

# DRAFT COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

## Meeting Minutes 3-14-2016 COPIC, Mile High Room

**Commissioners Present:** Bill Lindsay, Elisabeth Arenales, John Bartholomew, Sue Birch, Alicia Caldwell, Jeffrey Cain, Steve ErkenBrack, Ira Gorman, Dorothy Perry, Marguerite Salazar, Cindy Sovine-Miller, Christopher Tholen, Jay Want, Larry Wolk

**By phone:** Rebecca Cordes, Linda Gorman

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### Meeting Minutes:

#### I) Approval of the Minutes

- A) Cindy Sovine-Miller provided a motion for approval of the February 8<sup>th</sup> meeting minutes which was seconded by Dorothy Perry.
- B) Ira Gorman provided a correction on page 4 under the Physical Therapy Rehabilitation presentation to change the presenter's name to "Dr. Cameron McDonald."
- C) With this addition, the February 8<sup>th</sup> Minutes were approved unanimously.

#### II) Bylaws revision and election of officers

- A) Eight voting members of the Commission were present to vote on the revision to the Bylaws.
  - 1) The proposed revision changes the definition of "presence" for Commissioners to vote for officers.
- B) Elisabeth made a motion to amend the Bylaws to continue to require 12 Commissioners to vote on selection of chairs, but change the revision so that those who are absent can vote by ballot and everyone does not need to be present in the room during the vote.
  - 1) The motion was approved unanimously.
- C) Jeff Cain provided a motion to vote on Bill Lindsay as the Chair of the Commission which was seconded by Jay Want.
  - 1) The vote was approved unanimously.
- D) Steve ErkenBrack provided a motion to vote on Cindy Sovine-Miller as the Vice-Chair of the Commission which was seconded by Elisabeth Arenales.
  - 1) The vote was approved unanimously.

#### III) Transparency recommendations and parking lot discussion – CHI

- A) CHI provided a presentation on Transparency recommendation areas to the Commission. The [presentation](#) can be found on the Commission website. The proposed recommendation areas came from ideas that have been presented to the Commission over the last year. Commissioners voted on which proposed recommendation areas they would like CHI to develop more in depth recommendations to be included in their final report.
- B) Discussion on proposed recommendations:
  - 1) Disclosure of fees/taxes on providers
    - (a) Need to make sure measurements are clinically relevant
    - (b) There are measurable metrics around patient safety which is critical to include
  - 2) Increase ability to provide Explanation of Benefits (Medicaid)
  - 3) Create advisory committee on transparency
  - 4) Reference Pricing

- (a) Is there data on pricing compared to quality & outcomes?
- (b) The Commission shouldn't give impression we are trying to price everyone out of the market
- 5) Shared decision making
- 6) Provider reports
- 7) Consumer quality tools
  - (a) People need access to information when they are shopping for insurance, not just after they have purchased a plan.
- 8) Banning Most Favored Nation Clauses
  - (a) This is allowed but uncertain how prevalent the use is in Colorado. Historically this is used in states with a dominant payer.
- 9) Employer transparency tools
- C) Discussion:
  - 1) Need to be careful when we write our report to make it clear we are drawing some conclusions from older data. We also need to comment on how the markets have changed and the influence this might have and reflect certain observations related to this.
    - (a) Consumers are also savvier now and we need to be cognizant of this in our findings.
  - 2) CHI will take a deeper dive into the chosen recommendation areas and create more specific recommendations based on the Commission's vote.
- D) Recommendation leaders after voting:
  - 1) Consumer quality tools
  - 2) Shared decision making
  - 3) Provider reports
- E) Public Comment:
  - 1) Cliff Croan, Enigma Systems: It is possible that technology is usable to rate providers. It's simple to rate or rank a provider by their performance on condition. It's not a bad way to incentivize to pay folks by performance.

#### **IV) Social Determinants presentation – Dorothy Perry**

- A) Commissioner Dorothy Perry provided a presentation on Social Determinants of Health. The [presentation](#) can be found on the Commission website.
- B) Commission discussion:
  - 1) Appreciate seeing early childhood investments included in the conversation. Would like to ask the Children's Campaign at our next meeting about what they see with specific interventions.
  - 2) Are there specific things we can do to support early intervention on the mental health front, or align with specific efforts going on around Colorado already?
  - 3) Are there interventions or recommendations we can be looking at around diabetes? CDPHE has done a lot of work in this area.
    - (a) It is a big topic with a lot of places to intervene. Caution there is that there is only so much a group like the Commission can do in this area.
  - 4) Would like to keep the focus on why health care costs are going up.
  - 5) SIM is foundational on trauma informed care, there are effective strategies going on in Colorado to base build social determinants of health. Need to focus on programs that are evidence based and show significant returns on investment to the state.
  - 6) The Commission is focused on cost of health care and can't boil the ocean – might be beneficial to think about how this relates to the desire for the state to develop more jobs in higher paying industries and how it relates to specific educational challenges in the state. When people talk about economic development they need to be reminded it also has an impact on health care and

- health. There are already activities underway to improve the workforce and we can remind people there is also this health care piece to the workforce discussions.
- 7) The Commission should highlight the effective strategies that are proven across the country for policymakers to consider; build something for people to look to as a reference point of what we ought to do in health care.
  - 8) Toxic stress and early childhood has a lot of impacts but with early intervention we can improve outcomes. There is a lot of data we can point to in this area.
  - 9) Thinking should be how we can incorporate someone or an entity to help us address social determinants of health.
  - 10) Agree that specifics are hard to do. It is important to address as we look at the future of our health care costs. This all needs to be included in our report.
  - 11) There are two sides: payment and who will pay for the costs of this, as well as the provider side and how we need to change the practices and behavior of providers – part of a clinical exam to look at social determinants.
  - 12) We need to emphasize that there are tradeoffs and how much we are already spending on these types of programs.
- C) Public Comment:
- 1) Cliff Croan: This is wonderful to think about recreating the world, but that's not what you're supposed to be doing. Should think about who the performers are and feed those. This is about affordable care and how to have the right amount of money. Look at symptom reductions and see who is performing well. Important thing is not the philosophy but how can figure out where our money is going and where it is best spent.

**V) Bridges to Care Hotspotting presentation – Heather Logan, MCPN, Dr. Christine McLemore, MCPN and Dr. Jenifer Wiler, University Hospital**

- A) Heather Logan, Dr. Jennifer Wiler and Dr. Christine McLemore provided a presentation on Metro Community Provider Network's hotspotting program, Bridges to Care. The [presentation](#) can be found on the Commission's website.
- B) Commission discussion:
  - 1) The social care work part of Bridges to Care is currently not reimbursable but hoping to show the cost savings through this pilot program that may eventually become a payer model. The program is currently only sustainable through grant funding and will not be sustainable moving forward. It is a potential best practice for an alternative payer model.
  - 2) The Commission needs help translating what works in grants to what works in policy –what would Bridges to Care recommend?
    - (a) We need to stop paying just for medical visits, fee for service is not the answer. Need to find a way to reimburse other services – navigators, social workers, etc. Bundling might be another way to look at paying for these services.
    - (b) Mental health component is critically important. Substance abuse is a challenge and there is a lack of addiction specialists in the state.
  - 3) Are you going to take risks on this with such a high return on investment?
    - (a) Our CEO wants to do a no-risk model right now then move to more risk after a few years of the program being implemented.
  - 4) What is the ratio of patients to a care coordinator?
    - (a) 25:1
  - 5) Can this work in rural areas as we think about policy options?
    - (a) It has been shown to work in more rural areas like Allentown, PA. Also looking at doing this program from a telehealth perspective.

- 6) Can you make this work or aware of examples in areas without a large population center in a rural community or resort community with provider shortages?
  - (a) We are brainstorming about this and think everyone can do “facetime” to address needs. Telemedicine might offer some of these answers. There is a small pilot out of Lincoln, NE looking at what can be done with technology to make an impact.
- 7) Are all payer sources engaged in this from the consumer perspective?
  - (a) We have a number of patients that are dual eligible and patients with commercial insurance; not just indigent and Medicaid patients.
- 8) When is the report on your findings going to be complete?
  - (a) Hoping to have the research out this fall, but may be a little further out.
- 9) Are there incentives or disincentives in your program for patients?
  - (a) A lot of times the incentive is that the patients don’t want to be in the ED, they are looking for a change but it hasn’t been provided to them. We try to identify what is important to the patient – seeing a grandchild grow up, walking to their apartment on the 3<sup>rd</sup> floor, etc.
- 10) Is this program replicable? How much have you thought about the future of this side of the model?
  - (a) We are investigating funding for peer to peer mentoring.

#### **VI) Primary Care update – Jeff Cain**

- A) Commissioner Dr. Jeff Cain provided a presentation on primary care to the Commission. The [presentation](#) can be found on the Commission website.
- B) Commission discussion:
  - 1) Is there a specific set of recommendations you would suggest?
    - (a) I would suggest the Commission should look at payment reforms moving towards value based payments, ACMH type payments.
  - 2) Important to keep in mind that results vary by systems, not convinced that fee for service is dead. Need to make it possible for people to do things differently.

#### **VII) Public Comment**

- A) Dan Gibbs, Summit Co. Commissioner: Prices are not getting cheaper in the high country. We are continuing to work with other counties on the western slope to try to explore possibilities to decrease premiums, look at total cost of health care in mountain communities and what we can do to decrease health care costs. Working with providers and insurance companies. We have run into situations with Most Favored Nations Clauses in the high country. We are introducing [HB16-1336](#) that will have its first hearing next Wednesday; it is endorsed by CCI, CML and Colorado Association of Ski Towns. The bill directs the Commissioner of Insurance to investigate the impacts and viability of creating a single geographic rating area, consisting of the entire state for purposes of determining premium rates for individual health benefit plans. It is a study bill that the entire state of Colorado can benefit from. We ask the Commission to act with urgency on issues you have consensus on now and would ask the Commission, or participants around the table, to consider supporting this bill.
  - 1) The Department of Insurance supports this bill and thinks it is important to get new data out. We are looking forward to having the bill pass and will bring the study back to the Commission when it is complete.
  - 2) The Commission didn’t think Most Favored Nation Clauses were an issue in Colorado, but it sounds like it might be an issue for us to look at if it is happening and effecting mountain communities.

#### **VIII) Updates and business – Bill Lindsay/Commissioners**

- A) Supreme Court ruling on *Gobeille v. Liberty Mutual Insurance Company*
  - 1) There was a recent Supreme Court ruling that All Payer Claims Databases (APCDs) cannot force ERISA plans to submit information to these databases.
    - (a) The argument was that this could not happen on a state-by-state basis with a patchwork of rules for various payers, but there is still an opportunity for Congress to set rules on reporting.
  - 2) This will make implementation harder to accomplish, it will be a matter of time to see which employers still decide to participate.
- B) Statewide meetings
  - 1) The Commission is revisiting the statewide meetings and have begun to lay out dates for the potential meetings. These meetings will be in addition to the monthly Commission meetings; they are for listening and feedback from communities across the state.
  - 2) [Potential dates](#) and locations have been provided to the Commissioners who should respond with their availability for the proposed meetings.
- C) Other updates:
  - 1) The Commission's budget request was included by JBC in the long bill. The request is for \$250K, which was not the full amount requested. The Commission hopes to augment the rest of the budget from other funding sources.
    - (a) \$250K could finance the Commissioner through May or June of 2017 if we follow our current path and could only do statewide meetings once on a shoestring budget.
  - 2) Rep. Ginal's Pharmacy transparency bill – which was presented to the Commission - has died.
  - 3) Commissioners should think about CICP dollars that are not currently being spent and the possibility to put forth a request for HCPF to use those dollars on a study about health care costs in rural areas.