Access to Care in Denver:

Progress Report of the Denver Access to Care Task Force

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Be Healthy Denver

COMMUNITY HEALTH MATTERS

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Executive Summary

Approximately one in five Denver residents, more than 100,000 persons, lacks health insurance, and an even higher number lack dental insurance, making it difficult to obtain medical, behavioral, and dental care. Moreover, these types of care are often split between different systems, with little coordination regarding the care of individual patients. The result is expensive, poorly coordinated care with sub-optimal health outcomes.

Denver residents and a city-wide, multi-stakeholder steering committee selected Access to Care as one of two priority areas for improving the health of Denver residents in the city's forthcoming Community Health Improvement Plan (CHIP), along with healthy eating and active living to reduce the city's obesity rate. The Denver Access to Care Task Force was set up in February 2013 to identify goals and strategies for improving access to care in the city. It includes representatives from medical care providers, behavioral care providers, governmental organizations, and community-based organizations serving lower-income persons in Denver.

The expansion of health care coverage through the Patient Prevention and Affordable Care Act (ACA) provides an unprecedented opportunity to increase access to care in Denver. The ACA will markedly expand eligibility for Medicaid and provide governmental assistance for many people to purchase health insurance in 2014. As such, the initial priority of the Task Force has been to assist in the forthcoming stages of the ACA roll-out in Denver. The Task Force also envisions a longer-term role in supporting greater care coordination for individual patients, and greater collaboration between public health and human services officials, health care providers, behavioral health care providers, and community-based organizations serving lower-income persons in Denver.

The Task Force anticipates four phases of activity to support greater access to care for Denver residents. Phase 1 supports the coming phases of implementation of the ACA in 2013 and into 2014. Phase 2 will build capacity for the care of persons becoming eligible for Medicaid and the new insurance plans in 2014. Phase 3 will support increased care coordination for individual patients among safety net providers in Denver. Phase 4 will promote better system collaboration among safety-net providers and other organizations serving lower-income persons in Denver, an effort that is likely to last at least five years.

The initial work of the Task Force for Phases 1 and 2 has involved an extensive environmental scan of access to care issues in the City and County of Denver. These are outlined in this report, and include the following:

- The current need for insurance coverage among city residents;
- Best practices in other states and cities;
- Current enrollment practices in Denver for Medicaid and other public health coverage programs;
- Preparations being undertaken by primary care providers, behavioral health care providers, governmental organizations, and community-based organizations in Denver for the forthcoming changes under the ACA; and
- Challenges and gaps foreseen in primary care, specialty care, and behavioral health care in Denver, once more people have health care coverage in 2014.

The Task Force has identified goals for Phase 1 of its work - to support the expansion of health care coverage under the ACA and facilitate the enrollment of at least 40,000 persons in Denver in Medicaid and the new insurance exchange by July 1, 2014. It has outlined a set of strategies and activities for meeting these goals, and a strategy for measuring progress in meeting them.

The Work of the Task Force

Approximately one in five Denver residents, more than 100,000 persons, lacks health insurance, and an even higher number lack dental insurance, making it difficult to obtain medical, behavioral, and dental care. Moreover, these types of care are often split between different systems, with little coordination regarding the care of individual patients. The result is expensive, poorly coordinated care with sub-optimal health outcomes.

In 2012, a Steering Committee led by Denver Public Health and Denver Environmental Health conducted a series of community meetings to help prioritize topics for the Denver Community Health Improvement Plan (CHIP). Access to Care was selected, along with Health Eating/Active Living and Reducing Obesity, as the two top priorities for improving the health of Denver residents.

The Denver Access to Care Task Force was set up in February 2013 to identify specific issues and strategies to improve access to care. The Task Force includes representatives from medical care providers, behavioral health care providers, governmental organizations, and community-based organizations (see Appendix 1 for a list of Task Force members). It has held five regular meetings to date, as well as a special session to learn about safety-net health care coordination in Seattle and King County.

The expansion of health insurance through the Patient Prevention and Affordable Care Act (ACA) provides an unprecedented opportunity to increase access to care in Denver. The ACA will markedly expand eligibility for Medicaid and provide governmental assistance for many people to purchase health insurance in 2014. Therefore, the initial priority of the Task Force has been to assist in the roll-out of the ACA in Denver. The Task Force also envisions a longer-term role in supporting greater care coordination for individual patients, and greater collaboration between public health and human services officials, health care providers, behavioral health care providers, and community-based organizations serving lower-income persons in Denver.

The Task Force anticipates four phases of activity to support greater access to care for Denver residents (see Figure 1). Phase 1 supports the coming phases of implementation of the ACA in 2013 and into 2014. Phase 2 will build capacity for the care of persons becoming eligible for Medicaid and the new insurance plans in 2014. Phase 3 will support increased care coordination for individual patients among safety net providers in Denver. Phase 4 will promote better system collaboration among safety-net providers and other organizations serving lower-income persons in Denver, an effort that is likely to last at least five years.

The initial work of the Task Force has involved an extensive environmental scan of access to care issues in the City and County of Denver, including:

- the current need for insurance coverage among city residents;
- best practices in other cities;
- current enrollment practices in Denver for Medicaid and other public health coverage programs;
- preparations being undertaken by primary care providers, behavioral health care providers, governmental organizations, and community-based organizations in Denver to prepare for the forthcoming changes under the ACA;

Preparation for Phase 2 has included an in-depth study, through key informant interviews with the principal safety net providers in Denver, to identify their current level of planning for handling the expanded populations who are likely to seek their services in 2014, and the challenges and gaps they

foresee in primary care, specialty care, and behavioral health care. The results of these assessments are reported in the following sections of this report.

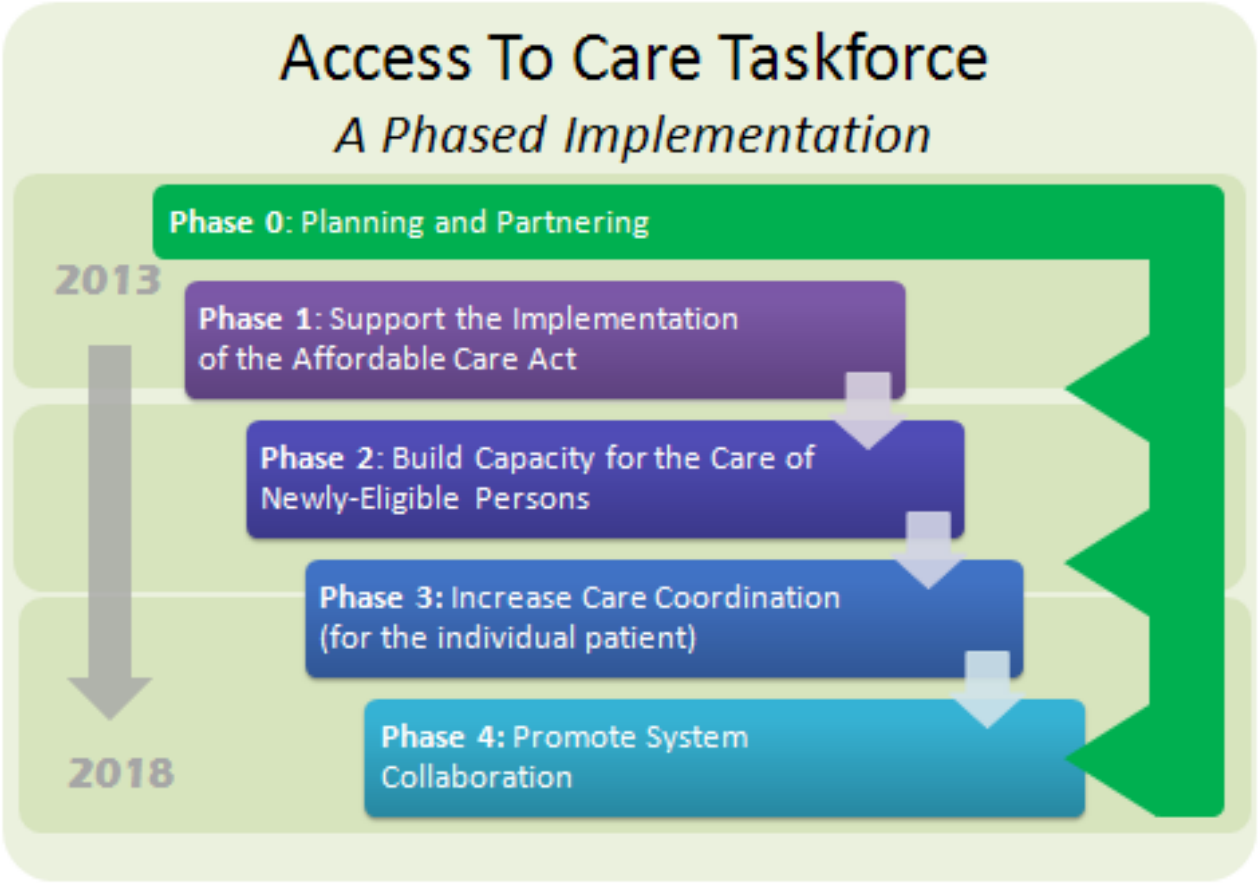


Figure 1: Denver Access to Care Task Force Phased Activities

The Need for Health Coverage in Denver

The American Community Survey (ACS) estimated that about 104,000 persons, or nearly 17% of Denver residents, were without health insurance in 2011, while the Colorado Health Access Survey (CHAS) estimated that 20% of Denver's residents were uninsured in the same period (Table 1).[1] Thus, approximately one in five Denver residents lacks health insurance, compared to a somewhat lower rate of un-insurance (16%) both in Colorado and the US as a whole. [2]

[1] American Community Survey (ACS), 2011 and Colorado Health Access Survey (CHAS), 2010-2011. Detailed ACS data on uninsured for the City and County of Denver were prepared by the Colorado Health Institute (CHI).
[2] Colorado Health Institute (2012), "Counting Colorado's Uninsured" and US Census Bureau (2011), Current Population Survey (CPS).

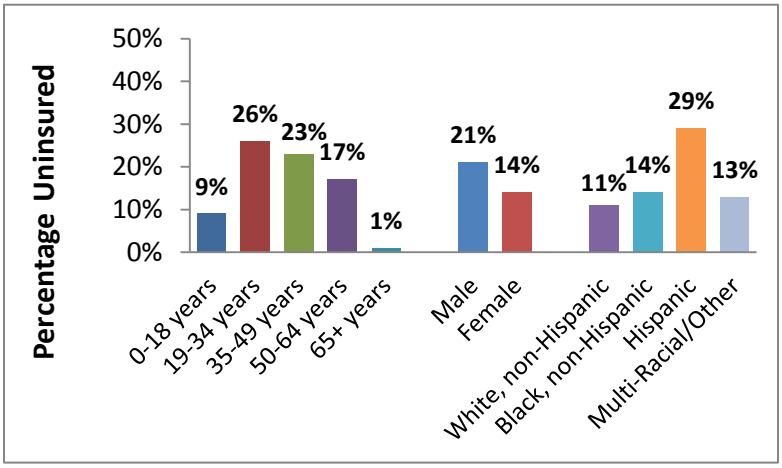
Table 1: Health Insurance Coverage in the City and County of Denver, 2011						
Health Insurance Status	**Total Population**		**U.S. Citizens, Nationals, and Legal Immigrants**		**Undocumented Persons**	
	Number	Percent	Number	Percent	Number	Percent
Uninsured	104,178	16.8%	84,450	14.5%	19,728	51.0%
Insured	517,756	83.2%	498,879	85.5%	18,877*	49.0%
Totals	**621,934**	**100.0%**	**583,329**	**100.0%**	**38,605**	**100.0%**

*This number may be over-estimated due to difficulties sampling this population.
Source: 2011 American Community Survey, Data prepared by the Colorado Health Institute

The number of uninsured U.S. citizens, nationals and legal immigrants, who will be potentially eligible for Medicaid or insurance plans on the Exchange, is estimated at 84,450 persons, or 14.5% of the population. The vast majority of these (75,483 persons, 89%) are likely to meet the eligibility requirements in 2014 either for expanded Medicaid (41,246, 49%) or subsidized insurance plans on the Exchange (34,237, 41%).

Undocumented persons and some legal residents will not be eligible for the new forms of coverage. While there is no formal assessment of documentation status within Denver, the ACS estimates that there are 38,605 undocumented persons in the city, nearly half of whom reported that they did not have health insurance. Many are being cared for by Denver's safety net clinics.

Figure 2: Lack of Insurance by Demographic Group



Source: 2011 American Community Survey and U.S. Census

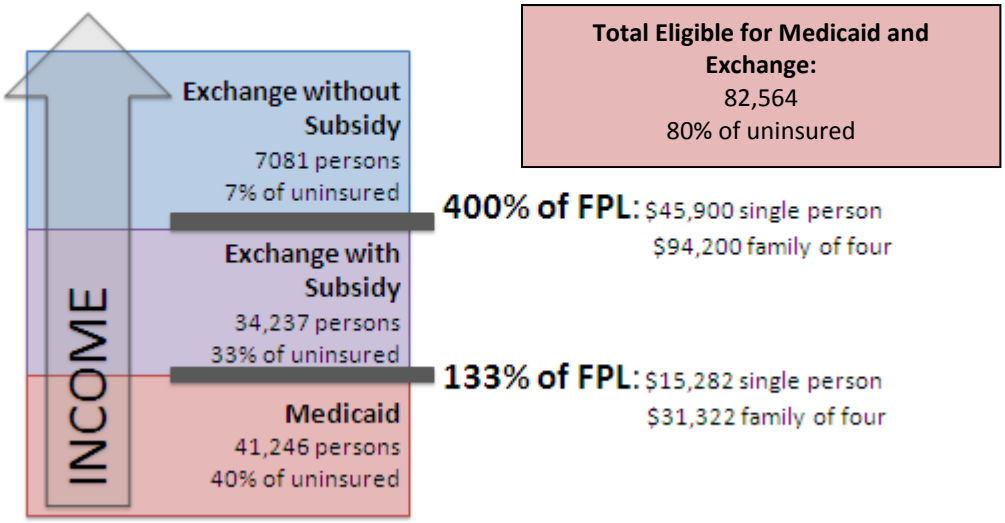
Although all parts of the community are affected by high rates of un-insurance, certain sub-populations were even more likely to be uninsured, including young adults 19-34 years of age (26%) and adults 35-49 years of age (23%) (Figure 2). More men were uninsured (17%) than women (14%), and Hispanics had the highest rate of un-insurance of any racial or ethnic group (29%), followed by Blacks (14%) and other races (13%). Whites had the lowest rate of un-insurance (11%).

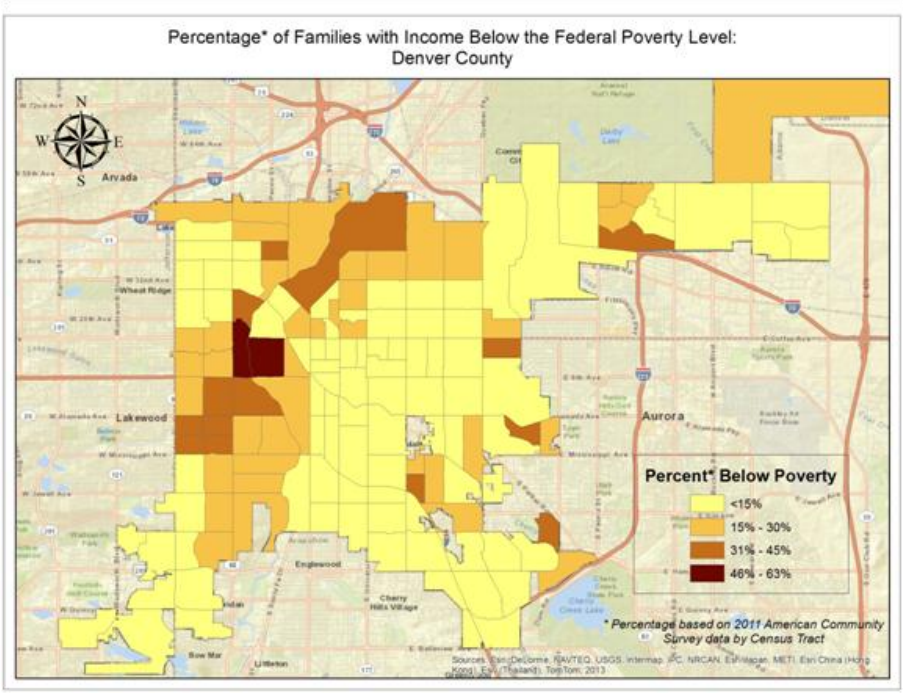
Medicaid eligibility will cover legal residents earning up to 133% of the Federal Poverty Level (FPL), or $15,282 per year for a single person and $31,322 for a family of four, regardless of their marital status or whether they are parents (Figure 3). Insurance subsidies will be available for legal residents earning 134-400% of FPL, or up to $45,900 per year for a single person and $94,200 for a family of four.

More than 41,000 persons in Denver, or 40% of the currently uninsured population, will be eligible for Medicaid in 2014. More than 34,000, or 33% of the currently uninsured, will be eligible for subsidies when purchasing insurance on the Exchange. About 7000 persons, or 7% of the uninsured population, will not qualify for subsidies, but can purchase insurance on the Exchange at rates that are

projected to be less than in the individual insurance market today.[3] The map below shows the distribution of persons at or below the FPL in Denver. The darker shaded areas indicate neighborhoods where a higher percentage of residents will qualify for health coverage under the ACA in 2014.

Figure 3: Denver Residents' Eligibility for Medicaid and Subsidies on the Exchange





[3] US Department of Health and Human Services (2013), "Market Competition Works."

Best Practices - Massachusetts

Massachusetts instituted a healthcare reform in 2006 that included an individual insurance mandate, expansion of Medicaid, a new insurance exchange, and a prohibition on denials for pre-existing conditions. Because the Massachusetts reform was a prototype for the ACA, experiences there could indicate what is ahead for Colorado and the US as a whole in regard to insurance coverage and access to care.

Massachusetts differs from Colorado in its low rate of un-insurance even before the 2006 reform. It had only 7.4% uninsured in 2004, the lowest rate in the US, which averaged 14.3% at that time.[4] Colorado's rate of uninsured in 2004 was 17%.[5] Despite its low rates to start with, Massachusetts was able to drop its uninsured rate by more than half, to 3.1% in 2011, while the national rate rose to 15.7% in the same period. Massachusetts continues to have the lowest rate of un-insurance in the US, but by a much greater margin than before the reform. Its remaining uninsured are predominantly young adults, males, Hispanics, and undocumented persons, much like the demographic profile of Colorado's current uninsured population.[6]

Massachusetts has seen good compliance with the individual insurance mandate among its citizens. Only 1% of residents were assessed a tax penalty in 2010 for lack of insurance, with the penalty being fixed at 50% of the lowest-priced plan on the state exchange. The reform has not crowded out employer-sponsored insurance (ESI), which was high in Massachusetts before the reform – 70% in 2005 and rising to 76% in 2011. In contrast, the US rate of ESI fell from 69.7% in 1999/2000 to 59.5% in 2011. Colorado's ESI rate fell from 71.8% in 1999/2000 to 63.0% in 2010/2011.[7]

Massachusetts has had 8% fewer ER visits since implementing its healthcare reform, an important indicator of better access to primary and preventive care.[8] It has also seen gains in the Health Status Index (HSI) relative to other states.[9] The HSI measures BMI, physical activity, and mental health status. It had higher health care costs than the US as a whole, both before and after its reform, but was able to contain costs on individual premiums, for which there was no net increase between 2006 and 2010.[10]

Best Practices - Seattle and King County, Washington

The Task Force held a special session on May 30, 2013 with Janna Wilson, Senior External Relations Officer for the Seattle and King County Public Health Department, to learn about Seattle's experience in coordinating and integrating services among safety-net medical and behavioral health providers, community-based organizations, and the public health and human services departments. The Task Force also learned about Seattle's efforts to better integrate medical and behavioral health care,

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[4] Blue Cross and Blue Shield Foundation of Massachusetts and Massachusetts Medicaid Policy Institute (2013), *Health Care Reform in Massachusetts, Expanding Access to Health Insurance Coverage: Assessing the Results.*
[5] Colorado Health Institute (2006), "Profile of the Uninsured in Colorado: An Update for 2005."
[6] Blue Cross and Blue Shield Foundation of Massachusetts (2013), *ibid.*
[7] State Health Access Data Assistance Center (2013), "State-Level Trends in Employer-Sponsored Health Insurance."
[8] Washington Post (2012), "Six Ways Romneycare Changed Massachusetts."
[9] *Ibid.*
[10] *Ibid.*

and to support expanded health care coverage under Medicaid and the new insurance Exchange in 2014.

Seattle and King County have a similar rate of uninsured as Denver, 16%, with a significant variance in health care coverage in different parts of the city, from as low as 3% to as high as 30%. Like Colorado, Washington State has elected to expand Medicaid, and is preparing to open its own Exchange in October 2013 to offer subsidized health insurance plans to those who qualify.

Seattle has been involved in multi-stakeholder system integration efforts since early in 2011, looking forward to the full implementation of the ACA in 2014. As such, it has had a head start in these important processes, from which Denver and its Access to Care Task Force can learn and profit. This process in Seattle has culminated in the recent production in July 2013 of a Transformation Plan for King County to create an accountable, integrated system of health, human services, and community-based prevention.[11]

The recent plan was informed by a 30-member panel with representatives from human services, health care delivery, prevention, public health, philanthropy, labor, local government, and other sectors – a similar composition to the Denver Access to Care Task Force. The Plan aims to reduce significant inequities in health and well-being across the County through a collective community response focusing on prevention, recovery, and provision of services. It includes strategies at the individual level for adults with complex health and social needs, and at the community level for high-risk communities with the greatest disparities.

Seattle and King County have also made iterative steps since 2006 to better integrate medical care and behavioral health care in primary care settings, through a state-wide mental health integration program, a County behavioral health sales tax, federal integration grants from SAMSHA[12] and HERSA,[13] a demonstration project for persons eligible for both Medicaid and Medicare, and a CMMI[14] planning grant. Washington State Medicaid is handled as managed care, which requires care coordination and management of complex social conditions for beneficiaries. Care coordinators are embedded in primary care clinics and are trained by and work with consulting psychiatrists from the University of Washington. Primary care providers are given high-quality training to handle mental health issues within the primary care setting, but care coordinators are also able to transfer patients to specialized community mental health agencies if their mental health issues need more attention.

Seattle and King County have also been active in planning efforts for expanding health care coverage under Medicaid and the new insurance Exchange in 2014. The Public Health Department set up a 20-member steering committee to direct efforts towards enrollment in Medicaid and the purchase of health insurance by residents, in three phases. Phase 1, from January through May 2013 involved analyzing and mapping the uninsured in the County and planning for an outreach campaign to support enrollment. Phase 2, from June through October 2013, involves training, technical assistance, and distribution of materials to an extensive network of community-based partners and launching a website to track enrollment events and progress. Unlike the Denver Public Health Department, the Seattle and King County Public Health Department in the in-person lead for enrollment assistance in the county, and as such, plays a direct role in outreach efforts.

[11] King County, Washington (2013), "Health and Human Services Transformation Plan," June 26, 2013.
[12] Substance Abuse and Mental Services Administration.
[13] Health Resources and Services Administration.
[14] Center for Medicare and Medicaid Innovation.

Phase 3 will begin with the opening of the Washington State Exchange in October 2013 and extends through April 2014, to execute the plans for supporting enrollment. City departments are all being engaged to assist in the enrollment effort, through activities such as ads in Parks Department fliers, providing speakers to inform city employees and citizen groups about the forthcoming changes under the ACA, and efforts to enroll people who are in jails.

After the forthcoming changes under ACA in 2014, the Seattle and King County Health Department and its ACA Steering Committee hope to reduce the uninsured in the county from 16% to 4%, and to narrow the range of uninsured to between 1 and 10%.

Current Enrollment Practices and Barriers to Enrollment in Denver

126 Denver-based organizations were surveyed in April 2013 to gather information about their current enrollment practices for Medicaid, CHP+ and other medical assistance programs, and current preparations for the forthcoming expansion of Medicaid and introduction of the state Exchange. 88% of responding organizations either directly enrolled clients in Medicaid or provided services linking clients to enrollment. Many others enrolled or assisted in the enrollment of clients in CHP+, CICP, and other health coverage and assistance programs. Just over half of the organizations surveyed (52%) provided education to patients or clients on Medicaid eligibility and enrollment.

Respondents noted a number of current barriers to enrollment in Medicaid, CHP+ and other medical assistance programs, many of which are likely to be exacerbated in the forthcoming expansion of Medicaid in 2014 (Table 2). Important barriers related to the clients themselves included transience, culture and language barriers, clients' lack of understanding regarding their eligibility, the documentation required to process cases, and correspondence they receive from state and other authorities. Structural barriers to enrollment included a lack of resources within organizations for processing cases, challenges with the use of the Colorado Benefits Management System (CBMS) and the Colorado Program and Eligibility Application Kit (PEAK), and long waiting times and other problems in the processing of applications.

Several barriers to accessing primary care were noted for clients who do obtain benefits, such as lotteries and waiting lists for care providers, confusion regarding benefits, and clients missing re-determination dates. Moreover, many people do not qualify for Medicaid and cannot afford insurance, including large numbers of undocumented families in Denver, while CICP coverage for persons living outside the City and County of Denver remains problematic, with persons outside Denver seeking care under CICP, while Denver-based providers are not authorized to extend it.

Table 2: Barriers to Enrollment in Denver

Barriers Related to Clients	Barriers Related to Organizations	Barriers for People with Benefits
Transience Culture and language barriers Not understanding eligibility criteria Documentation requirements Misunderstanding correspondence received from authorities Not qualifying for Medicaid Inability to afford insurance	Lack of resources for processing cases Challenges with the Colorado Benefits Management System (CBMS) Challenges with the Colorado Program and Eligibility Application Kit (PEAK) Long processing times and other problems in the processing of applications	Lotteries and waiting lists for access to health and behavioral care providers Confusion regarding benefits Missing re-determination dates Non-Denver patients attempting to use Denver safety net clinics

Preparations for the Medicaid Expansion and the Exchange

Many of the organizations surveyed were already engaged in activities to prepare for the forthcoming phases of the ACA rollout in 2014. About one third (32%) have already expanded their Medicaid enrollment services, while the same proportion are planning to expand services. Nearly half of the organizations surveyed (49%) had either submitted applications to become certified, in-person assistance sites for Connect for Health Colorado, or were planning to do so at the time of the survey in April 2013, to help clients navigate the Exchange and purchase subsidized insurance. 23 organizations in Denver were awarded grants to become certified assistance sites beginning in October 2013.

Just over half of the organizations surveyed (53%) were already engaged in educating their staff about the forthcoming ACA changes, while 47% were planning to do so. 42% of organizations were already engaged in educating healthcare providers, while 47% were planning to do so. 51% were already engaged in educating patients and clients, while 43% were planning to do so. 50% of organizations were already conducting outreach activities, while 52% were planning to do so.

Some of the activities underway or planned included developing training and education materials, conducting outreach and education events, advocating with state authorities for policy changes, projecting populations that will be eligible for Medicaid in 2014, coordinating with the county human services office and multi-stakeholder collaborative groups, applying for grants, and taking steps to connect medical and behavioral health providers and systems.

Respondents had different levels of comfort in answering questions about the forthcoming changes under the ACA. About a quarter of the respondents (23%) felt very comfortable about their knowledge of the ACA, while nearly half (46%) felt only somewhat comfortable. About one-third (31%) felt either somewhat uncomfortable (23%) or very uncomfortable (8%) about their knowledge of the ACA.

Given that the majority of respondents did not express a high level of comfort with their knowledge of the ACA, most organizations could benefit from staff training about the ACA rollout, and particularly about its complex details regarding state decisions, the Medicaid expansion, the insurance plans to be offered on Connect for Health Colorado, how the premium tax credits will work, and how the expansion of Medicaid will interface with other programs.

Respondents indicated a number of important tools and types of training that would assist them in preparing for the forthcoming ACA changes. Some of the tools included seminars and meetings, websites and printed materials to give to staff, patients, and clients, training in outreach and communication skills, specific trainings about Medicaid and the insurance exchange, trainings for specific professional groups and about how particular beneficiary groups will be affected by the ACA changes, and financial resources to support the new efforts.

The survey pointed out many projected challenges and gaps likely to be seen with the rollout of the ACA. Projected challenges related to the new programs included the short time-frame for implementation, vague or confusing program guidelines, IT challenges with the exchange, and potential difficulties in communications with HCPF and the exchange authorities. Likely gaps related to the capacity of enrollment and assistance organizations included shortfalls in knowledge, training, communication skills, networking, and funding.

Gaps related to clients included a lack of knowledge about the forthcoming changes, what they will be eligible for, and health insurance vocabulary. There were concerns that low-income families who do not qualify for Medicaid may not be able to afford insurance on the exchange, even with the tax credits offsetting the cost, that people may "churn" between Medicaid and the exchange as their income changes, and that certain communities may excluded or actually lose services in the transition, such as undocumented and HIV positive persons. Finally, there were concerns that many people with benefits will not be able to access care due to the lack of staff and facilities, both for primary care and behavioral care.

Challenges and Gaps in Access to Care in 2014 – Key Informant Interviews

The above survey on enrollment and ACA preparations was followed by extensive key informant interviews with 27 directors and clinic managers of 16 safety net providers in Denver that offer primary care, specialty care, mental health care, substance abuse treatment, and dental care to lower-income persons. Also included was the designated Behavioral Health Organization coordinating Medicaid specialty mental health care in Denver. The interviews sought to further investigate the projected challenges and gaps in access to care across the various areas of medical and behavioral health care as more people obtain Medicaid coverage and new insurance plans through the Exchange 2014. The evaluation was conducted to support the Denver Access to Care Task Force in closing these gaps and better coordinating care among safety net providers in the city.

Eleven of the 17 organizations interviewed (65%) offered primary care services and 4 (24%) offered some specialty care on their premises, while 3 (18%) had systems for referral to specialty care within a larger hospital system. 15 of the 17 organizations (88%) offered mental health care and 9 (53%) offered substance abuse treatment. 6 organizations (35%) offered dental care. See Appendix 2 for a list of the organizations interviewed and the principal safety net services each offers.

Current Payment Sources and Populations Served

All 17 organizations provided services to Medicaid patients, while 13 (76%) provided services to patients with CHP+ (Table 3). For some organizations, patients on these public assistance programs made up only a small proportion of their total caseloads, while for others, a majority of their patients

had this type of coverage. The average proportion of Medicaid and CHP+ patients seen by these organizations was 39%, and ranged from almost none to 88%. 11 organizations (65%) provided services to patients with Medicare, but these patients made up only a small proportion of their caseloads on average (2%).

Table 3: Payment Sources and Special Populations

Organizations Providing Care to Patients With:	No	%	Average Estimated Proportion of Caseload
Medicaid	17	100	39%
CHP+	13	76	
Medicare	11	65	2%
No Insurance	16	94	52%
CICP	7	41	
Private Insurance	10	59	11%
Organizations Providing Care to:	**No**	**%**	
Homeless Persons	13	76	not available
Undocumented Persons	16	94	not available

Nearly all the organizations (16, or 94%) provided services to uninsured patients, usually on a sliding fee scale where the patient makes a contribution to the cost of care at the time of the visit. 7 organizations (41%) provided services to uninsured persons through the Colorado Indigent Care Program (CICP). The average proportion of uninsured and CICP patients seen by these organizations was 52%.

Ten organizations (59%) provided services to patients with private insurance, and these patients made up 11% of their caseloads, on average. Thirteen organizations (76%) provided services to homeless persons, and 16 (94%) to undocumented persons, but organizations did not generally track the proportions of patients in these categories.

Enrollment Services

Thirteen of the 17 organizations interviewed (76%) had on-site enrollment assistance services to help patients get enrolled in Medicaid and CHP+, and so will be well-placed to assist persons who become eligible for Medicaid in 2014 to get enrolled. 7 organizations (41%) received grants to become Health Coverage Guides for Connect for Health Colorado, to help clients check for eligibility and enroll in subsidized insurance plans to be offered on the Exchange starting in October 2013.

Waiting Lists and Turning Patients and Clients Away

Nearly 60% of safety-net organizations interviewed had waiting lists

Average Wait Time: 4 weeks

Nearly 60% of the organizations interviewed (10 of 17, 59%) had waiting lists for patients to access services for the first time, with an average wait time of 4 weeks. Some organizations made exceptions for pregnant women, children, people recently discharged from a hospital, and people with certain types of payment sources, such as those covered under a state contract for indigent mental health care and those with private insurance, citing the need to balance paying and non-paying clients. Other organizations used waiting lists strictly on a first-come, first-served basis. Several organizations did not

bother to have a wait list, because there would be too many people on it, with no means of assuring that patients or clients could be seen within a reasonable time-frame.

65% had to turn patients away

Eleven organizations (65%) were forced to turn people away regularly or deny service, most often due to a lack of staff and resources and the need to prioritize the groups to whom they extend services. Criteria for turning people away included the patient or client not being a good match with the mission of the organization, being less in need of care than others, and having an option to go elsewhere for care. Most organizations that turned people away did their best to refer them to other organizations that might be able to help.

Planning for Expanded Populations in 2014

82% plan to take new Medicaid patients in 2014

65% plan to take patients with insurance from the Exchange

Fifteen of the 17 organizations interviewed (88%) indicated that they were planning to take additional Medicaid patients in 2014. Those not planning to take on more Medicaid patients cited capacity problems as the reason, and in particular the inability to hire new staff in advance of the Medicaid expansion. Twelve organizations (71%) indicated that they were planning to accept patients with insurance purchased on the Exchange in 2014, some under their own organizations' insurance plans to be offered on the Exchange.

Some organizations were unsure if they would be taking new patients with insurance from the Exchange, or were planning not to do so. The reasons for this uncertainty, or deciding against taking insured patients, included not having the staff and resources to take on more patients even if they had insurance, not expecting their current clientele to be able to purchase the new insurance plans, not expecting the newly insured to approach their clinics, and not having any history of working with insured patients, such that their mission statements and current business models would have to be revised if they took on these patients.

More than a third of the organizations interviewed (7,or 41%) had done some modeling of the projected populations their organizations are likely to see in 2014 that will be newly eligible for Medicaid or insurance on the Exchange. Modeling for increases in Medicaid caseloads were more common than for projected patients with insurance from the Exchange, with some organizations estimating particular numbers of new patients that ranged from hundreds to tens of thousands, and others reporting percentages of current, uninsured patients getting covered, from 15 to 80 percent.

About a third of organizations (6, or 35%) had only a vague idea of how their populations might change, without any specific data for the trends they foresaw (for example predicting that "the majority" of their caseload or "thousands" of their patients would be eligible for Medicaid). Organizations specialized in providing services to children did not expect a large increase either in Medicaid enrollment or insurance coverage in 2014, given that children are already widely covered under Medicaid and CHP+. Similarly, organizations seeing large numbers of undocumented persons did not expect to see big changes in coverage for their caseloads, since undocumented persons will not be eligible for the new forms of coverage.

The organizations were asked about changes they were thinking about or already making to get ready for the expanded populations they are likely to see in 2014, and the changed payment sources

these patients and clients are likely to have. In the sections that follow, planned activities and changes are outlined for primary care, mental health care, substance abuse treatment, and dental care services provided by safety net clinics in Denver.

Primary Care Planning

Organizations were planning for a variety of new activities in or around primary care to support the forthcoming health coverage changes. Some were planning to make a big push for Medicaid enrollment, for example to get current CICP patients and people on the CICP waiting list on Medicaid as soon as possible, or to get newly eligible people enrolled in Medicaid who have been paid for through charity funds before 2014. As mentioned above, 13 of the 17 organizations interviewed (76%) already have on-site enrollment assistance services for Medicaid and CHP+; 7 organizations (41%) received grants to become Health Coverage Guides for Connect for Health Colorado, and will be supported by grants to increase their staff and resources for helping clients enroll in insurance plans on the Exchange.

Many organizations were making changes to their operations and facilities, such as extending working hours, expanding current facilities, moving to new facilities, and building new facilities from scratch. They were looking at adding a variety of staff – senior management staff to help run the more complex operations; administrative staff to facilitate enrollment, set up contracts with insurance companies, and bill for both Medicaid and private insurance; navigators to assist in care coordination for patients and clients; and providers to give care. The focus for new providers is primarily in internal medicine and family medicine rather than pediatrics and obstetrics and gynecology, given that it will be largely an adult, non-pregnant population that acquires the new forms of coverage in 2014.

Some organizations were already adding staff, while others recognized the need to do so, but were proceeding cautiously on a "wait and see" basis, given that reimbursement for the expanded services will not be forthcoming until well into 2014, and that not all the newly eligible persons will get coverage and show up for care at the start of the year. Some organizations are making their expansion plans for later in 2014 or into 2015, once the demand for services and the revenue streams from the new forms of coverage become clearer.

Some organizations, including those that see primarily children, who are already well-covered by public insurance programs, were not planning for expanded caseloads or for significant changes in their operations. They were nevertheless anticipating better financial outcomes, more sustainability in their programs and operations, and less of a need for subsidization from parent organizations with more universal coverage of their current patient populations. In addition to the financial benefits, some clinics expected advantages such as the ability to reduce waiting lists and wait times for patients to access care.

On the other end of the spectrum of eligibility, clinics that see a large number of undocumented persons, who will not be eligible for the new types of coverage, were also not making many plans for changes. For some clinics, the structure of the clinic precluded the addition of patients, even if they came with Medicaid or insurance coverage. An example are clinics that are set up in large part to serve graduate medical education and whose providers are primarily residents; these hospitals do not plan to increase the number of residents passing through their training programs, even if a higher percentage of patients had better payment sources.

Some clinics were planning to make major changes to their business models, to accommodate Medicaid patients or insurance holders for the first time and possibly market themselves for the first

time as being open to new patients. At the same time, they wish to retain their central or founding missions to serve persons without coverage or another place to get care. These organizations are wondering how adding these new types of patients and payment sources will impact their clinics. For example, clinics taking insurance for the first time are trying to anticipate what the different needs and demands of an insured population will be, and how to prepare for this. They wish to be able to see insured patients in order to ensure that their current patients can continue getting care at the clinic once they get insurance.

Other clinics were not making such a push to accommodate privately insured patients, because they do not expect their current populations to be willing or able to buy insurance, or because they do not expect people with private insurance to come to their clinic, even if they were patients at the clinic before getting the insurance.

One organization that already has a large insured population, but is adding a larger Medicaid component to respond to the Medicaid expansion, is trying to equalize the experience of these different patients, also to facilitate smooth transitions and continuity of care as people move between Medicaid and private insurance plans, as they are likely to do in 2014 as their employment and income status changes.

Most organizations were expecting better financial results in 2014 and beyond, with more revenues coming from the patients themselves and therefore greater self-sufficiency in programs with the expansion of Medicaid and the wider availability of insurance among their patients and clients. However, because Medicaid reimbursement does not cover the cost of services and many patients and clients will continue to be ineligible for Medicaid and unable to purchase insurance, many organizations were concerned that they could lose grant funding and other sources of revenue that have supported their operations up until now and that they will still need to be viable.

Mental Health Care Planning

Two of the organizations interviewed who offer mental health care services had recently moved to newer, larger premises, and several are planning for expansions or moves in the near future, as well as partnerships with other organizations, to accommodate more clients in 2014. Both of the adult inpatient psychiatric units in the City and County of Denver, at Denver Health and Porter Hospital, are prepared to expand the number of beds in their current facilities if needed in 2014.

Several of the mental health care organizations interviewed had already added staff or have plans to do so in the near future to handle increased caseloads in 2014. Many recognized the need for a variety of staff - providers, patient navigators and care coordinators, billing staff, and administrative staff to assist with the transition to electronic medical records and scheduling appointments - but most are unable to add these staff until the new payment sources are actually in place for clients in 2014.

Some organizations are reviewing their staff's training and credentials and swapping staff between programs to make sure they meet the criteria for obtaining reimbursement for mental health care under Medicaid and the new insurance plans in 2014. Many organizations are planning to add billing staff, both for Medicaid and for clients coming in 2014 with private insurance through the Exchange. Some organizations recognized that it will not be easy to get on the insurance panels of many different insurance companies by 2014, and as a result are prioritizing Medicaid billing in the short run. One organization will coordinate with a county mental health agency to assist in billing for private insurance. Another with staffing needs in several areas is planning to use interns and funding from

foundation grants to bridge their staffing gap until reimbursement is forthcoming from Medicaid and private insurance payments in 2014.

One large provider of mental health services noted that it was limited in taking on new patients even if they came with a payment source, due to severely limited capacity now, but that new payment sources should at least better cover the current caseload and make their programs more sustainable.

Many of the mental health care providers were already providing care in integrated programs with primary care clinics, and were planning to continue this focus to deal with the projected flux of new clients in 2014, many of whom are expected to have mild to moderate mental health conditions that are amenable to treatment in an integrated primary care setting. Some had already added primary care physicians who are able to prescribe medications, and some will focus on adding advanced practice providers – nurse-practitioners and physician assistants, to help with the medical side of mental health care.

Most mental health care providers were not planning to take on high-need patients, who are seen now primarily by the Mental Health Center of Denver (MHCD) and will continue to be seen by MHCD in 2014. Even MHCD with its specialization in high-need cases is gearing up for an increase in mild to moderate cases in need of short-term care in 2014.

Many mental health care organizations mentioned areas into which they would like to expand in order to create better access, including a number of non-traditional, non-face-to-face methods of seeing clients, such as telephone counseling, online chat rooms, and tele-psychiatry to make better use of the extremely limited number of psychiatrists in the state. All mentioned that they expected to face challenges in getting reimbursement for these services that are not delivered in traditional face-to-face meetings between providers and clients.

Substance Abuse Treatment Planning

Organizations are also gearing up for providing more substance abuse treatment in 2014, and are looking forward to better reimbursement for this type of treatment, both from Medicaid and insurance plans sold in the Exchange. A new Medicaid substance abuse benefit is expected to be rolled out in 2014, and substance abuse treatment is among the 10 essential health benefits that must be provided by plans sold in the Exchange. As such, organizations are looking for information about how to bill for these services in 2014.

Two organizations were planning to add substance abuse treatment for the first time. Many are reviewing the training, certifications, and supervisory requirements for their staff, to allow them to obtain reimbursement both from Medicaid and the new insurance plans for substance abuse treatment. Some organizations are adding new substance treatment staff, while many are assisting their current staff to obtain needed credentials such as Certified Addiction Counselor (CAC).

One organization mentioned wanting to better integrate mental health and substance abuse treatment, which has been challenging up to now because of the different payment sources and billing codes for the two, despite their frequent co-occurrence in the same patient or client. Another organization that is primarily a substance abuse treatment provider has recently placed its staff, through partnerships with other organizations, in a number of primary care clinics to better reach clients who need these services.

Organizations are using a number of new tools to assist them in substance abuse treatment, such as bracelets for monitoring alcohol levels and smart phone apps that help clients manage their substance use.

Dental Care Planning

Six of the 17 organizations interviewed (35%) offered dental care, but not all offered a full range of dental services. Only two organizations were planning to add more dental services in 2014. One organization mentioned that it was not planning to add dental services due to the high cost of setting up and staffing a dental clinic.

Children have been prioritized for dental services up to now, given the limited capacity of clinics, the high level of demand, and the fact that Medicaid has not yet covered adult dental services. Organizations have not yet had time to respond to and plan for implications of the recent Colorado legislative decision to add an adult Medicaid dental benefit in mid-2014, nor was dental care included among the 10 essential health benefits to be covered under the new insurance plans to be sold in the Exchange.

Challenges and Gaps Foreseen in Access to Care in 2014

Organizations were asked about the challenges they foresee in 2014, once a larger number of people are covered under Medicaid and private insurance. Appendix 3 provides in detail the particular challenges and gaps foreseen for primary care, specialty care, and behavioral health care. Table 4 summarizes the challenges and gaps related to the new programs themselves, the organizational capacity of safety net providers, and factors related to patients and clients.

Important challenges related to the new programs included a lack of information and misunderstandings about the ACA, both within organizations and among the general public. A recent Kaiser Family Foundation poll found that 42% of Americans were unaware that the ACA was an approved law.[15] There is much confusion about program guidelines and what the plans sold on the exchange will cover. There is a big concern that people will "churn" between Medicaid, the Exchange, and being uninsured as their income and employment status change. Providers are concerned about low reimbursement rates and continued difficulties getting reimbursement from Medicaid, and about challenges in getting on insurance panels and in provider networks for the new insurance plans.

Important challenges related to organizational capacity included a lack of funding for enrollment assistance guides to help get people enrolled, especially for Medicaid. Of great concern is the lack of capacity to handle the inflow of new patients in 2014, given the waiting lists already in place and the fact that many organizations already have to turn people away. Concerns were particularly high about the lack of capacity to see new mental health clients, especially severe cases. Nearly all organizations lack funding to hire new providers in all fields before the new coverage regimes are put into place and are proven to work. Moreover, even if funding were available now, there is a lack of providers in many fields relevant to the expansion of coverage, including internal medicine, family medicine, nurse-

[15] Kaiser Family Foundation (2013), "Kaiser Health Tracking Poll: April 2013."

midwifery, and all types of behavioral healthcare providers. Particularly concerning is the lack of an organized referral system from primary to specialty care.

Important challenges related to patients and clients included the potential inability of many people to afford insurance even with the subsidies that will be offered, the possible lack of enthusiasm for enrolling in Medicaid or purchasing insurance on the Exchange, especially in the early years of the expansion, and the need for education among the newly covered about how to use the coverage appropriately and avoid unnecessary use of emergency rooms and urgent care clinics.

Table 4: Challenges and Gaps Foreseen in Access to Care in 2014

Gaps: New Programs	Gaps: Organizational Capacity	Gaps: Patients/Clients
Lack of information and misunderstandings about the ACA, within organizations and among the general public and patients/ clients Vague or confusing program guidelines, lack of information about plans and coverage, and how people might lose coverage Short time-frame for implementation Potential IT challenges with CBMS and the Exchange Difficulties in communications with HCPF and Exchange authorities "Churn" of people between Medicaid, insurance plans, and un-insurance Exclusion of certain communities Difficulties getting on insurance panels and into provider networks Low reimbursement rates for Medicaid Difficulties securing reimbursement for mental health care and substance abuse treatment Lack of reimbursement for care coordinators and wrap-around social services	Lack of funding and capacity for enrollment assistance Lack of capacity to handle the inflow of new patients in 2014 - longer waiting lists, turning more people away Large lack of capacity to see new mental health clients, especially severe cases Shortage of beds in in-patient psychiatric units and poor follow-up after discharge Lack of funding before 2014 to hire providers in all fields Lack of providers available to hire even when funding will be available: *Primary care* - internal medicine, family medicine, nurse-midwifery *Behavioral care* - psychiatrists, psychiatric nurses, psychologists, LCSWs, MSWs, culturally diverse workers at all levels *Substance abuse*—Board Certified Addictions Physicians, Certified Addictions Counselors Lack of funding for care coordinators Lack of an organized referral system from primary to specialty care Challenges to organizational missions when patients and clients have coverage in 2014 and beyond	Lack of knowledge about the ACA, what they will be eligible for, new health insurance vocabulary Inability to afford insurance even with subsidies Lack of enthusiasm for enrolling in Medicaid or purchasing insurance on the Exchange Education needed about how to use new coverage for preventive and primary care, and avoid unnecessary use of emergency rooms and urgent care clinics

Enhanced Opportunities for Cooperation with the ACA

One clinic director commented that with the ACA, it was a "new day for collaboration" between safety net clinics in Denver. The ACA has exposed the glaring gaps in the system, allowing the safety net clinics to realize that there are not enough providers to serve the population, and that it is in all of their interests to cooperate in closing the gaps. The forthcoming ACA changes present an opportunity for safety net organizations to be less guarded and protective with each other, and to increasingly cooperate in a division of labor between the larger and smaller providers, with the various providers being increasingly recognized for the unique contributions they can make. This enhanced cooperation should lead to better access to and quality of care for lower-income Denver residents.

Modeling Enrollment and Access to Care in Denver

The Task Force has used the following conceptual model to envision how some of the persons newly eligible for either Medicaid or the new insurance plans on the Exchange will become enrolled and be able to access care (see Figure 4).

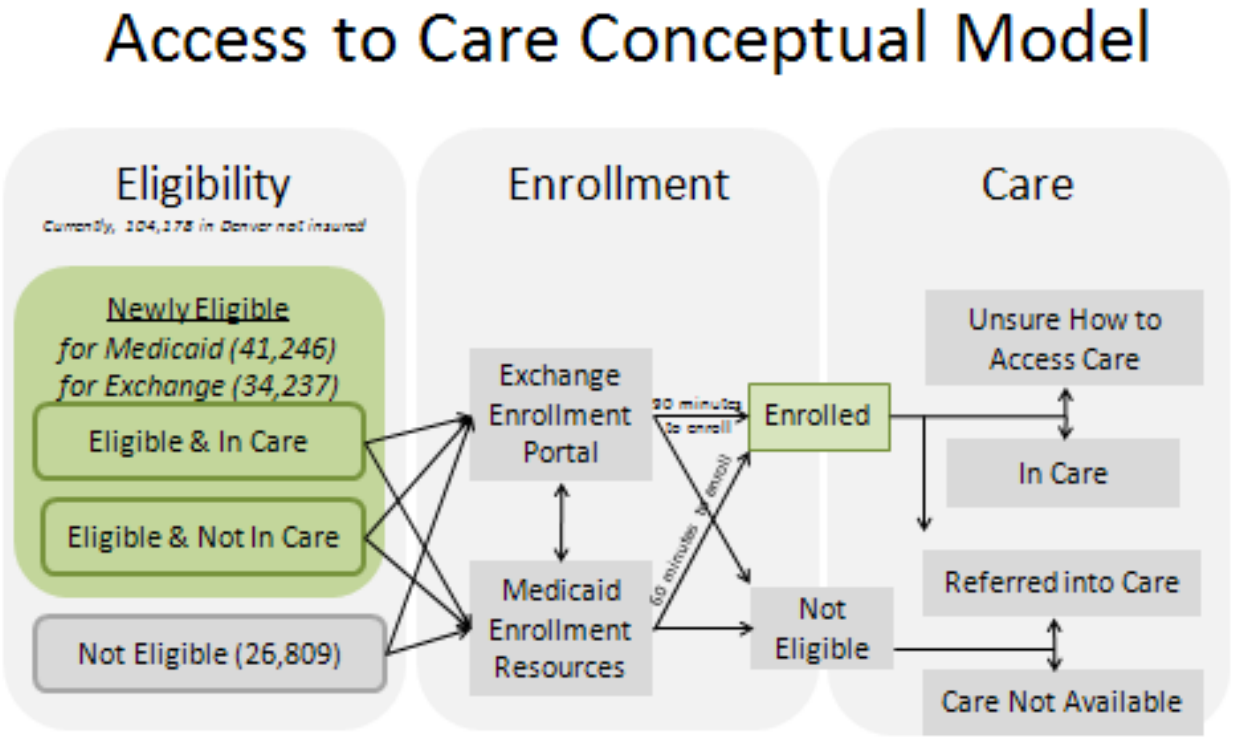

Figure 4: Eligibility to Care Model

A substantial number of uninsured patients currently receive medical care within safety-net clinics. A large safety-net provider, Denver Health, estimates that approximately 17,000 of its patients currently engaged in long-term primary care will be eligible for Medicaid or the Exchange. An additional

30,000 eligible, uninsured patients are seen intermittently, predominantly in urgent care settings (e.g., the Emergency Department). Other safety-net institutions care for large numbers of eligible uninsured patients, but it is not possible to produce an overall estimate of the proportion of the estimated 84,500 eligible, uninsured patients who are currently in care.

The newly eligible may not all be aware of the benefits available to them, and some of those who are aware of their options may choose not to enroll in Medicaid or purchase insurance. Some may opt to pay the penalty for lack of insurance when filing their 2014 income taxes, which will be only $95 per individual/$285 per family or one percent of income, whichever is greater.

Those who are aware and interested will find their way to the two main avenues for gaining coverage - enrollment in Medicaid or purchasing insurance on the Exchange. In both cases, a person can visit the respective websites directly, Colorado PEAK for Medicaid (Colorado.gov/PEAK) and Connect for Health Colorado for the Exchange (ConnectforHealthCO.com), or get in-person assistance from numerous enrollment assistants for Medicaid and health coverage guides for the Exchange, located throughout the city.

If people access the Exchange and find that they are eligible for Medicaid, they will be re-directed to Colorado PEAK to enroll there, whereas if they are not eligible for Medicaid, they can proceed to purchase an insurance plan. Once enrolled either in Medicaid or an insurance plan, some people will be able to access care directly, while others will be unsure how to use their new benefits. Those not eligible for either Medicaid or a plan on the Exchange may still be able to access care in safety-net clinics, while some will continue to have difficulties accessing care.

Phase 1 Goals, Strategies and Activities

Table 5 outlines the goals of the Access to Care Task Force in Phase 1 - to support the expansion of health insurance under the ACA, facilitate the enrollment of at least 40,000 persons in Medicaid and health insurance through Connect for Health Colorado by July 1, 2014, and achieve a 94% rate of insurance in the city by 2018. It also suggests a set of strategies and activities to meet these goals. Table 6 outlines baseline measures in four areas and prospective data sources to evaluate progress in meeting the goals.

Denver Access to Care Task Force Phase 1 Goals

Support the expansion of health insurance under the ACA

Facilitate work city-wide to enroll at least 40,000 newly eligible persons in Medicaid and subsidized health insurance through Connect for Health Colorado by July 1, 2014

Achieve a 94% rate of insurance by 2018

Table 5: Denver Access to Care Task Force Phase 1 Goals Support the expansion of health insurance under the ACA Facilitate work city-wide to enroll at least 40,000 newly eligible persons in Medicaid and subsidized health insurance through Connect for Health Colorado by July 1, 2014 Achieve a 94% rate of insurance by 2018		
Strategies	**Activities**	**Suggested Partners**
Aggregate and disseminate information related to health insurance expansion and ACA implementation in Denver	Convene the Denver Access to Care Taskforce quarterly to discuss and document changes and current events related to ACA	Denver Public Health, Denver Environmental Health, City of Denver agencies, state agencies, Denver Health, Denver-based safety net providers, community-based organizations.
	Inform important stakeholders about health insurance expansion and the ACA implementation, through outreach efforts, trainings, presentations, and providing materials	
	Develop enhanced electronic information on enrollment and access to care with interactive mapping technology; make available on the Be Healthy Denver website.	Denver Public Health, American Heart Association
Facilitate positive and consistent public messaging about the benefits of health insurance expansion and ACA implementation in Denver	Encourage public figures and politicians to speak about the benefits of health insurance expansion and ACA implementation. Provide information and talking points for them.	City officials, state officials, Access to Care Task Force Members
	Encourage positive media coverage about the expansion of health insurance and the implementation of the ACA	Denver Post, others
	Encourage professional sports teams to promote the expansion of health coverage under ACA	Denver Broncos, Denver Nuggets

Table 6: Evaluating Phase 1 Goals

Evaluation Question	Baseline Measures	ACA Implementation	Incremental Monitoring
Enrollment: Are people getting enrolled?			
• Who is enrolled in Medicaid, CHP+, Connect for Health Colorado?	2010 Colorado Health Access Survey (CHAS) • 21% of Denver was uninsured in the past year 2011 American Community Survey (ACS) • 17.2% of Denver have no insurance coverage	2013 CHAS • What type of insurance do you have? 2014 BRFSS *Possible Future Sources: HCPF Medicaid Data, CHP+ Data, CIVHIC data, MMIS and CBMS, Denver Department of Insurance*	2014 BRFSS and beyond 2015 CHAS *Possible Future Sources: HCPF Medicaid Data, CHP+ Data, CIVHIC data, MMIS and CBMS, Denver Department of Insurance*
Coverage: Who is covered?			
• What percent of Denver residents are insured? o For medical care? o For oral healthcare? o Who is/remains uninsured?	2011 ACS • 17.2% of residents have no health insurance • 19% of employed adults have no health insurance • 48% of unemployed adults have no health insurance 2010 CHAS • 21% of residents were uninsured in the past year 2009/2010 BRFSS • 83.2% of residents were insured	2013 CHAS 2014 BRFSS 2014 ACS	2015 CHA 2015 ACS
Utilization: Are people getting into care?			
• Who is engaged in primary care? • Who is engaged in dental care? • Who is using behavioral health services? • Are the newly insured getting into care?	2010 and 2013 CHAS 2010 BRFSS • 71.94% of Denver has only one HC provider and 8.10% has more than one • 19.94% reported no healthcare provider	2013/2014 BRFSS	2015 CHAS
• Are policy changes shifting healthcare costs or utilization patterns? • Are the newly insured using the healthcare system differently?	*Possible Future Sources: CHA data (ED Visits)*	*Possible Future Sources: CHA data (ED Visits)*	*Possible Future Sources: CHA data (ED Visits)*
• Is coverage adequate? Is underinsurance still occurring?	2013 CHAS 2010 BRFSS • 16.46% did not see a doctor because of cost in the past year		2015 CHAS
Outcome: Does it Make a Difference?			
• Is healthcare coverage driving down healthcare costs?	*Possible Future Sources: CHA data (ED Visits)*	*Possible Future Sources: CHA data (ED Visits)*	*Possible Future Sources: CHA data (ED Visits)*

Appendix 1: Denver Access to Care Task Force Members

Name	Affiliation
Bill Burman, Chair	Denver Public Health, Director
Ned Calonge, Chair	The Colorado Trust
Alok Sarwal	Colorado Alliance for Health Equity and Practice
Andrea Albo	Denver Human Services, Director of Family and Adult Assistance Division
Beth Truby	Denver Office of Economic Development
Cindy Laub	Denver Department of Safety, Crime Prevention and Control Commission (CPCC)
Comilla Sasson	University of Colorado Denver
Carl Clark	Mental Health Center of Denver
Chanel Freeman	Far Northeast Alliance, Colorado Department of Human Services, Division of Behavioral Health
David Burgess	CHARG Resource Center
Dawn Joyce	CDPHE, Director, Health Systems Unit
Denise Vincioni	State Controlled Substances Administrator
Diane States	Denver Public Health & Denver Health Mobile Crisis Unit
Doug Linkhart	Denver Department of Environmental Health
Emily McCormick	Denver Public Health, Epidemiology
Haley Ringwood	University of Colorado Denver
Jessica Forsyth	Denver Public Health
Jim Garcia	Clinica Tepeyac
Joe Sammen	Colorado Coalition for the Medically Underserved
John Simmons	Denver Public Schools, Student Services Division
Julie Farrar	Colorado Developmental Disabilities Council
Kathleen Noland	Denver Public Health
Katie Langland	Denver Public Health, Prevention Training Center
Kellie Teter	Denver Public Health, Maternal and Child Health
Kraig Burleson	Inner City Health Center
Leigh Fischer	SBIRT Colorado and Peer Assistance Services
Lisa McCann	Denver Public Health
Liz Meade	Phoenix Multisport
Liz Whitley	Denver Health, Community Health Services
Louise Boris	Colorado Coalition for the Homeless
Lourdes Yun	Denver Public Health, Epidemiology

Name	Affiliation
Mark Levine	U.S. Department of Health and Human Services, Region 8
Mark Thrun	Denver Public Health, HIV/STD Prevention and Control
Michelle Lohman	University of Colorado Denver
Michelle Shimomura	Denver Department of Environmental Health
Michelle Wheeler	2040 Partners for Health
Mirna Castro	Servicios de La Raza
Monica Buhlig	The Denver Foundation
Neysa Bermingham	Kaiser Permanente, Community Benefits
Paul Melinkovich	Denver Health, Community Health Services
Regina Huerter	Denver Department of Safety, Crime Prevention and Control Commission (CPCC)
Robin Valdez	Denver Department of Environmental Health
Sara Schmitt	Colorado Health Institute
Steven Federico	Denver Health, School and Community Programs
Terry Stewart	Denver Public Health, Prevention Training Center
Wanda Marshall	Denver Health, School-Based Health Centers
Webster Hendricks	Far Northeast Alliance, Colorado Department of Human Services, Division of Behavioral Health

Appendix 2: Organizations Interviewed on Challenges and Gaps in Access to Care

No	Organization	Services Provided					
		Primary Care	Specialty Care	Referral System to Specialty Care	Mental Health Care	Substance Abuse Treatment	Dental Care
1	Access Behavioral Care				✓		
2	Arapahoe House				✓	✓	
3	Asian Pacific Development Center	✓			✓		
4	Caritas Clinic, Exempla St. Joseph Hospital	✓	✓				
5	Children's Hospital Colorado Child Health Clinic	✓		✓	✓		✓
6	Clinica Tepeyac	✓			✓		✓
7	Colorado Alliance for Health Equity and Practice (CAHEP)	✓	✓		✓	✓	
8	Colorado Coalition for the Homeless, Stout Street Clinic and Dental Clinic	✓	✓		✓	✓	✓
9	Denver Health - Community Health Services	✓		✓	✓	✓	✓
10	Denver Health - Inpatient Behavioral Services				✓	✓	
11	Denver Health - Outpatient Behavioral Health Services				✓	✓	
12	Denver Health - School-Based Health Centers	✓		✓	✓		✓
13	Inner City Health Center	✓			✓		✓
14	Kaiser Permanente	✓	✓				
15	Mental Health Center of Denver (MHCD)	✓			✓	✓	
16	Porter Hospital In-Patient Psychiatric Unit				✓	✓	
17	Servicios de la Raza				✓	✓	
17	**Total**	**11**	**4**	**3**	**15**	**9**	**6**
	Percent	**65**	**24**	**18**	**88**	**53**	**35**

Appendix 3: Challenges and Gaps Foreseen in Primary, Specialty, and Behavioral Health Care in Denver

Primary Care

Many organizations are concerned about their capacity to handle the inflow of new patients and clients who are likely to approach them starting in January 2014. There are already waiting lists for care, and these may become longer as more persons get health insurance. One organization noted that people who need care now are deferring care until 2014, which could lead to clinics being inundated with new patients with high needs for care, just when they are least prepared to receive them. As such, organizations foresee having to prioritize the cases they will be able to see, and to coordinate better across the community of safety net providers. Lack of access to primary care due to the coming influx of patients could lead to more people using emergency rooms and urgent care clinics.

Many organizations saw the lack of providers as the most important limitation on providing services to more patients and clients in 2014. They already have facilities in place that can be used more intensively or kept open longer, but they cannot hire more providers until they have the funding to support them. Moreover, once the funding or revenue is in place, providers in fields such as Internal Medicine, Family Medicine, and nurse-midwifery are expected to be hard to find.

A big concern for many organizations is the "churn" of people between Medicaid and insurance from the Exchange, and the gaps in coverage and access to care that are likely to result. Currently, people lose Medicaid due to changes in their income levels and lack of adherence to re-enrollment requirements, many of whom do not know they have lost coverage. While some 3000 persons are newly added to Medicaid each month in Denver, 1500-2000 also drop off monthly. Many of the newly added have only been off for a month or two.[16]

There is also a lack of information about what situations will lead people to lose subsidies or insurance coverage for the plans purchased on the Exchange starting in 2014, and how people might be able to shift to Medicaid if their income suddenly drops or they are unable to make payments on their insurance premiums. Care coordination could be especially difficult if the type of coverage a person has changes frequently.

Some of the organizations interviewed expected that their patients and clients would not be eager to enroll in Medicaid or purchase insurance on the Exchange, given that they have been receiving charity care at little or no charge, distrustful of government, and unable to negotiate governmental systems. As such, organizations expect to need to be vigilant in checking for Medicaid eligibility, but their efforts to do so will be inhibited by the limited number of enrollment assistance staff they have.

Organizations serving children had concerns about what would happen to CHP+ and all the children currently covered under this program, given that the income ranges for CHP+ overlap with those for obtaining subsidies for plans under the Exchange, but at the same time, purchasing insurance will be more expensive for parents than the cost of enrolling in and using CHP+ now.

Organizations had concerns about getting on insurance panels and into provider networks for the new insurance plans, given a lack of staff to make the complicated arrangements for setting up these contracts. If organizations are unable to set up these arrangements, patients and clients with

[16] Information from Colorado Access, the Regional Care Collaborative Organization (RCCO) for the City and County of Denver (Region 5).

insurance are likely to go elsewhere for care, or continue to need charity care at these organizations despite having insurance.

There is also uncertainty about exactly what services the new insurance plans will cover, and if holders of plans from the Exchange will be treated differently in mainstream medical establishments than other insured people. Among organizations serving adolescents, there are concerns about whether the new plans could be used for confidential services such as pregnancy testing and STD treatment, given that an explanation of benefits (EOB) would likely be generated that would alert parents that these services were rendered. If this is the case, clinics will have to continue to fund these services under charity programs even after teens obtain insurance.

Organizations had many concerns about the lack of information about the forthcoming ACA changes, both within their organizations and among the general population and current patients and clients. Organizations felt they needed more guidance about the forthcoming changes, both in Medicaid and related to the Exchange, in the form of rules, directions, guidelines, and information about how the new rules will be enforced.

Also of concern were misunderstandings about the forthcoming ACA changes, such as that everyone will be covered and that traditional sources of funding for safety net clinics will no longer be needed. They felt it was important to clear up these misunderstandings: Many people will continue to lack coverage and safety net clinics will continue to need funding on top of the new forms of reimbursement that are coming in. Reimbursement from Medicaid is not expected to cover the cost of services, and large efforts will be needed from organizations to collect it. Funding is particularly needed in the run-up to January 2014 and for 12-18 months thereafter, to help clinics increase their staffing and capacity to see the new patients and clients, and to be able to bill Medicaid and insurance companies for services starting in 2014.

Several organizations mentioned challenges ahead in educating patients and clients about how to use their new coverage appropriately and avoid using hospital emergency departments and urgent care clinics for situations that are better dealt with in primary care settings. Navigators and care coordinators are important for directing patients and clients to appropriate care. However, the lack of reimbursement for care coordination, and of dedicated staff for this purpose, are hampering these efforts.

Several organizations are likely to face challenges to their organizational missions, as many have been set up to serve the uninsured, whereas large portions of their traditional caseloads will no longer be uninsured in 2014 and beyond. As such, many are in the process of planning for how they will accommodate patients and clients who are newly covered, while continuing to serve the uninsured and those who have nowhere else to go for care.

Specialty Care

While the organizations interviewed did not report specific planning for specialty care in 2014, many noted that access to specialty care was one of the areas of greatest need with the forthcoming changes under the ACA, particularly for neurology, orthopedics, and dermatology.

With the exception of the relatively few clinics located within large hospital systems, safety net clinics have great difficulties securing specialty care for their patients. If any specialty care is offered, it is generally on an ad hoc basis, depending on specialists who volunteer in the safety net clinics for a few

hours per week or month, or accept limited referrals on a charity basis in their private clinics. There is no established referral system for specialty care in most clinics, and patients' access depends on the limited availability of the volunteer specialists, with little continuity of care for ongoing conditions.

Access to specialty care is also problematic for patients with Medicaid. Low reimbursement rates for specialty care under Medicaid make specialists very reluctant to see these patients, while those who do agree to see Medicaid patients maintain a very small quota to be seen at any given time. As such, many specialists listed on Medicaid rosters as accepting patients do not in fact accept them when patients try to get an appointment. When patients do get in, the location of specialists is often difficult for low income and homeless persons to reach.

These issues of availability, access, and continuity of specialty care are expected to worsen dramatically when more Medicaid patients seek care in 2014.

Mental Health Care

Many of the organizations interviewed who offer mental health care services remarked that access to mental health care will be even more difficult in 2014 than it already is, given the huge unmet demand for services in Denver, which will only be exacerbated when more people have coverage and seek care. Moreover, many of those seeking mental health care for the first time in 2014 could have the more serious mental health conditions, putting even more strain on existing systems. One important access problem that will also continue is that people with mental retardation and developmental disabilities (MRDD) are excluded from coverage under mental health programs, making it very difficult for persons with these conditions to get both outpatient and in-patient care.

In addition to Medicaid covering both mental health and substance abuse treatment in 2014 to an expanded population, these services will be among the 10 essential health benefits to be covered by insurance plans sold through the Exchange, which could significantly increase the number of people seeking both types of care. As such, several organizations expect to have to turn even more people away in 2014 than they already do now, which could lead to increased use of emergency and in-patient psychiatric units. One organization planning to see patients and clients with new insurance plans from the Exchange foresaw access problems for culturally diverse persons, given that the Exchange will accommodate only Spanish on the website in addition to English, and because funding for interpretation by the designated health coverage guides was reduced.

The lack of capacity in mental health care is due in large part to a severe lack of mental health providers in the city and state, in particular of psychiatrists, psychiatric nurses, and bi-lingual, culturally diverse, licensed social workers. These professionals have many options for work in private practices, hospitals and clinics. Many private mental health providers accept neither Medicaid nor commercial insurance, because the high level of demand allows them to bill for cash. Given these conditions, safety net clinics face great difficulties recruiting and retaining mental health providers. Safety net clinics work around these staff shortages by having primary care doctors prescribe medications, and by hiring counselors, Social Work interns.

Similar to the situation for primary care, most organizations providing mental health care are unable to hire providers in advance of the new revenue sources coming in, with the added challenge of the provider shortages. Many reported that their facilities are sufficient for expansion, but that they are unable to recruit the staff they will need in 2014, particularly those who speak the languages and have the cultural expertise needed to provide customized mental health care to the populations they serve.

One organization with a large mental health program noted that it is already sending two-thirds of the people away who approach their facilities, even if these patients are insured, such that they have little or no capacity to see new patients in 2014 even if they come with Medicaid or new insurance plans purchased on the Exchange.

As with primary care, organizations offering mental health care were concerned about the "churn" of patients and clients between Medicaid and the Exchange. They feared that people would lose Medicaid as their income went up, but be unable or unwilling to buy insurance on the Exchange, leading to gaps in care. They felt that, for better continuity of care, it would be very helpful if HCPF would grant Medicaid eligibility annually rather than allowing it to be subject to monthly income fluctuations. Similarly, there were concerns that people who purchase insurance on the Exchange could also be subject to losing their coverage if they are unable to maintain payments on their premiums, fail to renew their policies, or lose their subsidies due to a rising income.

Access to specialty mental health care for Medicaid patients is problematic in Denver now and likely to worsen in 2014, given limitations set by many providers on the number of Medicaid patients they will see in a given period of time. While providers are listed in the official directory because in principle they take Medicaid patients, a patient approaching them for care will very often not be accepted into the practice if the practitioner's quota has already been reached. In this case patients must communicate the problem to the Behavioral Health Organization (BHO) to help find a provider who is actually taking Medicaid patients at that time. In the process, they may just give up and forego care, particularly if their mental health condition inhibits them from being proactive in seeking care.

Securing services for patients with chronic mental health needs is particularly difficult, given the lack of providers in Denver who are equipped to see them. Securing services for uninsured, whether with chronic or mild and moderate mental health problems, is also problematic. The Mental Health Center of Denver (MHCD) specializes in assisting high-need cases, but does not have the capacity to see all of the patients who approach them needing care. A further complication for high-need patients is the shortage of housing for low-income people in Denver, which is exacerbated by the high rate of migration of young adults to the city. Given the shortage of services for high-need cases, primary care physicians manage many complex mental health disorders for patients who are in need of, but do not have access to, specialty mental health care.

Organizations reported low rates of reimbursement for Medicaid and problems securing reimbursement from HCPF for mental health services rendered, as well as difficulties in getting reimbursement for privately insured patients, making their programs very difficult to sustain. Moreover, most insurance companies are unfamiliar with newer care models that involve services such as care coordination and housing support, making it difficult for organizations to get reimbursement for these services. Reimbursement problems were especially prominent when patients have multiple conditions – physical, mental health, and substance abuse, given the different payment sources established for these conditions.

Many of the organizations interviewed provided mental health services in integrated care programs within primary care clinics. Some mentioned challenges with these arrangements based on the different ways that primary care clinics operate, compared to mental health care in a more traditional sitting, such as shorter times allowed for seeing patients and a focus on acute problems.

Both of the adult in-patient facilities in the City and County of Denver, Denver Health and Porter Hospital, reported stress on beds due to the closure of in-patient facilities in other Denver hospitals and the lack of facilities in the state for persons in need of longer-term care in assisted living facilities and nursing homes. More than half of the beds in these facilities can be occupied at any given time by

persons who are no longer in need of acute care and should be moved to longer-term care facilities, but they are kept in the in-patient units for lack of more appropriate facilities. One of the in-patient facilities noted challenges related to its facilities, namely insufficient single-patient, seclusion and restraint rooms.

Once patients are discharged from the in-patient facilities, there are insufficient options for follow-up care, related to the same access issues mentioned above, particularly for high-need and uninsured patients. There are also many unmet social and housing needs for discharged persons.

Substance Abuse Treatment

Access to substance abuse treatment is more challenging even than access to mental health care and specialty medical care. In the words of one administrator, "It is easier to see a cardiologist than a psychologist, and easier to see a psychologist than a substance abuse counselor."

Many of the difficulties in access to substance abuse treatment stem from the different funding sources and reimbursement mechanisms available for physical health care, mental health care, and substance abuse treatment. Medicaid reimbursement for substance abuse treatment is the most uncertain and convoluted of the three types of care. It is handled differently than for mental health and physical health care, is paid at a very low rate, and includes limited charge codes and allowed procedures, which providers in turn have difficulty making use of. Reimbursement mechanisms both for Medicaid and private insurance focus heavily on outpatient care and what is minimally necessary, although many people need more intensive, in-patient care at an earlier stage to treat their conditions.

Although many patients have co-occurring mental health, physical health, and substance abuse disorders, Medicaid will not reimburse claims if the primary diagnosis is determined to be substance abuse, both for in- and out-patient care. On top of all these reimbursement problems with Medicaid, people regularly lose coverage on a month to month basis with fluctuations in their income, often not even knowing that they have lost coverage. Reimbursement for persons eligible for both Medicaid and Medicare is even more problematic, as Medicare must deny the claim before Medicaid will consider paying it, but at the same time, it is hard for providers to get a clear denial from Medicare. For opiate dependence, there is no payer that will cover treatment.

There are very few options for substance abuse treatment for people without health care coverage, despite the large number of people who need this type of care. These multiple reimbursement problems discourage providers from working in this field, and force substance abuse programs to rely on unsustainable grant funding and run deficits. Many patients in substance abuse programs are directed to the programs by social services personnel and parole officers, who sometimes cover the cost of treatment through social services and corrections budgets.

The payment dilemmas and lack of parity for substance abuse treatment inhibit the development of the preferred medical home model, wherein people could get both mental health and substance abuse treatment within a familiar primary care setting. The gap between primary care and substance abuse is thus bigger than that between primary care and mental health care, with substance abuse treatment continuing to be treated outside the circle of health care.

Substance abuse benefits under Medicaid are expected to be better covered in 2014, but the details of the forthcoming changes are not yet available. Substance abuse treatment is also among the 10 essential benefits to be provided by the new insurance plans purchased on the Exchange, but it is not

clear yet what will be covered, nor what changes, if any, existing insurers not on the Exchange will make to their own substance abuse benefits.

Substance abuse providers face the same dilemmas as other providers about how to grow their capacity for handling more patients in 2014 before the new reimbursements start to flow in. Providers are struggling to manage their current caseloads under the tenuous reimbursement mechanisms that are in place now, and will be ill-equipped to see new clients in 2014, even if they have coverage. Undocumented persons who are not eligible for Medicaid or insurance subsidies, and uninsured who are unable to navigate the system to get the new coverage will also still need treatment. As such, capacity and access to substance abuse treatment will continue to be a serious challenge in 2014,even though more people will have coverage.

Because more clients are likely to seek care in 2014 who have coverage for substance abuse treatment, providers expect that these new clients could have different characteristics than current ones, many of whom are uninsured and referred by social workers and the courts. Even those referred by the authorities are likely to be eligible for Medicaid or insurance through the Exchange in 2014, which will likely induce a reduction in direct payments from these authorities to substance abuse providers. It will also increase these clients' independence and decision-making power vis-à-vis these authority figures.

Organizations providing substance abuse treatment, like those offering mental health services, also face challenges in finding qualified staff to hire once they get the funding they need to expand. There is a shortage of Board-Certified Addictions Physicians and Certified Addictions Counselors (CAC), both of which have high training requirements. Addictions physicians are needed to prescribe medications in the increasingly popular, medically assisted therapies, but they are even more rare than psychiatrists and child psychiatrists. The CAC certification requires 2-4 years to complete, including a period of practical training. There is also a shortage of LCSWs and MSWs, which many insurance companies require to cover treatment. Moreover, many general mental health providers, which are in better supply than addictions specialists, are not confident in handling substance abuse cases.

Although the new sources of coverage will be available to people needing substance abuse treatment in 2014, the population most needing this service is likely to be ill-equipped to navigate the systems for getting enrolled in Medicaid or purchasing insurance, and will need assistance to do so. Many are transient and have multiple problems – physical, mental health, and substance abuse. Those who do acquire coverage will need training about how to better use the health care system to meet their multiple needs for care. Many have depended on emergency departments and detox centers in lieu of primary care, and they are not likely to change this behavior immediately upon getting coverage.