach units initiated by 18%, and were right on target for the number of MPAP (manufacturers' prescription assistance program) units initiated. Although Medicaid expansion has resulted in far more people with prescription coverage, there continue to be many in our community whose particular situation results in the continued need for prescription assistance.

COMMUNITY IMPACT

I. MENTAL HEALTH AND SUBSTANCE USE ALLIANCE OF LARIMER COUNTY (MHSU ALLIANCE)

Solutions to Behavioral Health Service Gaps in Larimer County

CIT staff continued working with the Guidance Team, NIATx consultants and key community partners to update the existing spectrum of key segments of behavioral health care and their utilization, calculate the unmet needs of behavioral health services, and make recommendations on facility design and a Pro Forma budget that would be required to address mental health care gaps in the community. At the end of the quarter, CIT staff were compiling the recommendations into a draft updated report, titled "What Will it Take? Solutions to Mental Health Service Gaps in Larimer County." The updated recommendations include a significant increase in service capacity across several levels of care in both the community and facility-wide, allowing for a greater number of Larimer County residents to be served than were recommended in 2016, but the recommendations would be doable according to anticipated increases in projected tax revenues since that time. CIT staff will be working closely with Larimer County's "Mental Health Matters" public education campaign to help raise awareness of the critical gaps in mental health and substance use treatment and the overall need for these recommended services in our community.

Transforming Perceptions and Treatment of Substance Use Disorders in Larimer County

Colorado Health Foundation Advancing Behavioral Health Grant: In October we learned that we were awarded the Colorado Health Foundation's Advancing Behavioral Health grant to support working with SummitStone Health Partners and the Larimer County Criminal Justice System to transform perceptions and treatment of substance use disorders within those systems. Work began on developing an assessment of knowledge, skills, attitudes and beliefs for staff of partner organizations that will kick off the transformation effort, and bringing partners together to plan education, planning and improvement activities.

Public Awareness Campaign: The Health District and the Mental Health and Substance Use Alliance (MHSU) of Larimer County are jointly funding a public awareness campaign to help change public perceptions about the nature of substance use disorders. A Request for Proposal (RFP) was released on December 1st and the Health District received five bids from both local and statewide marketing firms. The bids were scored by an internal committee and Toolbox Creative was awarded the contract. CIT staff are currently working with Toolbox to finalize the scope of work and contract agreement, with development work beginning in early February, and initial campaign messaging to be launched in May/June 2018.

Addressing the Opioid Epidemic

Naloxone Distribution and Education Project
CIT staff continue to facilitate a work group of community members from Weld and Larimer County (with support from the North Colorado Health Alliance for Weld County). All work group members received training on how to use naloxone. CIT staff conducted an audit of naloxone practices among law enforcement agencies, and made connections to the state Attorney General's office for those who needed additional support. CIT staff also began outreach to local pharmacies to ensure they are stocking naloxone, dispensing under standing orders, and following best practices for billing and patient education. CIT purchased 132 naloxone kits for distribution to partners in the community and to key areas of the Health District. A project to utilize a class of Master of Public Health students (at UNC) to collect data from local businesses on perception and experience with drug use on their premises was outlined, to be completed in first quarter of 2018.

Northern Colorado Opioid Prevention Workgroup
CIT staff and the Health District's Medical Director have been part of an informal "Steering Committee" helping the Northern Colorado Opioid Prevention Workgroup plan its processes and meeting approaches. In December, the Workgroup identified its third priority area (in addition to provider education and naloxone distribution and education) as expanding Medication Assisted Treatment (MAT) within our criminal justice system in both Larimer and Weld County. CIT staff researched existing MAT literature and programs across the country that are being integrated into jail and other correctional settings, as well as best practice Re-entry models (assuring transitional behavioral health assistance to people transitioning from the criminal justice system back into the community) to help identify gaps in our current transitions. Findings were presented to the Workgroup in December with a recommendation to identify key criminal justice partners to learn how MAT programs could be better utilized and possibly expanded. CIT staff members have organized and conducted several meetings with partners from Community Corrections, Probation, Courts and Parole and will be reporting our findings to the larger Opioid Prevention Workgroup in early February.

Frequent Utilizer Project/Pay for Success Project Development
The CIT team now has a staffperson with past experience with "pay for success" models and is planning to move forward with the implementation of the Administrative Data Pilot Grant with the University of Utah in spring of 2018, moving our community one step closer to a possible special project to create more effective approaches to assist those who frequently utilize the health, behavioral health, and criminal justice systems. This technical assistance grant will help us develop data sharing agreements and processes that need to be in place for a Pay for Success Project to work. In December, staff from CIT met with consultants from "Social Impact Solutions" a consulting group who have worked closely with the development of Denver's Pay for Success Project. This group not only brings significant knowledge and experience with a Pay for Success model similar to our needs in Larimer County, but also has relationships with potential investors, and could potentially help us structure a Larimer County Project. Staff have also continued participation in the Homeless Action Team meetings regarding development and implementation of a "Care Card" system due to the interest of this group in gathering and sharing data regarding homeless individuals' use of services through community providers and emergency services.

Early Identification and Early Intervention (EIEI)
CIT staff continue to sit on the Steering Committee of the Early Childhood Council's Leap Coalition (supporting socioemotional development of children ages 0-5) and also continue to work with the Integrated Care subcommittee of LEAP. The top priorities of this group are: 1) closing the communication loop between primary care providers and behavioral health providers; and 2) outlining core competencies for behavioral health and health care providers around socio-emotional development of ages 0-5 (in order to lead to training/support in those areas). Priority 1 overlaps significantly with Regional Health Connector and CAYAC work, and is being rolled into these efforts (not just focusing on ages 0-5). Priority 2 overlaps with CAYAC interests in training both our own staff and increasing the capacity of community behavioral health providers to work with ages 0-5. Core competencies are being developed. The LEAP coalition also facilitated a very well attended and received community training with a respected national expert to increase knowledge regarding trauma. Another training regarding addressing early childhood toxic stress is scheduled for February.

II. COMMUNITY IMPACT TEAM (CIT) PROJECTS

Regional Health Connector (RHC) Program
The RHC's work during fourth quarter focused on developing our approach to and materials for our 3 RHC projects previously defined in the RHC Roadmap. Projects include:

1) providing easy tools and processes for primary care providers and community tobacco cessation programs regarding tobacco, vaping and marijuana use;
2) connecting PCPs to community behavioral health resources and improving the bilateral communication loop between PCPs and behavioral health providers; and
3) building PCP skills in identifying substance use disorders and referring to available resources

The RHC gathered information on primary care practices in the community and which practices were involved in SIM and in referral processes with the Health District's Quit Tobacco Program and the Connections/CAYAC program. The RHC also

identified opportunities to piggyback on other physician outreach efforts happening in the community. Additionally, preliminary work began on developing a webpage dedicated to providing ongoing and easy access for physician practices to identified resources for each of the three RHC project areas.

Towards the end of the quarter, staff began to recognize the need to adapt original plans for the RHC projects to changing program capacity and focus. For example, the Health District's Quit Tobacco Program's new focus on targeting hospital discharges from the cardiac and pulmonary units who have quit during their hospital stay means less focus on expanding referrals from primary care practices to the Quit Tobacco Program. Similarly, for the Connections/CAYAC program, overwhelming increases in utilization of services is resulting in loss of available capacity. As a result, efforts to expand enhanced referral agreements between Connections and primary care offices are being reduced or curtailed. While a number of the elements of our three RHC projects will remain unchanged, some aspects of our original work plans and milestones will need to be adjusted. The Colorado Health Institute who provides TA to RHC's has several counties in the same situation and will provide protocols to change our milestones,

HealthInfoSource Redevelopment
During fourth quarter, a job description was developed for a part-time project manager for HIS redesign, to be posted at the beginning of the year. Work also began on developing an RFP for a strategic design consultant. Additionally, staff met with the City of Fort Collins to discuss information sharing needs in the community and plans and limitations for the HIS redesign.

Pain Management Project
Work began during the 4th quarter on a work plan that includes two areas of focus: 1) An update of the 2016 Pain Management report to include any major changes in research, recommendations and policy related to pain; and 2) A preliminary mapping of Larimer County services and providers specializing in pain and that consumers would initially find upon a web search. This is intended to give us a better sense of our pain provider landscape in Larimer County, and identify gaps and opportunities. The results of these activities will be reviewed by our pain workgroup as part of developing recommendations for next steps/approaches.

Assertive Community Treatment/Integrated Dual Disorder Treatment Teams (ACT/IDDT)
Preparations were made during fourth quarter to increase the Health District's nursing and psychiatric staffing levels slightly in the new year for the IDDT (co-occurring) component of the ACT Team in order to enable expansion of the program through adding additional clients. The ACT Team received a grant enabling expansion, but it did not cover all of the IDDT team's staffing needs associated with additional clients.

General (All)
Two new CIT staff began work on October 1st – Brian Ferrans and Jess Fear, both Managers of Behavioral Health Strategy and Implementation. The CIT Administrative Assistant left her position in early October and a new Admin Assistant was identified before the end of the year who will begin work in January.

III. MENTAL HEALTH/SUBSTANCE USE CONNECTIONS

The Mental Health Connections Adult Team and CAYAC (Child, Adolescent and Young Adult Connections) Team continue to be busier than the previous year, with client contacts, care coordination and unduplicated clients served well above the quarterly targets. The number of unduplicated clients seen in the 4th quarter of 2017 was 35% higher than the 4th quarter of 2016 and the number of client contacts was 67% higher. The number of unduplicated individuals receiving services through Connections (Adult) in the 4th quarter of 2017 was 1,079; 60% higher than the target of 675. The total number of contacts with clients exceeded the target of 1250 by 105% (2559 contacts), and the total number of services provided, at 5,514, exceeded the target of 2,250 by 145%. Care coordination services continue to significantly exceed all targets, with 2,716 provided compared to a target of 200. The majority of care coordination services provided continue to be related to referrals from Associates in Family Medicine (AFM), Poudre Valley Internal Medicine, Salud, the Youth Clinic and self-referrals. Pro Bono and associated low-cost psychiatry referrals continue to remain under target. There is also a decrease in the number of unduplicated clients receiving medication coordination between 2016 and 2017, this is related to a decrease in the medication clinic utilization for adults. For the year, Connections exceeded targets for unduplicated patients served by 14%, serving 3,072. 8,189 client contacts were made, 64% over targets, and 16,871 services provided, 87% over target.

The Adult team continues to see a decrease in the need for walk-in crisis services (directly related to the utilization of SummitStone Crisis Center) but an increase in clients being referred by partnering agencies and medical practices. During the 4th quarter, the Adult team began developing a collaborative working relationship with UC Health's Poudre Valley Hospital Emergency Department resulting in initiation of a pilot of Healthy U referrals from the ED to the Connections Program.

The Child, Adolescent and Young Adult Connections (CAYAC) team continues to be in high demand due to the lack of availability of timely and affordable services for youth. A total of 468 unduplicated clients ages 2 - 24 were served by the CAYAC team this quarter, compared to 339 clients during the previous quarter. CAYAC staff provided 3,309 services,

including psychiatric medication services, psychological testing, brief counseling, and community care coordination, during the quarter; 988 services above the previous quarter. CAYAC psychiatric service providers conducted 43 initial psychiatric assessments and 134 follow up medication monitoring appointments. For the year, 961 unduplicated clients were served, 140% higher than targets; and the number of client contacts and services provided were four times greater than anticipated.

Due to the high demand for CAYAC services, capacity is strained. So far, staff have avoided putting clients on a waitlist but this may become a necessity in the future, especially related to offering psychological testing services. Staff are working to identify ways to increase efficiency, ensure appropriate utilization management, and increase capacity through interns and other staffing changes. An additional challenge we are facing is the lack of outpatient medication providers in the community that we can refer clients to which sometimes results in us needing to keep clients in the CAYAC program for longer than intended to ensure we are able to connect the family to ongoing psychiatric prescribing services.

In addition to direct client care, Connections hosted a quarterly Therapist Network and Training (TNT) event with 84 clinicians participating. Three Mental Health First Aid classes were held for a total of 49 participants trained. Connections Adult and CAYAC teams also continued to coordinate and host a community mental health education series. These have been well attended with an average of 25 community members per topic.

> ***Case Example(s):*** **Adult Team -** A client called Connections seeking a psychiatrist. She reported that she had recently moved to the area, was between insurances and would have insurance in January from her employer. She was experiencing postpartum anxiety symptoms and grief and loss from the death of her first child. In further assessment with staff, it was determined that the client was experiencing extreme anxiety that was impacting her daily life, marriage and work. During several meetings with Connections staff, the client was given a number of tools for reducing anxiety and information on perinatal mood disorder, and was connected to community clinicians and psychiatrists who would take her new insurance starting in January. In the meantime, she was referred to the Medication Clinic and was prescribed medication until she could get scheduled with a psychiatrist. Client followed up with the community referrals given.
>
> **CAYAC Team:** A 6 year-old was referred to the CAYAC program from her therapist in the community. She was exhibiting a range of behaviors that were concerning to her parents, teachers and caregivers. The client and her family were seen for an intake and she received psychological testing and psychiatric services. A care coordination meeting with the client and her family, teachers, school principal, CAYAC school liaison, and CAYAC psychologist was held to provide the testing findings, discuss recommendations, and collaborate on a plan for how to best support the client and family in succeeding at school. With a solid mental health and school plan ahead of her, the client was successfully transitioned to SummitStone Health Partners for long-term psychiatry and mental health care.

INTEGRATION OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES INTO PRIMARY CARE

In the fourth quarter of 2017, Behavioral Health Providers (BHPs) provided 1,049 case management, therapy and behavioral health contacts to 462 unduplicated patients between the two primary care clinics. The number of direct contacts is lower than the quarterly target of 1,375 by 326, or 24%; annual contacts total 4,185, also 24% under target. The Integrated Care psychiatrist, in addition to serving as the consulting and teaching psychiatrist for all the physicians in both practices, provided 117 psychiatric contacts and services to 116 unduplicated patients at both clinics. In addition, he provided 14 psychiatric services to 8 unduplicated patients through the Community Dual Diagnosis Team (CDDT) program. The overall number of psychiatric services provided is 131. The overall number of unduplicated patients who received psychiatric services for the quarter is 124, which is right on target. Also, the IC psychiatrist provided 32 educational sessions and 37 curbside consultations for residents at FMC during their psychiatric rotation clinics. During the fourth quarter, BHPs co-facilitated 10 shared medical appointments (SMA's) at Salud, including prenatal, diabetes and pain clinics. Also, BHP staff participated in the 8 pain clinics and 9 Medication Assisted Treatment clinics at FMC.

> ***Case Examples:*** A young female patient was initially contacted by a BHP during a medical appointment. After this appointment she initiated therapy to address depression, anxiety and a significant trauma history. During the course of therapy the patient experienced an episode of homelessness; however she regularly attended her appointments despite this challenging living situation. The BHP utilized Eye Movement Desensitization and Reprocessing (EMDR) to help heal some of the traumatic memories and as a result the patient reports an improved mood and increased confidence. While ongoing treatment has completed, the patient remains connected to the BHP when she is in clinic for medical appointments.
>
> A middle aged medically and psychiatrically complex female patient received an additional cardiac diagnosis. This unfortunate development led to an understandable increase in the patient's reported depression and anxiety levels.

The BHP and PCP were able to work together with the patient to finally convince her that a referral to the Medicaid Accountable Care Collaborative (MACC) Care Coordination Team was worth considering. MACC provides moderately intensive to intensive care coordination to people with complex or exceptional needs. Previous attempts to refer had been declined by the patient. Together, the BHP, PCP and MACC staff are working to provide coordinated collaborative care to this complex and at times behaviorally challenging patient. The patient will also be seen in psych clinic in the future to address potential medication options for the increased anxiety and depression.

HEALTH PROMOTION

Tobacco Treatment

Delivery of tobacco cessation services remained below target goals for the fourth quarter, although performance was better than the 4th quarter in 2016. The Tobacco Treatment Specialists saw 33 new clients (target 44, -25%), enrolled 27 (target 35, -23%), and delivered 193 counseling sessions (target 295, -35%). 2017 total numbers also closed below targets—new enrollments, at 117, were 16% below the annual target. The number of counseling sessions was significant, at 836, but below target by 29%. Numbers of referrals from healthcare providers, the most common entry point into our program, have trended up from a program low of 58 in the first quarter of this year to 82, 83 and 75 in the second, third and fourth quarters. On another positive note, Medical Center of the Rockies sent six fax referrals during December to test the pilot inpatient referral program, which will kick off in January.

Marketing efforts continued with the staff and the communications department. Videos were recorded with the tobacco treatment specialists to use on social media. Marketing and advertising strategies were developed and implemented including a bus & bench campaign to begin in early 2018. Newly designed brochures and cards are being distributed to healthcare providers and other potential referral sources. Increasing awareness about cessation services and the fax referral program was a top priority in the fourth quarter. Information about the Quit Tobacco Program was shared with the director at Mountain Crest, 20 people at the Vida Sana coalition meeting, during a health fair at Red Tail Ponds, and Public Health Communities that Care. Thirty healthcare providers (17 medical and 13 dental) were contacted as part of our provider outreach effort. Presentations were given at Front Range Community College careers' class, to a physician and social worker at UCHealth Cancer Center, 40 medical staff at Salud, Family Dental Clinic, Banner Health Primary Care Clinic, and Allergy Partners of Northern Colorado.

> ***Case Example:*** A male who had been smoking for 42 years was referred to the program by his primary care provider. He had recently had a heart attack and needed an emergency surgical procedure to stabilize. At the initial consultation, he presented as anxious and doubtful. He did not believe he would be able to quit. He had many questions. Smoking felt very important to this client—it was a big part of his daily routine. The specialist started by providing him with validation and reflection, and as they built rapport, he began trusting the process, trusting his own ability to change and his own internal resources to make quitting cigarettes possible. He reluctantly set a quit date and to his own surprise was able to stick to it and quit. The longer he went without smoking cigarettes, the more empowered he felt to continue the journey.
>
> At the time of this writing, he has been tobacco free for two months. He reports his triggers and intrusive thoughts of cigarettes are almost gone. The client said he is very happy he was able to quit and found the process to be easier than he anticipated. He was pleasantly surprised. By embracing the process and staying committed, he achieved a valuable health behavior change.

Blood Pressure and Cholesterol Screening (Cardiovascular Risk Factor Screening)

Nineteen cholesterol and three blood pressure-only clinics were held in the fourth quarter of 2017, providing 256 cholesterol, and 289 blood pressure screenings, putting the program +6% and +7% above targets for the year. The program focused on providing worksite screenings to employers that are in their fall wellness/employee benefits enrollment periods. Seven worksite clinics were held at five worksites, screening 87 employees. The CV team also provided blood pressure screenings at the Housing Catalyst Services Fair for Redtail Ponds (permanent supportive housing) residents.

Health District-FMC Hypertension Control Project update: A formal evaluation of the pilot was completed and shared with the FMC Residency Program Directors. Challenges and lessons learned were discussed and ideas for improvement were brainstormed. The FMC Program Director responded with a favorable outlook and planned to present the proposal outline in early 2018 to her Executive Team for feedback and a decision on whether to continue, with changes.

> ***Case Example:*** A male client in his mid-fifties was referred by his PCP into the Health District-FMC Blood Pressure Control Project. Despite taking BP medications, his BP readings were high. He is hearing impaired and with the help of an interpreter, he discussed with the nurse the benefits of home BP self-monitoring. Finances are a barrier,

so the nurse told him about the Health District's free BP monitor loan program. He made an appointment to pick up a BP monitor at the Health District and met with the nurse to learn about correct technique for monitoring and recording his readings. The nurse took the time needed to speak slowly so he could read her lips and used hand gestures to facilitate the communication, using demonstration and the teach-back method of instruction. He tracked his BP for two weeks, reported his average readings, and planned to take his record in to discuss with his PCP.

OTHER SERVICES

I. POLICY

During the 4th quarter significant activity around health care reform at the federal level continued and funding had not been approved for the Children's Health Insurance Program and Community Health Centers. Staff continued to monitor the federal level policy activity, and to communicate with Federal legislators and other key policy leaders to convey the Health District Board of Director's positions on various reform efforts. The search for a new Policy Coordinator concluded and Alyson Williams was hired. Alyson began on November 20, 2017 and quickly engrossed herself in state budget meetings and hearings as well as developing relationships with our legislators and contacts at key health and human service organizations, in preparation for the 2018 Colorado legislative session.

II. ASSESSMENT, RESEARCH, AND PROGRAM EVALUATION

- After the Evaluation and Data Specialist (EDS) resigned at the end of July, Team members conducted a successful search for a new EDS in September. The new EDS quickly got up to speed on the CAYAC Program and set in motion many enhancements to the evaluation of this grant funded program. This included expanding the evaluation planning framework and setting timelines for each required step. After a pilot, procedures to collect longer term feedback from CAYAC clients and family members was implemented. Staff of participating medical practices were interviewed, as were key mental health staff evaluators with Colorado Health Institute.
- The Team continued to analyze and report on the findings from the 2016 Triennial Community Health Survey. The Communications Team produced *Compass* stories featuring survey results concerning the large drop in uninsured adults following implementation of the ACA and a story about local increased rates of alcohol consumption. A press release about increased use of marijuana from 2013 to 2016, especially by young adults, resulted in stories highlighting local survey results in the *Coloradoan* and on *Colorado Public Radio*.
- At CPHA's annual conference in September, *Public Health in the Rockies*, RE-Team staff delivered four oral presentations that were well attended and received. Topics included evaluating the Mental Health First Aid trainings, demonstrating how we use our Community Health Assessment work to guide health priorities, data describing changes in health insurance coverage and access to care for lower income residents following the ACA.
- In preparation for the next Community Health Survey, planned for the fall of 2019, the Team ramped up our professional development on current survey best practices. We have purchased and are viewing webinars produced by the American Association of Public Opinion Research – the leading organization of survey experts.

III. SPECIAL PROJECTS

Advanced Care Planning Project

The Advance Care Planning Team and community partners continued with a high level of output during the fourth quarter of 2017. Results include 331 directives completed and in play and 942 individuals educated and engaged during various presentations and events. Of the 331 directives completed during the quarter, 224 were completed by ACP staff and volunteers, 75 were done by the Aspen Club, and 32 were done in joint events with the ACP staff and another Partner (Banner Health, UC Palliative Care, Sharing the Care, or others). Of those directives completed and in play, an unduplicated count of 312 clients were served through one-on-one sessions. The year-to-date estimates show that 83% of those we assisted in completing and sharing directives were over 50 years of age and/or at elevated medical risk. The ACP team very significantly exceeded all quarterly and annual goals, educating 4,773 people and achieving 1,705 advance care directives in play by the end of the year. In all, over 1750 unduplicated clients were assisted by staff for the year.

Two critical initiatives contributed to the accomplishments for the quarter:

1) The ACP Team collaborated with the Wellness Program for the City of Fort Collins employees to complete an employee outreach campaign around Advance Care Planning. The campaign included use of custom designed web-based learning tools through our program website over a 3-week period and culminated in on-site assistance at three City of Fort Collins worksites over a three-day period. Over 30 individuals completed and shared documents, and at least 75 participated in the online learning campaign. The City requested a follow up campaign in 2018 and presentations (Lunch and Learns) are scheduled throughout the year.

2) The ACP Team continues to grow its volunteer capacity and the success of that is evident in the enthusiasm that the Estes Park community has for their Advance Care Planning Community Wide Initiative. During the fourth quarter the Estes Park Medical Center participated in a successful three day on-site campaign for their employees, a total of 50 individuals completed documents and the campaign was staffed by local volunteers (two have become Notaries on their own) and ACP staff. The local volunteers are continuing to guide individuals and help them complete documents at the Estes Park Library. In addition, the Estes Park faith community took part in The Conversation Sabbath in November and different churches sent six members of their congregations to participate in advance care planning training. Those trained encouraged conversations in their churches. Four of the local churches sponsored classes for their members, which our ACP Volunteers helped to facilitate.

   Client Story: A woman in her 90's who attended a workshop shared, "It was so important to come to the session at my church. My husband passed away a few years ago and I hadn't thought about updating my documents to reflect his death. I feel much better knowing that all of my sons will know my wishes should anything happen to me."

Medicaid Accountable Care Collaborative
Staff members have been working with Tri-West, the evaluation vendor for the Larimer County Medicaid Accountable Care Collaborative (NLC-MACC), on the qualitative portion of the evaluation and getting the necessary agreements in place to share the quantitative data. Check-in meetings are held weekly with Tri-West to ensure the evaluation is on track. The Oversight Committee held a meeting in November and received a brief overview about Reunion Health Partners, which is the management structure working with Rocky Mountain Health Plan (RMHP) for Region 1, which includes representation from the Federally Qualified Health Care Centers and the Community Mental Health Centers. The group is working around the clock to develop the policies, procedures and structure for implementation of Phase II in the region and in Larimer County, which officially launches in July of 2018.

IV. RESOURCE DEVELOPMENT

During the fourth quarter of 2017, Resource Development continued to work closely with program managers and key staff on numerous Health District funding priorities, submitting proposals/funding applications for the Larimer Advance Care Planning Team and Larimer Health Connect, coordinating budget and contract logistics for awarded proposals and producing reports for various grant initiatives.

- The Health District received three grant awards:
  - $122,500 from the Colorado Health Foundation to transform the perceptions and treatment of substance use disorders in Larimer County.
  - $15,600 in supplemental funding from Connect for Health Colorado to support targeted outreach activities and increase awareness of Open Enrollment and Larimer Health Connect services.
  - $2,000 from the Woodward Governor Trust to support out-of-district Dental Connections services.
- The Larimer Advance Care Planning individual giving campaign was launched in October and included a direct mail piece, three email solicitations, and online giving throughout the 4th quarter. The campaign raised $7,185, surpassing the goal of $7,000.
- Resource Development submitted two grant requests for $193,600 (NextFifty Initiative and Kaiser Permanente) and funding requests to seven additional prospects to sustain the Advance Care Planning program.

In addition to completing funding applications, funder reports and coordinating awarded contracts, Resource Development continued fundraising efforts for the 2017 United Way Employee Giving Campaign, raising over $9,000, a 16% increase over the 2016 campaign.

V. COMMUNICATIONS / HEALTHINFOSOURCE

Information ads placed: Cholesterol & Blood Pressure Testing – Coloradoan, Recreator; Dental – Coloradoan, Scene, Recreator, Rocky Mountain Parent, Facebook, Instagram; Step Free from Tobacco – Coloradoan, Scene, Facebook, Instagram; Connections – NoCo News, Rocky Mountain Parent, South Fort Collins/Timnath Neighbors; Larimer Health Connect – NoCo News, Coloradoan, Rocky Mountain Parent, Recreator, Facebook; HealthInfoSource – Recreator, South Fort Collins/Timnath Neighbors.

Other marketing activities:

- Dental marketing/outreach activities during the quarter included a second mailing to adult Medicaid recipients in the district – this time to approximately 2,600 people in ZIP Codes 80521, 80535, 80536, 80545, and 80549. Print and online advertising continued. A 15-second theater ad was readied for January debut at the Worthington 6 theater in Fort Collins.

- Quit-tobacco marketing activities focused on new outdoor/indoor ads to begin January, including bus benches and posters in all Transfort buses.
- Connections marketing activities included social media promotion for a new series of mental health and substance use talks for parents, and adult and youth Mental Health First Aid trainings.
- Larimer Health Connect marketing activities included print and online advertising and a four-page insert in the October issue of Compass.
- Compass was mailed to approximately 85,000 households in October. The editorial advisory committee was convened.
- Staff hosted seven Community at Work shows featuring guests representing Sexual Assault Victim Advocate Center, Health District Quit Tobacco program, Center for Neurorehabilitation Center (adaptive driving), Larimer Health Connect, City of Fort Collins Human Relations Commission, Northern Colorado AIDS Project, and Health District Integrated Care program
- The Coloradoan highlighted the Community Health Survey and its recent findings on local marijuana use (11/5/17)
- A Coloradoan story on the start of the insurance open enrollment featured information about Larimer Health Connect (11/2/17)

HEALTHINFOSOURCE

Colorado-based use of HealthInfoSource (excluding Health District staff use):

- Users: 3,262(a 3% decrease from third quarter 2017)
- Sessions: 4,138 (a 4% decrease from third quarter 2017))
- Page Views: 15,623 (a 11% decrease from third quarter 2017)

Five most popular topics for the quarter:
"Colorado Indigent Care Program (CICP)," "Health Insurance – What If I Don't Have It," "Health Statistics," "Mental Health – Choosing a Therapist," and "Mental Health Counseling – Frequently Asked Questions."

Database Record Numbers (at end of fourth quarter):

- MHSA: 318 organizations; 420 programs; 448 providers
- Non-MHSA: 623 organizations; 689 programs; 1,383 providers
- Total: 941 organizations; 1,109 programs; 1,831 providers

VI. SUPPORT SERVICES (HIGHLIGHTS)

- The Health District conducted four job searches with 462 applicants screened and 12 interviewed. Two of the positions have been filled.
- Three Master's level students were placed at Mental Health Connections, and CAYAC. The interns volunteered approximately 20 hours a week for a combined total of 600 hours this quarter. The students come from Denver University and the University of Northern Colorado.
- Designed, bid, contracted and commenced work on the painting and remodel of the Health District buildings at 120 and 202 Bristlecone Drive.rence Room.
- Dentrix and Dexis software was upgraded to most recent version, including work to update user rights and module security. Provided training to Dental and other staff on upgraded version.
- The 2018 Budget was completed, approved by the Board and submitted to the State in compliance with all local government fiscal regulations.
- Purchased and installed a new panorex x-ray machine, two nitrous oxide delivery regulators and a new intraoral x-ray head for the Dental program.
- The Human Resources Committee worked on recommended updates to the Employee Handbook for Management team review.
- Completed 73 out of 77 facility and equipment work orders submitted in the second quarter, for a 95 percent completion rate.

OTHER EXECUTIVE DIRECTOR AND MISCELLANEOUS ACTIVITY

Internal/Board
Significant work continued on budget preparation for 2018, including the submission of the draft budget by October 15, and subsequent amendments for final approval before December 15. The selection process for the new Policy Coordinator was

completed, and the Executive Director sent a notification to our local legislators, and began to set up meetings to introduce her to them in person. The position was increased to a full-time position year round, with the intent to be more proactive during off-session months. The ED and policy committee kept a close watch on national health care and tax reform debates to attempt to understand their impact locally and to discuss positions and communications with the Board. The ED began to meet individually with each board member in follow-up to the board retreat.

The ED participated in several planning meetings to update the report on gaps in mental health services in Larimer County, to deliberate with the Guidance Team what solutions should be presented, and to develop public awareness of the gaps; the report is anticipated to be finished by CIT staff the first part of 2018, and will include gaps, solutions, and cost estimates. In related work, the ED participated in the review of vendor proposals to begin work on a substance use disorder public awareness effort, which is also set to begin in the first half of 2018.

Internally, significant progress on updating the Travel Policy was made, and an indepth analysis of whether or not to bill Medicaid for Tobacco and CAYAC services was also in progress. Plans for creating an educational series for staff on planning for retirement were honed in anticipation of the series in early 2018. It was a very busy quarter for the Resource Development department, and multiple grant requests and reports were prepared by staff, then reviewed by the ED. Cybersecurity was highlighted, and a security assessment is in process. Significant progress occurred on the healthinfosource.com redesign, with the development of a job description for the program manager, and an RFP for a vendor for the development of a blueprint and options. Work began on the development of an RFP for a consultant to work with the Health District on improvements to its communication approaches.

With the resignation of the Director in charge of Advance Care Planning and Aging Planning, plans were put in place for new leadership in ACP, which continues to exceed expectations, and to seek significant funding for its continuation. The Aging report was anticipated to be completed by the end of the year, but was not finished, so other staff will work on bringing that to completion in 2018.

The ED participated in a site visit from Kevin Patterson, the CEO of Connect for Health Colorado (Colorado's health insurance exchange), who shared that he considered Larimer Health Connect a model for the state.

Community/State/Education

In the community, the ED continued to participate in meetings of the local MACC (Medicaid Accountable Care Collaborative) Oversight Committee, which is closely tracking the changes to come in 2018 when the Regional Care Coordinating Organizations (RCCOs) change to Regional Accountable Entities (RAEs), and take on the managed care of behavioral health services in addition to medical services. In this quarter, it was announced that Larimer County will remain in Region 1, and that Rocky Mountain Health Plans (the former RCCO) won the bid, which is considered promising news by the MACC members since RMHP has the reputation of a good partner that pays close attention to community needs. The evaluation of the MACC project is in progress and the report expected in the first half of 2018.

The ED also participates locally in the Northern Colorado Health Sector Partnership, the Mental Health and Substance Use Alliance, the local Opioid Workgroup, and a new local Health Care Working Group comprised of local leaders and developed by former state senator and former HCPF Director Steve Tool. She participates in regular meetings with the CEOs of UCHealth North, Salud, and SummitStone Health Partners, and was requested to join the Advisory Committee of the Homeward 2020 organization.

The TIF (tax increment financing) Intergovernmental Agreement committee continued to meet in this quarter, developing a draft IGA to be sent to participating organizations' attorneys for review & comment in preparation of proposing a final IGA to all boards in spring 2018.

At the State level, the ED continues to participate in the PIAC (state advisory committee to the Medicaid accountable care changes), and as a chair of the PIAC's Improving and Bridging Systems Committee. The PIAC IBS Committee was restructured in this quarter, with a new focus on improving and bridging systems between Medicaid and Criminal Justice (which also involves considerable attention to substance use disorders), and between those who are eligible for both Medicaid and Medicare (who often have high needs).

The ED also participated in the state Hot Issues in Health Care Conference, the CBHC (Colorado Behavioral Health Council) conference, and attended a Special District Association (SDA) training on Health District Governance.

At the national level, she attended the APHA conference (American Public Health Association).

HEALTH DISTRICT
of Northern Larimer County
March 2018
Summary Financial Narrative

Revenues

The Health District is 7.1% ahead of year-to-date tax revenue projections. Interest income is 24.2% ahead of year-to-date projections. Lease revenue is at year-to-date projections. Yield rates on investment earnings increased slightly from the previous month from 1.47% to 1.67% (based on the weighted average of all investments). Fee for service revenue from clients is 8.9% behind year-to-date projections and revenue from third party reimbursements is 18.2% behind year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are 5.2% ahead of year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 14.5% behind year-to-date projections. Program variances are as follows: Administration 8.4%; Board 65.2%; Connections: Mental Health/Substance Issues Services 27.0%; Dental Services 15.2%; Integrated Care 9.1%; Health Promotion 11.3%; Community Impact 4.2%; Program Assessment and Evaluation 7.5%; Health Care Access 13.3%; HealthInfoSource 10.9%; and Resource Development 9.9%.

Capital Outlay

No capital expenditures have been made year-to-date.

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 3/31/2018

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	$753,791.92
Deposits	1,000.00
Deferred Revenue	453,426.78
Total Current Liabilities	1,208,218.70
Long-term Liabilities:	
Compensated Absences Payable	15,410.00
Total Long-term Liabilities	15,410.00
Deferred Inflows of Resources	
Deferred Property Tax Revenue	4,098,686.48
Total Deferred Inflows of Resources	4,098,686.48
Total Liabilities & Deferred Inflows of Resource	5,322,315.18
EQUITY	
Retained Earnings	13,688,915.65
Net Income	1,300,369.20
Total Equity	14,989,284.85
Total Liabilities & Equity	$20,311,600.03

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 3/31/2018

LIABILITIES AND EQUITY

Current Liabilities:	
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Total Current Liabilities	1,208,218.70
Long-term Liabilities:	
Compensated Absences Payable	15,410.00
Total Long-term Liabilities	15,410.00
Deferred Inflows of Resources	
Deferred Property Tax Revenue	4,098,686.48
Total Deferred Inflows of Resources	4,098,686.48
Total Liabilities & Deferred Inflows of Resource	5,322,315.18
EQUITY	
Retained Earnings	13,688,915.65
Net Income	1,300,369.20
Total Equity	14,989,284.85
Total Liabilities & Equity	$20,311,600.03

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENSES

For 1/1/2018 To 3/31/2018

	Current Month	Year to Date
Revenue:		
Property Taxes	$464,184.47	$3,089,744.52
Specific Ownership Taxes	51,444.58	154,281.98
Lease Revenue	88,491.25	265,473.75
Interest Income	9,920.67	24,842.53
Sales Revenue	68.51	133.58
Fee For Services Income	19,033.48	49,875.85
Third Party Reimbursements	78,661.80	207,861.72
Grant Revenue	104,672.22	184,438.69
Partnerships	7,274.03	16,962.40
Miscellaneous Income	12,794.97	22,603.71
Gain on Investment	0.00	1,239.15
Total Revenue	836,545.98	4,017,457.88
Expenses:		
Operating Expenses		
Administration	$61,767.22	$217,486.94
Board Expenses	1,511.60	3,338.15
Connections: MentalHealth/Substance Issues Svcs	121,243.95	297,724.08
Dental Services	309,587.76	882,376.81
Integrated Care (MHSA/PC)	89,786.95	257,438.41
Health Promotion	66,870.25	192,725.33
Community Impact	53,325.03	159,179.12
Program Assessment & Evaluation	17,727.37	49,790.09
Health Care Access	84,012.93	251,779.34
HealthInfoSource	6,966.23	19,433.81
Resource Development	14,320.00	39,860.95
Special Projects	59,523.87	161,177.18
Grant Projects	63,061.69	184,778.47
Total Operating Expenses	949,704.85	2,717,088.68
Depreciation and Amortization		
Total Depreciation and Amortization	0.00	0.00
Total Expenses	949,704.85	2,717,088.68
Net Income	($113,158.87)	$1,300,369.20

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Revenue:								
Property Taxes	$365,889	$464,184	$98,295	$2,910,194	$3,089,745	$179,551	$7,188,431	$4,098,686
Specific Ownership Taxes	35,251	51,445	16,194	119,465	154,282	34,817	580,000	425,718
Lease Revenue	88,491	88,491	0	265,474	265,474	0	1,083,133	817,659
Interest Income	6,667	9,921	3,254	20,001	24,843	4,842	80,000	55,157
Sales Revenue	27	69	42	81	134	53	325	191
Fee For Services Income	22,668	19,033	(3,635)	54,753	49,876	(4,877)	234,606	184,730
Third Party Reimbursements	86,597	78,662	(7,935)	254,179	207,862	(46,317)	943,354	735,492
Grant Revenue	143,959	104,672	(39,287)	431,876	184,439	(247,437)	1,695,319	1,510,880
Partnership Revenue	3,708	7,274	3,566	11,125	16,963	5,838	44,498	27,535
Miscellaneous Income	1,661	12,795	11,134	4,982	22,604	17,622	19,930	(2,674)
Gain on Investment	0	0	0	0	1,239	1,239	0	(1,239)
Total Revenue	$754,918	$836,546	$81,628	$4,072,130	$4,017,461	($54,669)	$11,869,596	$7,852,135
Expenditures:								
Operating Expenditures								
Administration	68,492	61,767	6,725	237,459	217,487	19,972	825,915	608,428
Board Expenses	3,095	1,480	1,615	9,286	3,271	6,015	46,476	43,205
Election Expenses	300	32	268	300	67	233	18,000	17,933
Connections: Mental Health/Substance Issues Sv	135,704	121,244	14,460	407,959	297,725	110,234	1,564,904	1,267,179
Dental Services	335,464	309,587	25,877	1,040,494	882,377	158,117	3,847,166	2,964,789
Integrated Care (MHSA/PC)	93,619	89,787	3,832	283,282	257,438	25,844	1,083,230	825,792
Health Promotion	73,722	66,870	6,852	217,350	192,725	24,625	826,433	633,708
Community Impact	55,164	53,325	1,839	166,191	159,179	7,012	635,016	475,837
Program Assessment & Evaluation	17,676	17,727	(51)	53,853	49,790	4,063	205,411	155,621
Health Care Access	96,363	84,013	12,350	290,311	251,780	38,531	1,101,355	849,575
HealthInfoSource	6,907	6,967	(60)	21,810	19,434	2,376	82,850	63,416
Resource Development	14,681	14,320	361	44,247	39,861	4,386	169,844	129,983
Contingency (Operations)	0	0	0	0	0	0	239,000	239,000
Special Projects	155,411	59,524	95,887	465,936	161,178	304,758	1,879,519	1,718,341
Grant Projects	143,959	63,062	80,897	431,876	184,778	247,098	1,695,319	1,510,541
Total Operating Expenditures	1,200,557	949,705	250,852	3,670,354	2,717,090	953,264	14,220,438	11,503,348
Net Income	($445,639)	($113,159)	$332,480	$401,776	$1,300,371	$898,595	($2,350,842)	($3,651,213)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Non-Operating Expenditures								
Building	0	0	0	0	0	0	3,020,000	3,020,000
General Office Equipment	0	0	0	20,000	0	20,000	20,000	20,000
Medical & Dental Equipment	0	7,800	(7,800)	7,830	7,800	30	13,797	5,997
Computer Equipment	0	0	0	11,600	0	11,600	11,600	11,600
Computer Software	0	0	0	0	0	0	7,300	7,300
Furniture	0	0	0	0	0	0	10,000	10,000
Total Non-Operating Expenditures	0	7,800	(7,800)	39,430	7,800	31,630	3,082,697	3,074,897

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Administration								
Revenue:								
Miscellaneous Income	$792	$10,503	$9,711	$2,375	$19,237	$16,862	$9,500	($9,737)
Total Revenue	$792	$10,503	$9,711	$2,375	$19,237	$16,862	$9,500	($9,737)
Expenditures:								
Salaries and Benefits	42,815	43,967	(1,152)	128,446	123,354	5,092	513,783	390,429
Supplies and Purchased Services	25,677	17,800	7,877	109,013	94,133	14,880	312,132	217,999
Total Expenditures	$68,492	$61,767	$6,725	$237,459	$217,487	$19,972	$825,915	$608,428
Board of Directors								
Expenditures:								
Salaries and Benefits	$0	$0	$0	$0	$0	$0	$8,632	$8,632
Supplies and Purchased Services	3,096	1,480	1,616	9,286	3,271	6,015	37,844	34,573
Election Expenses	300	32	268	300	67	233	18,000	17,933
Total Expenditures	$3,396	$1,512	$1,884	$9,586	$3,338	$6,248	$64,476	$61,138
Community Impact								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$46,388	$47,456	($1,068)	$139,165	$140,515	($1,350)	$556,661	$416,146
Supplies and Purchased Services	8,776	5,868	2,908	27,026	18,664	8,362	78,355	59,691
Total Expenditures	$55,164	$53,324	$1,840	$166,191	$159,179	$7,012	$635,016	$475,837

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Program Assessment & Evaluation								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$14,997	$15,934	($937)	$44,992	$44,138	$854	$179,969	$135,831
Supplies and Purchased Services	2,679	1,793	886	8,861	5,651	3,210	25,442	19,791
Total Expenditures	$17,676	$17,727	($51)	$53,853	$49,789	$4,064	$205,411	$155,622
Connections: Mental Health/Substance Issue								
Revenue:								
Fees, Reimbursements & Other Income	$2,080	$1,389	($691)	$6,240	$4,135	($2,105)	$24,960	$20,825
Total Revenue	$2,080	$1,389	($691)	$6,240	$4,135	($2,105)	$24,960	$20,825
Expenditures:								
Salaries and Beneftis	$106,720	$81,639	$25,081	$320,159	$219,426	$100,733	$1,280,635	$1,061,209
Supplies and Purchased Services	28,984	39,605	(10,621)	87,800	78,298	9,502	284,269	205,971
Total Expenditures	$135,704	$121,244	$14,460	$407,959	$297,724	$110,235	$1,564,904	$1,267,180
Dental Services								
Revenue:								
Fees, Reimbursements & Other Income	$103,992	$94,400	($9,592)	$293,114	$248,056	($45,058)	$1,114,692	$866,636
Total Revenue	$103,992	$94,400	($9,592)	$293,114	$248,056	($45,058)	$1,114,692	$866,636
Expenditures:								
Salaries and Benefits	$246,118	$249,823	($3,705)	$738,353	$686,272	$52,081	$2,953,411	$2,267,139
Supplies and Purchased Services	89,347	59,764	29,583	302,142	196,105	106,037	893,755	697,650
Total Expenditures	$335,465	$309,587	$25,878	$1,040,495	$882,377	$158,118	$3,847,166	$2,964,789

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Integrated Care (MHSA/PC)								
Revenue:								
Fees, Reimbursements & Other Income	$2,917	$3,419	$502	$8,750	$6,803	($1,947)	$35,000	$28,197
Total Revenue	$2,917	$3,419	$502	$8,750	$6,803	($1,947)	$35,000	$28,197
Expenditures:								
Salaries and Benefits	$79,098	$82,078	($2,980)	$237,295	$227,736	$9,559	$949,180	$721,444
Supplies and Purchased Services	14,455	7,698	6,757	45,791	28,733	17,058	133,264	104,531
Total Expenditures	$93,553	$89,776	$3,777	$283,086	$256,469	$26,617	$1,082,444	$825,975
Health Promotion								
Revenue:								
Fees, Reimbursements & Other Income	$1,172	$835	($337)	$3,516	$2,093	($1,423)	$14,063	$11,970
Total Revenue	$1,172	$835	($337)	$3,516	$2,093	($1,423)	$14,063	$11,970
Expenditures:								
Salaries and Benefits	$52,710	$52,579	$131	$158,129	$145,180	$12,949	$632,516	$487,336
Supplies and Purchased Services	21,013	14,291	6,722	59,221	47,546	11,675	193,917	146,371
Total Expenditures	$73,723	$66,870	$6,853	$217,350	$192,726	$24,624	$826,433	$633,707

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 3/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Health Care Access								
Revenue:								
Fees, Reimbursements & Other Income	$0	$13	$13	$0	$152	$152	$0	($152)
Total Revenue	$0	$13	$13	$0	$152	$152	$0	($152)
Expenditures:								
Salaries and Benefits	$72,715	$74,685	($1,970)	$218,144	$206,710	$11,434	$872,574	$665,864
Supplies and Purchased Services	23,648	9,327	14,321	72,168	45,070	27,098	228,781	183,711
Total Expenditures	$96,363	$84,012	$12,351	$290,312	$251,780	$38,532	$1,101,355	$849,575
Health Info Source								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$4,989	$5,255	($266)	$14,966	$14,270	$696	$59,865	$45,595
Supplies and Purchased Services	1,918	1,712	206	6,844	5,164	1,680	22,985	17,821
Total Expenditures	$6,907	$6,967	($60)	$21,810	$19,434	$2,376	$82,850	$63,416
Resource Development								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$12,048	$13,127	($1,079)	$36,144	$35,662	$482	$144,574	$108,912
Supplies and Purchased Services	2,633	1,193	1,440	8,103	4,199	3,904	25,270	21,071
Total Expenditures	$14,681	$14,320	$361	$44,247	$39,861	$4,386	$169,844	$129,983

Health District of Northern Larimer County

Investment Schedule
March 2018

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	$ 1,329	0.018%	1.55%	N/A
Local Government Investment Pool	COLOTRUST	$ 5,724,769	77.452%	1.85%	N/A
Local Government Investment Pool (Children's Oral Health Care Assistance Fund)	COLOTRUST	$ 8,003	0.108%	1.85%	N/A
Local Government Investment Pool (Oral Health Care Assistance Fund)	COLOTRUST	$ 22,633	0.306%	1.85%	N/A
Flex Savings Account	First National Bank	$ 289,726	3.920%	0.90%	N/A
Certificate of Deposit - #714626	Advantage Bank	$ 134,770	1.823%	0.80%	6/27/2018
Certificate of Deposit - #742487	Advantage Bank	$ 107,911	1.460%	1.39%	9/2/2019
Certificate of Deposit - #35083766	First National Bank	$ 110,808	1.499%	1.35%	9/6/2019
Certificate of Deposit - #40010527	Points West	$ 111,425	1.507%	0.80%	6/4/2018
Certificate of Deposit - #40010448	Points West	$ 150,853	2.041%	0.80%	4/2/2018
Certificate of Deposit - #23002918	Adams State Bank	$ 229,145	3.100%	1.29%	10/7/2019
Certificate of Deposit - #824149	Cache Bank & Trust	$ 250,000	3.382%	0.80%	12/27/2018
Certificate of Deposit - #1100000578	Farmers Bank	$ 250,000	3.382%	1.20%	6/27/2018
Total/Weighted Average		$ 7,391,372	100.000%	1.67%	

Notes:

The local government investment pool invests in U.S. Treasury securities, U.S. Government agency securities, certificate of deposits, commercial paper, money market funds and repurchase agreements backed by these same securities.

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING
March 27, 2018

Health District Office Building
120 Bristlecone Drive, Fort Collins

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., President
Tracy L. Nelson, Ph.D., Vice President
Deirdre Sullivan, Secretary
Faraz Naqvi, M.D., Treasurer

BOARD MEMBERS ABSENT: Tess Heffernan, Liaison to UCHealth-North/PVHS Board

Staff Present:

Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Richard Cox, Communications Director
Rosie Duran, Larimer Health Connect
Lorraine Haywood, Finance Director
Devin Kepler, Larimer Health Connect
Laura Mai, Finance
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Board & ED
Sarah Tilleman, Dental Services Director
Lin Wilder, Community Impact Director
Alyson Williams, Policy Coordinator

CALL TO ORDER; APPROVAL OF AGENDA
President Michael Liggett called the meeting to order at 4:00 p.m. There were no changes to the meeting agenda. Ms. Heffernan was excused from the meeting.

PUBLIC COMMENT
No comments.

PRESENTATIONS
Larimer Health Connect: Results of Last Open Enrollment and Future
Ms. Karen Spink, Assistant Director, introduced Ms. Rosie Duran and Mr. Devin Kepler, Co-Supervisor Leads for the Health District's Larimer Health Connect program, noting that they have been very instrumental to the success of the program.

For this latest open enrollment period, Larimer Health Connect staff served more people in an open enrollment period that was 19 days shorter than last year. Specifically, they served 1,092 households in 1,692 encounters, resulting in at least 914 people being enrolled in either Medicaid/CHP+ or a marketplace health plan. Total marketplace enrollments overall in Larimer

County were down 3% when compared to the previous enrollment period, but when compared with other similar counties that also saw a decrease, Larimer County had the least.

Other successes for the Larimer Health Connect program: 59% of customers were repeat customers (the health insurance system is still changing each year, is complex, and people have questions and need assistance); there was increased efficiency with problem solving (staff had access to support at the state level that did not exist before); the program increased availability with extended hours (more evening appointments available as well as some weekend hours); and also added a few "walk-in only" days. While there were amazing successes, some things created challenges, including: the volume of clients to be served in the shortened enrollment period; 95% of customers assisted by our program were enrolled in financial assistance; while the system improves every year, there remain some problems with glitches; and staff needed to provide post-enrollment troubleshooting to address issues on the carrier side.

Larimer Health Connect staff received a 97% customer satisfaction rate and clients consistently expressed their gratitude for the assistance. Since most of our customers receive financial assistance, they saw very little increase, if any, in premiums – while premiums increased, so did tax credits.

One of the remaining problems with the health system is the "family glitch" – the part of the regulations that state that if a person is eligible for employer-sponsored health insurance, and the cost of the insurance is affordable for the employee, the family cannot qualify for financial assistance for health insurance purchased on the exchange, even if family coverage is not affordable. Another big challenge is those who are "functionally uninsured" - who choose policies with the lowest premiums, but then have cost sharing costs for deductibles, copays, and coinsurance that is too high for them to afford. Carrier pricing drives people to different payers, which means that customers often have to change doctors. A silver lining for some was Colorado's buy-in program for 'working adults with disabilities,' which allows access to the Medicaid program for qualified individuals.

In the interim between open enrollment periods, Larimer Health Connect staff work on enrollments for those qualified to enroll year round, continue outreach activities (including a targeted Latino outreach effort), are working on a health insurance literacy program to help people understand how to use their insurance which will include Health Coverage User's Manual. Future issues: the next open enrollment period will be even shorter, at just 6 weeks. Staff will be submitting a grant application for continued funding from Connect for Health Colorado. Staff are considering having trained counselors who can help clients who are aging into Medicare, but only if it works with the existing Medicare Assistance System (SHP). There continues to be uncertainty about the stability of the marketplace and Medicaid. Connect for Health plans to develop a new eligibility system that will not be so tied to Medicaid eligibility, and staff will be assisting with the testing of the new system.

DISCUSSION AND ACTIONS

Policy

Federal Issues:

- **The Omnibus Spending Bill** was recently passed. The bill is 2,232 pages and includes $1.3 billion in spending. Included in the bill are increases in funding for Mental Health Block

Grants, Substance Abuse and Prevention and Treatment Block Grants, Mental Health First Aid, funding for NIH to research addiction and non-opioid alternatives, and a boost in the Affordable Housing Tax Credits. Of particular import of what was left out is funding for health insurance marketplace stabilization, including reinsurance, risk corridors, or cost-sharing reductions.

- **White House Opioid Plan** - The plan is not comprehensive, but does list several positive actions – though without providing explanations as to how they might be accomplished or paid for. It recommends such changes as expanding naloxone to first responders, providing screening and treatment for federal inmates, increasing access to drug courts and to medication assisted treatment, and changing the IMD law that restricts Medicaid funding for residential substance use disorder treatment.

State Issues:

The legislative session has been in session for 77 days; 566 bills have been introduced; 103 of them postponed indefinitely (PI'd) and 79 bills have been passed. Ms. Williams gave a quick run-down on the status of the House and Senate bills for which the Board has taken previous positions. Also reviewed were two bills which saw substantial amendments: HB18-1003: Opioid Misuse Prevention and HB18-1007: SUD Payment/Coverage.

New Bills for Board Consideration

- **HB18-1284: Disclosure of Prescription Costs at Pharmacies** – Would prohibit insurance carriers and pharmacy benefit managers from prohibiting a pharmacy or pharmacist from providing a covered individual with information regarding the amount they will have to pay or the clinical efficacy of affordable alternative drugs ("gag clause"). The bill also prohibits carriers and PBMs from requiring the pharmacy to charge a copayment that exceeds the total charges that are submitted by the pharmacy ("clawbacks").

  MOTION: To SUPPORT HB18-1284.
  Motion/Seconded/Carried Unanimously

- **HB18-1279: Electronic Prescribing of Controlled Substances** – would require podiatrists, dentists, physicians, physician assistants, advanced practice nurses, and optometrists to prescribe controlled substances only through electronic prescribing, with some exceptions. Prescribers must comply with this requirement by July 1, 2020 and would report their compliance through the license renewal process. Right now in Colorado, physicians can, but are not required, to prescribe controlled substances electronically. Some of the benefits to e-prescribing include avoidance of drug interactions, access to information more quickly, decreased likelihood of abuse, less incidence of stolen prescriptions pads, etc.

  MOTION: To SUPPORT HB18-1279.
  Motion/Seconded/Carried Unanimously

- **SB18-214: Request Self-Sufficiency Waiver for Medicaid Program** – This bill directs the Colorado Department of Health Care Policy and Finance to develop and submit an application for a Section 1115 Medicaid waiver to implement certain provisions as a part of Colorado's Medicaid program. Per the bill, the waiver application must include: the requirement for able-bodied adults, with stipulated exceptions, to work, seek work, attend job training, or volunteer for Medicaid eligibility; able-bodied adults must verify their income on a monthly basis for eligibility; there would be a life-time limit of five years on Medicaid

benefits; and HCPF may also impose copayments to deter use of emergency departments and ambulance services for nonemergent services. Board and staff expressed concerns that this bill would be very costly to implement, does not take into consideration other reasons for people to be unable to work (for example, care of a family member who, if not cared for at home, would require much more costly care in a nursing home), does not account for those whose age and serious chronic conditions impact their ability to work, and in general could have unintended major consequences for many people who need Medicaid for their health needs, costing the state even more.

MOTION: To STRONGLY OPPOSE SB18-214.
Motion/Seconded/Carried Unanimously

Revisions to Employee Handbook
A copy of the Employee Handbook and proposed changes was presented to the Board for their review and consideration. Every other year the Employee Handbook is reviewed to ensure that it is up to date with current employment laws and that the information provided in the Handbook is clear and easy to understand. President Liggett recommended some revisions to reduce ambiguities, and those revisions were provided to the Board.

MOTION: To approve the Employee Handbook revisions as presented.
Motion/Seconded/Carried Unanimously

Larimer County Community Health Improvement Plan Priorities
Recently, as part of the process of developing their 2018 Community Health Improvement Plan, the Larimer County Department of Public Health and Environment held a Healthy Larimer Summit, a day long public event focused on looking at community health data, identifying and prioritizing community health needs, and learning about community resources. At the summit, community partners worked together to identify and prioritize community health needs. After the Summit, the rankings of these priorities were evaluated and after consulting with leaders representing government, healthcare, and large non-profit entities, and taking into consideration funding and capacity, the Health Department identified two priorities: Promoting Mental and Emotional Well-being and Access to Quality Childcare.

In a related issue, however, Ms. Sullivan noted that SNAP (formerly the food stamp program) enrollment is an issue in Larimer County, which Larimer County ranks 9th out of the 10 largest counties in Colorado for the number of people eligible for the program but not enrolled. The Health District is starting to investigate whether it might be possible for Larimer Health Connect staff to be 'deputized' by Larimer County to perform SNAP interviews (staff already help people apply through the electronic application process) to help people enroll more expeditiously.

Update on URA Board, Special District Membership
Efforts are underway to select a board member from a special district to participate on the local Urban Renewal Authority (URA) Board. The proposed process for assigning a special district member representative for the URA Board is to include interviews with interested candidates to learn their interests, background and level of interest in participating as a member of the URA Board. The interviews will be conducted by a staff and board member from each interested organization, plus a person from the County. At this time, there are only two special districts interested – the Poudre River Library District and the Health District. The board members from each board whom have expressed interest in representing are Mr. Joe Weiss (Library District)

and Ms. Deirdre Sullivan (Health District). The goal is that whomever is chosen be dedicated, knowledgeable of the process, and able to keep the other affected special district informed. The Board expressed support for this process and supported having Mr. Sheafor be the Health District staff member on the interview panel.

UPDATES & REPORTS

New Board Members (May 22); Cancellation of Elections

At one time there were four nominees for this year's board elections. By the deadline for nomination applications, however, Ms. Tess Heffernan had withdrawn her nomination, which left three nominees for the three open positions, allowing the Elections Official to cancel the elections. The new board members are incumbent Mike Liggett, and new members Dr. Joseph Prows and Dr. Molly Gutilla. An orientation for the new members has been scheduled for May 21. Mr. Sheafor will swear in the new members at the May 22 board meeting and elections for board officers will be held at the June meeting.

Executive Director Updates and Other Updates

It was announced that Ms. Sarah Tilleman, the Dental Services Director, will be leaving the Health District very soon. She has accepted a position with the American Dental Association in Chicago, Illinois as a Senior Manager of Credentialing and Third-Payer Party advocacy. Staff and Board expressed their appreciation to Ms. Tilleman for her work at the Health District and wished her well as she goes forward.

Other updates: Supervisors and Directors are almost finished with the personnel review process; and Ms. Wilder announced that a part-time project manager has been hired for the Healthinfosource project to help move forward on the next steps, which include conducting focus group meetings to determine user needs and preferences; and that the vendor "Nerdy Minds" has been selected to develop the blueprint and options.

UCHealth-North/PVHS Board Liaison Report

Since Ms. Heffernan is absent, there was no report.

PUBLIC COMMENT (2nd opportunity)

None.

CONSENT AGENDA

- Approval of February 27 Board Meeting Minutes.
- Approval of the January and February 2018 Financials.

MOTION: To approve the Consent Agenda as presented.
Motion/Seconded/Carried Unanimously

DECISION

- Approval of the February 21 (Joint Board Meeting) and March 13, 2018 Board Meeting Minutes.

MOTION: To approve the February 21 meeting minutes as presented.
Motion/Seconded/Carried (Sullivan abstained)

MOTION: To approve the March 13 meeting minutes as presented.

Motion/Seconded/Carried (Sullivan and Nelson abstained)

ANNOUNCEMENTS

- April 10, 4:00 pm, Board of Directors Special Meeting
- May 1, 4:00 pm, Board of Directors Regular Meeting (moved from April 24; extended)
- May 16, Rethinking Addiction Kickoff (SUD transformation project),7:00 p.m.

Board members were encouraged to attend one of the May 16 "Rethinking Addiction" public awareness events. The event is a Kickoff for a special project funded by the Colorado Health Foundation to begin to transform how the community perceives and tackles substance use disoders, and includes a breakfast for primary care providers and other healthcare providers and an evening event for community members.

EXECUTIVE SESSION

A motion was made to go into Executive Session.

MOTION: For the purpose of discussion pertaining to personnel issues pursuant to §24-6-402(4)(f) of the C.R.S. (Executive Director review)
Motion/Seconded/Carried Unanimously

The Board retired to Executive Session at 5:25 p.m.
The Board came out of Executive Session at 6:00 p.m.

ADJOURN

MOTION: To adjourn the meeting.
Moved/Seconded/Carried Unanimously

The meeting was adjourned at 6:01 p.m.

Respectfully submitted:

Nancy Stirling, Assistant to the Board of Directors

Michael Liggett, President

Tracy Nelson, Vice President

Deirdre Sullivan, Secretary

Faraz Naqvi, M.D., Treasurer

[ABSENT from the March 27, 2018 meeting]
Tess Heffernan, UCHealth-North (PVHS) Board Liaison

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS
SPECIAL MEETING
April 10, 2018

Health District Office Building
120 Bristlecone Drive, Fort Collins

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., President
Tracy L. Nelson, Ph.D., Vice President
Deirdre Sullivan, Secretary
Faraz Naqvi, M.D., Treasurer
Tess Heffernan, Liaison to UCHealth-North/PVHS Board

Staff Present:
Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Richard Cox, Communications Director
Lorraine Haywood, Finance Director

Others Present:
Sue Hewitt, Evaluation Coordinator
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Board & ED
Lin Wilder, Community Impact Director
Alyson Williams, Policy Coordinator

CALL TO ORDER; APPROVAL OF AGENDA
President Michael Liggett called the meeting to order at 4:01 p.m. There were no changes to the meeting agenda.

PUBLIC COMMENT
None**.**

BOARD DECISION
Pay for Success/Frequent Utilizer Approach – Spending Approval
Ms. Lin Wilder, Community Impact Director, reviewed with the board the concept of utilizing the Pay for Success model to develop a more effective approach for those who are frequent utilizers of health and criminal justice systems, but for whom much of the utilization could be avoided with proper prevention and treatment.

"Pay for Success" (PFS) is a performance-based funding mechanism in which a critical unmet need in social services is identified, and an investor (usually foundations or private philanthropic funds, in an approach similar to venture capital) agrees to invest funds in an innovative program designed to have a significant impact on the need. The investor is paid back by a specified government entity, but only if the specified results are achieved. The process encourages innovation and rigorous evaluation, shifts the financial and political risk of setting up a new

program to an outside funder, and provides a longer funding window than grants (usually 5-7 years).

The project being considered by our community focuses on individuals who seem to have a continuous "revolving door" through services – law enforcement & criminal justice system, shelters, ambulance, detox, emergency rooms, etc. – and would work to implement various interventions to better address their needs. There are 4 phases to the project:

- **Phase 1: Frequent Utilizer Study** – to determine the characteristics, needs, service utilization of frequent utilizers and how much their service utilization costs the community (completed; results included: 9 of 10 of those who had 4 or more bookings into the jail had a substance use disorder; 155 people had costs of at least $2M; of that, only $240,000 was for treatment; the rest was for acute/crisis services).
- **Phase 2: Intervention Planning and Feasibility Study** – apply study recommendations, identify potential interventions, estimate how interventions may impact utilization and associated costs, and determine potential feasibility for Pay for Success (completed; conclusion was that a feasible project with good cost/benefit was likely).
- **Phase 3: Administrative Data Pilot** (TA Grant) – determine how to share data, how to overcome barriers to data collection, analysis, sharing and utilization, and put into place necessary processes, agreements, releases, etc. (current stage)
- **Potential Phase 4: Structuring Pay for Success Project** – determine who are potential investors, potential payers, how contracts may be structured, contracting, and implementation.

To complete Phase 3, the Administrative Data Pilot, we have been approved for a technical assistance grant, but there is a requirement for a cash grant match of $12,000. Staff is requesting permission from the Board to put up the grant match with some of the funds already set aside in the 2018 Reserves budget for the Frequent Utilizer Project.

MOTION: To approve the expenditure of up to 12,000 of the $25,000 currently in Reserves for the Frequent Utilizer project for the Administrative Data Pilot Phase for a potential Pay for Success project focused on frequent utilizers of the health and criminal justice systems.
Moved/Seconded/Carried Unanimously

What Would it Take? Solutions to Mental Health Gaps in Larimer County
Ms. Wilder distributed copies of the recently updated report on what it would take to fill the gaps in mental health services. Staff will move next to developing an outreach plan and materials to get the information out to the public. The Board expressed their support of these efforts and asked staff to consider how the Board and others might be able to support efforts to get the word out to the community, and encouraged a set of unified messages.

DISCUSSION AND ACTIONS

Policy

Federal Issues

- **Opioid Bills** – There are many bills coming out addressing opioids. Ms. Williams highlighted the following:
  - ***The Opioid Crisis Response Act of 2018*** – The Senate HELP Committee will be holding a hearing tomorrow on this legislation which comes from 6 hearings on the opioid crisis

with a variety of stakeholders. The legislation is the most comprehensive, but does not have a price tag. It includes provisions for various agencies as they pertain to opioids, including: the National Institutes of Health (NIH) for research, the US Food & Drug Administration (FDA) regarding packaging and safe disposal, the Substance Abuse and Mental Health Services Administration (SAMHA) for comprehensive opioid recovery centers, the Centers for Disease Control (CDC) for controlled substance data collection, the Drug Enforcement Administration (DEA) for telemedicine regulations and new rules regarding medication assisted treatment, and the Health Resources and Services Administration (HRSA) for education and training for providers. This is a bi-partisan, well thought-through effort. Once it is further along, staff will bring back more details.

- ***House Energy and Commerce Committee*** - This Committee has 34 individual bills coming out; unlike the Senate approach, they are disparate and piecemeal. Bills tackle opioids in areas such as: education (non-opioid alternatives; opioid prescribing rates), data/research (accessing abuse-deterrent opioids; behavioral health measures), insurance (CHP, Medicaid, Medicare), and technology (incentivize EHRs).
- ***Senate Finance Committee*** – The Senate Finance Committee has also expressed interest in this topic and is expected to present some legislation in the next couple of weeks. Policy categories identified include: how federal programs could be adapted to better address substance abuse; facilitation of prescriber and patient education; utilization of non-opioid treatments for managing pain; and improving data-sharing by enhancing how state PDMPs interact with Medicare and Medicaid. There is a push for ideas with bipartisan support, and with little or no costs or identified offsets.

- **The 2018 Farm Bill** – The text for the proposed Farm Bill was expected to be released before the Easter break but was not. The Farm Bill authorizes most federal policies that govern food and agriculture programs. There are 12 titles that deal with nutrition programs, crop insurance, conservation programs, and commodity programs and include both mandatory funding and discretionary funding. Title IV is the Nutrition Title and includes programs such as SNAP (Supplemental Nutrition Assistance Program – mandatory funding), TEFAP (The Emergency Food Assistant Program – mandatory funding) with administrative costs coming from discretionary funds, and CSFP (Commodity Supplemental Food Program – discretionary funding). The Senate Agriculture has agreement and bipartisan support and wants to get this done so families can get what they need. It is likely that there will be a bill from the Senate in the next month. The House, on the other hand, is seeing a lot of disagreement and some members wanting to make a lot of changes. Their bill will likely come out after the Senate's. The "asks" by anti-hunger groups include: Congress should protect SNAP; strengthen SNAP; increase benefit allotments; ameliorate time limits on SNAP benefits for jobless; increase mandatory funding ceiling for TEFAP.

  Ms. Sullivan raised a question as to who in Larimer County will lead advocacy around this issue, noting that while there is some advocacy at the State level, there is little at the local level. Staff will reach out to other interested organizations, such as the Food Bank, to determine interest; likely after the Colorado session is over.

State Issues

As of today, we are 91 days into this legislative session (29 days left); 599 bills have been introduced; 116 bills postponed indefinitely (PI'd), and 125 bills have passed. Ms. Williams reviewed the status of some of the bills the Board has taken previous positions.

- *HB18-1182: Advanced Directives Registry* (Board Supported) – failed in House Committee.
- *HB18-1184: Disclosure of Rx Costs at Pharmacies* (Board Supported) – passed House and is on to Senate Health Committee.
- *SB18-214: Medicaid Work Requirements* (Board Strongly Opposed) – failed in Senate Committee.
- *SB18-108: iDrive* (Board Supported) – in House Appropriations; passed Senate and House Committees.
- *SB18-132: 1332 Waiver Catastrophic Health Plans* (Board Opposed) – passed Senate and passed out of House Committee.

The Long Bill – HB18-1322 – Ms. Williams reviewed a few House and Senate amendments. Both provide funding for Suicide Prevention ($400,000); Medical Marijuana Research ($3M); SB16-202 Programs – MSOs addressing SUDs ($3M); Circle Program (H: $6M, 2 new locations; S: $3M in "Northeastern CO"); Peace Officers' mental health ($2M). The House adds funding for behavioral health crisis response system ($400,000) and to the Tony Grampsas Youth Services grants ($1M). Items that failed in the House: funds to provide wraparound services during 72-hour holds; eliminate funding for 1 year of contraception through Medicaid; eliminate funding for Healthy Kids Colorado Survey; and eliminate funding for Medicaid expansion. Items that failed in the Senate: $400,000 to behavioral health crisis response system; funds to promote NEMT efficiency; $12.5M to CCAP to serve more kids; and funds to build a mental health hospital in Denver. Next step for the Long Bill is Joint Budget Committee conference committee.

New Bills for Board Consideration

- **HB18-1311: Single Geographic Rating Area Individual Health Plan** – This bill prohibits insurance carriers from considering the geographic location of the policyholder for individual health plans issued, amended, or renewed on/after January 1, 2019. This requirement creates a single geographic rating area for the entire state for individual health plans. Staff recommends that the Board oppose this legislation, largely on the grounds that while it may lower costs for higher cost areas (i.e., mountain communities), it will likely increase costs everywhere else in the state. And if it raises costs, more people will drop out of health care coverage.

  MOTION: To OPPOSE HB18-1311.
  Moved/Seconded/Carried Unanimously

- **HB18-1313: Pharmacists to Serve as Practitioners** – This bill clarifies that a pharmacist may serve as a practitioner and prescribe over-the-counter medications (Medicaid), and may also utilize a statewide drug therapy protocol pursuant to a collaborative pharmacy practice agreement.

  MOTION: To SUPPORT HB18-1313.
  Moved/Seconded/Carried Unanimously

Ms. Sullivan inquired about whether the Health District is involved with the City of Fort Collins City Plan efforts. Ms. Spink was invited to participate in outreach and engagement efforts which

would select individuals to work on the actual City Plan, but that did not seem the best match for the Health District. Staff will look for other opportunities that would be more appropriate for our involvement. Ms. Heffernan suggested that perhaps there might be areas of the process where Board members could also have some influence.

ANNOUNCEMENTS

- May 1, 4:00 pm – Regular Meeting of Board of Directors (replaces April 24 meeting date)
- May 16, SUD Kick-off Events – Rethinking Addiction: Using Science to Build an Ecosystem of Treatment and Recovery
    - 8:00 – 10:00 am – Physician and Behavioral Health Provider Breakfast, Fort Collins
    - 7:00 – 8:30 pm – Lincoln Center, Magnolia Theater
- May 22, 4:00 pm, Regular Meeting of Board of Directors

The next board meeting is scheduled for May and will be longer to include an Executive Session for the purpose of conducting the Executive Director review. This will also be the last meeting for our departing board members, Tess Heffernan and Tracy Nelson. May 22 will be the first meeting for the new board members.

ADJOURN

MOTION: To adjourn the meeting.
Moved/Seconded/Carried Unanimously

The meeting was adjourned at 5:18 p.m.

Respectfully submitted:

Nancy Stirling, Assistant to the Board of Directors

Michael Liggett, President

Tracy Nelson, Vice President

Deirdre Sullivan, Secretary

Faraz Naqvi, M.D., Treasurer

Tess Heffernan, UCHealth-North (PVHS) Board Liaison