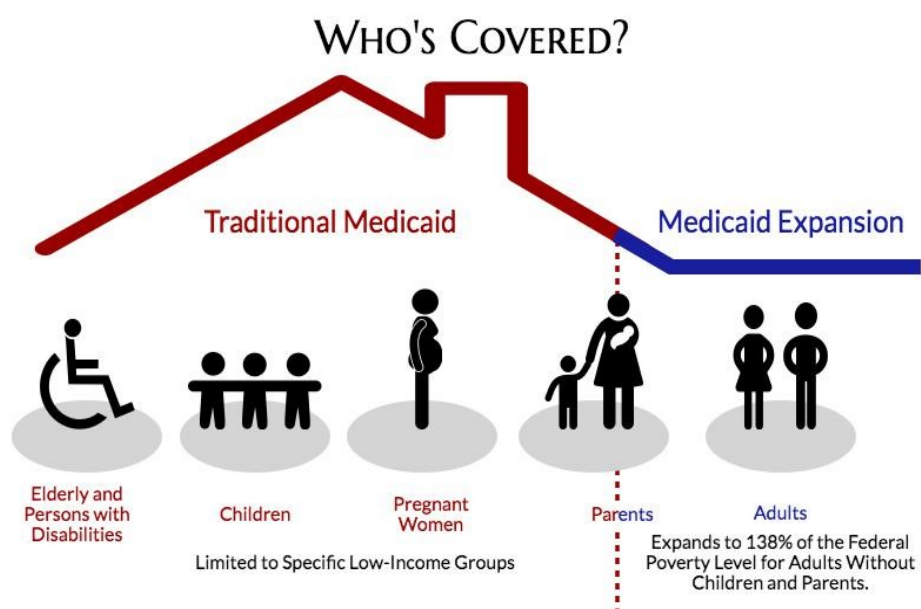




# HEALTH DIVIDES

A quarterly publication examining equity and economics in health care

## What Republican Plans for Repealing and Replacing the ACA Could Mean in Colorado



By Chris Stiffler  
CFI's Economist

Republicans in Congress have vowed to make repeal of the Affordable Care Act a top priority in 2017. To better understand the health care debate coming in 2017, we need to understand how Obamacare changed health care policy in Colorado and just what is at stake if the ACA is repealed.

### What did Obamacare do in Colorado?

As a result of the major changes from the Affordable Care Act (often referred to as Obamacare) Colorado expanded

Medicaid and created a health insurance marketplace.. Medicaid, which is jointly funded by state and federal dollars, provides health care to low-income individuals and children, elderly individuals and Coloradans with disabilities. Traditional Medicaid does not cover low-income adults without children. Colorado's legislature voted to expand Medicaid in 2013, which expanded coverage to low-income adults. The ACA also created a health insurance marketplace for individuals who don't get insurance through an

See "ACA Repeal," on page 2

## Cost, Coverage and Access to Health Care in the Undocumented Community

By Thamanna Vasan, CFI's Economic Policy Analyst

Affordable and accessible health care is the cornerstone of a healthy community. But, as most health care researchers and advocates know, good access to care isn't an experience shared by all. In fact, some communities experience greater barriers to getting the care they need at a price they can afford, and according to a recent survey by the Colorado Fiscal Institute, this is especially true for the Latino community.

Much of what we know about health care use, access and cost in America comes from information collected in large-scale surveys, like the Medical Expenditure Panel Survey (MEPS). These surveys, which are most often conducted at the national and state levels using representative samples, provide a glance at how the American population uses health care as a whole. Unfortunately, due to the broad nature of the questions

See "Latino Health Care" on page 3

## “ACA Repeal”

### Continued from page 1

employer or other means. Many Coloradans buying private insurance through the marketplace get assistance from the federal government in paying monthly premiums.

### Most of the Medicaid expansion and much of marketplace is supported by federal dollars

The Medicaid expansion population is mostly funded by federal dollars. In 2017, federal dollars will pick up 95 percent of the expansion costs and the other 5 percent will be funded through a mechanism called the Hospital Provider Fee (a fee paid by Colorado hospitals to the state which then generates federal matching funds). No dollars from Colorado’s General Fund are used to pay for the Medicaid expansion. This means that rolling back the Medicaid expansion would not free up additional state dollars to pay for other important priorities like schools, roads or colleges.

The federal match ratio steps down

until the federal government pays for 90 percent of the cost in 2020. This is a significant amount of funding that flows through Colorado health care facilities and local economies. All those federal

premiums. In 2016, Coloradans who enrolled in the marketplace received an average premium tax credit of \$318. Nationwide, statistics show that the federal credit [covers 73 percent of the](#)

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**“PULLING BACK THE MEDICAID EXPANSION AND ELIMINATING THE FEDERAL SUBSIDIES IN THE MARKETPLACE WOULD CAUSE THE UNINSURED RATE TO DOUBLE IN COLORADO TO MORE THAN 1 MILLION PEOPLE.”**

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dollars represent a huge injection of economic activity into Colorado. It is estimated that more than [31,000 jobs in Colorado were created because of the expansion of Medicaid](#) and the large injection of federal dollars into Colorado.

Coloradans buying private health insurance through the marketplace also get a chunk of change from the federal government via the individual subsidies. Currently, the federal government provides subsidies to individuals below 400 percent of the federal poverty line to help offset the cost of their monthly

[total monthly premiums](#) for comprehensive coverage.

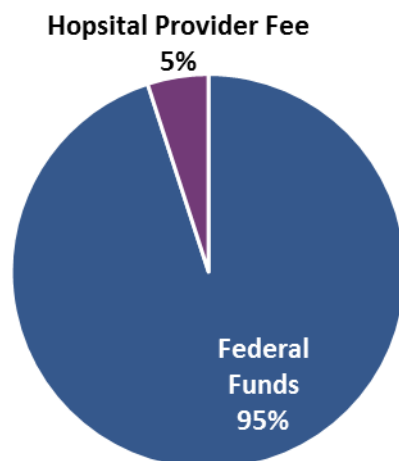
### What does this mean for health equity in Colorado?

The marketplace and the Medicaid Expansion could be in jeopardy if federal funding is cut. Last year [324,000 adults enrolled in Medicaid](#) because of the expansion. Many of these adults are working in low-wage jobs that don’t pay enough to boost them above the poverty thresholds for Medicaid. Without the several billion dollars of federal dollars to flow into Colorado to pay for the expansion population, many will lose health insurance. Pulling back the Medicaid expansion and eliminating the federal subsidies in the marketplace would cause the uninsured rate to double in Colorado to more than 1 million people.

That’s almost one in five Coloradans.

It’s projected that the Republican alternative to the ACA would create an insurance market very welcoming to young, healthy and upper-income people while being less welcoming to

Medicaid Expansion is Mostly Funded By Federal Dollars



\*None of Colorado's General Fund is used to pay for Medicaid expansion population

Continued on page 3

**“ACA Repeal,” continued from page 2**

sicker, older and low-income individuals. For instance, there are currently mandates for insurers to include a standard package of benefits for each health care policy. Eliminating those mandates would allow younger/healthier people to buy cheaper plans while simultaneously making those benefits more expensive for those who need them. There are also limits on how much insurers can charge their oldest enrollees compared to the youngest. If those limits are removed, it would make private insurance more expensive for older enrollees and less expensive for

the young.

**The bottom line:**

Years of work by advocates to expand Medicaid to low-income Coloradans and to lower the rate of uninsured are now in jeopardy of being reversed substantially. As the year begins, here are some important things to watch for:

- Before March, Congress is likely to enact some repeal of Obamacare.
- A replacement could include block granting Medicaid, reducing the expansion match rate from the current 90 percent to a 50 percent

match or completely eliminating federal support for expanded Medicaid.

- Federal subsidies for moderate-income Coloradans to buy insurance could be rolled back or eliminated.
- By May, insurers must submit bids to participate in Colorado’s marketplace. Depending on what happens to Obamacare, insurers may choose not to enter the marketplace, potentially driving up premiums due to less competition.

**“Latino Healthcare”****Continued from page 1**

in these surveys, they don’t necessarily ask the culturally specific and nuanced questions that would shed light on the experiences of immigrant and racial minority communities. In an effort to further disaggregate data and to better understand how Latinos in Colorado use health care services, the Colorado Fiscal

Institute distributed a survey across the state with the help of local community organizations. These trusted community partners conducted surveys in person and online during regular meetings, regional trainings and conferences. While the data collected through the survey is anecdotal and is not representative of Colorado’s population as a whole or of the Latino or Hispanic population as a whole, it shines a light

on the health care usage, costs and gaps to access for immigrant populations.

In particular, the methodology employed in the survey allowed for the collection of responses from undocumented immigrants, providing data points for a community that contributes but is never formally

counted in large-scale surveys. Through our survey, CFI found gaps

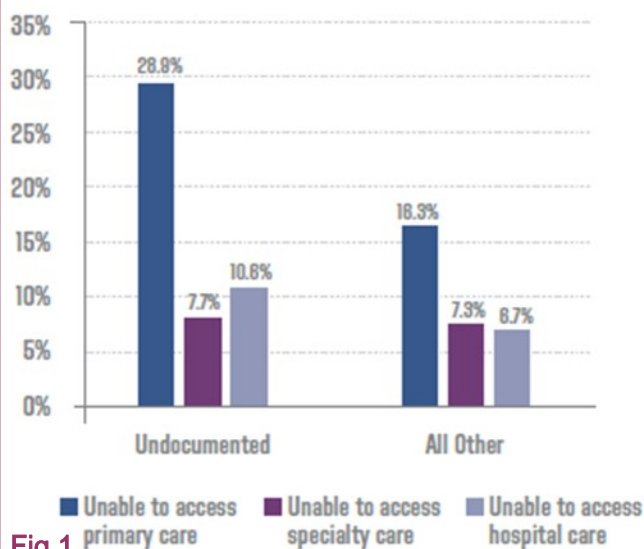
in Colorado’s current health care delivery and financing systems that make it more difficult for immigrants, particularly

undocumented immigrants, to access and pay for health care. We find the undocumented population is far less likely to have any health care coverage at all and spends more out of pocket on medical needs.

**Access and cost**

One of the primary indicators of good access to care is the ability to access primary, hospital and specialty care when necessary (Fig 1). When asked if an individual was able to access care that they needed, most people said they were able to access care. However, only half the undocumented immigrants surveyed said they were able to access the care they needed in the last 12 months. Another 28.9 percent of the undocumented population said they were unable to access primary care, 7.7 percent said they were unable to access specialty care and 10.6 percent said they were unable to access hospital

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**Were you able to access the care you needed?**

# Telehealth Parity Laws

By Tony Yang , Health Affairs Journal  
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Ongoing reforms are expanding the landscape of telehealth in the US health care system, but challenges remain.

## *What's the issue?*

Despite the fact that no other developed country even comes close to the United States in annual spending on health care, 20 percent of Americans still live in areas where shortages of physicians and health care specialists exist, and the United States still ranks the lowest overall among 11 industrialized countries on measures of health system efficiency, access to care, equity and healthy lives. Many believe that the answer to issues of cost and access in the U.S. health system lies in telehealth, which increases access to care, alleviates travel costs and burdens and allows more convenient treatment and chronic condition monitoring.

With the implementation of the Affordable Care Act (ACA), the federal government announced the move toward encouraging and including telehealth services in health care coverage. The ACA, however, only implemented telehealth at the federal level through Medicare in selected circumstances; the power to determine which, if any, telehealth services is covered by Medicaid still remains largely within the powers of individual states. Also, states can govern private payer telehealth reimbursement policies. This means that telehealth implementation varies from state to state in terms of what services providers will be reimbursed for delivering, as well as what sort of "parity," defined as "equivalent treatment of analogous services," is expected between in-person health services reimbursements and telehealth reimbursements. This variation affects



providers' ability to implement telehealth options, thereby reducing the patients' ability to use these services and become comfortable with the telehealth processes. Consequently, telehealth faces significant obstacles in becoming an accepted and used health care option for individuals, and states and the nation as a whole cannot fully realize the cost savings of telehealth.

## *What's the background?*

Telehealth is "the use of technology to deliver health care, health information or health education at a distance." It increases contact between patients and health care providers, generally without requiring the physical contact of in-person physician visits. Within telehealth, there are three main types of services: store-and-forward (also known as asynchronous communication), real-time video (synchronous conversation), and remote patient monitoring.

Asynchronous communication or store-and-forward services are those that transmit medical data to a physician or practitioner for later review and do not require real-time communication between the sender and receiver of the information. Generally, store-and-forward services are good for diagnosis and treatment. Synchronous communication is real-time communication using

interactive audio and visual equipment, such as video conferences between a patient and specialist. These types of interactions resemble typical physician appointments without the travel. Remote patient monitoring allows a provider to continue to track health care data for a patient released to his or her home or a care facility, potentially reducing readmission rates. Effective treatment plans might require use of all three types of telehealth, as well as services that might not fall into these categories. Currently, though, the distinction among these types of services is important in understanding what private and public insurance policies cover.

Telehealth has the potential to resolve a number of issues in the U.S. health care system. Most importantly, telehealth can improve access to health care in populations that are underserved, such as rural areas, as 20 percent of Americans live in rural areas, but only 9 percent of physicians practice in these areas. Telehealth allows patients to access care through real-time appointments and specialist consultations and to reduce the amount of time and resources rural patients

**See "Telehealth Parity" on page 5**



## “Telehealth Parity”

### Continued from page 4

spend to access some health care resources.

Additionally, some estimate that the combination of store-and-forward, real-time communication, and remote patient monitoring usage in emergency departments, prisons, nursing home facilities and physician offices could save the United States \$4.28 billion on health care spending per year. In particular, remote monitoring services allow patients to take greater control of and interest in their personal health, manage their health and chronic disease and receive more monitoring and feedback from health care providers.

Chronic disease affects 1 million Americans, while accounting for about 75 percent of health care costs; studies have found that the use of technology in chronic disease care is associated with reductions in hospitalizations, shorter lengths-of-stay, reduced care costs and better adherence to medication regimes. Many costs either covered or not covered by existing payment methods might

not be consistent with coverage under telehealth-friendly paradigms. Telehealth is believed to have the potential to level inequity in care and access across socioeconomic and cultural levels and to improve the efficiency, coordination and integration of health care systems. Finally, some argue that telehealth has the potential to create more patient-centered care while reducing costs by "promoting and improving patient-centered services; patient-provider communications; patient self-management with provider feedback; health literacy; medication management; provider-provider consultants; and changes in health and lifestyle behavior."

Although telehealth has a wide range of potential benefits, the delivery of health care via telecommunication technology presents health care providers and organizations with unique risks and challenges. Some of the main areas of concern include the following: fears of a breakdown in the relationship between health professional and patient (for example, inability to perform the whole consultation); problems with the quality of health information (for example, lack

of access to a patient's full medical record); and organizational complications (for example, problems with infrastructure planning and development). Moreover, the United States still faces considerable hurdles in implementation of telehealth, including variations in state coverage, lack of uniformity in parity laws, variations in physician licensure requirements and unresolved questions around patient privacy and reimbursement. Malpractice liability concerns

have also been exacerbated by the move toward more telehealth-based services. For example, liability policies generally specify that coverage is only available for a claim that occurs in a specific jurisdiction. A telehealth physician sued in a state other than the jurisdiction in which he or she is covered might find that no coverage is available to either defend the claim or pay indemnity if there is an adverse judgment. As long as these concerns persist, they threaten to impede implementation and development of telehealth services and reduce incentives for developing and using them to deliver care.

### What's in the law?

Telehealth in the United States is currently affected by laws and regulations at the federal and state levels. Currently, there is no uniform legal approach to telehealth, and this continues to be a major challenge in its provision. In particular, concerns about reimbursements, for both private insurers and public programs such as Medicaid, continue to limit the implementation and use of telehealth services. When certain telehealth services are not reimbursed or are reimbursed at lower levels than in-person services, the incentives to provide telehealth services decrease.

### At the federal level

The federal government provides some incentives through the ACA to develop telehealth services at the state level, including grants and reimbursement incentives. Additionally, the federal government largely leaves decisions about implementing or reimbursing for telehealth in Medicaid programs to the states. It does, however, play a role in shaping telehealth services for Medicare programs, and the limitations the

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**Continued from page 5**

government places on those programs provide a less-than-ideal example for states to follow.

Medicare will only reimburse for synchronous communications and does not cover any store-and-forward services or remote patient monitoring for chronic diseases, except in Alaska and Hawaii. Telehealth services that Medicare covers as substitutes for in-person visits include consultations, office visits, psychiatry services and some physician fee schedule services. Many restrictions apply to this type of coverage. The patient must be present at an originating site for the visit or treatment and cannot be at home to receive services. Originating sites must be one of the following: the office of a physician or practitioner, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital, a renal dialysis center, a skilled nursing facility or a community mental health center.

Furthermore, only originating sites located in areas designated as a rural health profession shortage area, in counties that are not included in a metropolitan area or in entities that approved by the secretary of health and human services, are eligible for reimbursement of telehealth services. Additionally, the practitioners must have admitting privileges in the distant location where they provide services and hold a license recognized by the state where that location is. The Centers for Medicare and Medicaid recently introduced a new coverage model that would extend telehealth coverage to up to 80 percent of Medicare beneficiaries in metropolitan areas, but the current structure strictly limits the services provided for and reimbursed by Medicare.

**At the state level**

States have significant control over reim-

bursement schemes for telehealth services, both within their state Medicaid programs as well as through laws governing private insurers. While states have implemented telehealth coverage laws, of greater concern and controversy are telehealth parity laws that require reimbursement by health plans for telehealth services at the same or equivalent rate as paid for in-person services. Without parity laws, health plans can pay for telehealth services at only a percentage of what they pay for in-person services. Many telehealth coverage laws passed by states fail to include parity language,



meaning some states have provided for telehealth coverage but have not implemented the necessary cost reimbursements to incentivize health care professionals to provide telehealth services over in-person services. The next section of this brief looks at the state laws for reimbursement of Medicaid telehealth services before turning to state parity laws for private insurers.

**State Medicaid and telehealth**

States retain significant control over what telehealth services are covered and will be reimbursed by Medicaid. Forty-nine states and the District of Columbia

have some coverage for telehealth, and nearly all reimburse for live video telehealth. Under Medicaid, only nine states reimburse for store-and-forward services, while at least 16 states have some sort of reimbursement for remote patient monitoring. Two additional states, Pennsylvania and South Dakota, reimburse for remote patient monitoring through their departments of aging, instead of Medicaid. Most states do not reimburse e-mail, phone or fax communications in telehealth. Four states only allow reimbursement for telehealth from physicians, while 19 states restrict pro-

vider types to a list of nine. Fifteen states and the District of Columbia do not restrict reimbursement based on provider types. While there are restrictions on provider types, the majority of states do not restrict Medicaid reimbursement for telehealth to rural locations, unlike current Medicare requirements.

**Private insurers and state telehealth coverage**

Thirty-two states and the District of Columbia have parity laws that cover private insurers and reimbursement to

**Continued on page 9**

## Why were you unable to access necessary health care?

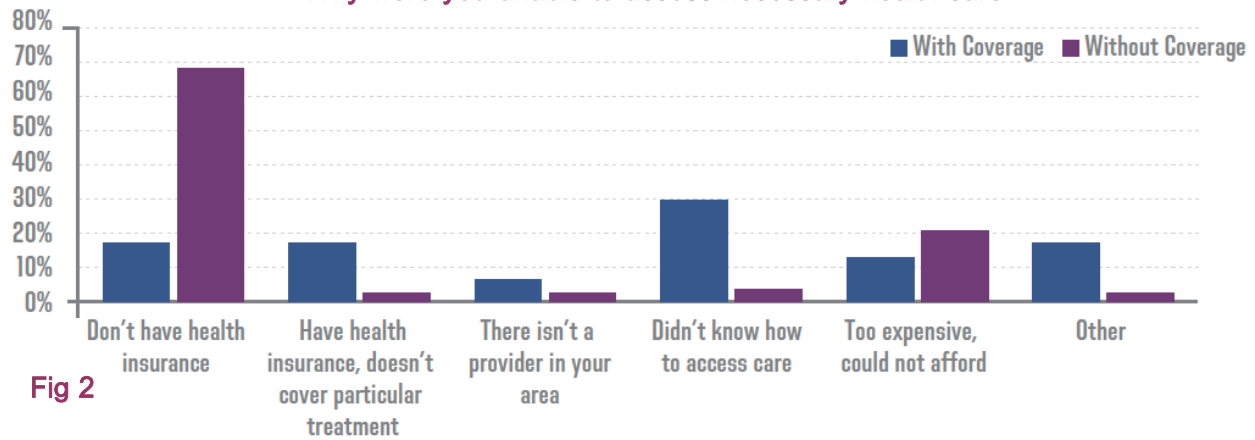


Fig 2

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care. In other words, 47.2 percent of the undocumented population was unable to access the care they needed. For all other Hispanics and Latinos surveyed, care appeared to be more accessible. A third of all other respondents reported having trouble accessing care. It is important to note, however, that just because they were able to access care doesn't mean it wasn't a financial burden to do so.

Respondents were then asked why they were unable to access care. Many, especially those without coverage, responded that it was because they didn't have health insurance or enough health insurance. In other words, one of the greatest barriers to accessing health care in the existing system is not having coverage or adequate coverage.

But who are the folks who don't currently have coverage? Of those surveyed in the Hispanic and Latino community, those who are U.S. citizens experienced the lowest uninsured rate and reported the highest rate of public health care coverage among adults. This is likely the case because citizens face fewer

restrictions when accessing Medicaid and other public health care due to the residency requirements of these programs. The reporting from citizens for coverage is very similar to the data collected by the Colorado Health Access Survey (CHAS) for Latinos and Hispanics overall. However, the Hispanic and Latino population is still covered at lower rates than the population as a whole.

Expense, eligibility and not knowing where to go were listed as the main barriers to acquiring coverage. Among noncitizens, eligibility ranked highly, most likely due to residency requirements for public health coverage. Among citizens, not knowing where to begin was often a barrier to access. In all three groups of respondents, expense was the main

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## Health Care by Coverage Type

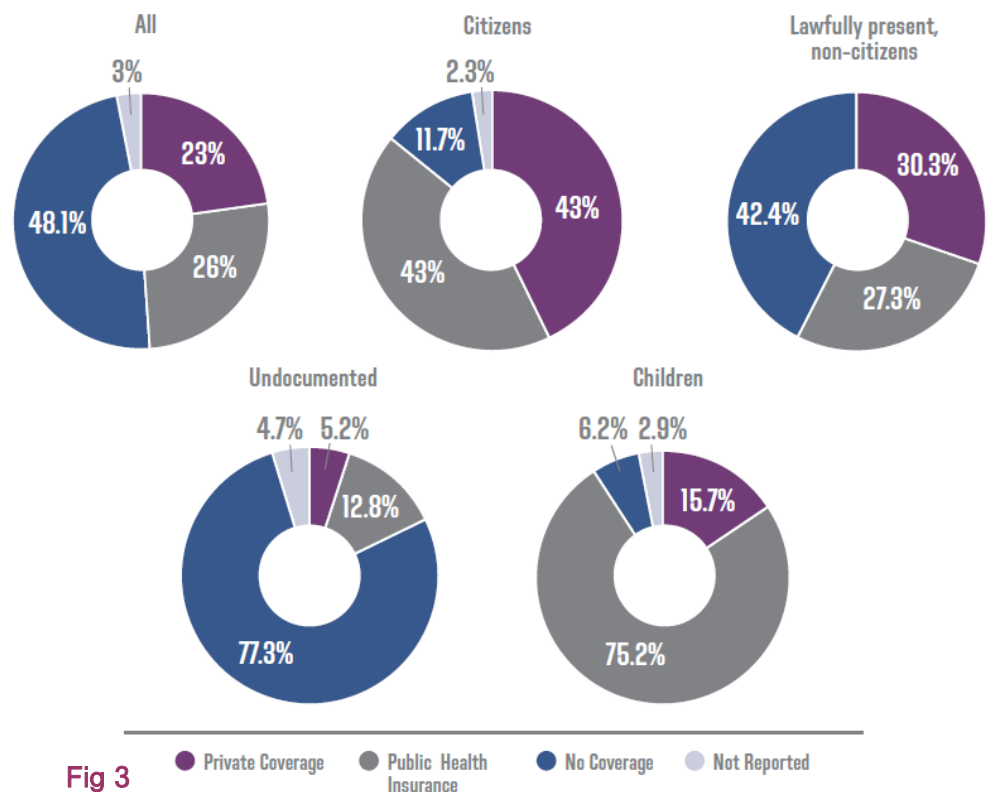


Fig 3

## Why were you unable to access necessary health care?

	Total Hispanic and Latino	Citizen	Lawfully present, noncitizen	Undocumented
Do not need or want health insurance	5.7%	20.0%	10.7%	3.0%
Rarely sick/"I take care of myself"	8.0%	20.0%	10.7%	6.0%
Too much hassle/paperwork	5.7%	13.3%	3.6%	5.3%
Too expensive/could not afford	50.0%	60.0%	53.6%	48.1%
Don't like benefits package	0.6%	0.0%	3.6%	0.0%
Not eligible, other	40.3%	6.7%	21.4%	48.1%
Will get health insurance soon	4.5%	6.7%	10.7%	3.0%
Don't know where to begin/where to go	14.8%	20.0%	10.7%	15.0%
Already have/covered by other health insurance	0.6%	0.0%	0.0%	0.8%
Received tax credits through Connect for Health Colorado	0.6%	0.0%	3.6%	0.0%

Fig. 4

## Continued from page 7

reason individuals lacked access (Fig. 4).

When individuals have insurance, they are able to access care at even greater rates. Of those with public or private coverage, only 22.5 percent of individuals could not access some form of primary, specialty or hospital care.

Other respondents also cited not accessing the care they needed or not having adequate coverage because they

did not know how to access care, their health insurance did not cover the care they needed or the care and insurance costs were too expensive.

## Competency

We also find that the health care literacy rate among Colorado's Latino and Hispanic population is low, especially among the noncitizen cohort (Fig. 5). This could be due in part to confusion associated with how to navigate the American health care

system. Many Hispanic and Latino immigrants come from countries with less complicated health care and insurance systems. While more pronounced with immigrants, citizens also reported confusion on how to access necessary care and had low basic health care literacy. The results of this survey also highlight important cultural competency issues that must be kept in mind for future survey design. For example, when asked where they go for

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## Why were you unable to access necessary health care? Respondents who said "yes"

	All	Citizen	Lawfully present, noncitizen	Undocumented Immigrant
Premium	42.1%	60.2%	42.4%	28.5%
Deductible	45.6%	58.6%	51.5%	33.7%
Copayment	53.8%	69.5%	59.1%	40.1%
Coinsurance	31.4%	48.4%	36.4%	17.4%

Fig. 5



**Continued from page 6**

telehealth services. These laws require commercial health insurance companies to cover services provided through telehealth to the same extent as those services are covered in person. Many variations exist across the states, though, in how states and private insurers pay out these reimbursements and what they cover. The variations in these parity laws created large differences in telehealth coverage across the country.

While many states mandate reimbursement, not all require reimbursement to be equivalent to or at the same rate as in-person services. Colorado, Missouri and Virginia require payment on the same basis as in-person services, which allows them to take into consideration the cost differences of telehealth versus in-person services. Twenty-three states and the District of Columbia have full parity, meaning coverage and reimbursement is comparable from in-person to telehealth services. Arizona is the only state that limits parity to geographic regions and specific services. Michigan, Oregon, and Vermont only authorize reimbursement for telehealth that uses interactive, audiovisual systems and Arkansas places "arbitrary limits" on patient locations and provider types, as well as requiring an in-person visit to establish a patient-provider relationship. Nevada is the only state to extend parity to workers' compensation programs.

**What's the debate?**

Proponents of telehealth and parity in reimbursement laud the potential cost savings over in-person care. Telehealth could achieve such substantial savings for a number of reasons, including the potential reduction of chronic condition-associated readmissions through mo-

bile health monitoring technologies and a decrease in unnecessary use of emergency appointments through remote visits with nurses instead.

Likewise, consumer demand for telehealth services is on the rise, with more and more patients looking to mobile applications, online services and health tracking devices to monitor blood pres-

sure and heart rate continuously. Additionally, many consumers see the positive benefits of telehealth: access to care, efficiency in services, saved time and energy, less stress and anxiety and even improved well-being for family caregivers.

Opponents of telehealth, however, argue that telehealth services are not equivalent to in-person services and therefore should not receive parity to in-person services in reimbursements.

- First, opponents suggest that new technology should be approached with caution, as it sometimes proves unreliable and might lead to improper diagnosis and treatment, absent the physical examination. For example, the American Optometric Association opposed online eye exams (and parity in their reimbursement) and called such methods "substandard model[s] of care."
- Second, many express concerns about the overall quality of care that can be provided using tele-

- Third, there are also concerns that many telehealth appointments might be one-time engagements, which creates problems when the

health data from that appointment might not be added to a patient's primary care physician. This creates gaps in records, which ultimately could have major effects on diagnosis and treatment at later times. Some telehealth services might place the burden of communicating telehealth appointments and results on the patient.

- Fourth, many are concerned about patient privacy, an area of growing concern in traditional services. The move toward telehealth programs means moving toward more digitalization of medical records, which then could leave records vulnerable to hacking and infiltration.
- Fifth, some argue that telehealth simply should not be reimbursed the same amount as in-person care precisely because of the cost savings associated with it. If telehealth services save money and are more efficient, the opponents argue, reimbursement for services should

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**"MANY CONSUMERS SEE THE POSITIVE BENEFITS OF TELEHEALTH: ACCESS TO CARE, EFFICIENCY IN SERVICES, SAVED TIME AND ENERGY, LESS STRESS AND ANXIETY, AND EVEN IMPROVED WELL-BEING FOR FAMILY CAREGIVERS."**

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**Continued on page 10**

**“Telehealth,” continued from page 9**

mirror those savings. Because of the high risks, possible lower quality of care, and cost savings of telehealth, many physicians believe that telemedicine should not be reimbursed on the same levels as in-person care.

In response, many point to the need to develop and support telehealth services to improve the quality of care provided and create incentives for patients and doctors to use telehealth. By reimbursing at the same rates as in-person services, states support the growth and development of telehealth, while encouraging more and more physicians to use it as a method of care. A 2014 study dispelled concerns that the convenience and accessibility of telemedicine will lead to overuse and increased total costs. Additionally, while privacy remains a concern for all of health care, many believe that the risks associated with telehealth are no greater than those posed by the move toward digital records in general. Furthermore, if reimbursements for telehealth do not align with in-person services, the cost savings projected for telehealth will never be realized because providers will stay with in-person services to recoup their costs.

**What's next?**

With telehealth technologies, providers can deliver high-quality care at a lower cost, a critical imperative in the accelerating era of value-based payment. On balance, the benefits of telehealth are substantial, assuming that more efforts will reduce or address the risks and challenges.

Congress is now considering a nationwide telehealth parity act. The Medicare



Telehealth Parity Act is intended to modernize the way Medicare reimburses telehealth services and to expand coverage for Medicare beneficiaries. The act would expand the number of qualifying geographic locations and expand coverage of telehealth services, although its likelihood of enactment is unclear.

To reap the benefits of telehealth services, states are likely to move toward full parity laws for telehealth services. Without parity, there are limited incentives for the development of telehealth or for providers to move toward telehealth services. If there are no incentives to use telehealth, then providers will continue to focus on in-person care, which will keep health care costs high, continue to create access issues, and possibly provide lesser standards of care for chronic disease patients who benefit from remote monitoring.

In addition, states are likely to gradually remove restrictions from their parity laws that limit providers, locations, and services, and focus on integrating telehealth into regular health care coverage. It is possible that reimbursement will eventually cover store-and-forward ser-

vices and remote monitoring, while leaving open the likelihood of covering services that fall outside of these categories, such as mobile applications and devices.

As the United States moves from uncoordinated, volume-based delivery of health services to an integrated, patient-centric, value-based model, health care delivery will increasingly focus on achieving higher-quality care, improved care access, and lower costs. In enabling health care organizations to provide high-quality, "anytime, anywhere" care to patients and operate more cost effectively, telehealth programs and play an important role in achieving these goals.

Source: "Health Policy Brief: Telehealth Parity Laws," *Health Affairs*, August 15, 2016. Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

**Continued from page 8**

their care and advice regarding their health, many immigrants noted leaving the U.S. to access care in their home country. There is also confusion around how federally qualified health centers (FQHCs) provide care, despite the fact that these centers are the main source of health care and information for the noncitizen cohort. For instance, some noncitizens reported having “insurance” or “Medicaid” if they received a fee-for-service discount through an FQHC.

The most significant takeaway from the survey conducted was the ability to tell a story of those in our communities who are never formally accounted for. While additional questions could have been asked in the survey to allow for further specificity, the questions contained in the survey about citizenship and documentation status are easy steps that survey designers and researchers can take for more equitable health outcomes. These data points give advocates the tools to tell more nuanced stories and policy makers the insight to shape stronger policy. In addition, the process would have been less successful

had it not been for the involvement of community organizations. The involvement of these partners, from the inception of the survey to its administration, allowed for more accurate collection of data and greater cultural competency.

Researchers working in these communities should keep in mind that a survey that is not culturally competent might not result in strong and reliable

data points. Community organizers and partners play a significant and important role in ensuring this success.

For the full report and analysis see [“ColoradoCare: An Analysis of Health Care Costs for Latino and Immigrant Coloradans”](#)



*The Colorado Fiscal Institute provides credible, independent and accessible information and analysis of fiscal and economic issues facing Colorado. Our aim is to inform and influence policy debates and contribute to sound decisions that improve the economic well-being of individuals, communities and the state as a whole.*

*Our offices are located at 1905 Sherman St., Suite 225, Denver, CO, 80203. Please consider making a donation by mail or online at [coloradofiscal.org](http://coloradofiscal.org)*

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