February 10, 2017

The Honorable John Hickenlooper
200 Colfax Street
Denver, Colorado 80202

Re: Response to Senators' Letter of January 19, 2017

Dear Governor Hickenlooper:

The undersigned organizations submit these comments for your consideration in your response to the January 19, 2017 letter from U.S. Senators Rob Wyden, Debbie Stabenow, Maria Cantwell, Bill Nelson, Robert Menendez, Thomas R. Carper, Benjamin L. Cardin, Sherrod Brown, Michael Bennet, Robert P. Casey, Mark R. Warner and Claire McCaskill, ("Wyden Letter"), regarding potential changes in the Medicaid program. Our comments, as set forth below, augment and expand on our earlier submission regarding the December 2, 2016 letter from U.S. House Majority Leader Kevin McCarthy ("Majority Leader Letter"). We appreciate your thorough consideration of our earlier comments, and hope these will provide additional insights.

We are proud of our state and thank you for your leadership in bringing the Medicaid expansion to Colorado, and supporting efforts to protect the Medicaid program. To those in Congress who would reduce Medicaid funding, we emphasize that Health First Colorado, Colorado's Medicaid program, is already extremely lean, with minimal administrative cost, low provider reimbursement, and networks that are stretched to capacity. A higher level of state funding is currently barred by the Colorado Constitution's TABOR amendments, since such funding would have to be offset by cuts in other constitutionally-required programs, including K-12 education.[i] Any reduction in the over $5 billion dollars of federal funding, whether related to rollback of the Medicaid expansion, block grants, or per capita caps, would be devastating to the health of Coloradans who rely on Medicaid and would pose risks to the physical and economic health of all Coloradans.

We strongly support statements made in the Wyden Letter regarding the foundational role Medicaid plays in the nation's health care system. We emphasize that its role in Colorado is equally primary.

With approximately 1.3 million Coloradans now enrolled in Medicaid and an additional 51,000 children and pregnant women in Child Health Plus (CHP+),[ii] Medicaid and CHP+ cover close to one-fourth of Coloradans. Medicaid alone covers 43% of all births in the state, based on 2014 data.[iii] More than one in three children in Colorado are served by Medicaid, including children in foster care and children with disabilities. Colorado schools also utilize federal dollars through the Medicaid School Health Services Program, which brings expanded health services to all students in 53 Colorado districts, including access to nurses, behavioral services and health education.[iv] Any reduction in services for this population would be catastrophic, considering the lifelong benefits of comprehensive health care in pregnancy and childhood, and the lifelong harms that would result from its absence.

Coverage of services to treat mental illness and substance use disorders in Colorado are of particular value now, with Colorado experiencing alarming increases - particularly in rural areas – of death and disability due to addiction and mental illness.[v] Financing to cover mental health and substance use disorder services comes in large part through Medicaid, with Colorado's expansion dollars adding significantly to the total; more, rather than less, funding is desirable in this area. We also note that the ACA requirement that plans cover mental health and substance use disorder substantially increased access for both those who purchase plans on the individual and small-group market, as well as adults newly eligible for Medicaid coverage.

With access to federal matching funds through Medicaid, Colorado has the opportunity to reduce the adverse economic and health effects of untreated behavioral health.[vi] Loss of such funding would mean that Colorado's ability to stem the alarming increase in suicide and addiction would be severely hampered, and that loss would have a disproportionate effect on rural areas. Many San Luis Valley and Western Slope counties have rates of suicide, for example, that are as much as twice the national average.[vii]

Colorado Medicaid is also the primary payer for the long-term services and supports (LTSS) for which over 120,000 Coloradans are eligible and on which at least 65,000 Coloradans rely. Without LTSS, people with disabilities and low-income seniors would have nowhere to go, unable to remain at home and in their communities, and without coverage for extended nursing home services.[viii] The Colorado network of services includes Home and Community Based Services, the Program of All-Inclusive Care for the Elderly, nursing facilities and other state services that are a vital part of keeping recipients healthy and independent. Private options are neither affordable nor comprehensive, and Medicaid is the foundation of community based and institutional long term care for people with disabilities and the elderly, both in Colorado and nationally.[ix]

Medicaid brings economic benefits to Colorado by holding down costs and countering the upward trend in commercial healthcare costs, by bringing federal dollars to underserved rural and urban communities, and by bringing well-paying jobs in the medical, health technology and information technology sectors, all of which are vital to Colorado's economic health.

Colorado Medicaid provides more service for less money than the commercial market. Colorado projections for health care costs per Medicaid enrollee show minimal increases over the past decade, despite national costs for most health care services rising far beyond inflation rates for other goods and services. In the state of Colorado overall, medical care prices rose 39.7 percent between 2006 and 2015.[x] One reason for these lower cost trends in Medicaid is that administrative costs are a fraction of those seen with commercial payers.[xi] Forcing the Medicaid population into the private market, through vouchers or other mechanisms, would likely result in less care at greater expense. Block grants and per capita caps assume incorrectly that the Medicaid program can cut costs without cutting care. The same can't be said of commercial health care, where administrative costs are proportionately high for both payers and providers.

Medicaid has also helped bring federal and state dollars to regions outside the Front Range, where residents generally have less access to employer coverage.[xii] The loss of Medicaid dollars, particularly the increased federal dollars provided for the expansion population, would mean a major economic loss. For example, over a third of Montezuma residents are enrolled in Medicaid, and about a third of those are expansion population adults, whose care was 100% covered by federal dollars in 2016 and 95% covered in 2017. The approximately ten million federal dollars[xiii] that helped deliver care to Montezuma adults have generated economic benefit to the area both by improving individuals' health and ability to work, and by expanding jobs in the health sector. In Alamosa County, forty-four percent of residents are enrolled in Medicaid, and a third of those are expansion adults. In Gunnison, expansion adults constitute almost half the county's Medicaid population. Fifty-six percent of Costilla County residents are enrolled in Medicaid, and over a quarter of those are expansion adults. In Denver County, the 68,000 expansion adults bring in hundreds of millions of federal dollars. Even Kit Carson, with under 500 expansion adults, would lose approximately 1.75 million federal dollars worth of care, an amount those county residents would not see under block grants, per capita caps, or any plan that shifts financial costs to the state and to individuals.

Medicaid dollars also bring jobs to Colorado. The Colorado Health Foundation estimates that state gross domestic product is $3.82 billion larger as a result of Medicaid expansion, and will continue to grow as a result. As of March 2016, they estimated that the Medicaid expansion had brought Colorado an additional 31,074 jobs.[xiv] The contemplated cuts in funding, through either a block grant or per capita cap structure, would result in reversal of those gains, and would result in revenue losses, shrinkage of the health care workforce, and loss of jobs associated not just with health care, information technology and support services, but beyond. Colorado would be among the hardest hit nationally, in terms of job loss resulting simply from a rollback in the Medicaid expansion.[xv]

A truncated scheme of federal funding such as block granting or per capita caps would prevent Colorado from providing necessary medical, behavioral, and oral/dental services, and would lead to future deficits in health and economic wellbeing.

The current federal matching program is flexible, and gives Colorado the ability to address population and individual needs as they arise. Block granting and per capita caps would severely limit funding in the program overall, would likely decrease funding relative to need over time, and would prevent delivery of care to those who need it, when they need it.[xvi] Current proposals for block granting and per capita caps project a reduction in national expenditures by 25 percent, a situation that would leave state lawmakers with impossible choices. Programs would shrink drastically and costs would soar for those who can least afford it. The basic needs of our most vulnerable citizens would not be met.

Many medical services have short-term expense and long-term benefit, with the Early and Periodic, Screening, Diagnostic and Treatment program (EPSDT) establishing the paradigm that adequate services provided at an early point can prevent greater costs to the individual and society in the future. For example, preventive dental care reduces broader adverse health consequences. Treatment for hepatitis C requires significant up-front costs

that could not be supported with either block grants or per capita caps, though that treatment prevents future liver damage and decreases the future need for dialysis.[xvii]

Outbreaks in disease, demographic changes and natural disasters can be addressed with federal matching funds but would be unmanageable under block grants and per capita caps. The number of examples is unlimited, but just a few can illustrate the range of issues. No additional funding would be available for something as relatively mundane as an influenza or West Nile outbreak, and addressing the rapidly growing diabetes rate in Colorado will need many more, rather than fewer, dollars over time.[xviii] The number of Coloradans with Alzheimer's disease is expected to rise 37% in just the next nine years, meaning that thousands more may need the long-term services and supports that Medicaid provides.[xix]

The reduced funding that comes with block grants and per capita caps would, in fact, diminish the possibility of flexibility or innovation.[xx] Colorado's current efforts to develop and implement alternative payment models that improve provider accountability, or to put in place the proposed new Regional Accountable Entities,[xxi] would be hampered. Programs funded through the Centers for Medicare and Medicaid Innovation would be at risk, including the State Innovation Model (SIM), which involves a model for integrated care that can more successfully address mental illness and substance use disorder for more patients and at earlier stages.[xxii] That program, which involves partnership with commercial payers, could bring change beyond the Medicaid program, but not if cuts in funding make broader implementation impossible.

In summary, the current Medicaid system has given Colorado the tools, flexibility and funding to provide care to almost a quarter of state residents, to respond flexibly to shifts in population and levels of need, and to innovate systems of care that improve health with more efficient use of state and federal money. The physical and economic health of Coloradans, now and in future decades, will be damaged if the Medicaid program devolves into block grants or a per capita caps system. We urge you to strongly oppose any proposals or legislation that would move us away from the comprehensive, equitable program now in place.

Sincerely,

Organizations:
9to5 Colorado
The Arc of Adams County
The Arc of Colorado
The Arc, Arapahoe & Douglas Counties
American Diabetes Association
Asian Pacific Development Center
The Bell Policy Center
Chronic Care Collaborative
Colorado Association for School-Based Health Care
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Coalition for the Medically Underserved

Colorado Community Health Network
Colorado Consumer Health Initiative
Colorado Criminal Justice Reform Coalition
Colorado Cross-Disability Coalition
Colorado Diabetes Foundation
Colorado Fiscal Institute
Colorado Foundation For Universal Health Care
Colorado Mental Wellness Network
Colorado Nurses Association
Colorado School Medicaid Consortium
Colorado-Wyoming Chapter of the National Multiple Sclerosis Society
CREA Results
Doctors Care
Family Voices Colorado
FRESC: Good Jobs, Strong Communities
Grand County Rural Health Network
Healthier Colorado
Mental Health Colorado
OneColorado
Planned Parenthood of the Rocky Mountains
Stahlman Disability Consulting
Together Colorado

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Senator Cory Gardner
Representative Diana DeGette
Representative Ken Buck
Representative Jared Polis
Representative Ed Perlmutter
Representative Mike Coffman
Representative Scott Tipton
Representative Doug Lanborn

[i] A Closer Look at TABOR. Institute on Taxation and Economic Policy, August 2013, http://www.itep.org/pdf/pbtabor.pdf

[ii] Caseload reports as of the end of FY 2015-2016. Available at https://www.colorado.gov/pacific/sites/default/files/2016%20June%20Joint%20Budget%20Committee%20Monthly%20Premiums%20Report%20.pdf

[iii] Births Financed by Medicaid. Kaiser Family Foundation. http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0

[iv] https://www.colorado.gov/pacific/sites/default/files/2015-16%20Annual%20Report.pdf

[v] Suicide rates in Colorado are among the highest nationally. https://afsp.org/about-suicide/state-fact-sheets/#Colorado. The rate of addiction in Colorado is high and rising. http://www.cpr.org/news/story/colorado-drug-overdoses-almost-every-county-and-ahead-national-average. Deaths related to addiction have risen in rural Colorado. http://www.washingtonpost.com/sf/national/2016/08/31/opiods-and-anti-anxiety-medication-are-killing-white-american-women/

[vi] The business case for effective substance use disorder treatment. National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2015/01/14_Business-Case_Substance-Use.pdf.

[vii] Colorado Trends in Suicide. Colorado Department of Public Health & Environment. August 12, 2015, https://www.communityreachcenter.org/wp-content/uploads/2016/10/2015-Colorado-Trends-in-Suicide-Annual-Report-2015.pdf

[viii] Eligible enrollees are those for whom evidence of an institutional level of care is required. Department of Health Care Policy and Financing FY 2016-17 Medical Premium Expenditure and Caseload Report, "Medicaid Caseload Without Retroactivity," p. 4. Those accessing LTSS include waiver enrollees, PACE enrollees, and an estimate of the enrolled population's use of nursing facilities based on total days used and typical length of stay in those facilities. See https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY18%2C%20R-1%20Exhibit%20G.pdf; https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY18%2C%20R-1%20Exhibit%20H.pdf; https://www.colorado.gov/pacific/sites/default/files/2016%20June%20Joint%20Budget%20Committee%20Monthly%20Premiums%20Report%20.pdf

[ix] Erica L. Reaves and MaryBeth Musumeci. Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation, December 2015. Available at: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

[x] Memorandum. Colorado Legislative Council Staff. November 17, 2016. Available at: https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Trends%20and%20Cost%20Drivers%20IP%20Memo_11092016.pdf.

[xi] The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Chapter 4: Excess Administrative Costs. National Academies Press. Available at: https://www.ncbi.nlm.nih.gov/books/NBK53942/ (See Table 4-1)

[xii] Job-based Coverage. Colorado Health Institute. 2015. Available at: http://www.coloradohealthinstitute.org/uploads/postfiles/ABC_Maps_/J_Job_based.png

[xiii] Using Colorado budget documents showing expansion costs of between $2950 and $4496 per expansion enrollee, and department fact sheets. https://www.colorado.gov/pacific/sites/default/files/Montezuma%20County%20Fact%20Sheet.pdf; schedule EE-1, from https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY18%2C%20R-1%20Exhibit%20E.pdf

[xiv] Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35. The Colorado Health Foundation. March 2016. Available at: https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Expansion%20Analysis_Exec%20Summary_FINAL%20-%203-2016.PDF

[xv] Josh Bivens. Repealing the Affordable Care Act would cost jobs in every state. Economic Policy Institute. January 2017. Available at: http://www.epi.org/publication/repealing-the-affordable-care-act-would-cost-jobs-in-every-state/

[xvi] Judy Solomon. Medicaid Funding Caps Would Lead to Program Cuts, Impede Innovation. Center on Budget and Policy Priorities. January 2017. Available at: http://www.cbpp.org/blog/medicaid-funding-caps-would-lead-to-program-cuts-impede-innovation.

[xvii] CDC Fact Sheet: Viral Hepatitis and Liver Cancer. Available at: https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/viral-hep-liver-cancer.pdf

[xviii] Diabetes' Impact in Colorado. Colorado Dept. of Public Health and Environment. Available at: https://www.colorado.gov/pacific/sites/default/files/DC_Factsheet_Facts_For_Action_Diabetes_In_Colorado_November_2015.pdf

[xix] Alzheimer's Statistics: Colorado. Alzheimer's Association. Avialable at: http://www.alz.org/documents_custom/facts_2016/statesheet_colorado.pdf

[xx] Understanding and evaluating block grants and other capped funding proposals. Manatt Health. December 2016. http://statenetwork.org/wp-content/uploads/2016/12/State-Network-Manatt-Understanding-and-Evaluating-Block-Grants-and-other-Capped-Funding-Proposals-December-2016.pdf

[xxi] Accountable Care Collaborative Phase II. Colorado Department of Health Care Policy and Financing. Available at: https://www.colorado.gov/pacific/hcpf/accphase2

[xxii]https://www.colorado.gov/pacific/sites/default/files/CDPHE_WB_MentalHealthSubstanceAbuse.pdf