2007 SUNSET REVIEW

Colorado Department of Regulatory Agencies
Office of Policy, Research and Regulatory Reform

Community Contracted Health Care Providers

October 15, 2007

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
Office of Policy, Research and Regulatory Reform
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Bill Ritter, Jr.
Governor

D. Rico Munn
Executive Director

October 15, 2007

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the authority granted to municipalities to contract with health care providers. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2008 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination…

The report discusses the question of whether the authorization granted by sections 31-15-302(1)(i)(I) and 32-1-1003.5, C.R.S., serve to protect the public health, safety or welfare. The report also discusses the effectiveness of these provisions and makes recommendations for statutory and administrative changes in the event these statutes are continued by the General Assembly.

Sincerely,

D. Rico Munn
Executive Director

Department of Regulatory Agencies

Bill Ritter, Jr.
Governor

D. Rico Munn
Executive Director

2007 Sunset Review
Community Contracted Health Care Providers

Executive Summary

Quick Facts

What are community contracted health care providers? Colorado municipalities with populations of 20,000 or fewer residents, as well as health assurance districts, may contract with a physician, physician's assistant or nurse practitioner to provide services directly to their residents.

Who uses community contracted health care providers? The Department of Regulatory Agencies (DORA) was able to identify only four municipalities that have directly contracted with health care providers for the provision of services.

How is it administered? No state agency is charged with responsibility for overseeing the use of community contracted health care providers. Rather, individual Colorado municipalities are authorized to contract directly with health care providers.

What Does it Cost? There have been no state expenditures related to the use of community contracted health care providers.

Where Do I Get the Full Report? The full sunset review can be found on the internet at: http://www.dora.state.co.us/opr/oprpublications.htm

Key Recommendations

Continue the statutory provisions authorizing the use of community contracted health care providers.
The statutory provisions authorizing the use of community contracted health care providers were intended to address certain health care concerns of rural Coloradans, including increased premiums for health insurance, difficulties in obtaining health insurance and insufficient numbers of health care providers. Although relatively few communities have exercised their explicit authority to contract with health care providers and, in all likelihood, Colorado municipalities had the inherent ability to enter into such contracts without explicit statutory authority to do so, the authorization should be continued. During the course of this sunset review, DORA conducted a survey of Colorado communities with populations of 20,000 or fewer residents. Many had never heard of this explicit authority and expressed interest in pursuing such contracts in the future. Since repealing the explicit authority to contract with health care providers could be interpreted as legislative intent that such contracts should not be allowed, the authority to enter into contracts with health care providers should be continued.

Remove community contracted health care providers from the sunset review schedule.
The sunset criteria were originally designed for the review of professional and occupational regulatory programs and boards. They were not designed to review state statutes, such as those presented in this sunset report. Therefore, community contracted health care providers should be removed from the sunset schedule and no future sunset reviews of these statutory provisions should be conducted.

Expand the definition of "community contracted health care providers."
It is clear from the results of DORA's survey that municipalities want viable options for meeting the health care needs of their citizens. However, the *status quo* may also be construed as limiting because of how the statutes define community contracted health care providers as a physician, nurse practitioner, or physician's assistant. DORA's survey indicates that municipalities are interested in contracting with other health care professionals as well, such as dentists, physical therapists, and mental health providers. Since the current language could be interpreted as limiting the types of health care providers with whom communities may contract, the definition should be broadened to include all health care professionals.

Major Contacts Made During This Review

City of Burlington
City of Cortez
City of Sterling
Colorado Department of Local Affairs
Colorado Department of Public Health and Environment
Colorado Hospital Association
Colorado Municipal League
Colorado Rural Health Center
Health District of Northern Larimer County
Special District Association of Colorado
Town of Limon
Town of Silverton

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
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Table of Contents

Background

The Sunset Process

Regulation, when appropriate, can serve as a bulwark of consumer protection. Regulatory programs can be designed to impact individual professionals, businesses or both.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation. Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

As regulatory programs relate to businesses, they can enhance public protection, promote stability and preserve profitability. But they can also reduce competition and place administrative burdens on the regulated businesses.

Regulatory programs that address businesses can involve certain capital, bookkeeping and other recordkeeping requirements that are meant to ensure financial solvency and responsibility, as well as accountability. Initially, these requirements may serve as barriers to entry, thereby limiting competition. On an ongoing basis, the cost of complying with these requirements may lead to greater administrative costs for the regulated entity, which costs are ultimately passed on to consumers.

Many programs that regulate businesses involve examinations and audits of finances and other records, which are intended to ensure that the relevant businesses continue to comply with these initial requirements. Although intended to enhance public protection, these measures, too, involve costs of compliance.

Similarly, many regulated businesses may be subject to physical inspections to ensure compliance with health and safety standards.

Regulation, then, has many positive and potentially negative consequences.

The express authority for certain municipalities and health assurance districts to contract with health care providers, in accordance with sections 32-1-1003.5 and 31-15-302(1)(i)(I), Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2008, unless continued by the General Assembly. During the year prior to this date, it is the duty of the Department of Regulatory Agencies (DORA) to conduct an analysis and evaluation of the use of these providers pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed authority granted to communities and health assurance districts to contract with health care providers should be continued for the protection of the public. During this review, it must be demonstrated that these provisions serve to protect the public health, safety or welfare and that these statutes are the least restrictive means of achieving the stated goals consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly. Statutory criteria used in sunset reviews may be found in Appendix A on page 16.

Methodology

As part of this review, DORA staff conducted a literature review; reviewed legislative testimony; interviewed municipal employees; reviewed municipal contracts; interviewed health care providers; surveyed Colorado municipalities; reviewed Colorado statutes and the Colorado Constitution; reviewed the laws of other states; and interviewed staff from the Department of Local Affairs, the Colorado Municipal League, the Office of Legislative Legal Services, and the Special District Association.

Profile of the Program

Section 31-15-302(1)(i)(I), C.R.S., authorizes Colorado municipalities with populations of 20,000 or fewer residents to contract with a physician, physician's assistant, or nurse practitioner to provide services to their residents. In addition, section 32-1-1003.5, C.R.S., authorizes health assurance districts to organize, operate, control, direct, manage, contract for, or furnish health care services from a physician, physician's assistant, or nurse practitioner. In this context, these health care providers are known as "community contracted health care providers."

History of Regulation

The General Assembly passed the Colorado Rural Health Care Act of 2001 (Act) in Senate Bill 01-224 (SB 224) to address certain health care concerns of rural Coloradans, including increased premiums for health insurance, difficulties in obtaining health insurance, and insufficient numbers of health care providers.

The bulk of the bill made statutory amendments in an attempt to improve network adequacy, expand the use of telemedicine, and establish a legislative task force to evaluate health care needs. In addition, language was added to section 31-15-302(1)(i)(I), C.R.S., that allows a municipality with a population of 20,000 or fewer residents to enter into contracts with a physician, nurse practitioner, or physician's assistant to provide services to the residents of the municipality. The bill identified these providers as "community contracted health care providers."

Senate Bill 224 also authorized the formation of health assurance districts by adding section 32-1-1003.5, C.R.S. In addition to the general powers granted to a special district by Part 10 of Article 1 of Title 32, C.R.S., health assurance districts were granted the power to organize, operate, control, direct, manage, contract for, or furnish health care services from a physician, nurse practitioner, or physician's assistant. As with section 31-15-302(1)(i)(I), C.R.S., these providers are known as "community contracted health care providers."

The overall intent of the Act was to improve the affordability and availability of health care services for rural Coloradans. The provisions for community contracted health care providers were created as possible tools to solve this critical problem.

The General Assembly passed House Bill 07-1219 (HB 1219) and made several changes to statutes regarding both health assurance and health service districts (collectively, "health districts"). The bill removed certain requirements that, while appropriate for most special districts, were not appropriate for health districts (such as submitting a service plan of a proposed district to a county planning commission). The bill also required that elections of proposed health districts be held on the date of the general election. Health districts were also authorized, with the addition of Article 19 in Title 32, C.R.S., to levy sales taxes, with voter approval. Furthermore, the bill allowed health districts to contract with or work cooperatively with each other or with other existing health care providers or services.

A similar bill, Senate Bill 06-047 (SB 47), passed both houses but was vetoed by Governor Bill Owens on the grounds that it was an unnecessary expansion in scope and intent of SB 224 and that it would result in additional taxes on citizens.

House Bill 1219 also made several changes specifically affecting health assurance districts. Health assurance districts were authorized to be formed in any part of the state (not just rural areas) and to provide health care services directly or indirectly and not just through community contracted health care providers. The repeal date for health assurance districts was also removed. In particular, HB 1219 struck the language in section 32-1-1003.5, C.R.S., which specified that physicians, nurse practitioners, and physician's assistants could act as community contracted health care providers for health assurance districts. Instead, the language was broadened to allow health assurance districts to organize, operate, control, direct, manage, contract for, furnish, or provide, directly or indirectly, *health care services* to residents of the district.

Testimony regarding HB 1219 reflected the belief that this bill would give communities more tools for financing and providing health care services to residents. Proponents testified that communities would be more inclined to form these districts since the process was simplified and tailored to the needs of forming a health district. It further expanded a health district's ability to provide services by authorizing them to cooperate with other health districts and resources. Finally, the bill added broader language regarding a health assurance district's authority to furnish health care services by not limiting it to only contracting with community contracted health care providers.

Proponents of HB 1219 maintained that streamlining the processes and broadening the authorities of health care districts will encourage and improve the delivery of health care services to Colorado residents.

Legal Framework

Senate Bill 01-224 (SB 224) authorized municipalities with populations of 20,000 or fewer residents and health assurance districts to contract with health care providers pursuant to sections 31-15-302(1)(i)(I) and 32-1-1003.5, Colorado Revised Statutes (C.R.S.).

House Bill 07-1219 (HB 1219) became effective July 1, 2007. It impacts health assurance districts in several ways by:

- allowing a proposed service plan to be submitted directly to a board of county commissioners;
- adding specific requirements for a service plan for a health assurance district;
- prohibiting property owners from being excluded from a health assurance district;
- requiring a district court to review a petition for a health assurance plan instead of holding a hearing;
- requiring that the election for the organization of a new health assurance district be held on the date of the general election;
- allowing a health assurance district to be formed anywhere in the state;
- allowing a health assurance district to contract and cooperate with a health service district or other health care providers or services; and
- allowing a health assurance district to levy a sales tax with voter approval.

This bill also struck language regarding community contracted health care providers and struck the repeal language in section 32-1-1003.5, C.R.S. It also struck language in section 24-34-104, C.R.S., which required the Department of Regulatory Agencies to review section 32-1-1003.5, C.R.S.

Home Rule

In the state of Colorado, when a city or town adopts a charter, it becomes a “home rule municipality.” Article XX of the Colorado Constitution addresses home rule municipalities.

Section 6 of Article XX of the Colorado Constitution allows cities and towns to make, amend, add to or replace their charters. In addition to the powers granted to all municipalities by Colorado state statute, Section 6 grants specific powers to home rule municipalities, such as the ability to create and regulate municipal courts. Furthermore, Section 6 grants to home rule municipalities "all other powers necessary, requisite or proper for the government and administration of its local and municipal matters" and "the full right of self-government in both local and municipal matters." The charters and ordinances of a home rule municipality supersede conflicting state statutes on local and municipal concerns.

Overall, home rule municipalities have the power and right to address local and municipal matters, such as ensuring adequate health care services for their residents.

General Municipal Authority

Section 31-15-101(2), C.R.S., states that municipalities:

> have the powers, authority, and privileges granted by this title and by any other law of this state together with such implied and incidental powers, authority, and privileges as may be reasonably necessary, proper, convenient, or useful to the exercise thereof.

Additionally, section 31-15-101(1)(c), C.R.S., states that municipalities "may enter into contracts." Also, pursuant to section 31-15-401(1)(b), C.R.S., municipalities have the power to:

> do all acts and make all regulations which may be necessary or expedient for the promotion of health or the suppression of disease.

Program Description and Administration

The use of community contracted health care providers is not a formal program and, as a result, no state agency is charged with oversight. Rather, individual municipalities contract directly with the health care providers.

To determine the extent to which Colorado communities have exercised this grant of authority and to determine the results of such efforts, the Department of Regulatory Agencies (DORA) mailed a request to complete a web survey regarding community contracted health care providers to each of the 244 municipalities in Colorado that have 20,000 or fewer residents.

Two of the requests were returned as undeliverable and 36 municipalities participated in the survey. This is a response rate of 14.6 percent. The complete results of this survey can be reviewed in Appendix B on page 17.

In short, the results of the survey revealed that relatively few municipalities were aware of the grant of authority and even fewer had exercised that authority.

Health Assurance Districts and Contracts with Health Care Providers

DORA was unable to identify any health assurance districts that contract with a health care provider. Prior to the passage of House Bill 07-1219 (HB 1219), a health assurance district was authorized to contract with a community contracted health care provider. However, since a health assurance district has never been formed, it was not possible for this to take place. Furthermore, it is now impossible to review community contracted health care providers as they relate to health assurance districts because, subsequent to the passage of HB 1219, this language no longer applies to these districts.

Possible explanations for the lack of health assurance districts include:

- the language creating health assurance districts was located in a bill that mostly pertained to health insurance and escaped the notice of interested parties;
- the powers and definitions of health assurance districts were obscure and unclear;
- the creation of a health assurance district had cumbersome and unnecessary procedures; and
- the sunset date discouraged communities from creating them.

Proponents of HB 1219 maintained that the bill would help to alleviate these problems, that it would encourage the formation of health assurance districts and, thus, that it would promote the delivery of health care services.

Municipalities and Contracts with Health Care Providers

In order for a person to be qualified to work as a community contracted health care provider, the person must be a physician, nurse practitioner, or physician's assistant who is licensed as such by the State of Colorado.

In order for a municipality to contract with a health care provider, it must have a population of 20,000 or fewer residents. According to estimates by the State Demography Office, there were 244 municipalities in Colorado in 2005 that had a population of 20,000 or fewer residents. Of these, DORA was able to identify two that had contracted with health care providers.

The first of these is the Town of Silverton, located in San Juan County. This town was identified by staff at the Colorado Municipal League. Silverton has a population of 548 residents, according to 2005 census data, and currently contracts with a physician. Silverton's administration provided a copy of the contract that was effective from January 15, 2003 until December 31, 2003, which provides the same stipulations as the current contract. The town leases a medical clinic to this physician for a term of one year and charges the physician $1.00 for the use of the premises. Silverton also waives the business license fee so long as the physician provides medical services from the clinic. In addition, the town pays for the cost of electricity, water, sewer, trash pick-up, heat and local telephone services. The physician agrees to maintain good standing with the Colorado Board of Medical Examiners and to retain his or her status as a medical doctor licensed to practice in the state. The physician also signed a release and indemnification agreement. It is unknown how many patients are served by this physician.

The other community was revealed through the survey that DORA conducted during the course of this sunset review. That community chose to remain anonymous, but its responses to survey items revealed that it utilizes two community contracted health care providers. They are contracted with for one to two years and a facility is provided by the municipality. Services are paid for by patients. This municipality reported that community contracted health care providers are a "critical element to providing services in a small remote community."

Home Rule Municipalities and Contracts with Health Care Providers

Home rule municipalities have the power and right to address local and municipal matters. This includes matters such as ensuring adequate health services for their residents. Home rule municipalities can accomplish this even without the statutory provision for community contracted health care providers pursuant to section 31-15-302(1)(i)(I), Colorado Revised Statutes (C.R.S.). One example is the City of Burlington in Morgan County.

Burlington has a population of 3,818 residents and has been a home rule municipality since 1976. The City became concerned about dental services when a local dentist decided to leave the area. To ensure that dental services continued, the City entered an asset purchase agreement and purchased the dentist's equipment. The City then leased this equipment to another dentist through a dental practice agreement. This was a two year agreement in which the dentist agreed to pay a monthly fee to lease the equipment, to take over all the dental records from the original dentist, to practice at the original location, to not practice anywhere else unless it was over 75 miles away, and for at least a half day per month, to treat needy patients at a reduced fee or for no fee. There was also an option for the dentist to purchase the equipment at the end of the lease agreement. This dentist chose not to do so. However, the practice is now self-sufficient and Burlington is selling the equipment to another practitioner. Overall, the City saw that dental services would possibly leave the area. It stepped in to ensure that this did not happen. Now that the services are stable and established, the City is stepping back and selling the practice back to the private sector.

In sum, Burlington, a home rule city with fewer than 20,000 residents, was able to secure health care services for its residents outside the purview of section 31-15-302(1)(i)(I), C.R.S.

The City of Cortez, a home rule municipality in Montezuma County, was also successful in recruiting physicians outside the parameters of section 31-15-302(1)(i)(I), C.R.S. In this case, the business community, particularly the local banks, contributed to a challenge grant that raised funds to assist the local hospital in physician recruiting and retention. This was part of a strategic plan developed by the medical community and they were successful in recruiting a total of four physicians within six months.

Non-Home Rule Municipalities and Contracts with Health Care Providers

Silverton, on the other hand, is a statutory town pursuant to section 31-1-203, C.R.S., and is not a home rule municipality. Silverton has utilized community contracted health care providers pursuant to section 31-15-302(1)(i)(I), C.R.S.

The question that remains is whether a municipality that is not home rule, such as Silverton, would be able to contract with health care providers if Senate Bill 01-224 had not been enacted. Because of the powers granted to statutory municipalities by state statute, Silverton and any other town or city, whether home rule or not, has the power to contract with physicians, physician assistants, nurse practitioners, or any other health care provider. This authority exists with or without section 31-15-302(1)(i)(I), C.R.S.

Analysis and Recommendations

Recommendation 1 – Continue the statutory provisions authorizing the use of community contracted health care providers.

The first sunset criterion asks whether regulation is necessary to protect public health, safety, or welfare. While this criterion pertains specifically to professional and occupational licensure programs, it can be applied to the continuation of section 31-15-302(1)(i)(I), Colorado Revised Statutes, (C.R.S.). Is this statute necessary to protect the public health, safety, or welfare?

Cities and towns, even those that are not home rule, can contract with health care providers in order to procure health care services. This power existed before section 31-15-302(1)(i)(I), C.R.S., was implemented. This section of law basically identifies an action that municipalities could already carry out. The cities of Burlington and Cortez serve as examples of the execution of this power outside the purview of section 31-15-302(1)(i)(I), C.R.S.

As part of this sunset review, the Department of Regulatory Agencies (DORA) contacted the rural health offices of the states of Wyoming, New Mexico, and Kansas to find out if they had analogous statutes. None could identify a state statute in which municipalities could contract with health care professionals. Incidentally, all three states have provisions for home rule authority. In fact, it was pointed out that in Kansas, any city is able to contract with a health care professional because all cities have constitutional home rule authority and because there is no prohibition against it. As in Colorado, cities in Kansas have the authority to enter into such contracts without a specific statute (such as section 31-15-302(1)(i)(I), C.R.S.) being in place.

In sum, section 31-15-302(1)(i)(I), C.R.S., only reiterates a statutory authority that municipalities already have. However, there may be harm in repealing this statute as it might be seen as eliminating an important municipal power.

Repealing section 31-15-302(1)(i)(I), C.R.S., may be construed as taking away a municipality's authority to contract with a health care provider. It would be detrimental to the public's health and safety if cities and towns believed that this authority was lost. The Town of Silverton, for example, would not have secured needed services for its citizens had it not known or believed that this statutory power existed.

Results from DORA's survey indicate that most municipalities value section 31-15-302(1)(i)(I), C.R.S. For example, 70.4 percent of the respondents believed that their communities could benefit from community contracted health care providers. Furthermore, when asked if they believed that their community would actually utilize community contracted health care providers, 57.1 percent of the respondents said "yes."

Moreover, out of the total number of respondents, 17 (47.2 percent) believed that the statute should be retained. Almost half of the respondents indicated the need for this statute. Some of the reasons given for retaining the statute include:

- "Health care is in shambles and this could be used to try to minimize this problem."
- "(This) may be the only option to provide health services in small communities."
- "This is a critical element to providing services in a small remote community."
- "It gives more options to small local communities."
- "It (is) helpful with very small communities or…as a stop gap measure."
- "Communities need every option in order to best meet the needs of their citizens."

This statute should be retained because repealing it may be construed as taking away an important tool for providing health care services. While the authority to contract with health care providers already exists, removing this statute may affect the perception of such a power and be detrimental to the public's health and welfare.

Recommendation 2 – Remove section 31-15-302(1)(i)(I), C.R.S., from the sunset review schedule.

The sunset criteria were originally designed for the review of professional and occupational regulatory programs and boards. They were not designed to review state statutes, such as those presented in this sunset report. Therefore, section 31-15-302(1)(i)(I), C.R.S., should be removed from the sunset schedule.

Recommendation 3 – Expand the definition of "community contracted health care providers."

It is clear from the results of DORA's survey that municipalities want viable options for meeting the health care needs of their citizens. Whether real or perceived, they do not want these options limited or taken away. Leaving the statute in place assures that municipalities will not inadvertently perceive their powers as limited. However, the *status quo* may also be construed as limiting. This is because of how the statute defines "community contracted health care providers."

Section 31-15-302(1)(i)(I), C.R.S., defines a community contracted health care provider as "a physician, nurse practitioner, or physician's assistant who is licensed in this state to provide health care services…" The survey results indicate that municipalities are interested in contracting with other health care professionals as well, such as dentists, physical therapists, and mental health professionals. While this is currently possible, given the general authority that municipalities possess, the language that defines a community contracted health care provider might be perceived as limiting the health care providers with whom a municipality may contract. Therefore, the language should be broadened to include all health care professionals.

Administrative Recommendation 1 – The Colorado Department of Local Affairs should take steps to inform municipalities of their ability to contract with health care providers.

The true value of this statute is not that it grants power but that it stimulates ideas by spelling out and specifying a viable option for cities and towns to help their citizens. Many already know this power exists and several utilize it. However, for others, DORA's survey was the first time they had heard of this option.

Why don't municipalities use this power? Municipalities seem to be inclined to help provide health care services to their residents if they have the resources to do it, if they identify that the need exists, and/or if they know it is a possibility to do so. As one survey respondent pointed out, some cities and towns just do not have the resources to enter into such contracts. On the other hand, some municipalities are not interested or just do not need to enter into such contracts. Yet the survey revealed that many municipalities simply did not know that this express statutory authority existed.

When asked if they were aware of section 31-15-302(1)(i)(I), C.R.S., about two-thirds (66.7 percent) of the 36 respondents to DORA's survey indicated that they were not aware of this statute. Of the 24 that were unaware, 16 (66.7 percent) believed that the statute is beneficial and 12 (50.0 percent) believed that their communities would utilize community contracted health care providers.

These results suggest that most municipalities were unaware of this statute and that most of those who were unaware also believe that these health care providers are beneficial. Furthermore, half of the respondents would consider contracting with health care providers. These numbers become even more striking for towns (municipalities that have populations of 20,000 or fewer residents). Of the survey respondents, 20 identified themselves as towns. Of these, 85 percent of the towns were unaware of this statute, 75 percent believed that this statute would be beneficial, and 55 percent would consider utilizing community contracted health care providers in the future.

This is a vital tool for municipalities but it can only begin to have an effect on the public's health when it is recognized as such. It may be especially helpful to solve problems for smaller communities, where creative solutions for health care needs are essential. Yet these are precisely the communities that are more likely to be unaware of this option. Therefore, efforts should be made to communicate with these communities regarding this option for solving health care needs.

This could be as simple as mailing an informative letter to each of the 244 municipalities that have 20,000 or fewer residents. Contact by mail was done by staff at DORA when mailing out the request for completing the survey for this sunset review. The total time and cost to do this was minimal.

The Division of Local Government at the Department of Local Affairs (DOLA) would be the ideal state agency to communicate with municipalities, in cooperation with its partners at organizations such as Colorado Counties, Inc. and the Colorado Municipal League, regarding this issue. DOLA and its partners are the primary points of contact between the state and local governments. In addition, the Division of Local Government was created to provide information to local governments regarding available state programs and resources.

It may also be beneficial to use such a letter to list additional resources that are available to cities and towns for addressing health care needs, such as the Sharing Healthcare Accomplishments in Rural Environments program, the Linking Rural Needs to Services program, Colorado Rural Health Seed Grants and Seed Grant success stories, and grants of up to $10,000 from Colorado Rural Outreach Program.

During the course of this sunset review, a representative of DORA spoke with representatives of municipalities and staff members of various organizations. Almost none of them had ever heard of community contracted health care providers. Yet the idea was positively accepted as a viable option. This option should be communicated to rural areas, where tools for solving health care dilemmas are wanted and needed.

Appendix A – Sunset Statutory Evaluation Criteria

(I) Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

(II) If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

(III) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

(VI) The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;

(VII) Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Appendix B – DORA Survey Results

Question: Are you aware of section 31-15-302(1)(i)(I), Colorado Revised Statutes, which allows municipalities with populations under 20,000 to contract with physicians, nurse practitioners, and physician's assistants to provide health care services to their residents (these providers are known as "community contracted health care providers")?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Yes	12	33.3%	30.0%	30.0%
No	24	66.7%	60.0%	60.0%
Not Answered	4	N/A	10.0%	10.0%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	2.00
Average	1.67
Sum	60
Standard Deviation	0.48
Median	2
Mode	2

Question: Do you believe that your community could benefit from community contracted health care providers?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Yes	19	70.4%	47.5%	47.5%
No	8	29.6%	20.0%	20.0%
Not Answered	13	N/A	32.5%	32.5%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	2.00
Average	1.30
Sum	35
Standard Deviation	0.47
Median	1
Mode	1

Question: Now that you are aware of them, do you believe that your community would utilize community contracted health care providers?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Yes	16	57.1%	40.0%	40.0%
No	12	42.9%	30.0%	30.0%
Not Answered	12	N/A	30.0%	30.0%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	2.00
Average	1.43
Sum	40
Standard Deviation	0.50
Median	1
Mode	1

Question: Would your community need assistance and/or education in implementing this statute?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Yes	23	82.1%	57.5%	57.5%
No	5	17.9%	12.5%	12.5%
Not Answered	12	N/A	30.0%	30.0%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	2.00
Average	1.18
Sum	33
Standard Deviation	0.39
Median	1
Mode	1

Question: What problems might this statute solve in your community? (mark all that apply)

	Count	% Sample Answered
Limited access to health care services	18	45.0%
Lack of health care for low income residents	19	47.5%
Lack of health care for Medicaid residents	13	32.5%
Other (please specify)	3	7.5%

Question: How did you find out about it? (mark all that apply)

	Count	% Sample Answered
By following legislation	5	12.5%
Contacted by a state agency (please specify)	10	25.0%
Contacted by a special interest group/association (please specify)	1	2.5%
Other (please specify)	7	17.5%

Question: What problems did you encounter in contracting with community contracted health care providers? (mark all that apply)

	Count	% Sample Answered
Finding willing health care providers	1	2.5%
Getting the word out to residents	0	0.0%
Technical issues regarding contracts	0	0.0%
Other (please specify)	7	17.5%

Question: What problems remain in your community despite this statute?

	Count	% Sample Answered
Certain residents remain unserved	4	10.0%
Unable to locate willing health care providers	1	2.5%
Other (please specify)	5	12.5%

Question: Did you implement this statute and later discontinue it?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Yes	1	5.0%	2.5%	2.5%
No	19	95.0%	47.5%	47.5%
Not Answered	20	N/A	50.0%	50.0%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	2.00
Average	1.95
Sum	39
Standard Deviation	0.22
Median	2
Mode	2

Question: How are community contracted health care providers reimbursed?

	Count	% Sample Answered
Paid by the municipality	0	0.0%
Paid by the patients	1	2.5%
Paid by a combination of patients and municipality	0	0.0%
Other (please specify)	7	17.5%

Question: What is the fee structure?

	Count	% Sample Answered	% Sample Asked	% Sample Total
Fees are per patient	0	0.0%	0.0%	0.0%
Fees are a bulk rate	0	0.0%	0.0%	0.0%
Other (please specify)	3	100.0%	7.5%	7.5%
Not Answered	37	N/A	92.5%	92.5%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	3.00
Maximum Value	3.00
Average	3.00
Sum	9
Standard Deviation	0.00
Median	3
Mode	3

Question: How long do these contracts typically last?

	Count	% Sample Answered	% Sample Asked	% Sample Total
1-2 years	1	25.0%	2.5%	2.5%
2-5 years	0	0.0%	0.0%	0.0%
Other (please specify)	3	75.0%	7.5%	7.5%
Not Answered	36	N/A	90.0%	90.0%
Not Asked	0	N/A	N/A	0.0%
Total	40	100%	100%	100%

Statistics	
Minimum Value	1.00
Maximum Value	3.00
Average	2.50
Sum	10
Standard Deviation	1.00
Median	3
Mode	3

Question: Who is served by these community contracted health care providers?

	Count	% Sample Answered
Anyone	2	5.0%
Anyone not on Medicaid	0	0.0%
Only those with Medicaid	0	0.0%
Any resident of the municipality	0	0.0%
Anyone who is low income	0	0.0%
Any low income resident of the municipality	0	0.0%
Other (please specify)	5	12.5%

Question: Who is left unserved? (mark all that apply)

	Count	% Sample Answered
Medicaid patients	0	0.0%
Low income patients	0	0.0%
Home health care patients	0	0.0%
Residents outside of city limits	0	0.0%
Other (please specify)	4	10.0%

Question: With what other health care professionals should a municipality be able to contract? (mark all that apply)

	Count	% Sample Answered
Chiropractors	10	25.0%
Dentists	19	47.5%
Physical Therapists	16	40.0%
Other (please specify)	3	7.5%

Question: What problems might this statute solve in your community? (mark all that apply)

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	3	100.0%
Total	3	100%

- There is a County Hospital, and three medical clinics associated with Town of La Jara. The Town itself would not contract with health providers outside those already available. The hospital district contracts for the Physicians.
- lack of city financing for project
- Travel

Not Answered: 37

Question: How did you find out about it? (mark all that apply)

Topic: Contacted by a state agency (please specify)

Item	Frequency	Percent
Department of Regulatory Agencies	2	22.2%
DORA	2	22.2%
Unique Responses	5	55.6%
Total	9	100%

- Department of Regulatory Agencies
- Department of Regulatory Agencies; direct mail piece from Brian S.W. Tobias, Senior Policy Analyst
- Letter from Dept of Regulatory Agencies
- Department of Regulatory Agencies
- DORA
- DORA
- DOLA
- Dept of Regulatory Agencies
- Dept. of Regulatory Agencies

Not Answered: 31

Question: How did you find out about it? (mark all that apply)

Topic: Contacted by a special interest group/association (please specify)

Item	Frequency	Percent
Unique Responses	1	100.0%
Total	1	100%

- Colorado Municipal League

Not Answered: 39

Question: How did you find out about it? (mark all that apply)

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	6	100.0%
Total	6	100%

- previously knew
- Received letter from State of CO
- Police Chief
- notice of this survey
- web
- Experience with town of Fowler

Not Answered: 34

Question: What problems did you encounter in contracting with community contracted health care providers? (mark all that apply)

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	8	100.0%
Total	8	100%

- didn't contract
- none
- Have not done so
- n/a
- Never have
- Was not aware
- not interested
- location

Not Answered: 32

Question: What problems remain in your community despite this statute?

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	6	100.0%
Total	6	100%

- none
- Don't know
- n/a
- some citizens are not covered by insurance
- Limited hours and availability
- Limited hours the clinic is open

Not Answered: 34

Question:

Topic: If you answered YES to question 9, why?

Item	Frequency	Percent
Unique Responses	1	100.0%
Total	1	100%

- I think the past Manager may have known about this, a doctor was here previously.

Not Answered: 39

Question:

Topic: How many community contracted health care providers do you currently utilize?

Item	Frequency	Percent
0	7	36.8%
None	3	15.8%
none	4	21.1%
Unique Responses	5	26.3%
Total	19	100%

- none
- 0
- None
- 0
- 0
- None
- 0
- 0 (but the county may have a program)
- 0
- none
- one; only through w/c
- None the County Does we are the Town Government
- none
- none
- 0
- None
- Two
- 0
- n/a

Not Answered: 21

Question:

Topic: Of these, how many are physicians?

Item	Frequency	Percent
0	5	50.0%
Unique Responses	5	50.0%
Total	10	100%

- None
- 0
- 0
- one
- 0
- N/A
- 0
- One
- 0
- n/a

Not Answered: 30

Question:

Topic: Of these, how many are physician’s assistants?

Item	Frequency	Percent
0	5	55.6%
Unique Responses	4	44.4%
Total	9	100%

- None
- 0
- 0
- none
- 0
- N/A
- 0
- 0
- n/a

Not Answered: 31

Question:

Topic: Of these, how many are nurse practitioners?

Item	Frequency	Percent
0	5	55.6%
Unique Responses	4	44.4%
Total	9	100%

- None
- 0
- 0
- none
- 0
- N/A
- 0
- 0
- n/a

Not Answered: 31

Question: How are community contracted health care providers reimbursed?

Topic: Other (please specify)

Item	Frequency	Percent
N/A	2	28.6%
Unique Responses	5	71.4%
Total	7	100%

- don't know
- n/a
- Not involved in program
- N/A
- A County service
- N/A
- Paid by patients, but space provided by municipality

Not Answered: 33

Question: What is the fee structure?

Topic: Other (please specify)

Item	Frequency	Percent
N/A	2	40.0%
Unique Responses	3	60.0%
Total	5	100%

- n/a
- N/A
- don't know
- Unknown done by the county
- N/A

Not Answered: 35

Question: How long do these contracts typically last?

Topic: Other (please specify)

Item	Frequency	Percent
N/A	2	40.0%
Unique Responses	3	60.0%
Total	5	100%

- n/a
- N/A
- don't know
- unknown done by the county
- N/A

Not Answered: 35

Question: Who is served by these community contracted health care providers?

Topic: Other (please specify)

Item	Frequency	Percent
N/A	2	40.0%
Unique Responses	3	60.0%
Total	5	100%

- n/a
- N/A
- don't know
- unknown done by the county
- N/A

Not Answered: 35

Question: Who is left unserved? (mark all that apply)

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	3	100.0%
Total	3	100%

- don't know
- unknown done by the county
- N/A

Not Answered: 37

Question: With what other health care professionals should a municipality be able to contract? (mark all that apply)

Topic: Other (please specify)

Item	Frequency	Percent
Unique Responses	3	100.0%
Total	3	100%

- mental health professionals
- none
- mental health providers

Not Answered: 37

Question:

Topic: What problems might be caused by this statute?

Item	Frequency	Percent
Unique Responses	10	100.0%
Total	10	100%

- Lack of competition in some areas
- Administrative Time and Expense
- It makes it difficult for non-subsidized health care providers to begin operation. Confusion as to who is private and who is government subsidized, fee structures, and longevity are some possible problems.
- This is an extremely self-selected and non-scientific survey that is highly unlikely to produce any type of statistically valid empirical data (please see next field for continued comments).
- City can't afford it
- unknown
- don't know
- not sure
- people taking advantage of the service when they financially do not need it
- How to find local funding in an already stressed budget.

Not Answered: 30

Question:

Topic: What improvements or recommendations would you make regarding community contracted health care providers?

Item	Frequency	Percent
Unique Responses	6	100.0%
Total	6	100%

- everyone being served
- We have never worked with this statute but we did subsidize a dentist. Currently the dentist is purchasing the practice from the City.
- I found out about this survey as specified above and have no real opinion about contracted healthcare providers. However, I am very concerned about my tax dollars paying for a survey that is written in a way that favors one side of any issue (continued).
- educate us about it
- not sure would like to check more into the State Statute
- Do not know that much about the process.

Not Answered: 34

Question:

Topic: Do you believe the state of Colorado should retain this statute? Why or why not?

Item	Frequency	Percent
yes	3	13.6%
Unique Responses	19	86.4%
Total	22	100%

- don't know
- If the statute is beneficial to other communities without access to close hospitals and clinics, it should be retained for their benefit.
- Yes - There are communities who can benefit
- yes
- Yes, Gives communities the option.
- I think it helpful with very small communities or used as a stop gap measure. I would not like to see it become the norm for the reasons stated above. This is just a brief initial reaction, not a well thought out position.
- Yes- provides medical care in rural areas
- It is obvious by the wording of these survey questions that the Department of Regulatory Agencies is biased towards retaining this legislation and that they are not concerned with the proper structure of a clean scientific survey. This is disappointing.
- Yes
- Yes. Communities need every option in order to best meet the needs of their ciizens.
- Yes--many of us have no health insurance. This is the first I've heard of this.
- Yes, it gives more options to small local communities
- yes
- don't know enough about it to say
- would like to investigate this more
- Yes, it is good to care for those who really need help
- Yes, health care is in shambles and this could be used to try to minimize this problem.
- no opinion
- Yes, may be the only option to provide health services in small communities.
- yes
- This is a critical element to providing services in a small remote community.
- yes, for low income assistance

Not Answered: 18

Question:

Topic: What municipality do you represent?

Item	Frequency	Percent
Unique Responses	28	100.0%
Total	28	100%

- Town of Ovid
- Town of La Jara
- Town of Eaton
- Town of Columbine Valley
- Elizabeth
- City of Burlington
- Crestone
- Town of Otis
- Town of Garden City
- City of Sheridan
- Town of Frisco
- Jamestown
- Town of Mancos
- Town of Carbondale
- Town of Sedgwick
- Town of Saguache
- Town of Brookside
- Ignacio
- Town of Eagle
- Fowler
- Town of Sanford
- Town of Kiowa
- City of Evans
- Rocky Ford
- Town of Limon
- City of Idaho Springs
- Town of Oak Creek
- Town of Naturita

Not Answered: 12

Question:

Topic: What is the population of your municipality?

Item	Frequency	Percent
1200	3	9.7%
6000	2	6.5%
Unique Responses	26	83.9%
Total	31	100%

- 330
- 875
- 4500
- 1200
- 1500
- 3600
- 130
- 507
- 8,000
- 350
- 5000
- 2682
- 287
- 1200
- 6000
- apprx. 191
- 578
- 215
- Approx. 740
- 6000
- 1200
- 10,000
- 817
- 637
- 18,200
- approx. 4,200
- 1800
- 2055
- 1885
- 950
- 654

Not Answered: 9