

COMMISSION ON AFFORDABLE HEALTH CARE
COPIC, Mile High Room
June 8, 2015
12:30 – 3:00 PM

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, Dee Martinez, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Chris Tholen, Jay Want, Larry Wolk
Staff Present: Lorez Meinhold, Johanna Gibbs, and Kim Haller (Keystone Policy Center)

Follow-up/Action Items:

- May 2015 Commission meeting minutes to be edited to better reflect public comment made by Mr. Swan.
- Request from Communications-Liaison Committee for Commissioners to help with outreach to legislative and stakeholder contacts.
- Commissioners to provide feedback to Bill Lindsay on future funding needs for both the Research and Communications Committees. Assuming additional funding is available, what’s the best possible availability of funds?

Meeting Summary:

I) Review of the Agenda

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

II) Approval of Minutes

- A) A motion to approve the May minutes was made and seconded.
- B) Minutes from the May Commission meeting were approved unanimously by the Commission with no opposition or changes to the minutes.
- C) Public Comment:
 - 1) George Swan, retired hospital administrator: Words to alter in the May minutes from Mr. Swan’s public comment include, “lack of timely and meaningful data” and “provide a pivot table with community information.”

III) Standing Committee Reports

- A) **Communications Liaison Committee** – Jeff Cain
 - 1) Moving forward with communications plan:
 - (a) Targeted communications have been prioritized to the Legislative and Executive branches
 - (b) Utilizing stakeholder input
 - (c) Potential budget needs from Communications Committee
 - (i) A second round of meetings. Revisit communities to review what has been learned and how to move forward.

- 2) Website process has been approved; working with CDPHE and Keystone to have the webpage go live by July 2015.
 - (a) Website will feature meeting dates and topics, community topics, and community input
 - 3) Request for Commissioners to help with outreach:
 - (a) Stakeholders: Committee members asked to work with the Communications Committee by identifying individuals or stakeholder groups, hospitals, insurers, and other contacts in these areas
 - 4) *Commission Discussion:*
 - (a) Elisabeth asked about the timing of the legislative meetings
 - (i) Jeff responded that the intention is before the statewide meetings in the districts (6-8 weeks)
 - (b) Questions about media
 - (i) Reminded Commissioners that all articles will be shared
 - (ii) Important charge of Commissioners to help individuals/ stakeholders to understand how the Commission has formed, timelines, and cost and quality messages
 - (iii) Refer all media to Bill Lindsay but Communications will share common messaging developed
- B) Research Committee – Ira Gorman**
- 1) The Committee agreed to continue to meet twice a month and the times have changed to 9am-12pm with the Third Thursday meeting running from 9am-12pm to use more time to complete discussions with public comment.
 - (a) ReadyTalk is also available at these Committee meetings and the public is welcome to attend.
 - 2) Reviewed 208 committee recommendations
 - 3) The Committee has compiled a list of topics to address each month – presentations to be held once a month with a second meeting follow-up discussion
 - (a) Transparency was presented and briefly discussed during the June meeting
 - (b) The upcoming topics include:
 - (i) Workforce – July
 - (ii) Social Determinants – August
 - (iii) Incentive Mechanisms – September
 - (iv) Regulatory Costs – October
 - (v) Admin Costs – November
 - (vi) Payment & Delivery – December
 - (vii) Market Competitiveness – January
 - (viii) Technology – February
 - 4) *Commission Discussion:*
 - (a) Would it be appropriate to bring back presentations of the topics to the Commission?
 - (i) Scale it down to a short synopsis (10-15 minutes)
 - (b) For each topic, have you thought about how the rural vs. urban variables will be filtered?
 - (i) Drivers of rural vs. urban are different than what is being discussed now, but it is helpful for us to think about how the full Commission can be involved.
 - (ii) While these variables come up, they should really be included in all topics explored.
 - (c) How do you think the topics can be brought to the Commission?
 - (i) Determine the value and how the information can be packaged in a way to efficiently present to the Commission

- (ii) Need to put information together in a streamlined way. Focus on impact and action in a timely manner.
- (iii) Commission isn't trying to set a requirement to report back, the topics will be helpful in order to formulate ideas around specific areas – one topic will inform the next, they are not mutually exclusive.

C) **Planning Committee** – Bill Lindsay

- 1) Monthly discussions put in place to make there is communication and continuity between each committee; there should be a healthy overlap between all committees
- 2) Commissioners are getting together as small groups as well as the committee chairs to discuss:
 - (a) Work plans and timelines
 - (b) Statewide meetings
 - (c) Group collaboration
- 3) Budget: not much activity in this area yet but there will be more after July
- 4) Meeting with each of the major foundations that have health orientation in their purview
 - (a) Not much substance yet, however, outreach meetings have been well received
 - (i) Examples: Colorado Health Foundation, BC3, etc.
 - (b) The meetings will help inform a work plan, information sharing, and roles within statewide meetings
- 5) The Committee meetings last month and this month are focused on identifying speakers to bring in and to build a schedule so there is information for the benefit of the Commission
 - (a) There is no intent to duplicate work between the Commissioners; however, the intent is to inform the Commission of what is happening. Remain brief and provide an overview of information regarding interests moving forward.
- 6) HB15-1083: An evaluation of impact that physical therapy co-pays have on health care costs
 - (a) Milliman will likely be the contractor for this study – they have no bias or perspective on this topic and have a local office in Denver.
 - (b) A proposal has been received and the Committee is currently working on the contract
 - (c) Legislation has responded to the concerns, not questions:
 - (i) Health care dollars spent, how much and where?
 - (ii) How much is included in services?
 - (iii) Providing opinions on pricing mechanisms
 - (iv) What's the expectation of copay's impact on utilization?
 - (v) Appropriate charges for specific skill sets
 - (vi) Ability to finish their work for review and comment
- 7) Bill discussed the AGO's attendance at Commission meetings. It was decided Mr. Kuhn does not need to attend meetings where there are no obvious legal or technical issues to address; many of the Commission's substantive issues such as by-laws, policies and procedures, and contracting for consultants have been addressed. The request was made solely for fiscal reasons as the Commission's finances are limited and need to engage in controlling expenditures that are not vital to the Commission's mission.
 - (a) Commissioners should know that at any time if an individual Commissioner feels the need to reach out to the AG because of legal issues, they can do so themselves or make a request through Bill (as the Chair of the Commission).
 - (b) Mr. Kuhn will be copied on all minutes, agendas, and topics involving potential controversy to render his input on those items, as needed.

- (c) Mr. Kuhn will be present when the Commission comes to the stage of making recommendations, or interpreting our “charge” as a Commission.
- 8) *Committee Discussion:*
 - (a) HB15-1083 provides an opportunity for the Commission, it does come to the Commission with funding.
 - (b) It might be a good idea to bring in guest speakers to present different perspectives on specific topics
 - (i) The Committee has discussed this and is talking to the foundations about the need for additional funding. Topic specialists coming in from other states can be very expensive. The Committee is currently looking at topics that will benefit the Commission and the goal is to bring differing perspectives.

D) Public Comment:

- 1) Ken Connell, Colorado Health Champions: Impressed with the Research Committee meetings and Committee dedications and differences in perceptions. Working on ballot initiative for November 2016, Colorado Care Initiative 21. Signatures are needed and a flyer available for Commissioners.

IV) Presentations

A) “Importance of Consideration for End of Life Care: How Palliative Care is an Important Strategy” – Presented by Tina Staley, Clinical Social Worker, University Health

- 1) The presentation reviewed how to improve a patient’s quality of life while improving health care costs. The presented findings are based on two research studies including late stage breast cancer patients and a 17 hospital study with 160 participants. Through end of life conversations, patients are able to face their fears, cope with illness, and communicate more effectively with physicians leading to an overall better quality of life. A short documentary clip showed that when patients had their questions answered, there were less ER visits and the subsequent health care costs diminished. Additionally, patients who were provided end of life conversation services didn’t want to go for a heroic treatment, instead they took advantage of life. This is said to be the “million dollar conversation” and Staley reviewed the importance of a better quality of life and a more cost effective system. This can happen when comprehensive care teams are formed with nurses, social workers, and physicians communicating with the patient throughout their journey. There are currently several insurance programs that are reimbursing physicians for having these conversations.

2) *Commission Discussion/Questions:*

- (a) Colorado has made the decision at the state level to train physicians; however, it’s going to need more lift. Hospice has been extended to nine months but there is not much movement with physicians. The state has moved in some ways, but do you have any ideas for what else needs to be done?
 - (i) More teams need to be formed involving nurses, social workers and doctors. Many conversations need to happen, not just a 30 minute conversation.
- (b) The culture in Grand Junction is to prepare from diagnosis. One-third of health care spending is at the end of life. It’s important to have patients living their life fully in the time that they are alive. Conversations need to happen sooner.
 - (i) Care for undocumented workers and end of life discussions are hot topics currently. Grand Junction has higher hospice rates and lower health care costs. The quality and cost discussion lies around patient empowerment, regardless of how that impacts

extraordinary measures at the end of life. Insurance and government aren't typically the most supportive.

- (c) Is there movement on the Medicare side? End of life physicians don't always want to have those conversations and sometimes the amount of time the patient has is unknown.
 - (i) Education needs to improve regarding hospice; those conversations need to begin earlier. Palliative care conversation teams are crucial in terms of providing supportive care and getting better cost outcomes. This also impacts the negative association with hospice – education is key.
 - (d) There is movement in the payment world (\$150 per conversation), but is the movement in the right direction?
 - (i) It's just a first step but is certainly moving in the right direction
 - (e) There could be barriers on the uptake and physicians involved, is being sued by family member and/or hospitals ever an issue?
 - (i) Doctors are afraid of being sued if they don't actually perform tests
 - (ii) Research shows that chemo only extends life an additional month
 - (i) It comes back to the patient.
 - (ii) Physicians aren't taught to talk about these issues with patients
 - (iii) There is uncertainty of talking with patients about end of life however it needs to happen in a patient-centered way and physicians need to not worry about being sued.
 - (f) It's important for people to understand their choices. That being said, the choice still needs to rest with the patient. The current system is too far one way to driving every possible option; we need to find a balance.
 - (i) It's a more difficult process if patients don't have an understanding of what is to come and how to deal with their families and emotions
 - (g) Our culture today and medical students should be learning how to communicate in medical school. Doctors are not ready to take this on. Residency and medical school should include this in their curriculums.
 - (h) Thus far, we haven't had to worry about the government because they have chosen to ignore this. There is a struggle to gain traction due to cultural issues and family barriers. What does good look like 10 years out without barriers? Quality agenda, patent and cost agenda?
 - (i) Comfort care, not having people due in IC units hooked up to machines. Managed care with organizations like hospice. Family and patients on the same team and pain and symptoms being managed. Having a better deal with a physical and psycho-social balance before dying.
 - (i) There are two components: changing the culture of a practice and the continuity of care. The continuum of conversation around end of life conversations. Continuity of care is a great model for it.
 - (j) It's the patient's choice to determine what is most important. Choices are being made based on what the patient wants.
- B) **DOI presentation** – presented by Marguerite Salazar, Insurance Commissioner, Colorado Division of Insurance, DORA
- 1) The presentation provided an overview of the variation in insurance premiums for health care across the state of Colorado. There are a variety of factors that come into play while determining health care premiums. The Department of Insurance evaluates health care costs over three years of time per region to determine rates for the upcoming year. Areas such as specialty drugs and

narrowing of networks continue to be explored in addition to evaluation by the National Association of Consumers. Ratings factoring variables of health care premiums include: age, tobacco use, geographic rating and benefit design. Approved plans for 2016 premiums will not be available until September 2015. (The PowerPoint presentation is available upon request).

2) *Commission Discussion/Questions:*

- (a) Are you at all concerned about the financial condition of Colorado based on other states?
 - (i) Yes, we are currently watching other states very closely and Colorado seems to be in a good position right now.
- (b) Can you elaborate on the issue in the mountain communities? If there are more exercise induced trauma, or is it an issue of per unit cost?
 - (i) Cost is the driving factor. The same treatment in Denver is cheaper than in the mountain towns.
- (c) Factors including seasonal workforce are important. We are the highest cost region in the country. With a free-market system, you can't tell providers what to charge. What's the balance between the way the market works and whether or not there are regulatory enforcements?
 - (i) We need to take a deeper look into this.
- (d) What's the approach in the case of market failure? What does one do with that, especially for rural Colorado?
- (e) Is it possible that one reason resort costs are higher is because there are less OB services? When people have a medical event, is it more costly?
 - (i) 40 percent of births in Colorado are paid for by the state; there's a sheer lack of volume and monopolistic behavior.
 - (ii) There are many factors; we need a regulatory balance and need to be transparent about it.
- (f) The creation of this data looks at where the patients resided that had the cost. For example, Aspen residents who have serious health conditions – are those patients going elsewhere? Costs are most likely being incurred elsewhere as well.
 - (i) Could look at the actual locations of the care being delivered.

C) **Public Comment**

- 1) George Swan, retired hospital administrator: After downloading data on OB costs, it appears that it's only through 2012 and has not yet been updated. There is a need for a current database. A suggestion would be to create a rolling 12 month database with current data.
 - (a) There is a claim period involved and data sets can't be drawn from that, we are running as fast as we can but it takes a while.
 - (b) Utilization services should be revisited as hospital data is vital to understand health policy.
- 2) Mike Huotari, VP for Rocky Mountain Health Plans & APCD data (CIVHC): Special data has been presented. A suggestion is to look at specific data and different data sets. Look at cost and utilization in these areas. It is helpful for this group to know which data sources are available.

V) **November Report Outline**

- A) A working draft of this report will need to be started in September. It's too early in the detailed work. Lorez is the staff lead for the report.
 - 1) We are laying the groundwork for the work ahead of the Commission

- 2) Blending-in the current administration's path forward and their previous attempts (Section VI). Intention is to highlight all initiatives.
 - 3) Developing a questionnaire for public input from those unable to attend or participate in meetings.
- B) Commission Timeline:
- 1) This is the work plan for the Commission and committees – a way for interested parties to follow the work of the Commission.
 - 2) Folded in Communications and Research Committees (30-60-90 day Plans)
 - 3) Commission feedback is helpful.
- C) Public Comment:
- 1) George Swan, retired hospital administrator: Perspectives regarding spending. Relationship indicators breakdowns are great for spending.

Meeting adjourned.

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