Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING

March 28, 2019
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
March 28, 2019
4:00 pm
Health District, 1st Floor Conference Room

AGENDA

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

4:05 p.m. **Call to Order; Introductions; Approval of Agenda** ..... Michael Liggett

4:08 p.m. **PUBLIC COMMENT**
Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

4:10 p.m. **PRESENTATIONS**
- Our Larimer Health Connect Experience: Past, Current, Future ..... Devin Kepler, Rosie Duran
- Changing Minds Outreach Project: Moving to Phase 2 ..... Brian Ferrans

4:45 p.m. **DISCUSSION & ACTIONS**
- Board General Approval of Changing Minds Outreach Project Contract ..... Michael Liggett
- Replat, Amendments to Covenants, 1075 Pennock Place ..... Chris Sheafor
- Policy ..... Alyson Williams
  Proposed State Legislation
  - Overview of Recently Released State Budget Proposal and Implications
  - HB19-1176: Health Care Cost Task Force
  - HB19-1216: Reduce Insulin Prices
  - HB19-1233: Investments in Primary Care
  - Projections on Proposed Reinsurance Bill

  Status of legislation discussed previously; issues on the horizon

5:20 p.m. **UPDATES & REPORTS**
- Update: Tax Increment Financing: TIF Intergovernmental Agreement, Drake/College, Chris Sheafor
- Executive Director Updates ..... Carol Plock
- UCHealth North Liaison Updates ..... Faraz Naqvi, MD

5:25 p.m. **PUBLIC COMMENT (2nd opportunity)** See Note above.

5:30 p.m. **CONSENT AGENDA**
- Approval of January 2019 Financial Statement
- Resolution 2019-03 Safe Deposit Box 2219 – 5542
- Resolution 2019-04 Safe Deposit Box 4919
- Resolution 2019-05 Safe Deposit Box 5546
- Resolution 2019-06 Safe Deposit Box 5742

5:32 p.m. **DECISIONS**
- Approval of the December 2018 and January 2019 Board Meeting Minutes

5:35 p.m. **ANNOUNCEMENTS**
- April 9, 4:00 pm – Board of Directors Special Meeting
- April 23, 4:00 pm – Board of Directors Regular Meeting

5:40 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

2019 Open Enrollment Snapshot

Health District
LARIMER HEALTH CONNECT

Larimer Health Connect Open Enrollment Numbers

1,187 Unique households served

1,468 Client encounters

1,110
total number of people enrolled *at time of appointment* with assistance from Larimer Health Connect staff

747 lives covered through Marketplace Plans

259 lives covered by Medicaid

54 lives covered by CHP+

"I very much appreciate the service Larimer Health Connect provides. Being able to meet with someone in person is so much better than on the phone or computer. I got all my questions answered.
Thank you for being there!"

★★★★★

76 Days
Length of open enrollment period
(11/1/18 - 1/15/19)

Connect for Health Colorado

170,741
Colorado

11,877
Larimer County

People covered by medical insurance

Health First Colorado/CHP+

1,342,468
Colorado

67,108
Larimer County

Monthly caseload as of Dec. 2019

ADDICTION IN OUR COMMUNITY

Substance misuse is estimated to cost society $442 billion each year in health care costs, lost productivity, and criminal justice costs

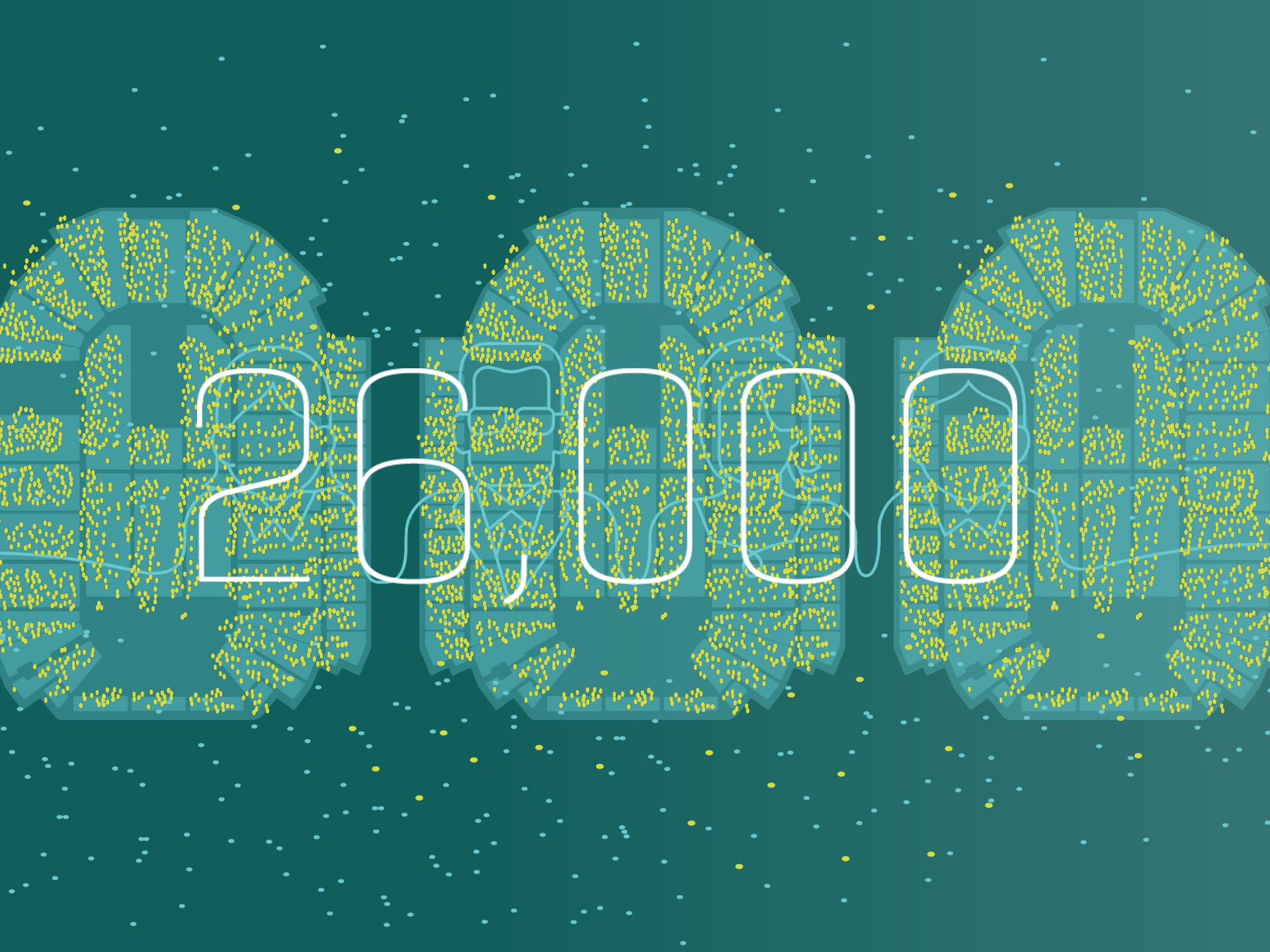
Surgeon General's Report on Alcohol, Drugs and Health, 2016

SHORT-TERM HEALTH IMPACT

Heart rate	Blood Pressure
Mood	Heart attack
Stroke	Psychosis
Overdose	Death

LONG-TERM HEALTH IMPACT

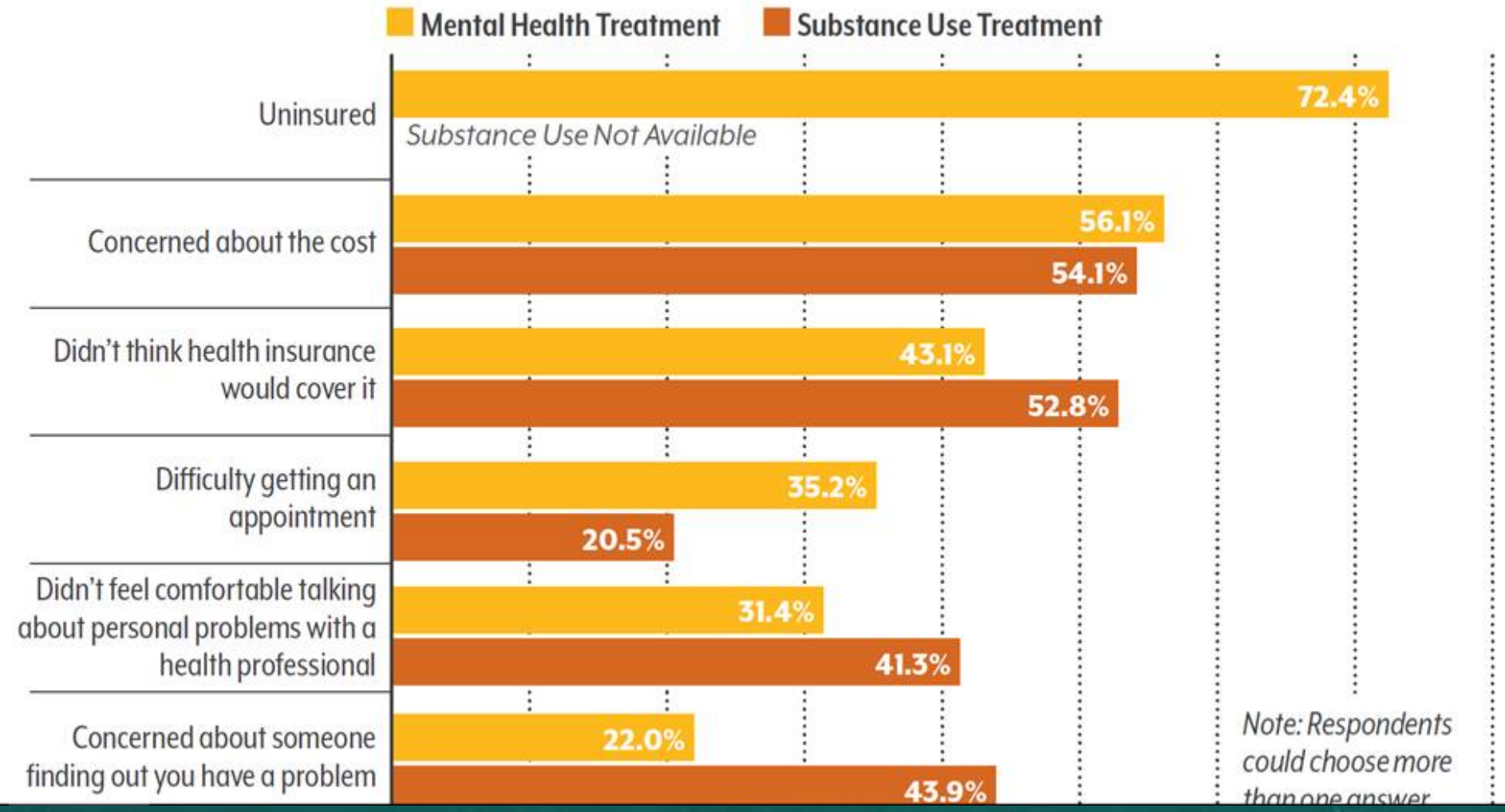
Heart/Lung disease	Cancer
Mental Illness	HIV/AIDS
Hepatitis	Psychosis


2600


living with addiction
26,900
1 in 10
get treatment
23,660
in need of
addiction care

STIGMA | CARE

FIGURE 3. Reasons Coloradans Who Needed Behavioral Health Care Give for Not Receiving It, 2017



Health District of Northern Larimer County
August 10 ·

Heading to New West Fest this weekend? Look for one of our “brain pods” in Old Town and help us start a community conversation about the public health crisis of addiction and how treatment can save lives.
www.changingmindslarimer.org #ChangingMindsLarimer


WHAT ARE THE ODDS?
CHANGING MINDS
sunglass hut


WHAT ARE THE ODDS?
CHANGING MINDS
ROCKY MOUNTAIN COLLEGIAN
STUDENT MEDIA


GRACE PLACE
TRAILHEAD CAFE

Living proof

Gina is one of the many faces of addiction in our community.

Starting in junior high, Gina's substance use turned to physical dependence and ultimately landed her in Drug Court. There she had access to effective and ongoing treatment that helped her regain control of her life. Her disease now in remission, Gina volunteers her time to help educate young people about the reality of addiction — living proof that long-term recovery pays big dividends.

Read Gina's Story >

Share your story >


uchealth


LARIMER
COUNTY


COLORADO STATE UNIVERSITY


KRFC 88.9 FM
RADIO FORT COLLINS


Health District
OF NORTHERN LARIMER COUNTY


SUMMITSTONE
HEALTH PARTNERS


Colorado Judicial Branch

WHAT'S NEXT?

- ✓ More community presentations/trainings
- ✓ New educational/training video (general public & client-centered)
- ✓ Additional recovery stories (Social media storytelling series)
- ✓ New website for MHSU Alliance
- ✓ Brain Pod Community Scavenger Hunt
- ✓ Poster campaign
- ✓ Strategic social media campaigns and website promotion
- ✓ New "Addiction is not fiction" campaign video (launched at Rethinking Addiction community event in August)

Memorandum

Date: March 21, 2019

To: Health District Board of Directors

From: Brian Ferrans
Behavioral Health Strategy & Implementation Manager, Community Impact Team

Subject: Request for general approval of Toolbox Creative contract to complete the development of Phase Two of the Health District's "Changing Minds" addiction public awareness campaign

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Purpose

The purpose of this memo is to:

1. Provide a review of the history and an update on the current status of the Health District's and Mental Health and Substance Use Alliance's addiction public awareness campaign, "Changing Minds", developed by CIT and Toolbox Creative.
2. Request approval to fund the Phase Two Development and Outreach of the campaign, through a contract with Toolbox Creative. Funding is included in the existing budget.

Review of History and Update on Current Status

The Health District recognizes substance use disorders, a chronic brain disease, as one of the largest health burdens in our community, with 26,000 Larimer County residents experiencing addiction and only an estimated 10% who are actually receiving treatment for their disease. The Health District also recognizes that one of the biggest barriers to receiving care for substance use disorders is stigma and a public misunderstanding that the disease of addiction can only be addressed, treated or cured with individual "moral fortitude" or support groups, rather than with evidence-based medical and behavioral health care.

In 2017, the Mental Health and Substance Use Alliance and the Health District prioritized raising awareness around substance use disorders as a chronic disease to help dispel misunderstanding in the community, through the development of a public awareness campaign.

The Health District executed a contract in early 2018 with Toolbox Creative, to conduct research, design, and launch a three-year public-facing outreach campaign with a goal to transform public perceptions of addiction in Larimer County by promoting public understanding that 1) addiction is a chronic disease requiring adequate levels and quality of treatment; 2) treatment works and recovery is possible; 3) recovery has significant benefits for individuals, families and the community.

The three-year project was also envisioned as a critically important precursor to community understanding of the changes in substance use disorder treatment emerging from the expansion of state of the art behavioral health services, should the 1A ballot initiative pass.

Health District staff worked with Toolbox to create the "Changing Minds" campaign as a result and the Health District launched Phase 1 of the campaign in August of 2018.

Project Budget

Full funding for this project exists within the Health District's 2019 budget, in a combination of places. $20,000 is allocated from the SUD Transformation Project – SUD Public Awareness Campaign line item, and $20,000 from other Mental Health & Substance Use Alliance (MHSU)-related reserve funding. An additional $15,000 is being utilized from a combination of the Advancing Behavioral Health grant funds and the Health District's match funds for that grant, and $4,500 is allocated from partner funds from the MHSU Alliance.

Request for Board Approval

The Community Impact Team is requesting general Board approval to engage in a contract for $59,500 with Toolbox Creative, to complete Phase 2 of the of the Health District and Mental Health and Substance Use Alliance's addiction public awareness campaign, "Changing Minds". The Health District will contract with Toolbox Creative again to utilize their existing knowledge and expertise of the goals and needs of the project, to further develop specific addiction messaging, and to understand and utilize marketing best practices, in order to develop new strategies and campaign elements that will help broaden the campaign's current reach in the community and continue to increase community learning about addiction as a chronic disease and the need for better services and care.

CIT has proposed a three-segment approach with Toolbox Creative that would launch new and exciting campaign elements in each phase throughout 2019, some specifically to be revealed at a large community event being planned for late August called, "Rethinking Addiction: A Call to Action for Northern Colorado". This event will include targeted addictions-related trainings and best practices for health service providers, criminal justice stakeholders and other community partners delivered by national, state and local addiction experts.

Memorandum

To: Health District Board

From: Chris Sheafor

Date: 3/22/2019

Re: Replat and Amendment to Covenants at 1075 Pennock Place

We have received a request from UC Health in Fort Collins to approve a change to the Subdivision Plat, and amend the Declaration of Covenants for a property in a subdivision where the Health District owns all of the property (leased to PVHC/UCHealth North) except one parcel which contains a Pizza Hut restaurant. The property is used for UC Health Family Medicine Center and other UCHealth services, but because it was part of Poudre Valley Hospital's property before 1994, the ownership is in the Health District's name. Any change to the property must be approved by the Health District Board.

Here is a little background information about why this request is being made. The shopping center was developed in the early 1980s by a developer that has since gone bankrupt, and several problems with the original subdivision documents have recently come to the current owner's attention.

The Pizza Hut's landlord, Hankster, LLC, owns the property under the footprint of their existing building with a valid deed. That parcel is located within Lot 1 of the Riverside Shopping Center Subdivision. The Health District owns lots 2 and 3 as well as the portion of lot 1 not within the Pizza Hut property. This does not seem to be a question of legal title and ownership, however, the developer did not complete the subdivision process by forming the intended association, deeding common area or parking to the association, or creating a legal lot for the parcel known as 1075 Pennock Place. This did not come up as an issue until the owner of the Pizza Hut property owner tried to get a Land Title ALTA Endorsement and was denied coverage.

The attached Amendment to Declaration of Covenants seeks to remedy the problem of not having a workable owner's association. PVHC/UCHealth has always provided maintenance of the entire subdivision (e.g., repaving, snowplowing, etc.) without being able to collect an assessment from the Pizza Hut owners. This would designate PVHC as Property Manager and define how assessments are charged to each owner. The Amendment also leaves common area ownership with both property owners rather than conveying common areas to a Property Owner's Association.

Our attorney has reviewed this document and wants the Board to be aware of a couple of issues. First, it moves the authority to make capital improvements to common areas and repave the parking lots to the Property Manager. Previously that was decided by agreement of all property owners. Second, it gives all responsibilities and decisions previously made by the Owner's Association, Architectural Control Committee and Association Board to the Property Manager. I have reviewed the original property covenants, and the only decisions that can be made by the Property Manager without concurrence of all of the owners relate to maintenance activities and exterior changes. Significant

decisions like mortgaging common area property or levying special assessments require the approval of all owners.

The attached ALTA/NSPS Land Title Survey shows the property boundaries which will be reflected in an amended Subdivision Plat for Parcel 1. The plat has not been finalized yet, but will require the Health District's signature when it is completed and approved by the City. When this is finalized, it will provide square footage numbers for Exhibit 3 under Paragraph 7 of the Amendment to Declaration of Covenants.

One last issue is that the Pizza Hut has added a metal walk-in cooler that has encroached on the Health District's property for many years. The attached Easement Agreement for Encroachment allows the building to remain as long as it is being utilized and maintained by the owner. Our attorney has suggested a couple of changes which are redlined in the attached document. Those have been forwarded to UC Health and as far as I can tell, are being incorporated into the final documents for signature.

I can provide additional information or documents if you would like to review them. Your approval is requested to proceed with executing the documents described here when the final versions are received.

EASEMENT AGREEMENT FOR ENCROACHMENT

THIS EASEMENT AGREEMENT FOR ENCROACHMENT ("Agreement") is made and entered into this ____ day of _____, 2019, by and between HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, a political subdivision of the State of Colorado, the address of which is 120 Bristlecone Drive, Fort Collins, Colorado 80524 ("Grantor"), and HANKSTER, L.L.C., a Colorado limited liability company, the address of which is 809 Hillcrest Drive, Basalt, Colorado 81621 ("Grantee").

RECITALS

A. Grantor is the owner of the following described real property ("Grantor's Property"):

> Lot 1, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, recorded at Reception No. _____, in Larimer County records, except that portion described as Lot 1A, being a portion of Lot 1, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, according to Subdivision Plat thereof recorded on _____, 2019 at Reception No. _____ of the Larimer County, Colorado records.

(Street Address: 1025 Pennock Place, Fort Collins, CO 80524)

B. Grantee is the owner of an adjacent parcel of real property located east of the Grantor's Property legally described as follows ("Grantee's Property"):

> Lot 1A, being a portion of Lot 1, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, according to Subdivision Plat thereof recorded on _____, 2019 at Reception No. _____ of the Larimer County, Colorado records.

(Street Address: 1075 Pennock Place, Fort Collins, CO 80524)

C. The building located upon the Grantee's Property currently encroaches upon the easterly portion of the Grantor's Property.

D. At Grantee's request, Grantor has agreed to grant an easement for such encroachment upon the terms and conditions set forth herein.

NOW, THEREFORE, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration, the receipt and adequacy of which are hereby confessed and acknowledged, Grantor and Grantee hereby agree as follows:

1. Definitions. For purposes of this Agreement, the following terms shall have the following meanings:

A. "Survey" shall mean and refer to the ALTA/NSPS Land Title Survey dated September 7, 2017 (Project No. 17106.001), a copy of which is attached hereto as Exhibit A and incorporated herein by reference.

B. "Metal Addition" shall mean and refer to the existing metal addition attached to the westerly side of the commercial building located upon the Grantee's Property which encroaches upon the Grantor's Property.

C. "Easement Area" shall mean and refer to that portion of the Grantor's Property upon which the Metal Addition is located as of the date hereof, which Metal Addition is located upon a portion of the most easterly seven and three/tenths (7.3) feet of the Grantor's Property as more fully depicted upon the Survey attached hereto as Exhibit A.

2. Grant of Easement. Grantor hereby grants and conveys to Grantee an exclusive easement during the Term (as defined in Section 3 below) to use, repair, maintain, occupy and enjoy the Metal Addition located within the Easement Area for purposes directly or indirectly associated with the operation of a restaurant facility located within the commercial building on the Grantee's Property.

3. Term. The "Term" of the easement granted herein shall commence upon the date hereof and shall terminate upon the earlier to occur of the following: (i) the date upon which Grantee, its successors and assigns, cease utilizing the Metal Addition within the Easement Area for the purposes granted hereunder for twelve (12) consecutive months; or (ii) the date upon which Grantee, ~~its successors or assigns,~~ removes, or fails to repair and reconstruct within six (6) months of a casualty, the Metal Addition within the Easement Area. Within one hundred twenty (120) days following the termination of the Term of the easement granted herein, Grantee shall remove or cause to be removed the Metal Addition within the Easement Area.

4. Maintenance and Repair of Metal Addition. Grantee shall maintain and repair the Metal Addition in a good and sightly order, condition and repair. Without limiting the generality of the foregoing, Grantee shall furnish all labor, materials and equipment necessary to properly maintain the Metal Addition and Grantor shall have absolutely no responsibility therefor.

5. No Mechanic's Liens. Grantee acknowledges that nothing in this Agreement shall authorize Grantee or any person dealing with, through or under Grantee to subject any portion of the Easement Area to a mechanic's or materialman's lien.

6. Insurance. Grantee shall carry comprehensive general liability insurance to insure all risks with minimum coverage limits of One Million Dollars ($1,000,000.00) for injury or

death for any one (1) occurrence and Three Hundred Thousand Dollars ($300,000.00) for property damage per occurrence. Grantor shall be listed as an additional insured under such policy. Grantee shall provide Grantor with a certificate evidencing such insurance upon execution of this Agreement and shall thereafter provide a copy of such certificate evidencing such insurance upon renewal during the Term of this Agreement.

7. Liability and Indemnification. Grantor assumes no liability for use, operation or existence of the Metal Addition within the Easement Area, or Grantee's use of the Easement Area hereunder. Grantor makes no representations or warranties as to whether Grantee has obtained or needs to obtain permits or governmental approvals for the Metal Addition for its use under this Agreement. Grantee shall indemnify and hold harmless Grantor and Grantor's tenants, together with their respective officers, directors, employees, agents, successors and assigns, from any and all liability, claims, losses, damages and expenses, including reasonable attorneys' fees, arising in connection with the use of the Easement Area by Grantee, its tenants, contractors, guests and invitees.

8. Notices. All notices and other communications required or permitted under this Agreement shall be in writing and shall be (a) personally delivered, (b) deposited with a nationally recognized overnight delivery service that routinely issues receipts, or (c) given by registered or certified mail, return receipt requested. Any such notice or other communication shall be effective when such notice is delivered to the addresses set forth below and received or refused by the addressee:

To Grantor:

Health Services District of Northern Larimer County
Attention: _____
120 Bristlecone Drive
Fort Collins, CO 80524
Telephone: _____

With copy to occupants of Grantor's Property:

To Poudre Valley Health Care, Inc.:

Poudre Valley Health Care, Inc.
Attention: _____
_____
_____
Telephone: _____

To University of Colorado Health:

University of Colorado Health
Attention: _____
_____

____
Telephone: ____________________

To the Grantee:

Hankster, L.L.C.
Attention: Mary A. Winter
809 Hillcrest Drive
Basalt, CO 81621
Telephone: (970) 927-4768

Any party, by ten (10) days' prior written notice given as set forth above, may change the address to which future notices or other communications intended for such party shall be sent.

9. Compliance with Laws. Grantee shall use the Easement Area in compliance with applicable Laws (defined below) and in a manner that does not interfere with Grantor's use and enjoyment of the Grantor's Property. "Laws" shall mean all laws, statutes, ordinances, rules, codes, regulations, orders, and interpretations of all federal, state, and other governmental or quasi-governmental authorities having jurisdiction over the Easement Area.

10. Successors and Assigns – Covenants Run With Land. The terms and conditions of this Agreement bind and inure to the benefit of the parties, and their respective successors and assigns. This Agreement and the easement granted herein shall constitute a covenant running with the land and shall be binding upon the Grantor's Property described herein and inure to the benefit of and be binding upon Grantee, its successors and assigns, and any persons claiming by, through or under them.

11. Modification. No provision or term of this Agreement may be amended, modified, revoked, supplemented, waived, or otherwise changed except by a written instrument duly executed by Grantor and Grantee with the written consent of Poudre Valley Health Care, Inc., a Colorado nonprofit corporation, and University of Colorado Health, a Colorado nonprofit corporation, for so long as they shall occupy the Grantor's Property.

12. Entire Agreement. This Agreement constitutes and incorporates the entire agreement among the parties hereto concerning the subject matter of this Agreement and supersedes any prior agreements concerning the subject matter hereof.

13. Attorneys' Fees. If any action is commenced between Grantor and Grantee concerning this Agreement or for the enforcement of rights and duties of any party pursuant to this Agreement, the court shall award the substantially prevailing party in the action its reasonable attorneys' fees in addition to any other relief that may be granted.

14. Severability. If any provision of this Agreement shall be held invalid, illegal, or unenforceable in any jurisdiction, the validity, legality, and enforceability of the remaining provisions of this Agreement shall not be impaired thereby.

15. Construction of Agreement. This Agreement resulted from review and negotiations between the parties and their attorneys. This Agreement will be construed to have been drafted by all of the parties so that the rule of construing ambiguities against the drafter will have no force or effect.

16. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado.

17. Authorization. Each party is authorized and empowered to execute this Agreement and all necessary corporate or company action has been taken to authorize execution of this Agreement.

18. No Partnership. Nothing in this Agreement shall be construed to make any party hereto or beneficiary hereof partners or joint venturers or to render any partner or beneficiary liable for the debts or obligations of the other party.

19. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed to constitute an original and all of which when taken together shall constitute one and the same instrument; provided, however, that this Agreement will not become binding upon any party unless and until executed (whether or not in counterpart) by all the parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates set forth below.

[Remainder of Page Intentionally Blank]

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF EASEMENT AGREEMENT FOR ENCROACHMENT

The undersigned hereby executes this page as part of the attached Easement Agreement for Encroachment by and between HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, as Grantor, and HANKSTER, L.L.C., a Colorado limited liability company, as Grantee.

HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, f/k/a THE POUDRE VALLEY HOSPITAL DISTRICT, a political subdivision of the State of Colorado

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, a political subdivision of the State of Colorado.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

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HANKSTER, L.L.C.,
a Colorado limited liability company

By_____
Name: Mary A. Winter
Title: Member

STATE OF _____)
) ss.
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by Mary A. Winter, as Member of HANKSTER, L.L.C., a Colorado limited liability company.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

(HF&G 02/19/19)

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF EASEMENT AGREEMENT FOR ENCROACHMENT

The undersigned, being an occupant of the Grantor's Property above described, hereby executes this page as part of the attached Easement Agreement for Encroachment by and between HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, as Grantor, and HANKSTER, L.L.C., a Colorado limited liability company, as Grantee, and expressly consents to, approves of and subordinates its interest in the Grantor's Property to said Easement Agreement for Encroachment.

POUDRE VALLEY HEALTH CARE, INC.,
a Colorado nonprofit corporation,
d/b/a Poudre Valley Health System

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of POUDRE VALLEY HEALTH CARE, INC., a Colorado nonprofit corporation, doing business as Poudre Valley Health System.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

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UNIVERSITY OF COLORADO HEALTH,
a Colorado nonprofit corporation

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of UNIVERSITY OF COLORADO HEALTH, a Colorado nonprofit corporation.

WITNESS my hand and official seal.

My commission expires: _____

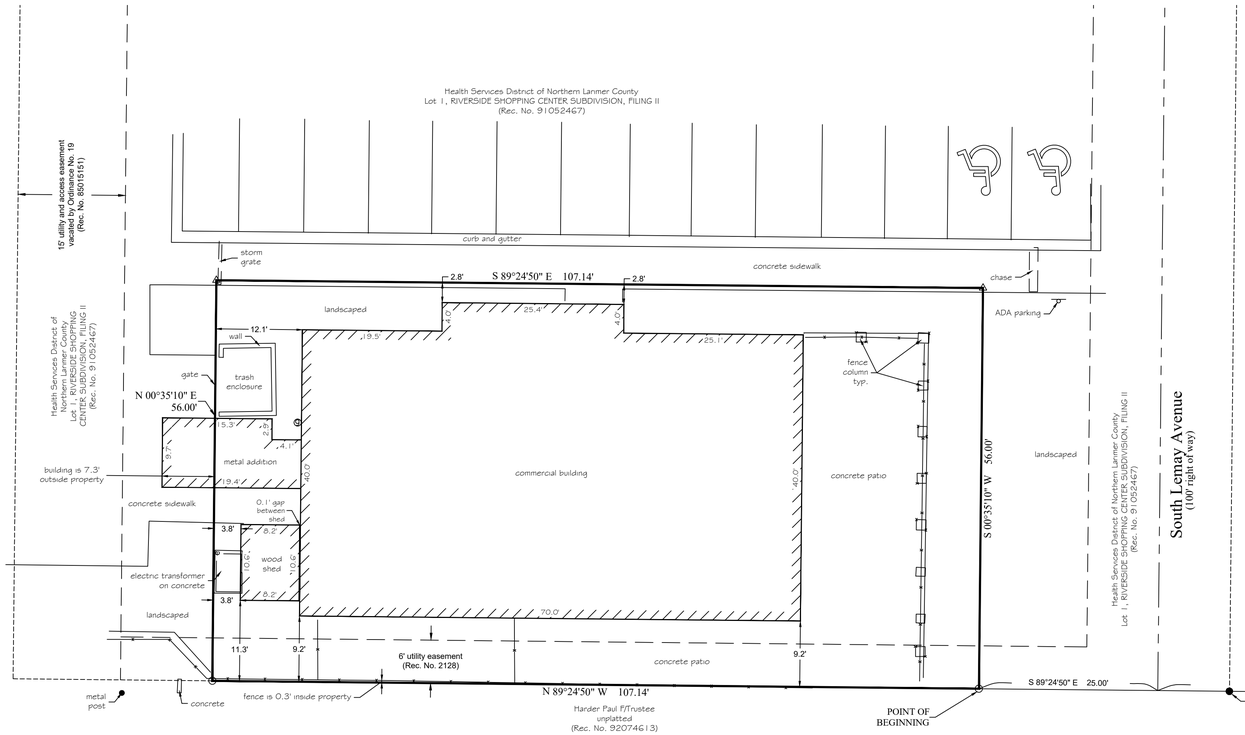
_____
Notary Public

EXHIBIT A

Survey

[To be attached]

ALTA/NSPS Land Title Survey



vicinity map
scale 1"=400'

LEGAL DESCRIPTION:

A TRACT OF LAND BEING LOCATED IN LOT 1, RIVERSIDE SHOPPING CENTER SUBDIVISION, FILING II, CITY OF FORT COLLINS, COUNTY OF LARIMER, STATE OF COLORADO, LOCATED IN THE NE 1/4 OF SECTION 13, TOWNSHIP 7 NORTH, RANGE 69 WEST OF THE 6TH P.M., COUNTY OF LARIMER, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

CONSIDERING THE EAST LINE OF THE NE 1/4 OF SAID SECTION 13 AS BEARING N 0° 25' E FROM A FOUND NO 4 REBAR AT THE E 1/4 CORNER OF SAID SECTION 13 TO A FOUND BRASS CAP AT THE NE CORNER OF SAID SECTION 13 AND WITH ALL BEARINGS CONTAINED HEREIN RELATIVE THERETO:

COMMENCING AT THE E 1/4 CORNER OF SAID SECTION 13; THENCE ALONG THE SAID EAST LINE OF SAID NE 1/4, N 0° 25' E, 350.00 FEET; THENCE N 89° 24' 24" W, 48.92 FEET TO THE SE CORNER OF SAID LOT 1; THENCE ALONG THE SOUTH LINE OF SAID LOT 1, N 89° 24' 24" W, 25.00 FEET TO THE POINT OF BEGINNING;

THENCE CONTINUING ALONG SAID SOUTH LINE, N 89° 24' 24" W, 107.14 FEET; THENCE DEPARTING SAID SOUTH LINE, N 0° 35' 36" E, 56.00 FEET; THENCE S 89° 24' 24" E, 107.14 FEET; THENCE S 0° 35' 36" W, 56.00 FEET, MORE OR LESS, TO THE POINT OF BEGINNING.

TITLE COMMITMENT NOTES:

PLS Group relied upon Title Commitment Number: FCC25149847-2
effective date of August 22, 2017 at 5:00 p.m., provided by Old Republic National Title Insurance Company.

SCHEDULE B-1:

PLS Group did not address or research these Items.

SCHEDULE B- Section 2 Exceptions:

Items 1-7: PLS Group did not address or research these Items.

8. EXISTING LEASES OR TENANCIES, IF ANY.

9. EASEMENTS, CONDITIONS, COVENANTS, RESTRICTIONS, RESERVATIONS AND NOTES ON THE PLAT OF RIVERSIDE SHOPPING CENTER SUBDIVISION, FILING II RECORDED JANUARY 14, 1985 UNDER RECEPTION NO. 2128.
APPLIES, SHOWN HEREON

10. TERMS, CONDITIONS AND PROVISIONS OF ORDINANCE RECORDED APRIL 02, 1985 AT RECEPTION NO. 85015151.
DOES NOT APPLY

11. RESTRICTIVE COVENANTS, WHICH DO NOT CONTAIN A FORFEITURE OR REVERTER CLAUSE, BUT OMITTING ANY COVENANTS OR RESTRICTIONS, IF ANY, BASED UPON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, FAMILIAL STATUS, MARITAL STATUS, DISABILITY, HANDICAP, NATIONAL ORIGIN, ANCESTRY, OR SOURCE OF INCOME, AS SET FORTH IN APPLICABLE STATE OR FEDERAL LAWS, EXCEPT TO THE EXTENT THAT SAID COVENANT OR RESTRICTION IS PERMITTED BY APPLICABLE LAW, AS CONTAINED IN INSTRUMENT RECORDED JANUARY 29, 1985, UNDER RECEPTION NO. 8504769.
APPLIES, UNPLOTTABLE, ENCOMPASSES ENTIRE PROPERTY

12. RESTRICTIVE COVENANTS, WHICH DO NOT CONTAIN A FORFEITURE OR REVERTER CLAUSE, BUT OMITTING ANY COVENANTS OR RESTRICTIONS, IF ANY, BASED UPON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, FAMILIAL STATUS, MARITAL STATUS, DISABILITY, HANDICAP, NATIONAL ORIGIN, ANCESTRY, OR SOURCE OF INCOME, AS SET FORTH IN APPLICABLE STATE OR FEDERAL LAWS, EXCEPT TO THE EXTENT THAT SAID COVENANT OR RESTRICTION IS PERMITTED BY APPLICABLE LAW, AS CONTAINED IN INSTRUMENT RECORDED FEBRUARY 26, 1986, UNDER RECEPTION NO. 8609953.
APPLIES, UNPLOTTABLE, ENCOMPASSES ENTIRE PROPERTY

13. RIGHT OF WAY EASEMENT AS GRANTED TO CITY OF FORT COLLINS IN INSTRUMENT RECORDED APRIL 02, 1985, UNDER RECEPTION NO. 85015152.
DOES NOT APPLY

14. RIGHT OF WAY EASEMENT AS GRANTED TO CITY OF FORT COLLINS IN INSTRUMENT RECORDED APRIL 02, 1985, UNDER RECEPTION NO. 85015156.
DOES NOT APPLY

15. RIGHT OF WAY EASEMENT AS GRANTED TO CITY OF FORT COLLINS IN INSTRUMENT RECORDED APRIL 02, 1985, UNDER RECEPTION NO. 85015157.
DOES NOT APPLY

16. RIGHT OF WAY EASEMENT AS GRANTED TO CITY OF FORT COLLINS IN INSTRUMENT RECORDED SEPTEMBER 09, 1985, UNDER RECEPTION NO. 85045432.
DOES NOT APPLY

Notes:

- No wetlands determinations were made this date.
- No improvements, other than those shown, were located this date.
- Any utilities shown are based on surface evidence only.
- No underground utilities were located this date.
- This survey is not intended for to be used for engineering design.
- No offsite improvements, other than those shown, were located this date.
- No identifiable parking spaces on the subject property.
- No evidence of recent earth moving work, building construction, or building additions observed in the process of conducting the fieldwork.
- Bearings are based on the East line of the Northeast ¼ Section 13, Township 7 North, Range 69 West, assumed to bear N 00°24'34" E.
- Observed Address: 1075 Pennock Place, Fort Collins, Colorado 80524
- Distances shown are in U.S. Survey Feet
- The total area contains 6,000 square feet (0.138 acres) more or less.

Legend:

- found Section corner monument as described
- found 0.5" iron rod with 1.0" plastic cap marked as described
- set 0.5" iron rod with 1.0" plastic cap marked PLS 32444
- set nail and disk marked PLS 32444
- gas meter
- fence line
- boundary line
- easement line
- right of way line
- adjacent lot line
- building outline

To Mike Howland, Hankster, LLC, a Colorado limited liability company and Old Republic National Title Insurance Company:

This is to certify that this map or plat and the survey on which it is based were made in accordance with the 2016 Minimum Standard Detail Requirements for ALTA/NSPS Land Title Surveys, jointly established and adopted by ALTA and NSPS, and includes Items 1, 2, 4, 7(a), 8, 9, 13 and 16 of Table A thereof. The fieldwork was completed on *8.29.2017.*

COLORADO REGISTERED M. BRYAN SHORT 32444 PROFESSIONAL LAND SURVEYOR

Date of Plat or Map: 9.7.2017
M. Bryan Short. Colorado Licensed Professional Surveyor Registration No. 32444

NOTICE: According to Colorado law you must commence any legal action based upon any defect in this survey within three years after you first discover such defect. In no event, may any action based upon any defect in this survey be commenced more than ten years from the date of the certification shown hereon.

P:\Projects\2017\17106\dwg\17106.dwg September 08, 2017 - 5:32pm

REVISIONS					
Date	By	Description			
Date	By	Description			
Date	By	Description			

Field Date	8.29.2017	ST	MDG
Party Chief	ADS	PM	MBS
Scale	1"=10'	PLS	MBS

CLIENT: Cushman & Wakefield

PLS Group
6843 North Franklin Avenue, Loveland, Colorado 80538
Phone: 970.669.2100 Fax: 970.669.3652

TITLE: **ALTA/NSPS Land Title Survey**
A portion of Lot 1, RIVERSIDE SHOPPING CENTER SUBDIVISION, FILING II
Section 13, Township 7 North, Range 69 West, 6th P .M., Larimer County, Colorado

PROJECT NO.	SHEET NO.	NO. OF SHEETS
17106.001	1	1

FIRST AMENDMENT
TO
DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS
FOR THE
RIVERSIDE SHOPPING CENTER
SUBDIVISION FILING NO. II

THIS FIRST AMENDMENT TO DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIVERSIDE SHOPPING CENTER SUBDIVISION FILING NO. II ("First Amendment") is made and entered into by HANKSTER, L.L.C., a Colorado limited liability company ("Hankster"), and HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, a political subdivision of the State of Colorado ("Health District"). Hankster and the Health District are sometimes referred to herein as "Owners."

RECITALS

A. The Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II was recorded on February 26, 1986, at Reception No. 86009953 of the Larimer County, Colorado records ("Declaration").

B. Unless otherwise defined or modified in this First Amendment, all capitalized terms used herein shall have the same meaning as set forth in the Declaration.

C. The Declaration pertains to certain real property situate in the City of Fort Collins, County of Larimer, State of Colorado, legally described as follows ("Property"):

Riverside Shopping Center
Subdivision, Filing No. II,
City of Fort Collins,
County of Larimer,
State of Colorado.

D. The Property was platted into three (3) separate lots known as Lot 1, Lot 2 and Lot 3, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, pursuant to the Plat of Riverside Shopping Center Subdivision, Filing II, recorded January 14, 1985, under Reception No. 852128 of the Larimer County, Colorado records ("Original Plat").

E. A portion of Lot 1, Riverside Shopping Center Subdivision, Filing II, was further subdivided by Subdivision Plat recorded on _____, 2019, at Reception No. _____ of the Larimer County, Colorado records ("New Subdivision Plat"), creating a new lot known as Lot 1A.

F. Lot 1A is owned by Hankster and the remainder of Lot 1, Riverside Shopping Center Subdivision, Filing II, is owned by the Health District.

G. The Health District and Poudre Valley Health Care, Inc., a Colorado nonprofit corporation, doing business as Poudre Valley Health System ("PVHC"), are parties to that certain Hospital Operating Lease Agreement entered into as of May 1, 1994, by and between the Health District and PVHC, as amended by: (i) the First Amendment of Hospital Operating Lease Agreement dated as of November 1, 1994; (ii) the Third Amendment of Hospital Operating Lease Agreement dated as of October 27, 1999; (iii) the Fourth Amendment of Hospital Operating Lease Agreement dated as of November 8, 1999; (iv) the Addendum to Hospital Operating Lease Agreement dated as of June 17, 2004; (v) the Fifth Amendment of Hospital Operating Lease Agreement dated as of March 1, 2005; (vi) the 6th Amendment to the Hospital Operating Lease Agreement adopted by resolution of the District dated April 11, 2008; and (vii) the Operating Lease Amendment and Consent Agreement dated February 12, 2012 ("Operating Lease").

H. A Memorandum of Lease dated June 22, 1994, evidencing the Operating Lease was recorded in the Office of the Clerk and Recorder of Larimer County, Colorado, on July 27, 1994, at Reception No. 94063152, as amended by the Amendment to Memorandum of Lease (Hospital Operating Lease Agreement) ("Amendment to Memorandum of Lease") recorded in the Office of the Clerk and Recorder of Larimer County, Colorado, on July 3, 2012, at Reception No. 20120043969 and re-recorded in the Office of the Clerk and Recorder of Larimer County, Colorado, on November 13, 2012, at Reception No. 20120080001.

I. PVHC was and remains a ground lessee of the Property under the terms of the Operating Lease.

J. Under the terms of a Joint Operating Agreement entered into among PVHC, The University of Colorado Hospital Authority, and University of Colorado Health, a Colorado nonprofit corporation ("JOC"), JOC agreed to be bound by the terms and conditions of the Operating Lease and PVHC and JOC agreed to be jointly and severally liable to the Health District for the performance of the obligations and covenants under the Operating Lease.

K. Section 14.3.1 of the Declaration provides as follows:

> 14.3.1 Any provision contained in this Declaration may be amended, or additional provisions may be added to this Declaration, by Recording of a written instrument or instruments specifying the amendment or addition executed by not less than one hundred percent (100%) of the Owners and First Mortgagees or their authorized agent(s).

L. Hankster and the Health District are one hundred percent (100%) of the Owners of the Property encumbered by the Declaration and there are no First Mortgagees having a Mortgage encumbering a Lot.

M. PVHC and JOC evidence their consent to this First Amendment and the subordination of their interests in the Operating Lease to the Declaration as amended pursuant to this First Amendment as indicated hereon.

N. The parties desire to amend and modify the Declaration to more closely represent the manner in which the Property subject to the Declaration has been operated in the past, including, but not limited to, (i) the elimination of the requirement to establish an Association or transfer Common Area to an Association, it being the intent of both parties that all rights, duties and obligations previously granted to the Association, its Board of Directors, its Managing Agent or its Architectural Design Committee be discharged by the Property Manager (as defined below).

NOW, THEREFORE, the undersigned Owners do hereby publish and declare that the Declaration is amended and modified as follows:

1. Article 1 – Definitions. Article 1 of the Declaration entitled "Definitions" is hereby amended as follows:

A. Section 1.6 – Common Area. The definition of the term "Common Area" in Section 1.6 of the Declaration is hereby amended and restated in its entirety as follows:

> *1.6 "Common Area" shall mean and refer to all areas within the interior boundaries of the Property excluding (i) any Building now or hereafter existing and (ii) a ten (10) foot envelope surrounding the exterior of each Building now or hereafter existing on the Property and shall specifically include rights-of-way, easements for private streets, driveways, access ways, pedestrian walkways, landscaped areas, loading zones, parking areas and Easements as more fully set forth in Article 6 of the Declaration located within the Property.*

B. Section 1.16 – Lot. The definition of the term "Lot" in Section 1.16 of the Declaration is hereby amended to mean and refer to the following lots, as may hereafter be amended or modified:

(1) Lot 1A of the New Subdivision Plat.

(2) Lot 1 of the Original Plat less and except Lot 1A of the New Subdivision Plat.

(3) Lots 2 and 3 of the Original Plat.

C. New Defined Term. Article 1 of the Declaration entitled "Definitions" is hereby amended to include the following additional definition:

1.30 "Property Manager" shall mean and refer to (i) PVHC or such other Person designated jointly in writing by PVHC and the Health District until such time as PVHC is no longer a tenant under the Operating Lease and thereafter (ii) the Health District, as the Owner of a majority of the Building square footage located within the Property, or such other Person designated in writing by the Health District.

2. Article 3 – Rights in the Association. Article 3 of the Declaration entitled "Rights in the Association" is hereby deleted in its entirety.

3. Section 5.3 – Annual Assessments. Section 5.3 of the Declaration entitled "Annual Assessments" is hereby amended to delete the limitation on capital expenditures which may be incurred without approval of all Owners.

4. Section 5.5 – Special Assessments. Section 5.5 of the Declaration entitled "Special Assessments" is hereby amended to delete the restriction for asphalt repaving without first obtaining the approval of all Owners and without regard to any limitation measured as a percentage of the annual assessment applicable to each Lot.

5. Article 6 – Easements. The Owners hereby expressly reaffirm, confirm and ratify the validity of the easements created on all Lots within the Property as more fully set forth in Article 6 of the Declaration entitled "Easements."

6. Article 10 – Insurance. Article 10 of the Declaration entitled "Insurance" is hereby amended and restated in its entirety as follows:

10. INSURANCE

10.1 Insurance Generally. The Owner of each Lot shall provide and maintain commercial general liability insurance (including contractual liability coverage) insuring (to the extent coverage is provided by such insurance) each such Owner against claims for personal injury, bodily injury or death, and property damage or destruction arising out of such insured party's negligent acts or omissions in its use, operation and/or occupancy of the Property. Such insurance shall be written with an insurer licensed to do business in the State of Colorado and shall name the Owners of other Lots within the Property as additional insureds as long as such Owner(s) owns any one (1) or more Lots within the Property. The limits of liability of all such insurance shall be not less than One Million Dollars ($1,000,000.00) for personal injury or bodily injury or death of any one (1) person, Two Million Dollars ($2,000,000.00) for personal injury or bodily injury or death of more than one (1) person in one (1) occurrence

and Three Hundred Thousand Dollars ($300,000.00) with respect to damage to or destruction of property; or, in lieu of such coverage, a combined single limit (covering personal injury, bodily injury or death and property damage or destruction) with a limit of Three Million Dollars ($3,000,000.00) per occurrence. Limits of liability may be provided under a commercial general liability and umbrella policy, if desired. Except as provided below, each Owner shall furnish the other Owners with certificates evidencing such insurance. To the extent commercially obtainable, the policies of such insurance shall provide that the insurance represented by such certificates shall not be cancelled without the giving of thirty (30) days' prior written notice to the holders of such insurance and the holders of such certificates (including the Owners as long as such Owner[s] owns one [1] or more Lots within the Property). The limits of insurance set forth in this Section 10.1 may be adjusted either up or down by the Property Manager, so long as the requested change is consistent with the limits of insurance carried by owners and tenants of similar properties in the Fort Collins, Colorado area, and does not require an Owner to carry "terrorism" insurance.

10.2 Casualty Insurance. Each Owner shall obtain and keep in full force and effect at all times, to the extent reasonably obtainable, casualty, fire and extended coverage insurance with respect to all Improvements located upon such Owner's Lot, including the common Improvements located thereon, in such amount and upon such terms as each such Owner shall determine.

7. Exhibit 3. Exhibit 3 to the Declaration is hereby amended to eliminate reference to votes and to provide as follows with respect to the obligation to pay assessments:

Obligation to Pay Assessments Among the Lots

Lot	Total Square Footage of Building(s) Lots*	Percentage of Assessments**
Lot 1A	2,902	____%
Lot 1 less and except Lot 1A	[xxxx]	[xxxx]
Lot 2	[xxxx]	[xxxx]
Lot 3	[xxxx]	[xxxx]

8. Association/Board of Directors/Managing Agent/Architectural Design Committee. All references in the Declaration to the "Association," the "Board of Directors" or "Board," the "Managing Agent" and the "Architectural Design Committee" shall mean and refer to the Property Manager and all of the rights, powers, duties and obligations of the

"Association," the "Board of Directors" or "Board," the "Managing Agent" and the "Architectural Design Committee" shall be deemed to be granted to and assumed by the Property Manager. The Property Manager shall discharge all of such rights, powers, duties and obligations previously assigned to or authorized to be undertaken by the "Association," the "Board of Directors" or "Board," the "Managing Agent" and the "Architectural Design Committee," provided that the Property Manager shall act in a commercially reasonable manner with respect thereto.

9. No Conveyance of Common Area to Association. All references in the Declaration to the conveyance of the Common Area to the Association are hereby deleted in their entirety from the Declaration, it being acknowledged that no real property within the boundaries of the Property has been conveyed to any party other than the Owners of the Lots.

10. Binding Effect. Except as expressly amended and modified herein, the terms, covenants, conditions, easements, restrictions and reservations contained in the Declaration shall remain in full force and effect, and the Declaration (as amended and modified herein) shall be deemed to run with the Property, shall be a burden and benefit to the Property, and any Person or Persons acquiring or owning any interest in the Property, and their respective grantees, heirs, administrators, personal representatives, successors and assigns.

11. Conflicts. In the event of any conflict between the terms and provisions of this First Amendment and the Declaration, the terms and provisions of this First Amendment shall control.

12. Effective Date. The effective date of this First Amendment shall be the date of recording of the same in the Larimer County, Colorado records.

13. Counterparts. This First Amendment may be executed in any number of counterparts; when so executed, all of such counterparts shall constitute a single instrument binding upon all parties hereto, notwithstanding the fact that all parties are not signatory to the original or to the same counterpart.

IN WITNESS WHEREOF, the undersigned have executed this First Amendment on the dates set forth below.

[Remainder of Page Intentionally Blank]

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF FIRST AMENDMENT TO DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIVERSIDE SHOPPING CENTER SUBDIVISION FILING NO. II

The undersigned, being one (1) or more of the Owners of Riverside Shopping Center Subdivision, Filing II, a subdivision in the City of Fort Collins, County of Larimer, State of Colorado, hereby executes this page as part of the attached First Amendment and expressly consents to the amendment of the Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II as more fully provided therein.

REAL PROPERTY OWNED BY UNDERSIGNED:
Lot 1A, being a portion of Lot 1, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, according to Subdivision Plat recorded on _____, 2019 at Reception No. _____ of the Larimer County, Colorado records.

HANKSTER, L.L.C.,
a Colorado limited liability company

By_____
Name: Mary A. Winter
Title: Member

STATE OF _____)
) ss.
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by Mary A. Winter, as Member of HANKSTER, L.L.C., a Colorado limited liability company.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF FIRST AMENDMENT TO DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIVERSIDE SHOPPING CENTER SUBDIVISION FILING NO. II

The undersigned, being one (1) or more of the Owners of Riverside Shopping Center Subdivision, Filing II, a subdivision in the City of Fort Collins, County of Larimer, State of Colorado, hereby executes this page as part of the attached First Amendment and expressly consents to the amendment of the Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II as more fully provided therein.

REAL PROPERTY OWNED BY UNDERSIGNED:
Lots 2 and 3, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, according to the Plat of Riverside Shopping Center Subdivision, Filing II, recorded January 14, 1985, under Reception No. 852128 of the Larimer County, Colorado records, and Lot 1 less and except Lot 1A, being a portion of Lot 1, Riverside Shopping Center Subdivision, Filing II, City of Fort Collins, County of Larimer, State of Colorado, according to Subdivision Plat recorded on _____, 2019 at Reception No. _____ of the Larimer County, Colorado records.

HEALTH SERVICES DISTRICT OF
NORTHERN LARIMER COUNTY,
f/k/a THE POUDRE VALLEY HOSPITAL
DISTRICT, a political subdivision of the
State of Colorado

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of HEALTH SERVICES DISTRICT OF NORTHERN LARIMER COUNTY, formerly known as THE POUDRE VALLEY HOSPITAL DISTRICT, a political subdivision of the State of Colorado.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF FIRST AMENDMENT TO DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIVERSIDE SHOPPING CENTER SUBDIVISION FILING NO. II

The undersigned, being a tenant under the Operating Lease above described, hereby executes this page as part of the First Amendment to Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II and expressly consents to, approves of and subordinates its interest in the Operating Lease to the Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II as amended pursuant to said First Amendment to Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II.

POUDRE VALLEY HEALTH CARE, INC.,
a Colorado nonprofit corporation,
d/b/a Poudre Valley Health System

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of POUDRE VALLEY HEALTH CARE, INC., a Colorado nonprofit corporation, doing business as Poudre Valley Health System.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

SIGNATURE PAGE ATTACHED TO AND MADE A PART OF FIRST AMENDMENT TO DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIVERSIDE SHOPPING CENTER SUBDIVISION FILING NO. II

The undersigned, having assumed the obligations of tenant under the Operating Lease above described, hereby executes this page as part of the First Amendment to Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II and expressly consents to, approves of and subordinates its interest in the Operating Lease to the Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II as amended pursuant to said First Amendment to Declaration of Covenants, Conditions and Restrictions for the Riverside Shopping Center Subdivision Filing No. II.

UNIVERSITY OF COLORADO HEALTH,
a Colorado nonprofit corporation

By_____
Name: _____
Title: _____

STATE OF COLORADO)
) ss.
(CITY AND) COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019, by _____, as _____ of UNIVERSITY OF COLORADO HEALTH, a Colorado nonprofit corporation.

WITNESS my hand and official seal.

My commission expires: _____

_____
Notary Public

Health District
OF NORTHERN LARIMER COUNTY

3/22/2019

STAFF: TRENTEN ROBINSON
& ALYSON WILLIAMS

POLICY ANALYSIS

HB 19-1176: HEALTH CARE COST SAVINGS ACT OF 2019

Concerning the enactment of the "Health Care Cost Savings Act of 2019" that creates a task force to analyze health care financing systems in order to give the general assembly findings regarding the systems' costs of providing adequate health care to residents of the state

Details

Bill Sponsors:	House – *Sirota* (D) *and Jaquez Lewis* (D), Benavidez (D), Singer (D) Senate – *Foote* (D)
Committee:	House Health & Insurance Committee
Bill History:	2/12/2019 – Introduced
Next Action:	3/27/2019 – Hearing in Health & Insurance Committee
Fiscal Note:	3/20/2019 Version

Bill Summary

This bill responds to increasing health care costs and pricing inequities by creating the Health Care Cost Analysis Task Force. The purpose of this task force is to select a professional analyst to prepare a report for the General Assembly on a variety of health care funding mechanisms. The bill identifies three financing systems that could be potential solutions this policy issue: a public option, multipayer health care, and publicly-funded and privately financed universal health care. The analyst's report shall take into account costs, premiums, coverage rates, and the effect on various types of health care. The report must be delivered on or before January 1, 2021.

Issue Summary

Health Care Costs in Colorado

Health care quality in Colorado has been steadily improving and currently ranks sixth in the nation according to the Commonwealth Fund.[1] However, Colorado still struggles to increase access to health care, particularly in rural areas, Coloradans continue to have strong concerns about the cost of health insurance and care, and people in Colorado can have dire financial circumstances if they develop chronic illness or have emergency or other needs for health care that result in high out-of-pocket costs. Coloradans spend an average of $6,804 per capita (14 percent of their income) on health care, and costs can be far higher for many. Analysis shows that costs will continue to rise and manifest in increased deductibles, with nearly all insurance plans in Colorado relying on deductibles to cover costs.[2] A few of the reasons that the cost of care continues to rise include expensive technologies, consolidation, fee-for-service payments, prescription drugs, low-value care, and the continued aging of the population.[3] Currently, some say that health care costs are rising unsustainably, making the availability of affordable health care a concern for many Coloradans.[4] Moreover,

[1] The Commonwealth Fund. (2017). "Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance." Retrieved from https://interactives.commonwealthfund.org/2017/mar/state-scorecard/.
[2] Colorado Health Institute (CHI). (Dec. 14, 2018). *Affordability in Colorado: Questions and Answers about Health Care Costs.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf.
[3] CHI. (2017). *A Fresh Look at Health Care Cost Drivers: Exploring Free Market and Regulatory Solutions*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/X_Cost_Drivers_fact_sheet_SENT.pdf
[4] Colorado Consumer Health Initiative (Feb. 2019). *What Coloradans Are Saying About Health Care.* Retrieved from https://www.cohealthinitiative.org/what-coloradans-are-saying-about-health-care

access to health care is still limited, with rural residents paying disproportionately higher premiums, which may be largely due to the lack of competition in the health care market.[2]

1999 Colorado Health Care Task Force

The 1999 Colorado Health Care Task Force was created in order to review the state of older adult care coverage at the turn of the century. It was dedicated to reviewing long-term health care for older adults but also spent significant time reviewing modern developments in the health care field, including issues regarding pharmacy benefit managers, rural hospitals, health care work force shortages, and telemedicine.[5] The commission was given a five-year time frame for completion.

After its five-year term, the Health Care Task Force sent recommendations to the General Assembly and was extended for the next three years in order to continue to provide recommendations for the General Assembly based on the other parts of their research. Some of the recommendations were introduced in the General Assembly include expanding Medicaid eligibility to 21 years old for those in the foster system, expanding eligibility for CoverColorado[6], requiring school districts to check for health coverage of students, expanding eligibility for the Child Health Plan Plus (CHP+), and the creation of a state maximum allowable cost program in Medicaid for prescription drugs.[7] Of these listed proposals, only one, expanding Medicaid eligibility for foster youth, passed out of the General Assembly and was signed into law by the Governor.

Looking back, the 1999 Colorado Health Care Commission had some success, but access to health care and costs of health care remained significant challenges. While some legislation regarding coverage and financing was recommended, the majority of the legislation was largely focused on other issues. Nonetheless, the 1999 Commission was objectively the most successful in regards to the number of recommendations signed into law. The 1999 Colorado Health Care Task Force was terminated at the end of 2007 after the creation of the Blue Ribbon Commission for Health Care Reform (208 Commission).

2007 Blue Ribbon Commission for Health Care Reform (the 208 Commission)

The Blue Ribbon Commission for Health Care Reform, commonly referred to as the 208 Commission, was created in 2006 to address expanding health care coverage and reducing costs after the expiration of the 1999 Colorado Health Care Task Force. The Commission was tasked with responding to growing uninsured rates and premium increases, which were asserted to be a result of the uninsured rate. The Commission requested proposals for different approaches, chose a few of the proposals for modeling, and selected an analyst from the Lewin Group to perform the modeling and analyze the results.[8] At the time, the Health District worked closely with other experienced leaders (including the head of Denver Health, a renowned health economist, physicians studying alternatives, etc.) to develop one of the proposals, which was one of the few selected for modeling.

The final Commission report consisted of 31 policy suggestions that the Commission believed would address the problems highlighted in their mission. The group believed the solution should be to stabilize rising costs and extend health coverage to more people. The report put their proposals into three parts: “Reduce Health Care Costs, while Enhancing Quality of Care”; “Improve Access to Care, with Mechanisms to Provide

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[5] Health Care Task Force. (2002). “Report to the Colorado General Assembly.” Pursuant to Section 26-15-107. Research Publication No.497. Retrieved from https://www.colorado.gov/pacific/sites/default/files/healthcaretaskforce.pdf.

[6] CoverColorado was a high-risk pool that operated from 1991 to 2013. 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%).

[7] Burger, Elizabeth. (July 2009). “Activities of the Health Care Task Force from 2005 to 2008.” Memorandum to Members of 2009 Health Care Task Force. Retrieved from http://hermes.cde.state.co.us/drupal/islandora/object/co%3A13829/datastream/OBJ/view.

[8] Blue Ribbon Commission for Health Care Reform (January 2008). “Final Report to the Colorado General Assembly – Executive Summary.” Pages 7-10. Retrieved from https://www.colorado.gov/pacific/sites/default/files/700-832-Commission%20Final%20Report-Executive%20Summary.pdf.

Choices"; and, adopting all 30 proposals under the previous 2 parts as a "comprehensive, integrated package" in various implementation stages.

Of the final 31 recommendations, only 4 were selected for consideration by the General Assembly. The four proposals were an attempt to address both concerns over uninsured rates and health care costs. Under Governor Bill Ritter (D), the Commission's efforts resulted in limited steps towards fixing issues, including the creation of the Center for Improving Value in Health Care (CIVHC), a higher reimbursement rate for doctors treating Medicaid patients, and the expansion of Medicaid in Colorado. Further work was difficult when the national economy crashed and the State's revenues fell dramatically, and the reimbursement and Medicaid policies were shelved at that time. However, later – before the Patient Protection and Affordable Care Act (ACA) - Colorado began to modestly expand Medicaid utilizing limited state revenues. Many of the recommendations were similar to those ultimately included in the ACA, and were more achievable with national regulations and funding.

Public Option

A public option system would create a state-financed health care insurance option that would be available to citizens alongside the private insurance market. This public insurance option could largely mirror a similar existing structure, such as Medicare or Medicaid. A public option was included in early drafts of the ACA but later removed in the final draft of the law.[9] However, as researchers note, there is nothing in current federal law that prevents states from pursuing their own public option.[10] No state has completely enacted a true public option system, though some states (and cities) have begun considering such policies, including New Mexico, Colorado, Washington, Connecticut, and New York City.

In Colorado, HB19-1004 is currently being considered. The bill requires the Colorado Department of Health Care Policy and Financing (HCPF), Division of Insurance (DOI), and Department of Regulatory Agencies (DORA) to develop and submit a proposal to the General Assembly in regards to the design, costs, benefits, and implementation of a state option for health insurance coverage. The proposal must have a detailed analysis of the state option and identify the most effective implementation based on affordability, burden to the state, ease of implementation, and likelihood of meeting outlined objectives.

Universal Health Care

The United States is the only large rich country without universal health care.[11] There are a variety of different types of universal health care systems, including the following.

The Beveridge Model – Health care is provided and paid for by the government using tax dollars.[12] The government represents the "single-payer" for all medical bills. Under this system, care tends to be free at the point of service and the majority of the health workforce are government employees. Examples of this model include the United Kingdom, Spain, New Zealand, and Cuba. Within the U.S. this model is similar to the Veterans Health Administration.[13]

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[9] Halpin, H.A. & Harbage, P. (June 2010). The Origins and Demise of the Public Option. *Health Affairs.* Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363

[10] Halpin, Helen A. and Peter Harbage. (2010). "The Origins and Demise of the Public Option." *Health Affairs* 29 (10): 1117-1124. Retrieved from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0363.

[11] The Economist (Apr. 26, 2018). *America is a health-care outlier in the developed world.* Retrieved from https://www.economist.com/special-report/2018/04/26/america-is-a-health-care-outlier-in-the-developed-world

[12] Frontline PBS. (April 15, 2008). *Health Care Systems – The Four Basic Models*. Retrieved from https://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html.

[13] Chung, M. (Dec. 2, 2017). Health Care Reform: Learning from Other Major Health Care Systems. *Princeton Public Health Review.* Retrieved from https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/

The Bismarck Model – The insurance market remains private as does the ownership of most health care facilities and contracts. However, health insurance covers every person and all insurance plans are jointly-funded by employers and employees. The number of insurers in the market varies by country; France has a single insurer, Germany has multiple, competing insurers, and Japan has multiple, non-competing insurers. No matter the number, government controls prices and insurers do not make a profit.[13] Examples of this system include France, Germany, Japan, Belgium, and Switzerland. Within the U.S. this model is similar to some aspects of Medicaid as well as employer-funded health plans.

The National Health Insurance Model – This model incorporates aspects of the previous two systems. The government acts as the single payer for services and the providers are private. In the most popular version of this system, Canada, this has driven down pharmaceutical costs. The specific aspects of this model vary from country to country. Under Canada's system, private insurance contracting is permitted for those individuals that prefer to do so. This system covers most procedures regardless of the individual's income. Examples of this system include Canada, Taiwan, and South Korea.[13] Within the U.S., this model is similar to Medicare.

Multipayer Health Care

A multipayer system allows multiple private health insurers to operate and receive funding from consumers, employers, government, or some combination of these groups. A recent literature review found that in general, multipayer systems tend to yield additional options to patients but involve a higher administrative cost.[14] Although similar to what is occurring currently, some may point to examples of the Bismarck Model, such as Germany, an example of multipayer health care.

This Legislation

The bill declares the following: health care costs are rising unsustainably; affordable health care is a major concern for most Americans; rural Coloradans pay disproportionately higher premiums; 850,000 Coloradans are uninsured or underinsured; and Colorado needs more facts to determine the most "cost-effective" method of financing health care.

It defines "at-risk insured" as a resident who is not underinsured because they are currently healthy but would become underinsured if they developed a serious medical condition. It defines a "public option system" as a system under which all residents are able to purchase a health care plan managed by the State or Connect for Health Colorado. The bill defines "underinsured" as a person who has health insurance but has health care costs that exceed ten percent of the person's personal income, including high deductibles and out-of-pocket expenses. "Universal health care" is defined as a system under which every resident has access to adequate and affordable health care.

The purpose of the task force is to develop comprehensive fiscal analyses of current and alternative financing systems. The following appointments must be completed by September 1, 2019. The task force shall be composed of eight members from the General Assembly, with two each appointed by the Speaker of the House, the Minority Leader of the House, the President of the Senate, and the Minority Leader of the Senate. The Governor appoints nine members to the task force that are socially, demographically, and geographically diverse as well as demonstrate the ability to represent all Coloradans and can present nonpartisan and evidence-based ideas. Finally, the executive directors, or their designees, of the Department of Human Services (DHS), the Department of Public Health and Environment (CDPHE), and Department of Health Care Policy and Financing (HCPF) will serve on the task force. A chair and vice-chair are chosen from the members. A member of the task force can be removed from their seat with a majority vote from the other members. If there is a vacancy, the original appointing entity fills that seat. Members of the task force

[14] Petrou, P., Samoutis, G., & Lionis C. (Oct. 2018). Single-payer or a multipayer health system: a systematic literature review. *Public Health.* doi: 10.1016/j.puhe.2018.07.006

are not entitled to per diem or compensation for performance, but can be reimbursed for actual and necessary expenses while performing official duties. The members are subject to the Colorado Sunshine Law[15] and state open public records laws[16].

On or before October 1, 2019, the task force shall issue a request for proposals in order to select an analyst to work on the analysis of the health care financing systems. Based on submissions, the task force will select and contract with a professional analyst by majority vote. The analyst should have experience conducting health care costs analyses, is familiar with different methodologies, and is employed by a nonpolitical and unbiased organization. The task force must provide a preliminary report of methodology to the General Assembly by January 1, 2020. Subsequently, by January 1, 2021 the task force is to submit a final report of the findings to the General Assembly. The task force can hire staff and consultants, if necessary, to complete its duties.

The analyst must determine the methodology to be used in the study and consider feedback from stakeholders including:

- Licensed physicians, nurses, dentists, pharmacists, hospitals, and other health providers
- Mental health and substance use disorder providers and advocates
- Health care education organizations
- Individuals with disabilities and advocates for those individuals
- Patient advocates
- Representatives of minority communities
- Representatives of underserved and rural communities
- Faith-based organizations
- Employers and employer organizations
- Employees and employee organizations

The analyst, at a minimum, is to study the following systems:

- Current Colorado health financing system
- A public option system where health plans are sold through, and revenues and premiums are received from, Connect for Health Colorado, with additional funding from the General Fund
- A multipayer universal health system where all residents of the state are covered under a plan with a mandated set of benefits, that is publicly and privately funded and also paid for by employer and employee contributions
- A publicly financed and privately delivered universal health care system that directly compensates providers

In the analysis of each financing system, the analyst must consider the following:

- First, second, fifth, and tenth year costs
- Compensation rates for licensed health care providers at levels that will retain necessary health care workers
- Effect of each system on the numbers of uninsured, underinsured, and at-risk insured individuals
- Health expenditures by payer
- Out-of-pocket costs including coinsurance, deductibles, and copayments
- How each system provides:
    - Services required by the Patient Protection and Affordable Care Act (ACA)
    - Medicare-qualified services
    - Medicaid services and benefits equal or greater to current services and Medicaid services and benefits for individuals with disabilities

[15] C.R.S. Title 24, Article 6, All government actions that discuss public business or take formal action must be open to the public.
[16] C.R.S. Title 24, Article 72 201-206.

  - Coverage for women's health and reproductive care, including abortion services
  - Vision, hearing, and dental services
  - Access to primary specialty services in rural and underserved areas as well as for underserved populations
  - Mental health and substance use disorder services
- Collateral costs to society, including:
  - Cost of emergency room, urgent care, and intensive care treatment for those unable to afford preventive or primary care in lower-cost settings
  - Cost in lost time from work, decreased productivity, or unemployment for those that develop a severe, urgent, or disabling condition due to being unable to afford primary or preventive care
  - Cost of bankruptcies caused by unaffordable medical expenses, including the cost to providers that do not get paid as a result of the bankruptcies
  - Costs and effects on those people that do not file bankruptcies due to medical expenses but are financially depleted by the costs
  - Medical costs due to the diversion of funds from other determinants, such as education, safe food and water
  - Other collateral costs determined by the task force

The analyst's report must consider at least four "sufficient and fair funding systems," that are viable for each of the studied systems outlined above. These systems can raise revenue from the general fund, federal waivers under Medicaid and the ACA, or a combination of income taxes, payroll taxes split between employers and employees, and other taxes (i.e. cigarette, alcohol, marijuana, sugary drink, and premiums based on income).

The General Assembly can appropriate money to HCPF for the purposes of the task force and analysis. HCPF and the task force can seek, accept, and expend gifts, grants, and donations. Appointments to the task force and the analysis are not to occur until there is sufficient funding. This bill is repealed September 1, 2021. The bill is effective upon the Governor's signature.

Fiscal Note

The fiscal note predicts that HCPF would need $95,268 for FY2019-20 for personal services, operating expenses, task force reimbursement, and other costs. Whereas for FY2020-21 this appropriation would need to increase to $378,395, mainly to account for the costs of the contract analyst. Funds needed to implement the bill in FY2021-22 would decrease $111,276 due to fewer hours necessary for the contract analyst, and the end of the task force. For both FY2019-20 and FY2020-21, the Legislative Department would expend $7,668 in order for per diem and reimbursement of legislators on the task force.

Reasons to Support

The bill may provide for a nonpartisan and fact-based analysis of different health care funding mechanisms and their effects in Colorado, specifically. At the least, it will expand knowledge of the pros, cons, and costs of various approaches. At its best, it may lead to viable changes for Colorado that could help contain fast-growing increases in the cost of health care. This bill largely mirrors the requirements of the 208 Commission in 2006, which many proponents argue was a very successful, and a bipartisan approach to health care reform that was interrupted by the economic crisis in 2008. The bill is a low-risk approach to beginning to address health care costs in Colorado. Some believe that the solution needs to be a comprehensive health care financing reform; this analysis could help determine if that is possible. Given recent rejections of one single-payer health care proposal by the voters, many want to explore options for Colorado to change the health care financing system.

Supporters

- The Arc of Colorado
- Colorado Consumer Health Initiative
- Colorado Foundation for Universal Health Care
- Colorado Cross-Disability Coalition
- Colorado Fiscal Institute
- Colorado Medical Society
- Colorado Rural Health Center
- Denver Health
- Healthier Colorado
- National Association of Social Workers, Colorado Chapter

Reasons to Oppose

State task forces are great information-gathering tools but sometimes have a low success record for significant policy accomplishments. Some may argue that neither the 1999 Commission nor the 208 Commission led to major improvements in access to, and cost of, health care. This bill mirrors both of the task forces and the result of this bill could lead to very little substantive policy change. All stated policy solutions involve a top-down, government-based solutions and largely ignore other potential market-based solutions. Some may argue that the bill requires an outlay of state resources when there are more immediate health care needs that must to be addressed.

Opponents

- Any opposition has not been made public at this time.

Other Considerations

The bill does not provide explicit definitions for a "multipayer universal health care system" nor for a "publicly funded and privately financed universal health care system." Additionally, the definition of "public option" states that all residents would be able to purchase coverage managed by the State or Connect for Health Colorado, this definition does not exclude those with employer-sponsored insurance. It is unknown if there is an intent to align a proposed public option with current federal law regarding the individual marketplace. Furthermore, the stakeholders that advise the analyst on methodology could be more robust if it included public and nonprofit health organizations as well as health system analysts and economists. In order to hear differing viewpoints, it would be helpful to require the task force members appointed by the Governor to be bipartisan.

It may be important for the analyst to be mandated to consider how federal law, specifically the Employee Retirement Income Security Act of 1974 (ERISA), would interact with any alteration in health financing system. ERISA regulates most of the private insurance market, specifically health plans that employers directly obtain for their employees, known as "self-insured" plans. ERISA requires that these plans be regulated at the federal level, so state policymakers and regulators cannot enact policies that affect these plans.

Colorado voted on one form of a single-payer health care system with Amendment 69 in 2016. Amendment 69 would have created ColoradoCare, a $36 billion program that would have eliminated private health insurance and established centralized health care through a single, state-run exchange. The measure was hotly debated and received national media attention with then-Presidential Candidate Bernie Sanders endorsing the Amendment.[17] That particular measure was defeated by a 79 percent to 21 percent margin.[18] It would be important to understand which elements were objectionable to Coloradans.

[17] Ingold, John. (November 8, 2016). "ColoradoCare Measure Amendment 69 defeated soundly." *The Denver Post.* Retrieved from https://www.denverpost.com/2016/11/08/coloradocare-amendment-69-election-results/.

[18] Staff. (December 2016). "Colorado Amendment 69. *Ballotpedia.* Retrieved from https://ballotpedia.org/Colorado_Creation_of_ColoradoCare_System,_Amendment_69_(2016).

A public option could offer consumers across the state, particularly those on the individual market who do not get ACA subsidies through the marketplace, a lower-cost plan option than would otherwise be available. Proponents argue that a public health insurance option is a more sustainable and reliable health care option that could drive down costs for private health insurance as well. On the other hand, if too many people move to the public option, some believe it may could negatively impact the private marketplace and possibly increase prices for those who buy health insurance without the use of tax credits.

In regards to a multipayer financing system, competition can drive down costs and encourage innovation. Some maintain that a multipayer system allows providers to meet more flexible needs of patients. Others argue that much like the status quo, a multipayer system does little to solve the high administrative costs and profits within the current system. Another concern is that a multipayer system may harm high-risk patients by allowing certain providers to select based on risk and potential cost.

While there are multiple options for a universal system, many assert that a universal system would create a more stable risk pool and would lower administrative costs, particularly if the system includes some form of single-payer option. They point to the general success of the Medicare program in the US. Opponents largely claim that most forms of universal health care would centralize too much power with the government, which would decrease competition and innovation.

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. This analysis is accurate to staff knowledge as of date printed. 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: March 22, 2019

Re: Staff Recommendation on HB19-1176: Health Care Cost Savings Act of 2019

The Health District Public Policy Strategy Team recommends that the Board of Directors support HB19-1176.

Health District
OF NORTHERN LARIMER COUNTY

3/22/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1216: REDUCE INSULIN PRICES

Concerning measures to reduce a patient's costs of prescription insulin drugs.

Details

Bill Sponsors:	House – *Roberts (D),* McCluskie (D) Senate – *Donovan (D) and Priola (R)*
Committee:	House Health & Insurance
Bill History:	2/28/2019- Introduced 3/20/2019- House Health & Insurance Refer Amended to House Appropriations
Next Action:	Hearing in House Appropriations
Fiscal Note:	3/18/2019 Version

Bill Summary

The bill establishes an out-of-pocket maximum for cost sharing at $100 per 30-day supply of insulin. The Department of Law is tasked with investigating the price of insulin that is made available to Colorado consumers in order to ensure adequate consumer protections in the pricing of insulin and whether further protections are needed. A report is to be published with the findings.

Issue Summary

Insulin & Diabetes

In a typical pancreas, beta cells make the hormone insulin. At each meal, the cells release insulin to assist the body use or store the glucose it gets from food.[1] In individuals that have type 1 diabetes, the pancreas no longer makes insulin; the beta cells have been destroyed so the person needs insulin shots to use the glucose from food. Those with type 2 diabetes still make insulin, but their bodies do not respond well to it. Some with type 2 diabetes need to use pills or insulin shots to assist their body in utilizing the glucose properly. In 2015, 30.3 million Americans (9.4 percent of the population) had diabetes, of those 1.25 million had type 1 diabetes.[2] Only 23.1 of those projected to have diabetes had been diagnosed and 1.5 million are diagnosed with diabetes each year.

There are a variety of types of insulin that differ in their strength, how quickly they work, when they peak, and how long they last. In order to be effective, insulin must be injected under the skin to reach the bloodstream.[1] Although individuals with type 1 diabetes must use insulin to manage their diabetes, those with type 2 diabetes can utilize medication other than insulin. There are a variety of drugs that can be used to treat diabetes, including medications like metformin, sulfonylureas, and meglitinides.[3]

Diabetes Medications in the U.S.

About 7.4 million people with diabetes use insulin in the U.S. [4] Presently, there are three insulin manufacturers in the U.S., Eli Lilly, Novo Nordisk, and Sanofi. There are no true generics of insulin sold in the

[1] American Diabetes Association (July 2015). *Insulin Basics.* Retrieved from http://www.diabetes.org/living-with-diabetes/treatment-and-care/medication/insulin/insulin-basics.html
[2] American Diabetes Association (2018). *Statistics about Diabetes.* Retrieved from http://www.diabetes.org/diabetes-basics/statistics/
[3] Mayo Clinic (2019). *Type 2 Diabetes.* Retrieved from https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/diagnosis-treatment/drc-20351199
[4] Cefalu, W.T., et al. (June 2018). Insulin Access and Affordability Working Group: Conclusions and Recommendations. *Diabetes Care 41*(6). 1299-1311. Retrieved from http://care.diabetesjournals.org/content/41/6/1299

nation. The average wholesale acquisition cost (WAC), a list price, for insulin increased by 15-17 percent per year from 2012 to 2016.[4] From 2012-2016 the average annual out-of-pocket spending per person with type 1 diabetes for insulin rose from $2,864 to $5,705.[5] During this period average daily insulin utilization in this population only rose 3 percent. Antidiabetics were the second most costly drug group in Medicaid in 2017.[6] Approximately 45 percent of people in the U.S. with diabetes report sometimes forgoing care due to cost.[7]

Diabetes in Colorado

The American Diabetes Association approximates that more than 416,000 people in Colorado have diabetes but estimate 118,000 have not been diagnosed.[8] In 2012, the total cost of care per patient with diabetes was over $13,000 in Colorado.[9] Diabetes is the 8th leading cause of death in the state.

Case Study: Nevada

The Nevada state legislature passed a bill in 2017, Senate Bill 539, which required the state Department of Health and Human Services to compile a list of drugs that are essential to treat diabetes and the manufacturers that produce those drugs. Reports are required to be submitted to the Department on these essential diabetes drugs manufacturers and pharmacy benefit managers (PBMs). A March 2019 report pursuant to the information required in the state law had a variety of findings for calendar year 2017.[10] The average reported profit reported for these drugs was more than $47 million but the median profit was below $300,000. Furthermore, 28 percent of reports of drugs either incurred a loss or earned no profit. The most frequent reported justifications for price increases of essential diabetes drugs were research and development, changes in marketplace dynamics, rebates, production costs, and inflation. Reports indicate that 60 percent of manufacturers provided $0 of patient financial assistance; however, for those that reported assistance, the average total amount was reported to be more than $10 million. The total PBM negotiated rebates was reported to be almost $1.7 billion. A rebate is the return of a portion of the purchase price; prescription drug rebates are generally paid by a manufacturer to a PBM, who then shares a portion with the insurer.

This Legislation

The legislative declaration asserts that almost 20,000 Coloradans are diagnosed with diabetes each year. It continues by stating that as of January 1, 2018, nearly 300,000 Colorado adults had been diagnosed and 100,000 were undiagnosed but living with the disease. Every person in the state with type 1 diabetes and many of those with type 2 rely on insulin to survive. Approximately four billion dollars are the annual medical cost related to diabetes in Colorado. Of that, about 18 percent ($700 million) is for prescription drugs to treat the disease. The declaration continues to affirm that insulin prices rose by 45 percent from 2014 to 2017, and rose by 545 percent (adjusted for inflation) in the past 14 years. A quarter of type 1 diabetics reported insulin underuse due to the cost of the drug. Due to these data points, the bill declares that it is

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[5] Biniek, J.F. & Johnson, W. (Jan. 21, 2019). *Spending on Individuals with Type1 Diabetes and the Role of Rapidly Increasing Insulin Prices*. Retrieved from https://www.healthcostinstitute.org/research/publications/entry/spending-on-individuals-with-type-1-diabetes-and-the-role-of-rapidly-increasing-insulin-prices

[6] Young, K. (Feb. 15, 2019). Utilization and Spending Trends in Medicaid Outpatient Prescription Drugs. *Kaiser Family Foundation.* Retrieved from https://www.kff.org/medicaid/issue-brief/utilization-and-spending-trends-in-medicaid-outpatient-prescription-drugs/?utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz-_yCJbDbYOq4G3HZRkC-FbXECRUx2pAJwdFd258lPxq1vV5N3o9tQt71A_o6Mvx7PVJBL2TgcNhIucMiDssSMLtGA1Fgw&_hsmi=2

[7] Balick, R. (Aug. 2018). Soaring insulin prices have patients terrified and pharmacists scrambling. *Pharmacy Today 24*(8). 43-44. Retrieved from https://www.pharmacytoday.org/article/S1042-0991(18)31099-5/fulltext

[8] American Diabetes Association (2016). *The Burden of Diabetes in Colorado.* Retrieved from http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/colorado.pdf

[9] CO Department of Public Health and Environment (Nov. 2015). *Diabetes' Impact in Colorado.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/DC_Factsheet_Facts_For_Action_Diabetes_In_Colorado_November_2015.pdf

[10] Nevada Department of Health and Human Services (March 8, 2019). *Supplemental Report: 2017 Essential Diabetes Drugs.* Retrieved from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/HCPWD/Supplemental%20Drug%20Transparency%20Report%203.7.19.pdf

important to enact policies to reduce the costs for Coloradans with diabetes to obtain life-saving and life-sustaining insulin.

The bill defines "cost sharing" as a copayment or coinsurance amount imposed on a covered person for a covered prescription drug, in accordance with their health plan.

If a carrier imposes a cost sharing amount for insulin, it is to cap the total cost sharing for insulin, including cost sharing once the deductible is met, at an amount to not exceed $100 per 30-day supply of insulin, regardless of the amount or type of insulin needed to fill the prescription. This does not prevent a carrier from reducing the cost sharing requirements further than this requirement. The bill allows for the Commissioner of Insurance to use their enforcement powers to ensure compliance.

The Department of Law, headed by the Attorney General, is to investigate the price of insulin that is made available to Colorado consumers in order to ensure adequate consumer protections in the pricing of insulin and whether further protections are needed. During the investigation, the Department is to gather, compile, and analyze information about the organization, practices, pricing information, data, reports, and other necessary information. Any publicly available information related to drug pricing should also be considered. If it is necessary to fulfill the investigation requirements, the Attorney General can issue a civil investigative demand that requires a state department, carrier, pharmacy benefit manager, or manufacturer of insulin drugs made available in Colorado to provide material, answers, data, or other relevant information. A business or person is not compelled to provide proprietary information or trade secrets, as previously defined in state law.[11] By November 1, 2020 the Department is to issue a report that details its findings. The report should be submitted to the Governor, Commissioner of Insurance, as well as the House and Senate Judiciary Committees. The report must include:

- A summary of insulin pricing practices and variables that contribute to pricing of health plans
- Policy recommendations to control and prevent overpricing of insulin in Colorado
- Any recommendations for improvements to the "Colorado Consumer Protection Act" to prevent deceptive sales acts related to insulin
- Any other information that the Department finds necessary

The bill takes effect August 2, 2019, unless a referendum petition is filed against the bill or section of the bill. The bill applies to health plans issued or renewed on or after January 1, 2020, unless a referendum petition is filed.

Reasons to Support

The bill takes into consideration of consumers' immediate needs while investigating the long-term effect and possible solutions regarding insulin pricing. This may allow diabetes patients to spread out their required costs longer before reaching their deductible instead of having to spend a lot of money at the beginning of each year on their required drug. Some assert that the out-of-pocket maximum may encourage adherence to the medication, which could avert costs associated with unmanaged diabetes that could increase the costs for health plans.

Supporters

- American Diabetes Association
- Colorado Center on Law and Policy
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition

[11] C.R.S. 7-74-102(4). "Trade secret" means the whole or any portion or phase of any scientific or technical information, design, process, procedure, formula, improvement, confidential business or financial information, listing of names, addresses, or telephone numbers, or other information relating to any business or profession which is secret and of value. To be a "trade secret" the owner thereof must have taken measures to prevent the secret from becoming available to persons other than those selected by the owner to have access thereto for limited purposes.

- Colorado Insulin for All
- Colorado Pharmacist Society
- Colorado Division of Insurance
- International Diabetes Federation

Reasons to Oppose

Some may assert that out-of-pocket maximum for insulin would increase plan costs, as the plan would need to cover any difference between the current consumer payment and what the health plan must pay. There is concern that there is a broad scope of duties delegated to the Department of Law, which could infringe of proprietary information of entities.

Opponents

- Colorado Bioscience Association
- CVS Health
- Pharmaceutical Research and Manufacturers of America (PhRMA)
- United Health Care

Other Considerations

It is notable that the report and investigation in regards to insulin pricing is to be conducted by the Department of Law rather than the Division of Insurance (DOI) or Department of Health Care Policy and Financing (HCPF). Some assert that the DOI or HCPF would be more appropriate, but others rebut that the Department of Law is appropriate as it is tasked with consumer protection and suited to understand the legal complexities that may be involved.

It is also important to note that the out-of-pocket maximum only applies to plans that are under the regulatory purview of the DOI, including the individual, small group, and portions of the large group market. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that does not allow state regulators and lawmakers to regulate self-insured plans, where employers become the insurer. In 2017, approximately 44 percent of private employers in Colorado self-insured at least one plan.[12]

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. This analysis is accurate to staff knowledge as of date printed. 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.

[12] Division of Insurance (Dec. 10, 2018). *Health Insurance Cost Report for Calendar Year 2017.* Retrieved from https://drive.google.com/drive/folders/0B_UoCf17OVmWfmdCd1g5bXJCZ2ZXZWdiWk1wbktpWUQwUTgwT2JiT3pMeWl1UU1zMEZOTG8

Health District
OF NORTHERN LARIMER COUNTY

Memo

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

From: Alyson Williams, Policy Coordinator

Date: March 22, 2019

Re: Staff Recommendation on HB19-1216: Reduce Insulin Prices

The Health District Public Policy Strategy Team recommends that the Board of Directors support HB19-1216.

Health District
OF NORTHERN LARIMER COUNTY

3/22/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1233: INVESTMENTS IN PRIMARY CARE TO REDUCE HEALTH COSTS

Concerning payment system reforms to reduce health care costs by increasing utilization of primary care.

Details

Bill Sponsors:	House – *Froelich (D) and Caraveo (D)*
	Senate – *Ginal (D) and Moreno (D)*
Committee:	House Health & Insurance
Bill History:	3/8/2019 – Introduced
Next Action:	3/26/2019 – Hearing in House Health & Insurance
Fiscal Note:	3/19/2019 Version

Bill Summary

The bill creates a primary care payment reform collaborative in the Division of Insurance (DOI). The Commissioner of Insurance is required to set affordability standards for premiums, including adding targets for insurance carrier investment in primary care. Also, the bill requires the Department of Health Care Policy and Financing (HCPF) and insurance carriers who offer health plans to state employees to set targets for investment into primary care.

Issue Summary

Primary Care

Currently, the U.S. spends 4 to 7 percent of total health care dollars on primary care.[1] Receiving primary care has been associated with significantly more high-value care and a better care experience.[2] Also, areas with higher ratios of primary care physicians to population had much lower total health care costs than other areas.[3] Studies have demonstrated that primary care providers utilize fewer resources, such as diagnostic tests and procedures, than specialists, while incurring equal or lower costs of care.[4] Patients with a usual source of care have greater satisfaction, lower rates of non-urgent emergency department use, and are more likely to receive recommended preventive services.

Fewer new clinicians are entering primary care fields and only about 35 percent of all clinicians (including nurse practitioners and physician assistants) provide primary care.[5] A 2014 survey found that 68 percent of

[1] Stream, G. & Tuggy, M. (Aug. 6, 2018). Delivering value in healthcare starts with increased primary care investment. *Medical Economics.* Retrieved from https://www.medicaleconomics.com/article/delivering-value-healthcare-starts-increased-primary-care-investment

[2] Levine DM, Landon BE, Linder JA. Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care. *JAMA Intern Med.*2019;179(3):363–372. doi:10.1001/jamainternmed.2018.6716

[3] Starfield, B., Shi, L., and Macinko, J. (2005). Contribution of primary care to health systems and health. *Milibank Q. 83*(3): 457-502. doi: 10.1111/j.1468-0009.2005.00409.x

[4] Friedberg, M.W., Hussey, P.S., and Schneider, E.C. (May 2010). Primary Care: A critical Review of the Evidence on Quality and Costs of Health Care. *Health Affairs 29*(5). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0025

[5] Lazris, A., Roth, A., and Brownlee, S. (Nov. 20, 2018). No More Lip Service; It's Time We Fixed Primary Care. *Health Affairs Blog.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20181115.750150/full/

family physicians would not choose the same specialty and would start their careers anew.[6] An underlying reason may include burnout, as 46 percent of physicians experience symptoms.[7]

Patient centered medical homes (PCMH) are being widely implemented throughout the country. There are five central aspects and functions of PCMHs, they provide comprehensive care, are patient-centered, coordinate care, deliver accessible services, and commit to quality and safety. A PCMH is not a location but rather describes the coordinated approach to patient care that is led by the primary care provider. For example, among patients with diabetes, studies have associated the PCMH with increased primary care visits, decreased emergency department use, and improved diabetes care process measures.[8]

Value-Based Payments and Fee-for-Service Reimbursement

Fee-for-service (FFS) is a system of health payments where a provider or facility is paid a fee for each service rendered. Many assert that this system rewards providers for volume and quantity of services, no matter the patient outcome. On the other hand, value-based health models provide payment to providers based on the health outcomes of the patient. The value aspect of this model comes from measuring health outcomes against the cost of delivering those outcomes.[9]

Affordability Standards in Rhode Island

In 2010, Rhode Island's Office of the Health Insurance Commissioner implemented affordability standards that imposed price controls on contracts between private insurers and hospitals while requiring the insurers to increase spending on primary care and care coordination services. There were two goals in implementing these affordability standards.[10] The first was to improve primary care through requiring insurer investment in primary care and encouraging practices to transform into PCMHs. The second goal was to reduce costs through payment reform strategies. The Office claims that primary care spending in the state increased by more than a third since 2008 and the rate of increase of hospital costs slowed.

A study of these standards was recently published in *Health Affairs.*[11] The study compared spending of 38,001 commercially insured Rhode Island adults and the same number of matched adults in other states in a period lasting from 2007 to 2016. After the implementation of the standards, quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee, a decline of 8.1 percent from 2009 spending, relative to the control group. Primary care coordination spending increased by $21 per enrollee. The decline in growth was driven by lower prices, not decreased utilization of services. However, the results suggest that that the increased care coordination spending did not drive the reduction in spending growth. The study concludes that this experience may indicate that states can slow total commercial health spending growth through price controls while maintaining quality.

Legislative History

A similar bill, HB19-1365, that intended to create a primary care payment reform collaborative was introduced during the 2018 session.[12] The bill was postponed indefinitely by Legislative Council in April 2018.

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[6] Kane, L. & Peckham, C. (Apr. 2014). *Medscape Physician Compensation Report.* Retrieved from https://www.medscape.com/features/slideshow/compensation/2014/public/overview#24

[7] Bodenheimer, T. & Sinsky,C. (Nov 2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine.12*(6). Retrieved from http://www.annfammed.org/content/12/6/573.full#ref-6

[8] National Institute of Diabetes and Digestive and Kidney Disease (n.d.). *The Patient Centered Medical Home (PCMH).* Retrieved from https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/team-based-care/patient-centered-medical-home

[9] NEJM Catalyst (Jan. 1, 2017). *What is Value-Based Healthcare?* Retrieved from https://catalyst.nejm.org/what-is-value-based-healthcare/

[10] Rhode Island Office of the Health Insurance Commissioner (2019). *Reform and Policy – Affordability Standards.* Retrieved from http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php

[11] Baum, A., et al . (Feb. 2019). Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs 38*(2). doi: https://doi.org/10.1377/hlthaff.2018.05164

[12] HB19-1365: Primary Care Infrastructure Creation. Retrieved from http://leg.colorado.gov/bills/hb18-1365

This Legislation

The Commissioner of Insurance is to convene a primary care payment reform collaborative with an outlined purpose. The collaborative is to:

- Consult with the Department of Personnel, HCPF, and the Center for Improving Value in Health Care (CIVHC)[13]
- Advise in the development of affordability standards and targets for insurer investments in primary care
- Analyze the percentage of medical expenses allocated to primary care, in coordination with CIVHC, by health insurers, Medicaid, and Child Health Plan Plus (CHP+)
- Develop a recommendation to the Commissioner on the definition of primary care
- Report on current insurer practices and methods of reimbursement that direct greater health resources and investments toward innovation and care improvement in primary care
- Identify barriers to the adoption of alternative payment models by insurers and providers, and develop recommendations to address barriers
- Develop recommendations to increase the use of alternative payment models that are not paid on a fee-for-service or per-claim basis in order to increase investment in primary care, align primary care reimbursement by all consumers, and direct investment toward higher value care with aim of reducing health disparities
- Consider how to increase investment in advanced primary care without increasing consumer costs or total cost of health care
- Develop and share best practices and technical assistance to insurers and consumers, including:
    - Aligning quality metrics, as developed in state innovation model (SIM)
    - Facilitating the integration of behavioral and physical health care
    - Practice transformation
    - Delivery of advanced primary care that facilitates appropriate utilization of services in appropriate settings

The Commissioner is to invite representatives to participate in the collaborative. These individuals shall represent the following individuals, industries and entities: health providers, primary care providers, consumers, employers, insurers, insurers that contract with HCPF as managed care entities, Centers for Medicare and Medicaid Services (CMS), Primary Care Office within the Department of Public Health and Environment (CDPHE), HCPF, and experts in health insurance actuarial analysis. The collaborative is to be convened by July 15, 2019. By October 15, 2019, and by each October 15 thereafter, the collaborative is to publish primary care payment reform recommendations, which is to be informed by the primary care spending report.[14] The payment reform report is to be posted publicly online. The DOI can seek, accept, and expend gifts, grants, or donations to implement the collaborative. The collaborative is scheduled to sunset on September 1, 2025, with the General Assembly to review the sunset before it occurs.

An additional duty is added to the Commissioner's responsibilities. The Commissioner is to encourage the fair treatment of health providers, including primary care providers. Additionally they are to encourage policies, including increased investment into primary care, that decrease disparities and improve quality, affordability, and efficiency of services and outcomes. Finally, the Commissioner is to view the health system as a comprehensive entity as well as encourage and direct insurers toward policies that advance public welfare of the public through overall efficiency, affordability, improved quality, and appropriate access.

During annual rate filing, in determining whether those rates are excessive, the Commissioner can currently only consider the expected filed rates in relation to the actual rates charged. The bill adds that the

[13] The current administrator of the All-Payer Claims Database

[14] Contents of the primary care spending report are detailed in Section 6 of the bill.

Commissioner can consider whether the carrier's products are affordable and whether the carrier has implemented effective strategies to enhance affordability of its products. The Commissioner is to promulgate rules that establish affordability standards for premiums. The standards must include appropriate targets for primary care investments by carriers. While developing the standards, the Commissioner is to consider recommendations from the Collaborative. In alignment with the affordability standards, a carrier is to adopt appropriate primary care investment targets to support value-based health care delivery.

By August 31, 2019, and every August 1 thereafter, CIVHC to provide a primary care spending, for the carriers and programs that report claims to the All-Payer Claims Database, report to the Commissioner for use by the Collaborative. The report is to include the percentage of medical expenses allocated to primary care, share of payments made through alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.

HCPF is to adopt appropriate targets for investments in primary care for the health programs that they administer (Medicaid and Child Health Plan Plus [CHP+]) to support value-based health delivery in alignment with the affordability standards adopted by the Commissioner.

The bill is effective upon passage and the Governor's signature.

Reasons to Support

Proponents assert that the bill will guide Colorado to achieve better health outcomes and health care cost savings. Greater investments in primary care may enable practices to offer services like extended hours, telehealth services, integrated behavioral health, and social workers to coordinate care for complex patients. The combination of the affordability standards and requiring increased investment in primary care may lead to a redistribution of spending toward primary care without losses to payers. Without investment in primary care practices, implementation of initiatives like care coordination and PCMH can have mixed results both on cost containment (since more services are being provided) and on sustainability, with providers often experiencing burnout in trying to keep up with the added demands and little or no additional resources provided. Transitioning from a FFS system may decrease administrative requirements, which may increase the time primary care teams can spend with patients and decrease professional burnout. The primary care spending report prepared by CIVHC can inform future policies or initiatives regarding the cost and utilization of care.

Supporters

- American Academy of Pediatrics- Colorado Chapter
- American College of Physicians- Colorado Chapter
- Colorado Academy of Family Physicians
- Children's Hospital Colorado
- Colorado Community Health Network
- Colorado Medical Society

Reasons to Oppose

The bill does not include details on how the affordability standards are to be enacted. This could lead to a variety of methods being utilized to achieve this aim. This uncertainty may lead to concerns for potentially affected insurers and providers and how these entities may react to these changes is unknown. Further, the affordability standards translate into increased government interference and control in the health care market. Some may assert that this is not an appropriate role for the state government to play.

Opponents

- Any opposition has not been made public at this time.

Other Considerations

Neither the number of members nor the exact makeup of the collaborative are dictated in the bill, rather these details are left up to the Commissioner of the Insurance. The timeline for the collaborative to convene and generate a report in 2019 is short, as the members are to be gathered by July 15 and have the report ready by October 15. The recommendations from the collaborative and the affordability standards can only apply to plans that are under the regulatory purview of the DOI, including the individual, small group, and portions of the large group market.

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. This analysis is accurate to staff knowledge as of date printed. 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: March 22, 2019

Re: Staff Recommendation on HB19-1233: Investments in Primary Care to Reduce Health Costs

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The Health District Public Policy Strategy Team recommends that the Board of Directors support HB19-1233.

HEALTH DISTRICT
of Northern Larimer County
January 2019
Summary Financial Narrative

Revenues

The Health District is 17.1% behind year-to-date tax revenue projections. Interest income is 13.2% 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 2.28% to 2.33% (based on the weighted average of all investments). Fee for service revenue from clients is 11.2% behind year-to-date projections and revenue from third party reimbursements is 14.9% behind year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are 13.4% behind year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 10.8% behind year-to-date projections. Program variances are as follows: Administration 23.2%; Board 23.2%; Connections: Mental Health/Substance Issues Services 12.8%; Dental Services 7.7%; Integrated Care 10.4%; Health Promotion 13.8%; Community Impact 11.7%; Program Assessment and Evaluation 3.1%; Health Care Access 6.9%; HealthInfoSource 24.0%; and Resource Development 11.4%.

Capital Outlay

No capital expenditures have been made year-to-date

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 1/31/2019

ASSETS

Current Assets:	
Cash & Investments	$6,742,302.28
Accounts Receivable	118,962.12
Property Taxes Receivable	7,181,456.38
Specific Ownership Taxes Receivable	112,830.31
Prepaid Expenses and Deposits	83,617.66
Total Current Assets	14,239,168.75
Property and Equipment	
Land	4,592,595.02
Building and Leasehold Improvements	4,421,115.73
Equipment	1,174,024.23
Accumulated Depreciation	(2,687,282.76)
Total Property and Equipment	7,500,452.22
Total Assets	$21,739,620.97

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 1/31/2019

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	$763,942.98
Deposits	1,000.00
Deferred Revenue	621,226.12
Total Current Liabilities	1,386,169.10
Long-term Liabilities:	
Compensated Absences Payable	12,215.00
Total Long-term Liabilities	12,215.00
Deferred Inflows of Resources	
Deferred Property Tax Revenue	6,993,868.96
Total Deferred Inflows of Resources	6,993,868.96
Total Liabilities & Deferred Inflows of Resource	8,392,253.06
EQUITY	
Retained Earnings	13,692,106.84
Net Income	(344,738.93)
Total Equity	13,347,367.91
Total Liabilities & Equity	$21,739,620.97

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENSES

For 1/1/2019 To 1/31/2019

	Current Month	Year to Date
Revenue:		
Property Taxes	$243,617.04	$243,617.04
Specific Ownership Taxes	56,799.89	56,799.89
Lease Revenue	91,145.99	91,145.99
Interest Income	13,207.12	13,207.12
Sales Revenue	44.68	44.68
Fee For Services Income	16,017.15	16,017.15
Third Party Reimbursements	58,292.03	58,292.03
Grant Revenue	60,504.12	60,504.12
Special Projects	1,095.33	1,095.33
Miscellaneous Income	511.56	511.56
Total Revenue	541,234.91	541,234.91
Expenses:		
Operating Expenses		
Administration	$51,533.13	$51,533.13
Board Expenses	885.61	885.61
Connections: MentalHealth/Substance Issues Svcs	118,342.95	118,342.95
Dental Services	291,794.15	291,794.15
Integrated Care (MHSA/PC)	81,892.08	81,892.08
Health Promotion	58,758.86	58,758.86
Community Impact	46,395.86	46,395.86
Program Assessment & Evaluation	17,273.21	17,273.21
Health Care Access	83,063.50	83,063.50
HealthInfoSource	7,151.20	7,151.20
Resource Development	12,984.65	12,984.65
Special Projects	61,294.26	61,294.26
Grant Projects	54,604.38	54,604.38
Total Operating Expenses	885,973.84	885,973.84
Depreciation and Amortization		
Total Depreciation and Amortization	0.00	0.00
Total Expenses	885,973.84	885,973.84
Net Income	($344,738.93)	($344,738.93)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	$310,238	$243,617	($66,621)	$310,238	$243,617	($66,621)	$7,237,486	$6,993,869
Specific Ownership Taxes	52,295	56,800	4,505	52,295	56,800	4,505	650,000	593,200
Lease Revenue	91,146	91,146	0	91,146	91,146	0	1,115,627	1,024,481
Interest Income	11,667	13,207	1,540	11,667	13,207	1,540	140,000	126,793
Sales Revenue	50	45	(5)	50	45	(5)	600	555
Fee For Services Income	18,039	16,017	(2,022)	18,039	16,017	(2,022)	216,467	200,450
Third Party Reimbursements	68,459	58,292	(10,167)	68,459	58,292	(10,167)	821,528	763,236
Grant Revenue	87,519	60,505	(27,014)	87,519	60,505	(27,014)	1,303,259	1,242,754
Partnership Revenue	1,812	1,095	(717)	1,812	1,095	(717)	61,748	60,653
Miscellaneous Income	1,725	512	(1,213)	1,725	512	(1,213)	20,500	19,988
Total Revenue	$642,950	$541,236	($101,714)	$642,950	$541,236	($101,714)	$11,567,215	$11,025,979
Expenditures:								
Operating Expenditures								
Administration	67,073	51,533	15,540	67,073	51,533	15,540	858,400	806,867
Board Expenses	1,153	886	267	1,153	886	267	61,920	61,034
Connections: Mental Health/Substance Issues Sv	135,761	118,343	17,418	135,761	118,343	17,418	1,650,745	1,532,402
Dental Services	316,163	291,794	24,369	316,163	291,794	24,369	3,809,046	3,517,252
Integrated Care (MHSA/PC)	91,414	81,892	9,522	91,414	81,892	9,522	1,107,315	1,025,423
Health Promotion	68,162	58,759	9,403	68,162	58,759	9,403	820,874	762,115
Community Impact	52,556	46,395	6,161	52,556	46,395	6,161	637,766	591,371
Program Assessment & Evaluation	17,819	17,273	546	17,819	17,273	546	213,652	196,379
Health Care Access	89,174	83,064	6,110	89,174	83,064	6,110	1,074,616	991,552
HealthInfoSource	9,414	7,151	2,263	9,414	7,151	2,263	109,263	102,112
Resource Development	14,659	12,985	1,674	14,659	12,985	1,674	174,236	161,251
Contingency (Operations)	0	0	0	0	0	0	60,000	60,000
Special Projects	158,135	61,294	96,841	158,135	61,294	96,841	2,139,363	2,078,069
Grant Projects	83,027	54,604	28,423	83,027	54,604	28,423	1,303,259	1,248,655
Total Operating Expenditures	1,104,510	885,973	218,537	1,104,510	885,973	218,537	14,020,455	13,134,482
Net Income	($461,560)	($344,737)	$116,823	($461,560)	($344,737)	$116,823	($2,453,240)	($2,108,503)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	24,000	24,000
Capital Equipment	0	0	0	0	0	0	20,000	20,000
General Office Equipment	0	0	0	0	0	0	20,000	20,000
Medical & Dental Equipment	0	0	0	0	0	0	28,425	28,425
Computer Software	0	0	0	0	0	0	7,300	7,300
Total Non-Operating Expenditures	0	0	0	0	0	0	99,725	99,725

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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
Net Income	$0	$0	$0	$0	$0	$0	($99,725)	($99,725)

Unaudited - For Management Use Only

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	$875	$0	($875)	$875	$0	($875)	$10,500	$10,500
Total Revenue	$875	$0	($875)	$875	$0	($875)	$10,500	$10,500
Expenditures:								
Salaries and Benefits	44,699	39,967	4,732	44,699	39,967	4,732	536,392	496,425
Supplies and Purchased Services	22,374	11,567	10,807	22,374	11,567	10,807	322,008	310,441
Total Expenditures	$67,073	$51,534	$15,539	$67,073	$51,534	$15,539	$858,400	$806,866
Board of Directors								
Expenditures:								
Salaries and Benefits	$0	$0	$0	$0	$0	$0	$8,635	$8,635
Supplies and Purchased Services	1,153	886	267	1,153	886	267	53,285	52,399
Election Expenses	0	0	0	0	0	0	18,000	18,000
Total Expenditures	$1,153	$886	$267	$1,153	$886	$267	$79,920	$79,034
Community Impact								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$46,272	$43,655	$2,617	$46,272	$43,655	$2,617	$558,259	$514,604
Supplies and Purchased Services	6,284	2,741	3,543	6,284	2,741	3,543	79,507	76,766
Total Expenditures	$52,556	$46,396	$6,160	$52,556	$46,396	$6,160	$637,766	$591,370

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	$15,493	$15,317	$176	$15,493	$15,317	$176	$186,418	$171,101
Supplies and Purchased Services	2,326	1,956	370	2,326	1,956	370	27,234	25,278
Total Expenditures	$17,819	$17,273	$546	$17,819	$17,273	$546	$213,652	$196,379
Connections: Mental Health/Substance Issue								
Revenue:								
Fees, Reimbursements & Other Income	$1,720	$2,588	$868	$1,720	$2,588	$868	$20,640	$18,052
Total Revenue	$1,720	$2,588	$868	$1,720	$2,588	$868	$20,640	$18,052
Expenditures:								
Salaries and Beneftis	$112,303	$78,704	$33,599	$112,303	$78,704	$33,599	$1,352,630	$1,273,926
Supplies and Purchased Services	23,458	39,639	(16,181)	23,458	39,639	(16,181)	298,115	258,476
Total Expenditures	$135,761	$118,343	$17,418	$135,761	$118,343	$17,418	$1,650,745	$1,532,402
Dental Services								
Revenue:								
Fees, Reimbursements & Other Income	$81,617	$66,954	($14,663)	$81,617	$66,954	($14,663)	$979,216	$912,262
Total Revenue	$81,617	$66,954	($14,663)	$81,617	$66,954	($14,663)	$979,216	$912,262
Expenditures:								
Salaries and Benefits	$247,738	$232,045	$15,693	$247,738	$232,045	$15,693	$2,978,861	$2,746,816
Supplies and Purchased Services	68,425	59,748	8,677	68,425	59,748	8,677	830,185	770,437
Total Expenditures	$316,163	$291,793	$24,370	$316,163	$291,793	$24,370	$3,809,046	$3,517,253

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	$2,916	$4,700	$1,784	$2,916	$4,700	$1,784	$35,000	$30,300
Total Revenue	$2,916	$4,700	$1,784	$2,916	$4,700	$1,784	$35,000	$30,300
Expenditures:								
Salaries and Benefits	$81,792	$74,005	$7,787	$81,792	$74,005	$7,787	$987,507	$913,502
Supplies and Purchased Services	9,558	7,563	1,995	9,558	7,563	1,995	119,045	111,482
Total Expenditures	$91,350	$81,568	$9,782	$91,350	$81,568	$9,782	$1,106,552	$1,024,984
Health Promotion								
Revenue:								
Fees, Reimbursements & Other Income	$1,145	$583	($562)	$1,145	$583	($562)	$13,739	$13,156
Total Revenue	$1,145	$583	($562)	$1,145	$583	($562)	$13,739	$13,156
Expenditures:								
Salaries and Benefits	$53,455	$49,757	$3,698	$53,455	$49,757	$3,698	$642,956	$593,199
Supplies and Purchased Services	14,707	9,001	5,706	14,707	9,001	5,706	177,918	168,917
Total Expenditures	$68,162	$58,758	$9,404	$68,162	$58,758	$9,404	$820,874	$762,116

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2019 To 1/31/2019

	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	$41	$41	$0	$41	$41	$0	($41)
Total Revenue	$0	$41	$41	$0	$41	$41	$0	($41)
Expenditures:								
Salaries and Benefits	$74,879	$71,585	$3,294	$74,879	$71,585	$3,294	$901,550	$829,965
Supplies and Purchased Services	14,295	11,479	2,816	14,295	11,479	2,816	173,066	161,587
Total Expenditures	$89,174	$83,064	$6,110	$89,174	$83,064	$6,110	$1,074,616	$991,552
Health Info Source								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$5,443	$4,810	$633	$5,443	$4,810	$633	$66,814	$62,004
Supplies and Purchased Services	3,971	2,341	1,630	3,971	2,341	1,630	42,449	40,108
Total Expenditures	$9,414	$7,151	$2,263	$9,414	$7,151	$2,263	$109,263	$102,112
Resource Development								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$12,431	$12,107	$324	$12,431	$12,107	$324	$150,720	$138,613
Supplies and Purchased Services	2,228	878	1,350	2,228	878	1,350	23,516	22,638
Total Expenditures	$14,659	$12,985	$1,674	$14,659	$12,985	$1,674	$174,236	$161,251

Health District of Northern Larimer County

Investment Schedule
January 2019

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	$ 1,351	0.021%	2.35%	N/A
Local Government Investment Pool	COLOTRUST	$ 4,956,331	75.804%	2.62%	N/A
Local Government Investment Pool (Children's Oral Health Care Assistance Fund)	COLOTRUST	$ 10,008	0.153%	2.62%	N/A
Local Government Investment Pool (Oral Health Care Assistance Fund)	COLOTRUST	$ 25,980	0.397%	2.62%	N/A
Flex Savings Account	First National Bank	$ 191,723	2.932%	0.90%	N/A
Certificate of Deposit	Advantage Bank	$ 135,986	2.080%	1.40%	12/27/2019
Certificate of Deposit	Advantage Bank	$ 108,922	1.666%	1.40%	9/2/2019
Certificate of Deposit	First National Bank	$ 111,957	1.712%	1.35%	9/6/2019
Certificate of Deposit	Points West	$ 112,402	1.719%	1.35%	6/4/2020
Certificate of Deposit	Points West	$ 152,579	2.334%	1.25%	4/2/2020
Certificate of Deposit	Adams State Bank	$ 231,115	3.535%	1.29%	10/7/2019
Certificate of Deposit	Cache Bank & Trust	$ 250,000	3.824%	1.40%	1/9/2020
Certificate of Deposit	Farmers Bank	$ 250,000	3.824%	2.00%	6/27/2020
Total/Weighted Average		$ 6,538,353	100.000%	2.33%	

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

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOXES 2219 AND 5542

Resolution 2019-03

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any two of the following signators are approved to have access to the Health District's Safety Deposit Boxes XX19 and XX42 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Celeste Kling, Secretary
Joseph W. Prows, Treasurer
Carol A. Plock, Executive Director
A. Lorraine Haywood, Finance Director
Anita K. Benavidez, Assistant to the Executive Director and the Board of Directors

ADOPTED, this 28th day of March, A.D., 2019.

Attest:

_____
Michael D. Liggett, President

_____
Molly J. Gutilla, Vice President

_____
Celeste Kling, Secretary

_____
Joseph W. Prows, MD, Treasurer

_____
Faraz Naqvi, MD
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2010-10 Approved July 21, 2010
2014-10 Approved May 21, 2014
2016-14 Approved July 21, 2016
2018-12 Approved September 25, 2018

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 4919

Resolution 2019-04

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box XX19 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Celeste Kling, Secretary
Joseph W. Prows, Treasurer
Carol A. Plock, Executive Director
A. Lorraine Haywood, Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors

ADOPTED, this 28th day of March, A.D., 2019.

Attest:

_____
Michael D. Liggett, President

_____
Molly J. Gutilla, Vice President

_____
Celeste Kling, Secretary

_____
Joseph W. Prows, MD, Treasurer

_____
Faraz Naqvi, MD
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2012-5 Approved September 6, 2012
2014-11 Approved May 21, 2014
2016-15 Approved July 21, 2016
2018-13 Approved Sept. 25, 2018

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 5546

Resolution 2019-05

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box X742 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Celeste Kling, Secretary
Joseph W. Prows, Treasurer
Carol A. Plock, Executive Director
A. Lorraine Haywood, Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors

ADOPTED, this 28th day of March, A.D., 2019.

Attest:

_____
Michael D. Liggett, President

_____
Molly J. Gutilla, Vice President

_____
Celeste Kling, Secretary

_____
Joseph W. Prows, MD, Treasurer

_____
Faraz Naqvi, MD
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2018-14 Approved Sept. 25, 2018

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 5742

Resolution 2019-06

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box XX42 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Carol A. Plock, Executive Director
A. Lorraine Haywood, Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors
Celeste Kling, Secretary
Joseph W. Prows, Treasurer

ADOPTED, this 28th day of March, A.D., 2019.

Attest:

_____ _____

Michael D. Liggett, President | Molly J. Gutilla, Vice President

_____ _____

Celeste Kling, Secretary | Joseph W. Prows, MD, Treasurer

_____

Faraz Naqvi, MD
UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:
2016-18 Adopted on November 15, 2016
2018-15 Adopted on September 25, 2018

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING

December 13, 2018

Health District Office Building
120 Bristlecone Drive, Fort Collins

MINUTES

BOARD MEMBERS PRESENT: Molly Gutilla, MS DrPH, Board Vice President
Celeste Kling, J.D., Board Secretary
Joseph Prows, MD MPH, Board Treasurer
Faraz Naqvi, MD, Liaison to UCHealth-North/PVHS Board

BOARD MEMBERS ABSENT: Michael D. Liggett, Esq., Board President

Staff Present:
Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Richard Cox, Communications Director
Lorraine Haywood, Finance Director
Chris Sheafor, Support Services Director
Dana Turner, Dental Services Director
Wendy Grogan, Administrative Assistant

Others Present:
Alyson Williams, Policy Coordinator
Suman Mathur, Eval. and Data Specialist
Pam Klein, Communications Specialist
Brian Ferrans, CIT BH Strategy Manager
Laura Mai, Assistant Finance Director
Vivian Perry, HealthInfoSource Project Mgr.

CALL TO ORDER; APPROVAL OF AGENDA

Ms. Gutilla called the meeting to order at 4:12 pm. Mike Liggett's absence was excused. No changes were made to the meeting agenda

MOTION: To approve the agenda as presented/amended.
Motion/Seconded/Carried Unanimously

PUBLIC COMMENT

None.

BOARD ACTION
2019 Budget Approval

Changes since the Draft Budget
Ms. Plock reviewed the significant changes made since the October 15 draft budget. he final budget can't be drafted until final valuations come in from the assessor's office; this year after final valuations, there was about $8,000 less in tax revenues than originally projected. The good news is that we project a decrease in insurance and worker's comp premiums, which balance out the lower revenue. The beginning balance for 2019 was adjusted down by about $300,000 to cover end-of-year expenses in 2018. The only changes in reserves were a slight increase in funds needed for medical billing software for CAYAC's psychiatrists, and an increase of about $11,000 in funding for transition management for high-level staff transitions.

Ms. Plock asked if there were any questions on the final budget, and Ms. Kling stated that Lorraine gave her all the answers she needed regarding her questions from last Board meeting.

Board Discussion/Amendments
None.

Budget Approvals:

MOTION: To approve Resolution 2018-17: Adopt Budget.
Motion/Seconded/Carried Unanimously

MOTION: To approve Resolution 2018-18: Set Mill Levies.
Motion/Seconded/Carried Unanimously

MOTION: To approve Resolution 2018-19: Appropriate Sums of Money
Motion/Seconded/Carried Unanimously

MOTION: To approve the Certification of Tax Levies
Motion/Seconded/Carried Unanimously

Dental Staff Change: Incentive Pay
Ms. Turner stated that after careful consideration of Dental Clinic utilization, a .5 dentist position was eliminated, as was an unfilled dental assistant position. The current dentist was asked to stay on through December 31st. Ms. Turner requested approval of temporary incentive pay of two weeks' pay if the employee stays through the end of the year, and outplacement assistance in the amount of $500.

MOTION: To approve the temporary dental staff incentive pay policy as proposed.
Motion/Seconded/Carried Unanimously

Pain Project Update and Request for Expenditures
Mr. Brian Ferrans presented on the topic. He noted that other Board members previously prioritized developing a different approach to chronic pain management due to its close relationship to effective treatment of substance use disorders. Since that time, the staff person working on the project has left the Health District, but due to the importance of the project, Mr. Ferrans has taken it on as a leadership project for his RIHEL (Regional Institute of Health and

Environmental Leadership) program. Since spending funds on this project requires approval from the Board, he began with a brief history and current status of the project..

Dr. Bruce Cooper and a previous Health District staff member did significant work in researching the issue and interviewing community providers and patients in order to draft a comprehensive report (Exploring the Issues Related to Pain: A Preliminary Assessment, March 2016). Since things have changed since then, staff membes have been working on updates to the report. In addition to work already done, CIT plans to re-engage with a select number of providers, add other key informant interviews, complete focus groups with chronic pain patients, and reintroduce the project back into the community, in order to gauge the interest in the community. The staff request is for Board approval of up to $18,000 in additional spending beyond the original $10,000 for this project, as noted in the written request. Once the steps are completed, staff will come back to the Board to present preliminary recommendations for next steps.

Ms. Plock noted that in prior board discussion, the Board stated that the Health District should only work on this issue if we can make a substantive difference. Since the community has made significant progress on the issue, we need to determine what the remaining issues are, what is left to be done, and whether we are the right ones to help stimulate more change. Dr. Naqvi agreed that there is a lot of momentum now for this problem, so getting input about the work that's going on will be useful. A question was whether we currently have a good sense of what else is or isn't happening, or whether we are in the investigational phase of understanding the scope of the unaddressed problems.

Mr. Ferrans answered that we are in the investigational phase. When the Board originally prioritized this issue, the community's focus was primarily on the opioid crisis and safer prescribing. While pain management can be a key issue for those who reducing or stopping opioids, there is also a separate population of chronic pain patients in the community, and this project needs to address both. Ms. Plock noted that we do not yet have conclusions on whether we will move forward after the report is complete, and if so, how. While there are many options for how pain management can be improved, it will be important to sort out questions like: What still needs to be done, that would make the biggest difference? Does it require collective work? Because none of the current Board members have seen the report, getting the update completed and reviewed is the first step before we re-engage partners.

Board questions and responses included the following: When this was defined as a project emphasis, was it more in response to the opioid crisis and how to address that as part of pain management treatment, or were we trying to define the issue? Was the issue that there are a lot people in pain and we need more providers? The response was that it came up in a Board retreat and board meetings, particularly when we were in discussions starting to focus on substance use disorders - and realizing that it is almost impossible to separate many substance use disorders from pain management. At the same time, the community was focusing on the opioid problem – but providers needed options for people being taken off opioids who were still in pain. Of the total budget originally intended for the project, will the requested amount be a small fraction? Yes, this expenditure will still leave the majority of the original budget remaining for future action. The memo states a request for $18,000 in expenditures, but the request for 2019 is $8,000 – where is the rest of the request? There is $10,000 that needs to be approved for 2018 expenditures that went beyond the original $10,000 approved by the board in 2017, and another $8,000 in funding for 2019. What is the definition of an on-line focus group? A group that

gathers on an online platform so participants can participate without leaving home, and remain anonymous by either using the audio function or typing responses.

It was noted that it might be useful for Dr. Cooper to give again his original presentation on pain management, which is very helpful in understanding the complexity and physiology of pain. The board acknowledged that there has been significant time already committed to this project, and indicated support for completing the assessment process in order to determine what action it might lead to.

MOTION: To approve the expenditure of $18,000 to proceed with the pain project, as proposed.

Motion/Seconded/Carried Unanimously

URA Project: 120 Day Notice; Appointment of Negotiating Team – Mr. Sheafor reminded the Board that at the last meeting, Josh Birks from the City of Fort Collins came to discuss the Urban Renewal Authority redevelopment tax increment funding (TIF) project at Drake and College. Mr. Sheafor explained that while there is new TIF legislation, locally we also worked on a new process that includes a Project Review Committee (PRC) consisting of representatives from the County, Special Districts, and City to review projects and make recommendations before they go to various Boards for negotiation and approval. The PRC has met four times, and is reviewing this first application of the new Fiscal Model that was developed by consultants working with the local group, which assesses direct costs to the entities, and the Qualitative Model, which has a series of non-quantitative questions such as the need for the project. The PRC has been looking at the City's assumptions, asking questions, and gathering information for use in the negotiation process.

Under the new statute, once project negotiations start, there is a 120-day window to reach an agreement. If an agreement is not reached, it may go to mediation. The City felt like negotiations started in October when the PRC started meeting, and sent a letter to that effect, although the entities did not enter into individual negotiations at that time. Setting the 120 days in October would put the 120-day window to the end of February, which is also the city's goal for when they want to take the negotiations back to the Urban Redevelopment Authority, so those two line up at this point, although timing could change. The PRC does not have all the information it needs (some is being provided by a consultant to the City) to evaluate the project, and is in the middle of their review process. Once the PRC has finished its work, the next step for the Health District would be to negotiate an intergovernmental agreement between the Health District and the City. We anticipate negotiations to start in January, and we hope to bring it back to the Health District Board for a vote by the end of February, depending on whether we have enough information by then.

One board question was whether it will be a multilateral agreement between all the different entities or a different one between each entity and the City? The PRC is hoping to come to agreement on the assumptions, numbers and information used for the Fiscal Model, but that is only one piece of negotiation. Originally, the hope was that the PRC would come up with a recommendation and entities would adopt the recommendation, but that may not happen because every Board has different interests, concerns, and issues. Each entity will have an agreement with the City with its own direct cost calculations; it's not known yet whether the agreements will otherwise be the same.

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Staff suggested that the Board appoint a negotiating committee to for when we are ready to negotiate with the City; proposed members could be Mike Liggett, Carol Plock, and Chris Sheafor.

MOTION: To appoint a negotiating committee for the purpose of negotiating with the City for the Drake/College TIF project, with members: Chris Sheafor, Carol Plock and Michael Liggett

Motion/Seconded/Carried Unanimously

Staff will keep the Board informed at future meetings as to the progress, and the Board can use Executive Session if needed to develop negotiating approaches.

PRESENTATIONS

Policy

Alyson Williams presented the process of public policy deliberations by the Board. First the internal policy strategy team, made up of the Policy Coordinator, Medical Director, Assistant Director, and Executive Director, meet on a regular basis during session to prioritize bills and determine those that may require an in-depth analysis or other type of policy document. Analyses or briefs on high-priority topics are reviewed by the Board, which may decide to take a position, as listed in Board Policy 99-7.

Ms. Williams presented examples of past positions for the Board and highlighted the 2019 legislative session that will begin on January 4 and end on May 3. She reviewed the changes in the make-up of the General Assembly (there is now a trifecta, with the Governor being a Democrat and both houses controlled by Democrats), the key dates, key committees, and leaders. The key topics likely to arise include: behavioral health (opioids, substance use disorders, criminal justice, treatment, mental health services for youth, zero suicide, behavioral health grants for schools), health costs (transparency, prescriptions, surprise billing), health insurance costs (Medicaid buy-in, reinsurance, single geographic rating), etc. Hospitals will likely be a big focus this session. She also noted that the state budget will constrain ambitious policy agendas, and we will be keeping a close eye on Gallagher, which can impact Health District revenues significantly.

A board question was what the terms 'support' vs. 'strongly support' (or oppose) mean. The response was that when the board puts a "strongly" in front of their decision, staff is more active in sharing the position, including such things as getting with legislators to share our position, sending our analysis to more legislators, and/or testifying in front of the committee.

Ms. Gutilla noted that the Poudre School District recently passed later school start times, and asked about the Health District's role in weighing in on local issues. Ms. Plock thanked her for raising the issue, and noted that although the Health District was invited to make a comment to the school board, the invitation came late in the process, when we didn't have time to do research on a topic we were not familiar with. After consultation with board Chair Mike Liggett, the decision was made to wait to see if the decision would be made quickly; if not, we would ask the board if they wanted us to research the issue and draft a comment. The school board made the decision very soon after the issue came to our attention. Ms. Williams noted that she follows the City and County as time allows, but not the school board; she will add that to her list. A board comment was that we should consider weighing in when an issue impacts our community's

health; another board comment was that it can be difficult to determine when to weigh in, since nearly anything can be related to health.

Pharmaceutical Briefing Paper

Included in the board packet was a draft of a pharmaceutical briefing paper, in order to give those considering policy changes background on the complex pharmaceutical funding situation. Dr. Naqvi noted that with the increased use of large molecule biologics and cellular therapy, health care is moving toward even more expensive 'standard of care' pharmaceuticals, creating a changing paradigm in how patients are treated. The price of the drug tends to be what the market will bear, not the development or manufacturing costs. In cancer, they are developing treatments where the cost for one person could approach a million dollars. In the field, many are now asking: how do you do value based pharmaceutical purchasing? Britain has a council called NICE, that looks at all medications on an economic basis to determine whether their benefits are enough to justify the cost. Ms. Williams noted that there is a similar model in the United States called ISER, but the government doesn't use the information.

Updates

Larimer Health Connect (LHC): Midst of Open Enrollment 6

Karen Spink reported on LHC's current busy Open Enrollment Period: about a month and a half in, there are 454 enrollments to date, about 53 more than at about the same time last year. The electronic system was changed, and is working better, with some remaining challenges – including enrollments for those in mixed eligibility households, confusing notifications to clients, etc. On the positive side, premium prices for those who qualify for the advanced premium tax credits are significantly lower than in previous years. Things that have helped inform and assist clients include the 4-page insert in the Compass, to be followed by another mailer, and walk-in clinics open nearly every Saturday. A challenge is letting Coloradans know that although the national deadline is December 15, Colorado's open enrollment lasts through January 15.

1A Passed: What's Next for Mental Health Services?

Ms. Plock reported on the next steps for the expansion of mental health services after the passage of the 1A ballot issue in Larimer County. Reviewing an initial graphic created by the County (likely to change over time), she reported that the County Commissioners will be the final decision makers on all the funds, because they cannot, by law, delegate that duty. For the 'distributed funds,' there will be a Behavioral Health Policy Council that will make recommendations to the Commissioners. The Policy Council will be primarily made up of the mayors, or their designees, of the municipalities located within the county, along with a few other members.

There will also be a Technical Advisory Committee, made up of subject matter experts, to give advice to the Policy Council, who may not have a lot of expertise on behavioral health. There will be about $1 million available in the first year for 'distributed funding,' and about $2 million in the second and subsequent years. The development of the facility, and services related to the facility, will be done by an Operationalization Team, led by Laurie Stolen. The Health District would not serve on the Policy Council, but will decide whether to apply to serve on the TAC.

Prior to the ballot issue, a guidance team reviewed the behavioral health needs assessment, worked on a facility planning, and a subgroup did detailed work on a budget for meeting the most critical needs. The guidance team met yesterday for a discussion about next steps on the

facility. The County has a facilities planning team and intend to hire a project coordinator, the design team (architects), and contractors; they want to move quickly. It is yet to be determined whether they will build the building first, then issue an RFP for the organization that would provide the services, select the provider before the building is designed, or a bit of both. The experience with CSU's new Health Center was that it was very helpful for the providers to be part of the design process. A board comment was that, given the challenges in finding a quality behavioral health workforce, it might be important to start early, and include the provider in the planning.

The Health District, County, and Health Department have begun working on planning a Summit for the Policy Council and other community leaders, in order to present foundational knowledge on behavioral health.

Board Contribution Reminder

Karen Spink reminded the board members that we make an annual request of board members to donate to the Health District, since some funders look at the level of Board giving as one of their selection criteria; any amount that is meaningful to the donor is helpful.

UPDATES & REPORTS

Executive Director Updates

In addition to the work on next steps after 1A, the CIT team has been kept busy assisting the jail in creating a workflow and plan to initiate Medication Assisted Treatment (MAT) in jail, in helping to initiate the Hub and Spoke model which helps connect the people and services in MAT together, and starting discussions with the hospital, who has recently become interested in doing MAT induction from the emergency room. Together, these changes are very significant.

The Medicaid Accountable Care Collaborative has started to discuss joint efforts they might be able to do as a community to meet Medicaid's key performance indicators (KPI's). In related news, there is a new 'hospital transformation program' (HTP) from HICPF, which will be a requirement for hospitals to receive full funding through hospital provider fees. The Health District has been sharing what is already happening in the community, gaps, and areas where change might make the most difference with the hospitals. Staff are also working on a new dental eligibility process to streamline getting people in to the dental clinic. Finally, our search processes for key staff are taking significant staff time.

UCHealth-North/PVHS Board Liaison Report

UCHealth just announced that it provided $850 million in community benefit last year, of which about $400 million was unreimbursed care. For UCHealth North, the amount was about $300 million in community benefit, of which about $100 million was unreimbursed care. The system cared for about 285,000 patients covered by Medicaid last year.

PUBLIC COMMENT (2nd opportunity)

None.

CONSENT AGENDA

- Resolution 2018-20: To Spend 2017 Revenues into Reserves
- Approval of October 2018 Financial Statements.
- Approval of November 8, 2018 Board Meeting Minutes.

MOTION: To approve the Consent Agenda as presented/amended.

Motion/Seconded/Carried Unanimously

ANNOUNCEMENTS

- January 22, 2019, 4:00 pm – Board of Directors Regular Meeting

ADJOURN

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

The meeting was adjourned at 5:43 pm

Respectfully submitted:

Wendy Grogan, Acting Assistant to the Board of Directors

Michael D. Liggett, Esq., Board President

Molly Gutilla, MS DrPH, Board Vice President

Celeste Kling, J.D., Board Secretary

Joseph Prows, MD MPH, Board Treasurer

Faraz Naqvi, MD, Liaison to UCHealth-North/PVHS Board

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING

January 22, 2019

Health District Office Building
120 Bristlecone Drive, Fort Collins

MINUTES

BOARD MEMBERS PRESENT: Molly Gutilla, MS DrPH, Board Vice President
Celeste Kling, J.D., Board Secretary
Joseph Prows, MD MPH, Board Treasurer
Faraz Naqvi, MD, Liaison to UCHealth-North/PVHS Board

BOARD MEMBERS ABSENT: Michael D. Liggett, Esq., Board President (Excused)

Staff Present:
Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Richard Cox, Communications Director
Lorraine Haywood, Finance Director
Chris Sheafor, Support Services Director
Dana Turner, Dental Services Director
Lin Wilder, Community Impact Director
Wendy Grogan, Administrative Assistant

Others Present:
Jim Becker, PAFC
Alyson Williams, Policy Coordinator
Jess Fear, CIT BH Strategy Manager
Laura Mai, Assistant Finance Director
Brian Ferrans, CIT BH Strategy Manager
Suman Mathur, Eval. And Data Specialist

CALL TO ORDER; APPROVAL OF AGENDA

Vice President Molly Gutilla called the meeting to order at 4:10 p.m.

MOTION: To approve the agenda as presented/amended
Motion/Seconded/Carried Unanimously

PUBLIC COMMENT

Jim Becker, Executive Director for Partnership of Age Friendly Communities (PAFC)
Mr. Becker stopped by to say thank you for the article in Compass about the PAFC, noting that if the Board was interested, and had time at a later meeting, he would come back and provide more information on the PAFC, which offers access to resources for the aging and caregivers of the aging. The PAFC is working for priority areas such as transportation, health and wellness, the culture of the aging, and housing in Larimer County for those over 50 years old. Rural transportation is a current are of interest for them.

PRESENTATIONS

Frequent Utilizer Systems Engagement (FUSE) Demo Project
Lin Wilder introduced Jess Fear who gave a presentation on the next steps for our work with improving treatment for frequent utilizers of high cost acute and crisis services. The Health

District has partnered with Homeward Alliance and Homeward 2020 to participate in the Corporation for Supportive Housing's Frequent Utilizer Systems Engagement (FUSE) Learning Community. This has resulted in development of a FUSE demonstration project (nine steps) which will focus on providing housing and wrap-around services to 20 chronically homeless high utilizers of the criminal justice system. This is a parallel process with a data sharing agreement project with the Sorenson Impact Center out of the University of Utah. Staff are requesting approval of up to $5,000 in allocated reserve funding for flexible funding to support the remaining needs of the FUSE project, including portions of its evaluation.

IF FUSE receives a likely grant from the Colorado Division of Housing (from marijuana tax dollars), Homeward 2020 will be able to hire a full time clinical case manager, and 20 housing vouchers will be provided. MOUs are also being developed with a range of local providers to provide wrap-around services. CSU will be evaluating the demonstration project by looking at the pre and post data on the 20 individuals, compared to a control group that don't get the provided intervention, to examine the cost diversion.

A board question was whether a 'pay for success' project is potentially part of this data collection and demonstration project. This demonstration project and evaluation through FUSE, along with the work with Sorenson - which is focused on collecting and sharing data – should, if successful, provide proof of concept and proof of our community's ability to share the data necessary create a pay for success project in the future. A 'pay for success' project, sometimes also called a 'social impact fund,' is a project where private funders invest in an intervention expected to result in significant cost savings. The intent is to prove that the intervention is successful so that in the future, government and other funders will continue to fund the projects. A similar project in Denver serving around 250 people resulted in $8.7 million in cost diversion or savings.

Our original study of frequent utilizers revealed a couple of important things that were a surprise to some people. First, it was assumed that most would be connected to the behavioral health system, but it was surprising to find that most were not. Second, while many assume the frequent utilizers are mostly transient, the study found that most of the people using services were people that had been homeless in Fort Collins for some time.

A board question was whether this project is related to the former Community Dual Disorders Treatment (CDDT) program and evaluation, or something new. The CDDT program and evaluation, done several years ago, did show great success with people with severe and persistent mental health issues and substance use disorders, including some savings. That project is similar to this one, although CDDT has a slightly different focus. Currently, the CDDT program is at capacity with a waiting list. One of the biggest barriers is that most of their funding comes from Medicaid but Medicaid doesn't fund a lot of the services needed to provide wrap around services for these individuals. Although it had been hoped that the program would become institutionalized, with housing vouchers and services for all participants, full funding didn't continue over the years.

DISCUSSION AND ACTIONS

Approval, Expenditure of Reserve Funding, Frequent Utilizer Project

Ms. Wilder stated that there were reserve funds of $25,000 set aside in the budget to support work on frequent utilizers and pay for success. The Board previously approved spending up to $12,000 of this as a match to the Sorensen Impact technical assistance grant for data sharing,

leaving $13,000 in the budget (though not all of the $12,000 is expected to be spent). She asked the Board to approve spending of up to $5,000 of that money in supporting this project, likely for evaluation, but also for other things that may come up. Ms. Fear said that the evaluation from CSU will cost approximately $20,000 and there are other partners pitching in portions of that amount. The Board approved this request.

MOTION: To approve expenditure of up to $5,000 in allocated reserve funding to support the Frequent Utilizer Systems Engagement (FUSE) Demonstration Project

Motion/Seconded/Carried Unanimously

City of Fort Collins Social Sustainability Application

Jessica Shannon presented the request for approval to apply for the City of Fort Collins Social Sustainability Funding for the Child, Adolescent, and Young Adult Connections (CAYAC) program. Grant funding for CAYAC will end in 2019, including funding that supports the Poudre School District–based School Liaison position. The Health District has been moving to integrate certain CAYAC positions into our own budget, but a key element of sustainability for the project was to have our partners fund their positions into the future. Up until December 2018, we anticipated that PSD would be able to fund the School Liaison Position after 2019. The position is critical to CAYAC's ability to provide the best assistance for students, because of important information sharing that allows for timely services, accurate diagnoses, and referrals to the right type of treatment providers.

In December, the school informed us that they were unable to commit to funding in the upcoming school year budget for the School Liaison position, due to their recent decision to switch school starting times for younger vs. older students, and the costs of that change. It is unknown whether this funding might be likely in future years. Meanwhile, the Health District already needs to try to incorporate funding for the full FTE of the CAYAC Psychologist, as well as to find funding for a full FTE Community Navigator in 2020. As grant funding expires, we will also lose indirect cost and program evaluation funding.

The lack of a person within the schools is anticipated to create notable challenges for the CAYAC program, since we really can't operate well without a position that is dedicated to communications with the school system. Our staff's time is expected to increase significantly because they will have to communicate with each of the different schools, try to figure out how to prioritize student needs, and try to navigate and find the right information to convey back to the clinical team members, all roles currently performed by the existing School Liaison.

In a meeting with Adam Molzer of the City of Fort Collins, staff learned that Social Sustainability funding is changing their funding priorities to focus more on long-term impact in alignment with their long-term strategic plan, which includes addressing behavioral health needs for youth. Early identification and access, which is CAYAC's focus, fits well with their priorities. The proposal is to seek funding through the City to support a CAYAC position to work directly with the schools, while we determine the longer term potential of an ongoing school position. CAYAC has served about 3,000 youth since 2016; 80% are in PSD schools.

Ms. Plock noted, however, that we had received a letter at about noon today, signed by representatives from five nonprofit organizations participating in Directing Change, asking the

board not to approve the request to apply for City of Fort Collins Community Development Block Grant funds. Their reasoning was that the Health District is financially well-positioned, and that CDBG funds are limited and many of their organizations rely on the funds for critical programs and services. In the past, the Health District received City funding for Dental Connections, but after a board decision a couple of years ago, made the decision not to apply for that funding because dental need had declined. Today's letter requested that we find non-grant sources to fund CAYAC; however, we already have a large burden to try to fund the other positions through operational dollars after grant dollars expire. Over the years, grant funding has allowed us to start pilot projects and to work with partners on promising projects. Our philosophy has been that it is up to the funding source to determine which of all competitive grant applications will best address their purposes. In this case, we could refrain from applying, although that could also risk the future of CAYAC. We can look for other funding sources, but there is no guarantee that we will be able to secure funding. While we want to retain good relations with our community nonprofit partners, CAYAC is also an important project; there is not a perfect answer to this situation.

A board question was how much funding would be needed from other sources for this position; the answer was about $24,000. Ms. Shannon noted that CAYAC serves many of the children that are served by the organizations in Directing Change, providing non-duplicative services to increase access to the right behavioral health treatment for their needs. Ms. Gutilla stated that a community criticism is that CAYAC is not designed for youth to stay for long-term treatment, and may be creating more work for nonprofits. Staff responded that the most important service provided by CAYAC is affordable and timely psychiatric assessment and psychological testing for prioritized children, which is extremely hard to find elsewhere, allowing for comprehensive evaluation of the child's needs so that the diagnosis and referral to treatment is appropriate and more likely to succeed.

Another board question was how big the CBDG grant program is, the deadline for applying, and whether there are parameters that let us know if we should/should not apply? The funding pot is typically around $1M for health and human services programs. Their grants tend to range from about $20,000 to $70,000. The pre-application deadline is January 25th, and they determine if the applicants are eligible and a good fit; if so, the complete application is due February 15th. When asked whether the school would be able to step back in to funding next year, staff responded that it's too early to know. Another board question was what our board's fiduciary responsibility was; the primary responsibility is to pursue our mission, which is to enhance the health of the community.

Noting that there are a lot of respected names and organizations in the letter, that their work is in line with the outcomes we are being asked to serve, and that the letter makes an argument that he found compelling that we are financially more solvent, Dr. Prows indicated that he was inclined to go with what they are asking. Ms. Gutilla agreed. She noted that she believes that the authors probably meant 'find other grant sources' rather than CDBG sources, and that since we receive tax funding, we shouldn't take other tax funding. She noted that she thought that the library district has been intentional about not competing for funding. She is in favor of funding and continuing CAYAC and seeking grant funding, but thinks our local CDBG funding is probably not the best place to look for it.

Ms. Kling noted that funders choose where they give their money and if they fully fund our $24,000 request, it doesn't mean that the other organizations won't get their requests. Decision makers decide where the highest priorities are and will put it where they think they will get the most leverage for our community. She indicated surprise at any organization choosing one of their competitors and asking them to not apply, while everyone else can. She was also concerned that it sends a message to the CDBG Board that our program is less important than other programs – including the unknown projects that may apply aren't represented by those who signed the letter. She was uncomfortable depriving our program and mission of the opportunity to continue, and was not inclined to pull us out of the running.

Dr. Naqvi noted that it feels that those who signed the letter are saying they will do a better job with the money than we will. Ms. Gutilla responded that her interpretation was not that; that instead, they want us to use our own money. Her concern was that if we choose to apply, that sends a message about where we stand in partnership and working together in collaborations. Ms. Kling noted that there are many things we can do jointly to be team players, but to take ourselves out of the running when we don't even know who will apply is to put them ahead of us without knowing the information. Ms. Gutilla suggested that if this is a critical position, then the Health District should move some of things into different funding streams and not rely on getting grant money; she asked if we didn't anticipate this coming up in the budget.

Staff responded that our operational dollars are fully budgeted. There is also support for this project from our reserve funds, including budgeting for a temporary match for this position that we thought would be needed until the school district could take on this position. Up until December, the school budgeted .2 FTE for the current school year, and were anticipated to increase their commitment to an ultimate .8 FTE position. The Health District still needs to find funding for the rest of the Psychologist FTE, the Navigator, and potentially for Psychology interns, along with replacing the indirect and evaluation funding. We have been anticipating the need to make this sustainable ever since we got the three-year grant. The Health District already funds provides major funding, but we can't take on all of the grant funding in operational dollars unless we cut funding for another program.

Staff are also concerned about setting a precedent that we would back away from any other grant funding, which is a resource that has significantly advanced our community projects over the years. Should the Board decide not to apply for these funds, it would be the staff's hope that it would be made clear that it was only for this one source of funding, this one time.

On the issue of competing for tax funds, staff clarified that tax money is often used for grants, and historically both nonprofits and government entities (universities, counties, municipalities, etc.) regularly compete for them. In response to a board question of where CDBG funding comes from – CDBG funding is federal funding that is allocated to communities to be used for local needs. The City's Social Sustainability funding also includes local dollars.

Ms. Kling indicated her opinion that if the Board thinks that CAYAC is an important program, having great results, and one of our partners isn't able to follow through with their commitment, the Board has a responsibility to apply for the gap in funding. Dr. Prows noted that these organizations do phenomenal work, and it would be good for us to collaborate with them. Staff noted that we collaborate with many of these organizations on a regular basis, and that we are providing a critical service that many of their clients need. In response to a board question of

what funding gap we are trying to close, staff responded that they will bring a complete assessment of the full funding needs for CAYAC to the next meeting, but for this position, the total cost is $60,000, and the current unmet need is for $24,000.

Ms. Gutilla called the question of whether to seek CDBG funding for $24,000 to fully fund the CAYAC position.

MOTION: To apply for City of Fort Collins Social Sustainability funding for the remaining funding needed for a CAYAC school navigator position
Motion/Seconded/2 For, 2 Opposed/Motion Failed

By consensus, the board agreed that this is a one-time decision, and applies only to this grant.

Indicating consternation about a difficult decision, and about making the decision without all board members present, there was a board question about whether there was a mechanism by which a pre-application could be submitted, and the issue could be considered at the next meeting, when all five board members were likely to be present. Staff responded that the pre-application must be submitted by Friday. The Board memo to approve the application is not due until the full application is due on February 15th.

MOTION: To table the question of whether to apply for City of Fort Collins Social Sustainability funding, for the remaining funding needed for a CAYAC school navigator position, until the next Board meeting in order to have the full board consider the issue. To approve submission of a pre-application at this time, in case the decision is to submit a full application.
Motion/Seconded/Carried Unanimously

Policy
Amendments to Policy 99-7: Establishing and Communicating a Position on Policy Issues

MOTION: To approve amendments to Policy 99-7: Establishing and Communicating a Position on Policy Issues, as proposed.
Motion/Seconded/Carried Unanimously

Local and Federal Issues
Local: Wood Smoke-Regulating Recreational Wood Smoke in Backyards: Upon request from city staff, Dr. Cooper wrote a brief statement for City Council on what we could find is known about the health impact of outdoor wood stoves (which is quite limited). The statement, and the board, did not take a policy position. This will be presented to the City Council tonight.

Federal: There is a proposed administrative regulation related to the ACA that, among other things, would eliminate automatic renewal and eliminate silver-loading, which would decrease financial assistance for those with low incomes and increase premiums. It could decrease funding for outreach and navigation. The regulation hasn't been officially published yet due to the Federal shutdown. How insurers count the cost-sharing requirement for brand name drugs toward max out-of-pocket costs would change, raising costs to consumers. Estimates are that the changes could increase the cost of premiums by $181M, decrease enrollment by 100,000 and save the government $900M. Once it is published, we may want to submit comments.

The Farm Bill passed; there are no big changes to SNAP.

State

Nineteen (19) days into the session and 101 days left, 210 bills introduced, and 5 bills have been killed. Proposals anticipated to emerge later in the session include: Zero Suicide implementation funding, behavioral health insurance parity bill to enforce current law and regulations so that physical health and behavioral health will be treated equally, the department that is the licensing entity for behavioral health care facilities is likely to change from OBH to CDPHE, and a re-insurance program; one of the priorities of the new Office on Saving People Money on Health Care run by the new Lt. Governor.

HB19-1010: Freestanding Emergency Departments Licensure

This bill creates a new license, "freestanding emergency department license," within the Colorado Department of Public Health and Environment (CDPHE), for health facilities that offer emergency care but are not attached to a hospital campus. A facility that was licensed under the "community clinics and emergency centers" license type before July 1, 2010 and operates in a rural community or serves a ski area is excluded from this new license type.

MOTION: To support HB19-1010: Freestanding Emergency Departments Licensure.

Motion/Seconded/Carried Unanimously

HB19-1038: Dental Benefit for Pregnant Women Covered by CHP+

Will add about 900 pregnant women to the dental benefit starting July 2019.

MOTION: To strongly support HB19-1038: Dental Benefit for Pregnant Women Covered by CHP+.

Motion/Seconded/Carried Unanimously

SB19-008: Substance Use Disorder Treatment in Criminal Justice System

This bill concentrates on a variety of factors in regards to substance use disorders (SUDs) and the interaction with the criminal justice system, including several that will promote the use of medication-assisted treatment.

MOTION: To strongly support SB19-008: Substance Use Disorder Treatment in Criminal Justice System.

Motion/Seconded/Carried Unanimously

SB19-010: Professional Behavioral Health Services for Schools

The Bill allows grant money to be used by recipient schools for providing behavioral health services or funding contracts with community partners. The Bill requires the Colorado Department of Education to prioritize grant applications based on certain provisions. The Bill also allows community partners to commit money to schools.

MOTION: To strongly support SB19-010: Professional Behavioral Health Services

For Schools.

Motion/Seconded/Carried Unanimously

UPDATES & REPORTS

Executive Director/Other Updates

Ms. Plock stated she was selected to continue on the State PIAC committee (Medicaid Accountable Care Advisory Committee) and was elected to serve as the Co-Chair. Ms. Wilder provided the following updates:

HealthInfoSource: We were ready to move into the RFP process when another vendor was found that provides a database of behavioral health services in a searchable format, so the RFP was delayed while we investigated it. In the end, the cost of that option was prohibitive, so we are developing an RFP for the design and development of HIS, and will be coming back to the Board once a vendor has been selected. We are following the phased approach previously discussed, which begins with behavioral health lists and limited health information (e.g., safety net dental care optinos), but will not include fully searchable other health options at this phase.

Followup from the new behavioral health facilities and services resulting from the 1A ballot measure continue to include the County's Policy Advisory Council (PAC) and Technical Advisory Council (TAC) that will help drive the decisions around the services that will be distributed throughout the community. Staff are continuing to work with the County and others to create a 1-day summit on February 23 for the PAC and TAC and other community decision makers to give them some of the foundational knowledge they need for decision making.

Medication Assisted Treatment (MAT) is a key approach to substance use disorder treatment. Currently, when people go to jail, if they are on MAT, they are taken off - and there is no induction into MAT in jail if needed. One of the riskiest times for overdose is upon release from jail, and currently, people are not given Naloxone (which can reverse an overdose) when they leave jail. Working with several partners, the jail is seriously considering MAT, both induction and continuation, in jail, and providing Naloxone upon release. Brian Ferrans and Maria Jorgenson on the CIT team have been working with county staff to map out the process and create a budget, which has helped move the concept forward quickly. Meetings are set with the Sheriff and County Manager, and the group is searching for grant funds to start the program before ongoing funds can be designated.

We are also assisting UCHealth North in doing training to help with the transition of having their ED be equipped to start induction of MAT in the emergency room. The local approach to substance use treatment is making huge progress.

UCHealth-North/PVHS Board Liaison Report

Dr. Naqvi stated that the 2018 financial analysis was good, but not as good at the end of the year. Should there be significant changes in the payer mix (for example, from commercial or Medicare to Medicaid), the financial picture would not be as healthy, since Medicaid does not cover costs. Health systems are very dependent on variable costs, and their variable cost curve, which over time steepens. Cost-cutting pressure is likely to emerge, which could be related to us in that it is our asset that they use, and they will be looking to cut costs that do not have a return.

PUBLIC COMMENT (2nd opportunity)

None.

CONSENT AGENDA

- Resolution 2019-01: Establish Meeting Days
- Resolution 2019-02: Public Posting of Meeting Notices
- Approval of November 2018 Financial Statements

MOTION: To Approve the Consent Agenda as Presented
Motion/Seconded/Carried Unanimously

Minutes were not available for approval.

ANNOUNCEMENTS

- February 12, 4:00 pm – Board of Directors Special Meeting
- February 26, 4:00 pm – Regular Board Meeting

EXECUTIVE SESSION

MOTION: To go into Executive Session for the Purpose of Discussion of Matters Pursuant to C.R.S. §24-6-402(4)(e) Regarding Negotiations and C.R.S. §24-6-402(4)(f) Pertaining to Personnel Issues
Motion/Seconded/Carried Unanimously

The Board retired to Executive Session at 5:53 p.m.
The Board came out of Executive Session at 6:28 p.m.

ADJOURN

MOTION: To Adjourn the Meeting
Moved/Seconded/Carried Unanimously

The meeting was adjourned at 6:30 p.m.

Respectfully submitted:

Wendy Grogan, Acting Assistant to the Board of Directors

ABSENT
Michael D. Liggett, Esq., Board President

Molly Gutilla, MS DrPH, Board Vice President

Celeste Kling, J.D., Board Secretary

Joseph Prows, MD MPH, Board Treasurer

Faraz Naqvi, MD, Liaison to PVHS/UCHealth North