

**COMMISSION ON AFFORDABLE HEALTH CARE**  
**COPIC, Mile High Room**  
**12:30 – 3:00 P.M.**  
**May 11, 2015**

**Meeting Minutes**

**Commissioners present:** Bill Lindsay (chair), Cindy Sovine-Miller (vice chair), Elisabeth Arenales, Sue Birch, Jeff Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Chris Tholen, Jay Want, Larry Wolk

**Commissioners absent:** Dee Martinez'

**Staff present:** Lorez Meinhold, Johanna Gibbs and Cally King (Keystone Policy Center), Amy Downs (CHI)

**Follow-up/Action Items:**

- Communications Liaison Committee to further discuss/consider media outreach and editorial boards during the state-wide outreach meetings.
- CHI to share their Research Committee presentation on spending by service area with the full Commission.
- Research Committee to further discuss process to share materials and literature given to the Committee.

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**Meeting Minutes:**

**I. Review of the Agenda**

Chair Bill Lindsay opened the meeting with a general welcome and review of the agenda.

**II. Approval of the Minutes**

- A. Motion for approval from Jeff Cain, seconded by Rebecca Cordes.
- B. Minutes from the April Commission meeting were approved unanimously with no opposition or changes to the minutes.

**III. Standing Committee Reports**

**A. Communications Liaison Committee – Jeff Cain**

- 1. Website: agreement with the State Internet Portal Authority (SIPA) has been signed for the Commission website; hope to have the website functional within the next 60 days.
- 1. State-wide Outreach Meetings: planning is underway and the Committee is coordinating with the Planning Committee to draft itineraries and agendas for the meeting beginning in mid-late August; considering how to invite media to participate in the outreach meetings.
- 2. Development of Communications Plan:
  - a. First communication priority is targeted to the legislative/executive branches
    - i. Targeting the Governor's office and key legislators (bill sponsors, chairs of committees of reference, and legislative leadership) to provide information on where the Commission is going and what it is doing.
    - ii. The outreach will take place before the start of the statewide meetings

- b. Creating a budget for ongoing communications needs
  - c. Working towards the creation of a long-term communications plan as the Commission progresses
    - i. Creating calendar/task chart for targeted communications and modes of communication
    - i. Social media may be a challenge and the Committee is working on how to appropriately use it.
  - 3. *Commission discussion:*
    - a. Are we thinking about meeting with editorial boards during state-wide outreach meetings? (FOLLOW-UP)
      - i. One question the Committee has discussed is how to use media, have not made specific plans but the consideration does include local editorial boards.
      - ii. Should consider not just editorial boards, but also reaching out to local press and inviting local reporter to attend the meetings.
    - b. Bill Lindsay has made a request to the Governor's Office for a meeting with Budget Director Henry Sobanet and other key members of the administration to provide a briefing. No meetings have been set at this time.
- B. Research Committee – Ira Gorman**
- 1. The Committee has met twice since last Commission meeting with the following outcomes:
    - a. The Committee received a presentation from CHI looking at health care spending by: types of service, disease condition, and per capita spending.
    - b. Established a framework which was approved at this morning's Committee meeting to address key topic areas related to spending and costs. Individual members will give presentations at each Research Committee meeting on various topics. This will be overlaid with the original framework approved a few months ago.
    - c. Established a 30-60-90 day timeline and are working backwards with specific goals
    - d. Established a timeline for distributing meeting materials in a timelier manner
    - e. Establishing an presentation format for topics
  - 2. The Committee has made good progress and should be ready to begin tackling substantive issues which they will bring back to the Commission
  - 3. *Commission discussion:*
    - a. Can you elaborate on the detailed work you are doing and how it fits in timeline with public meetings?
      - i. Hope to take the framework and use literature to help analyze cost drivers which will lead to ability to move forward on what the Committee believes are drivers of health care costs in Colorado and what is affecting those drivers. The Committee is not ready to make recommendations about solutions but are ready to share with public what they think are cost drivers and receive public feedback on their experiences with those drivers.
    - b. Can the Research Committee share with the full Commission their discussion/presentation from CHI?
      - i. Yes, the Committee will bring presentation to the full Commission (FOLLOW-UP)
    - c. Some Commissioners have received questions from stakeholders on information from the Research Committee will be shared and when is the appropriate time to approach the Committee?

- i. Part of the process of bringing forward articles and literature will be based on chosen topics and the Committee is working on having those materials available in a timelier manner moving forward so people can be prepared for the meetings. The Committee needs an overall discussion on how we are going to share materials that come to the Commission and research Committee. (FOLLOW-UP)

**C. Planning Committee – Bill Lindsay**

1. The General Assembly passed [HB15-1083](#) which requires the Commission to conduct a study of the costs of physical rehabilitation services and whether or not patient cost-sharing creates barriers to the use of these services; the Commission must report its findings to the health committees of the General Assembly by Nov. 1, 2015.
  - a. The Planning Committee discussed this bill and has begun reaching out to actuarial firms that can help with the fiscal analysis to include in the General Assembly’s report.
2. Colorado Managed Care’s April 22<sup>nd</sup> newsletter includes a piece about the Colorado Commission on Affordable Health Care and discusses the Commission’s role and mission.
3. The Committee has coordinated with the Research Committee on speakers/presenters to the Commission focused on providing Commissioners with information and education on cost drivers.
  - a. Will begin process to invite industry groups and others to come speak to the Commission.
  - b. Also looking to find independent experts to provide background and information to help understand the broad complexities of health care costs; i.e.,
    - i. Hospital charges and cost accounting, including CMS requirements - what’s malleable or changeable under CMS rules?
    - ii. Pharmaceutical costs in the U.S. – would like to invite independent, balanced speakers who can explain how the system works
  - c. The Committee has begun visiting with health care related foundations to: 1) make sure they are aware of what the Commission is doing, and 2) ask if they would consider providing funding for the Commission to enhance activities.
    - i. The Commission received generous support from the General Assembly, but the funding only goes so far. As an example, for the state-wide meetings the Commission may need sign language interpreters and do not currently have the funding to do so.
    - ii. There have been no promises or commitments from foundations at this point, but the dialogue has begun.
4. Planning the Statewide meetings: the Committee has discussed the planning and agendas which will be discussed in further detail later in today’s agenda.
5. *Commission discussion:*
  - a. Understanding background and information on health care costs/issues is a critical element of what the Commission is about; DOI receives a lot of questions on health care/insurance issues that really don’t fall under any agency’s purview or authority (i.e., co-payments, third-party issues, etc.)
  - b. The physical rehab mandate (HB15-1083) is an important issue to address which is a very narrow, specific item to look at; those findings may be elevated into a broader discussion for the Commission. Has the Planning Committee decided if we are going

to do this as an isolated report or are we including those findings in the November report?

- i. Did not discuss the fine details specifically but the Committee did decide the physical rehabilitation report was a specific charge that should be handled as a distinct report/activity; if in doing so the Commission finds there are correlations to take into the broader General Assembly report, we can include at that time. The two reports really do have two distinct purposes and audiences which seem to make more sense to handle separately.

#### **IV. Presentations:**

##### **A. CIVHC presentation on “Payment Reform in Colorado” – Presented by Kristin Paulson**

1. The presentation reviewed programs in Colorado focused towards health care payment reforms including: Sustaining Healthcare Across integrated Primary care Efforts (SHAPE), Comprehensive Primary Care Initiative (CPCi), Medicaid Accountable Care Collaborative (ACC), bundled payments, and Medicare Shared Savings. CIVHC also shared an inventory of programs in Colorado focused on improving health care costs. (Power point presentation available on request)
2. *Commission Discussion/Questions:*
  - a. One challenge heard from providers on payment reform is that this is a patchwork and it is hard to coordinate. Also, when you use high performing groups it is hard to get a delta
  - b. With regards to CPCi – what is different about Colorado? It would be interesting to tease out what is working in other states that isn’t in Colorado.
    - i. Unsure on exact reasons. It would be interesting to look at performance of practices prior to enrollment in the CPCi program. States seeing gains have very small number of practices which may skew the percentages – when you look at number of practices involved the difference between 0 and 5 percent may not be something to rely on.
  - c. With regards to CPCi - when there are changes in behavior and improved outcomes, are the measurements from the full universe of patient care and outcomes or is it focusing attention only on desired outcomes? How do we know if other things are pushing out somewhere else?
    - i. We have seen that reductions in 30 day admission rates are increasing 60 day admissions. Medicaid and HCPF seem to be looking at a much larger picture and metrics. You need to ask where to draw the line as far as what constitutes pushing out care; do you look at decreasing in other areas as well? Unfortunately there isn’t a good answer right now.
    - ii. Another part of the issue is inability to look at long-term results right now since the program is in its first year. Another issue is that you have to be a high performing practice to be a part of CPCi which creates onboarding issues.
      - What is the range of years needed when we talk about “long-term”? How long does it take to see changes in care?
        - ◆ This should be viewed like any other cultural change which is generally a multi-year process that also requires persistent utilization from leadership.
  - d. Can you comment on where \$100M in Medicaid savings came from and what percentage of the total Medicaid spend that represents? How was it calculated and where does the bulk of the savings come from?

- i. That is a cumulative growth savings over about 5 years. Most savings are from reduced ER utilization, fewer imaging, and fewer readmissions for both pediatric and adult patients. This is an evolving system of care and HCPF anticipates this will level out but it is an iterative process with early, positive indications of success.
- e. With regards to Medicaid ACC – what are specific non-medical needs that were addressed?
  - i. Transportation, nutritional needs, Rx delivery, supportive housing environments (care coordination and wrap-around services), etc.
- f. Challenge to long-term approach is that we need cultural changes and shifts and continuity in infrastructure – how are we looking at the common framework needed?
  - i. That is a problem we face – we are looking at common metrics that can be looked at across patients and programs.
- g. It would be helpful if policy makers had a consistent way to measure success in programs like this. Would also be helpful to look at various demographics and how the savings apply across those various demographics.

**B. “Colorado State Innovation Model (SIM)” presentation** – Presented by Vatsala Pathy, Colorado SIM Executive Director

1. The presentation provided an overview of Colorado’s State Innovation Model which was funded through a \$65M grant from the Center for Medicare & Medicaid Innovation. The initiative developed and tests models for transforming health care payment and delivery systems in Colorado. (Power point presentation available on request)
  - a. SIM vision statement: Create a coordinated, accountable system of care that will provide Coloradans access to integrated primary care and behavioral health in the setting of the patient’s medical home.
  - b. SIM goal: Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures for 80 percent of Colorado residents by 2019.
2. *Commission Discussion/Questions:*
  - a. Is SIM addressing concerns around a state-wide registry databases?
    - i. This will be aggregate data to help identify trends and provide support to help with decision making at the policy level and practice level as a whole. NY has a similar effort underway, this is at the cutting edge and we are learning as we go along; want it to provide valuable data while also protecting patient privacy.
  - b. Is it correct Colorado SIM wants 80% of the state’s population in the program? Where’s the evidence this works if it is an experiment? There is a lot of evidence that when Medicare patients become ill they dis-enroll to get care they need. How do you address extremes?
    - i. We explored evidence based on information prior to this initiative and can share that information with Commissioners.
  - c. If we want 80% of population in these programs for 2019 that requires coordination of efforts across payers – how is SIM going to accomplish that?
    - i. Working with multi-collaboration to discuss what a payment reform initiative would look like. Most folks spoken to believe primary care medical home is a place to start; those conversations are in motion right now.
  - d. Is Colorado SIM at a point to speak about extra payments and provider payments offsetting those costs?

- i. We are not there yet. Need to create an environment where payments of different health care plans are competitive but also have alignment in their payment approaches.
- e. What other states that received these innovation model awards that are comparable in population to Colorado?
  - i. NY received the largest award at \$99.9M (largest possible award was \$100M); TN is comparable in population and also received an award; unsure on the exact amount. There were another dozen states that applied and did not receive any funding.
  - ii. Is Colorado SIM in communication with these other states and is there feedback from what they are learning?
    - Yes. There was also an earlier round of states who received funding and opportunity to learn from them.
- f. When looking at the mission statement, it seems to be focused on behavioral health but when you talk about pay for performance payment reform – are you still talking about behavioral health or is that more widespread?
  - i. Our goal with payment reform is to create value in reform structures that take behavioral health into account; there are broader value based payment reform efforts that don't have anything specifically to do with integration.

**C. Colorado Dept. of Public Health and Environment presentation on “Population Health Strategy”** – Presented by Dr. Larry Wolk, CDPHE Executive Director

1. The presentation provided an overview of CDPHE's population health strategy and the framework for progress which includes: promoting prevention & wellness; expanding coverage, access and capacity; improving health system integration and quality; and enhancing value and strengthening sustainability.
2. *Commission Questions/Discussion:*
  - a. Struck by work from Trust for America's Health and some of their state-by-state analyses. How does that relate to CDPHE and how the Department is thinking about those interventions like community based health?
    - i. HCPF has been good at bringing in some of those programs and identifying where those investments should occur. CDPHE is looking at this from the public health angle to include local public health agencies as part of the equation when looking at payer as part of the total population which can be included in different demographics (i.e. location, insurer, etc.).
    - ii. Those are good baseline strategies but looking at this from a different angle – like asthma rates in NE Denver – there are a lot of strategies that might not be obvious to communities. Where are there targeted public health initiatives?
      - Those specific issues fall into local public health agency plans. Each community needs to identify their own local public health needs and then the State (through CDPHE) can help provide continuity in public health programming across the state.
  - b. What is environmental justice?
    - i. Similar to health equity but on the environmental side - making sure people have equal access to the same healthy environments (i.e. clean water, clean air etc.)
  - c. Over the past few years CDPHE's budget was cut significantly, has the Department's budget now moved up in terms of priorities for the legislature to look

at and take action? Much of CDPHE's initiatives correlate well with cost containment – has the legislature put those together?

- i. Complicated answer. We've done a good job demonstrating how we've shifted entitlement population to insured populations (i.e. AIDS treatments, contraception, etc.) which leads people to believe we've done a good job of transitioning to other funding sources but those aren't a steady stream of funding; 2/3rds of our funding comes from the federal government and it is a fight every year to preserve that funding.
- d. What does it mean to change context to default decisions?
  - i. An example is a mandate like creating a smoking ban so the default is "I can't smoke," creating a positive effect to your health; another example is NYC's attempt to ban supersize beverages. It's mostly looking at mandates that are related to health so a default is created to the benefit of one's health.
- e. Important to look at where public health can correlate with clinical health, there hasn't been a lot cross-coordination between these two.
  - i. Something to look at might be building and environmental design – i.e., staircase accessibility in buildings, walking/biking routes to schools/work, standing desks in offices.
- f. What might be missing from this presentation that couldn't be included today?
  - i. There is a link to the full 130 page report which is tied to metrics to evaluate our progress.

#### **D. Public Comment:**

1. George Swan, retired hospital administrator: With regards to data transparency. Every presentation heard today has a lot to do with the need for accurate data. The Colorado Health Foundation and CHI health report card is put together in annual trends and each indicator has a trend. We are also usually looking at data that is over two years old. The reports need to be brought together in a way that is comprehensive and easy to read and also includes health, economics, education, and other indicators. The lack of timely and meaningful data is shameful. I aggregated the numbers into one page (from 100s of pages) for all the counties in Colorado to see how they compare. I can provide a pivot table with community information data to the Commission.

#### **V. State-wide Outreach Meetings update**

##### **A. Progress underway and next steps:**

1. The outreach meeting itinerary in in development based on Commissioner availability
2. Working on creating the agenda structure
3. Commissioners are asked to help find the right locations and reach out to the right folks in their respective regions.
  - a. Stakeholder outreach includes, but is not limited to, elected officials (i.e., state legislators, county commissioners and the Congressional delegation)
4. Developing a questionnaire for public input from those unable to attend/participate in the meetings.

##### **B. Commissioner questions/comments:**

1. Hospitals and college campuses are not the best place to hold these meetings; public buildings may be better options.
2. Will we conduct regular business at these meetings or just focused on public input?

- a. The Commission is not required to do any additional business at the outreach meetings, but if there is a need to do business we can figure that out.

**VI. Other Business**

- A. There is a (printed) questionnaire for public input on Commission meeting location and parking. Meeting attendees asked to provide their feedback and return the questionnaire at the end of today's meeting.

**Meeting adjourned.**