

COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

10/23/2015

COPIC, Mile High Room

Meeting Summary

Participants: Bill Lindsay (chair), Cindy Sovine Miller (vice-chair), Sue Birch, Jeff Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Marcy Morrison, Chris Tholen, Jay Want, Larry Wolk

Staff: Lorez Meinhold and Cally King (Keystone)

Meeting Notes:

I) Approval of the Minutes

- A) Greg D'Argonne provided a motion to approve the meeting minutes from October 12th; the motion was seconded by Rebecca Cordes.
- B) The Minutes from October 12th were approved unanimously without changes or amendments.

II) Payment and Delivery Reform Presentations

A) **Presentation: Value Based Insurance Design (VBID) and Accurate Medical Cost**

Accounting, Utah Experience – Ira Gorman, Commissioner

(For presentation see the [Commission website](#), slides 18-31)

- 1) Commission Discussion on VBID:
 - (a) This approach tells employees what the employer values and it also just makes sense to the population in general. Where you run into problems is when deciding what is considered to be preventable or not.
 - (b) A component of this involves educating individuals as well, they need to understand “why” and why something is better in the long run. This doesn't seem to be information that is readily available.
 - (c) One challenge, in terms of cost effectiveness, is how to measure this over time.
 - (d) A positive aspect is that this allows for employee/patient choice which allows for consumer involvement; it includes an element of preserving patient choice.
 - (e) How does this interact with employers' formularies?
 - (i) It is a way of using financial incentives to affect consumer behavior. If you are trying to direct people to something that is better for them over the long term, that is sending a different message. For some formularies, cost avoidance is 100 percent of the design. The intent behind the formulary is very important in determining its objective.
- 2) Commission Discussion on Value Driven Outcomes:
 - (a) This implies that increasing quality will lower cost – how is quality defined? Also, how do doctors respond to this - they have standardized care and methodologies to follow - how does that work for them?
 - (i) Things like discharge rates and return for care are lowered, in terms of quality. There had to be physician buy-in to make this work, and ultimately it did work.
 - (ii) Younger physicians who live by social media understood how this works with ratings. Older physicians who were close to retirement didn't care too much either. The doctors in the middle are the ones who took the most convincing. Physician buy-in comes with

getting ahead of the curve and finding a way to have the fairest evaluation possible, especially with incentives provided. It is a psychological shift to have physicians begin rating on systems similar to trip advisor or yelp.

- (b) Is this going on at HealthOne as well? How is it going?
 - (i) HealthOne measures everything. We define quality by measures that are from government ratings. It has been a big change in our industry over the last decade.
 - (ii) This is more in play in metro areas than rural ones because of increased competition in metro areas.
- (c) In this assessment, has anybody been forthcoming in terms of cost on how to do this?
 - (i) Utah claims they saved \$2.5M in 2012, those are cost savings in terms of investment into this program. This also requires a sophistication of data systems, like EHR.
 - (ii) Nice thing about Utah example is there was no government intervention to do this; they are doing it as a business intervention. Virginia Mason in Seattle is another good example of this – they have been more profitable in a fee-for-service market and have changed business practices to be more efficient.
 - (iii) Only way to succeed in a value based environment is to know what your investments are. With personnel and investment in technology, the return may not always be the same.
 - (iv) The current environment favors big business because of economies of scale.
- (d) It seems academic medical centers make big gains, how do they make efficiencies from it? Also, how does overhead effect cost?
 - (i) Virginia Mason is not primarily an academic medical center. Anywhere of scale is now having to do this because they view it as competitive.
 - (ii) So it's not something new that we could make a recommendation on?
 - (iii) It is on the hospital side, but not on the physician side.
- (e) It may be worth while emphasizing that this is an example of how the market can start driving change in value without having to mandate it.

B) Presentation: Side Neutral Payment and Physician Gifts from Industry – Jay Want, Commissioner

(For presentation see the [Commission website](#), slides 32-46)

- 1) Commission discussion on side neutral payments:
 - (a) How does this effect specialty hospitals?
 - (i) It still follows the same idea. American Hospital Association did a one-pager on the regulatory requirements and the different sets of costs that I would recommend looking at. As policy is developed over time, those policies become imbedded in payments and fee schedules.
 - (b) With regards to cardiology, part of the reason for this occurring is because the driver was related to cardiologists getting their payments cut year-after-year until it became unsustainable and they had to come to the hospitals to become employed there instead of independently.
 - (c) Issue of big and urban vs. small and rural is similar to telephone services where we all pay a tax across the board to make rural delivery of services available. Could this have applicability to the health care situation?
 - (i) When you think about a public good, what is the proper financing mechanism behind it? Some might say that is a tax, but this is a matter of debate.
- 2) Commission discussion on physician gifts from industry:

- (a) Public trust in physicians to do what is right for them. It's important to have attention to this as there has been abuse in the past. This is also a CMS policy in terms of physician policy on ethics, this is something they suggest physicians do.
 - (b) There are papers that illustrate detailing these things show value. If you take it too far, the FDA doesn't haven't any contact with pharmaceutical boards because they are concerned with code of conduct. This seems to be a good ethical balance.
- C) **Presentation: Contemporary Capitation** – Patrick Gordon, Rocky Mountain Health Plans
(For presentation see the [Commission website](#), slides 1-17)
- 1) Commission discussion:
 - (a) Why does it matter if a private payer, like Anthem, has a different incentive plan vs. Medicaid?
 - (i) It's fragmenting. In most settings, Rocky Mountain Health Plans (RMHP) only comprises 30 percent of the groups. Government programs are huge and primary care in Medicare are still the biggest payer. We need a multi-payer process for this to be actionable.
 - (b) You mention Colorado and RMHP, what other groups currently have capitation?
 - (i) Private sector - many major payers are implementing accountable contracts of their own with a blended, mitigated risk model. Medicaid has great interest in expanding the concept being tested in the PRIME program, but there are limitations – availability of capital and policy factors with overall budget accountability and flexibility with respect to payments, but we don't yet have a waiver in place to do meaningful payment reform.
 - (c) Medicaid frequently defers to high-risk payment systems. We find people get stuck in the nomenclature and confines around managed care. It is very important to have this explained and how we can have value based mechanisms. It doesn't need to be one size fits all. Also, the accountable care framework paper was released this week by HCPF and I encourage Commissioners to read the ACC framework paper as it correlates with a lot of these same themes.
 - 2) Additional question made at end of meeting to be sent to Patrick Gordon for written follow-up:
 - (a) In the presentation, the British National Health Service was brought up – would like to know his impression on a system that has had capitation for a number of years and how it has worked.
 - (b) How do you track a patient to find out if their outcomes actually are better?

III) Review of the Draft *Cost of Rehabilitation Services Report*– Steve Melek, Milliman (via phone)

(Visit the Commission website to view the [draft report](#))

- A) Background: The majority of results in the report were derived from physical therapy and chiropractic use. A high level observation is that there are quite a few users who only use a small amount of services. Those who use the greatest amount of services tend to have the lowest out-of-pocket costs. There is a suggestion that patients run out of services at a certain point which implies there are probably a certain number of annual visits allowed per year for those patients – you could make argument that patients who run out of services at a certain point would have continued their services if there were no limit. There is correlation between lower patient out-of-pocket payments and lowered discretion in using services.
- B) Commission discussion:
 - 1) It is more uncommon to see co-pays in plans today as more employers are moving to deductibles and co-insurance. Is this a different paradigm than you would have when dealing with co-pays?
 - (a) Yes, the term we use here is cost sharing. We do have tables in the report that talk about percentage of claims that use co-pays vs. co-insurance and deductibles. About 70 percent of plans have co-insurance and cost share.

- 2) Why do co-pays go down as usage increases?
 - (a) This is a distribution of the average co-pay for people that used the number of services in the first column. It's not that co-pays are going down, it could be that the patient hits an out-of-pocket limit and then their share is zero. This is average out-of-pocket spending depending on how many visits were used for each row in the table.
- C) There will be additional edits made to the report, specifically around barriers which is explicitly outlined in the legislation.
- D) Senator Larry Crowder, HB15-1083 bill sponsor: There seems to be a discrepancy between rural and urban Colorado. In urban areas we seem to use physical therapy for home therapy. A lot of times we do believe the co-pay for physical therapy is a barrier. For example, Homelake nursing home, their therapy is on an ongoing basis. There is a barrier in rural Colorado for therapy and once they cannot afford it they turn back to Medicare or Medicaid. This issue is what brought it about for me originally. I appreciate the data on this and think this is an issue that can be more equalized.
 - 1) Point well taken between rural and urban areas, this leads to question for Steve on the difference between the number of providers available in rural areas opposed to in more urban areas. Does the different health care workforce in play have an impact in terms of how you structure the issue of co-pays in this regard?
 - (a) It's really differences between urban, rural and frontier areas and access to types of providers than can provide these services and how access changes utilization rates and if this should change benefit design and co-pays. Perhaps this is a question more applicable to payers.

IV) Review of Workforce Recommendations

(Copy of [draft recommendations](#) available on Commission website)

- A) There were suggestions made to the workforce recommendations following the last meeting. Are there other thoughts from Commissioners to include in these recommendations?
 - 1) On the third bullet, would like clarification on GME and also have concerns on the phrasing of the sub-bullet. (Jeff Cain to provide specific suggestions in writing to Lorez).
 - 2) The preface in the background about health care spending in different regions causes some heartburn. Need to provide more clarity in this area.
 - 3) Pharmaceutical transparency should be included in recommendations instead of in the background section.

V) Updates – Bill Lindsay, Chair

- A) The Commission's November report to the General Assembly is due on the 16th. Commissioners are encouraged to send their comments on the draft report to Lorez as soon as possible. The edits should also include comments on why you are making suggested changes to the document.
- B) The Commission recently secured \$75K in funding from Colorado Health Foundation. The Planning Committee is now looking into a second round of funding and putting in place a strategy to acquire additional funds.
- C) Discussion on what to include in the recommendations of the Commission's final report (separate from the report due this November):
 - 1) How to think about recommendations: Tradeoffs in evaluation and alternatives to consider, need to consider what the recommendations do to cost, what they cost to implement, and any unintended consequences of regulation. There are pros and cons to everything which all need to be carefully evaluated.

VI) Public Comment:

- A) Tim Bergman, Colorado Multiple Sclerosis Society: Mr. Bergman presented written comment on prescription drug affordability which was submitted on behalf of board members with MS. Consumers are paying increasing out-of-pocket costs for drugs. Under current plan designs there are an increasing number of tiers (levels of coverage) and/or addition of coinsurance (paying a percentage versus flat copayment) causing specialty drugs in particular to be prohibitively expensive. This is particularly problematic for chronic conditions, such as Multiple Sclerosis. (See [public input](#) section of Commission website for full submission)
- 1) Commission questions and discussion with Mr. Bergman:
 - (a) Limiting out-of-pocket helps the consumer in the short term but doesn't necessarily help in the long term with other aspects of spending. This doesn't necessarily reconcile the bigger problems we have to fix.
 - (i) We are aware of that but this is the most efficient way to address the issue at this time.
 - (b) Is there any data on value based design?
 - (i) There are some studies on that, but not on MS drugs specifically. There have been studies done with prior authorization as well as health insurance appeals and trying to avoid those.
 - (c) Concern is that if genesis of problem is the cost of drugs to begin with and the first is the cost of the drug itself. If you shift the cost to the general insurance market it exacerbates the problem. I would put this to the larger problem and not just MS specifically. It takes a more global approach and I'd welcome the partnership between consumers, the business community and general consumer population. You can't just shift prices and not have a conversation on the genesis of the problem and where pharma comes in with the general pricing of the drugs.
 - (d) This issue is becoming increasingly important to talk about; is there an ability to make a statement about the importance of this issue in our upcoming report?
 - (i) Sensitive that we haven't even actually discussed this and don't want to make a statement in writing that is publically irresponsible. Even though this is a critical issue, we should pace ourselves.
 - (ii) We do need to have respect with what we put in writing. It might be relevant to say that down the road this is a major issue and it requires time to come up with a thoughtful approach. Not try to solve or give an opinion at this point, but say it requires a lot of focused time and need more than a few meetings on pharmaceutical spending.
 - (iii) The report ends with next steps and this may be an important topic to include in that section recognizing there are critical issues to address that require a lot of time.
 - Another issue to include is on drug shortages that are currently happening in capital intensive drugs.