COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Minutes
4-11-2016
COPIC, Mile High Room

Commissioners Present: Elisabeth Arenales, John Bartholomew, Jeffrey Cain, Rebecca Cordes, Steve ErkenBrack, Linda Gorman (phone), Bill Lindsay, Dorothy Perry (phone), Cindy Sovine-Miller (phone), Marcy Morrison, Christopher Tholen, Marguerite Salazar, Jay Want, Larry Wolk, Alicia Caldwell

---

Meeting Minutes:

I) Approval of the Minutes

A) Chris Tholen opened the meeting and requested approval of the March 14th Commission meeting minutes.
   1) Elisabeth offered a correction to section II, on page 1, of the minutes. The motion was reword.

B) Rebecca provided motion to approve the March 14th minutes; Marcy seconded the motion.
   1) The minutes from March 14th were approved without objection.

II) Social Determinants Presentations

A) Supporting Local Public Health, Dr. Larry Wolk, CDPHE

1) Dr. Larry Wolk, Executive Director of the Colorado Department of Public Health and Environment (CDPHE) and Commission member, provided a presentation on Public Health in the context of the Affordable Care Act (ACA). The presentation can be found on the Commission website.
2) Commission Discussion:
   (a) Traditionally commercial payers have not funded prevention services because there is a lack of long term benefits. This seems like describing a model where the health department would become another provider. How does this differ from becoming another provider and competing with providers?
      (i) It depends on the community, CDPHE is not creating something that's not already in existence. Use North East Colorado as example where there is already a lack of providers. Why isn't there a role to be complementary to the system? Mesa County is another example where it works well and the health department is not viewed as a competitor.
   (b) Why you couldn't the health department be a provider?
      (i) Many Local Public Health Agencies (LPHAs) do serve as providers, but don't forget one local public health agency is just one local public health agency. Denver Health is very different than Huerfano or Las Animas County.
   (c) Multiple federal funding streams are tied to specific pools of money, curious as to whether or not this approach is able to bridge that? If not, what kinds of recommendations need to be made to help LPHAs?
      (i) ACA has helped; even the state public health agency is thinking more globally. Everything has to do with preparedness and to have an infrastructure that prepares us regardless of the emergency situation. There is still a culture that is hard to change but it is shifting.

(d) It seems we need to focus at the 10,000 foot level; the core function of public health looking at large scale population based interventions. If you have specific recommendations for the Commission, that would be very useful.
    (i) We have been trying to get actuarial analysis for different tiers and what it could look like as a way to think about the public health entity in a managed care context.
(e) How do you envision handling liability?
    (i) That is a good question. It defers to whatever existing liability structure is in place. It probably defers to public system rather than seeking private insurance.
    (ii) This also speaks to a concern among providers about who is providing services.
(f) Primary care is difficult to access in rural areas and there probably is room for public health to be a part of primary care screenings like 9Health Fairs, etc. We need to figure out ways to engage carriers to pay for these things and how to recreate and reinvent things.
(g) If you have different public health entities with their own capacity and interests, how would unifying those help? Wouldn't it be effective to just promote them each instead of dealing with one entity?
    (i) The point of creating the tiers was that it would make it easier for a health plan to evaluate so you can get some sort of unification in appealing to the language that health plans speak - communication and ease of contracting.
(h) This is an exciting topic the Commission needs to talk more about flushing out what a recommendation would look like.
    (i) Similar question – when you think about takeaways – are these intended to be recommendations for the Commission to consider in our report?
        - They could be recommendations but out of respect for CALPHO, CDPHE wouldn't want to speak on their behalf and this is something they have been working on and are interested in. The next step would be to get deeper dive from LPHAs as well as support for actuarial work to understand costs and benefits to see if this might have value.
(i) How do school based health centers fit into this model?
    (i) They are very similar, although LPHAs are much broader and have a deeper community based role than a school based health center. Many of the school based health centers are sponsored by their LPHA.
(j) What do we think are the chances the plans might pay for a public health intervention if there were data showing there was a connection between interventions and lower disease rates like asthma?
    (i) Plans are very formulaic and there needs to be a way to make these interventions fit within their formulas. At the end of the day, rates are based on actuarial projections and more significantly they look at the populations the plan is working within. It is a locally driven approach that gets harder as you move into larger population areas.

B) Early Childhood, Colorado Children's Campaign, Bill Jaeger and Erin Miller

1) Bill Jaeger and Erin Miller from Colorado Children's Campaign provided a presentation on the benefits of investing in children from a young age. The presentation from the Campaign can be found on the Commission website.
2) Commission discussion:
    (a) A part of the purpose in covering all women for prenatal care, no matter their insurance status, is because the care of babies in NICUs costs hundreds of thousands of dollars. More importantly is that it is important to be covered period, continuous coverage lowers costs over time.

(b) Are there issues with funding or convenience when we talk about low vaccination rates and numbers of people enrolling in insurance?
    (i) It depends on what topic we are talking about. For vaccination rates it seems to be out of convenience but for insurance it is for a number of different reasons.
(c) The programs presented are well established in terms of research, where we struggle as a society is that the funding source typically comes through some governmental program, to try to ask private insurers to fund these programs is probably not likely. Who benefits from the Returns on Investment (ROI)?
    (i) It gets back to that ultimately one strategy is to grow healthier Coloradans, if we have fewer adults experiencing chronic disease there are benefits to that. Early Childhood has been emerging as something from a public health initiative and how to mitigate adverse childhood experiences through multiple strategies.
(d) The financing data presented is compelling, but the structural financial problem is that the people making the investments are not the ones receiving the return. Health plans need to break even to make a profit but projections don't fit that criteria. What do you think is the proper financing mechanism?
    (i) It varies by recommendation. Some require greater public investments, some may come from private insurers.
(e) The ROIs presented are not just for health care, are there any specific ROIs provided to reducing health care expenditures?
    (i) The Campaign can follow-up with data that clarifies where the returns are seen.
(f) Might be a good follow-up to this conversation for the Commission to have a presentation on Social Impact Bonds.
(g) This presentation falls into a category where we all agree these things add to the value of health care and cutting down costs but we need to find an area where we can raise consciousness and understanding to say we really need to pay attention to this issue.

III) Rural Communities Discussion, Steve ErkenBrack and Commissioners

A) During the Commission's February 8th meeting, Commissioners were given a presentation on hospital rate setting in Maryland; this discussion is a follow-up to that presentation to look at the possible benefits of a similar concept in rural Colorado. The Planning Committee suggested there should be a discussion about this idea to see if there could be a recommendation from this framework. It was suggested the Commission needs to focus on issues within rural Colorado that are unique to rural Colorado. When the Commission talks about rural Colorado they are referring to places from the eastern plains, to the central mountains, western slope and all over the state.

B) Commission discussion:
    1) Believe that doing some kind of analysis around this topic would be helpful. Overall the state is doing well on hospital costs, but we don't have specific analysis on what is going on in resort and rural communities. The payer mix is also a specific problem in these communities which is very true in the eastern plains where there is a higher percentage of Medicaid patients. Does it make sense for Commission to dig into this, get more data and educate ourselves to better inform on the nature of the problem?
    2) The Commission does need to try to figure out what to do with respect to mountain communities, however, we are focusing entirely on rural Colorado and there are folks in urban areas that also have issues that will be compounded with the way the market is moving. We need to talk about how this plays out since the majority of the population is on the Front Range and will have problems as well.

(a) Working in both urban and rural areas, the solution and processes don't always match. Sometimes we need different procedures from one area to another.

3) Would the Commission hire someone to help look at data? This will be a very complex undertaking to come up with a well-researched recommendation.
4) Maryland has had a rate setting structure for 40 years and moved into new phase built on what they had been doing; the platform in Maryland made it possible for them to move to what they have today. There are many details to look at.
5) It would be hard to compare the health market from 2009 to today; today everyone can get health insurance even if they're sick whereas in 2009 it was only healthy people who had insurance.
6) We need to better understand how much difference is okay between the various geographical health care areas because there are differences that we need to take into account like the cost of living.
7) This topic weaves together all the different topic areas the Commission has looked at and may cost a lot to fund. The Commission should at least look at this topic to turn the General Assembly's attention to these topics. This can go hand-in-hand with the study underway at the Department of Insurance (DOI) which should be completed in August.

C) Straw poll vote: Are commissioners supportive of a study to look initially at rural health care costs - what is driving those costs - and focusing on rural areas of the state areas (using the federal definition of rural and frontier/DOI rating area)?

1) Discussion:
   (a) If the Commission proceeds with looking at rural areas, need to frame question in a way we all agree.
   (b) The Commission should start with a manageable geographic area because of the lack of overlap - start specific and then move to general.
   (c) This would be a great topic to discuss as the Commission holds meetings throughout the state. Any information the Commission has at that point can be shared to help people understand what might be pushing their premiums. The Commission could also get feedback from stakeholders on this topic.
   (d) We know DOI has all this data, why isn't it published already in an accessible form? There should be some detailed listing beyond what the Colorado Consumer Health Initiative has done.
      (i) The data is filed and public. There is a difference between health care costs and insurance premiums, which is what DOI is collecting from the plans.
2) Vote: The majority of Commissioners were in favor of the straw poll and indicated this is a direction to explore.

D) Possibility to fund the study with $100K from HCPF through CICP funds.

1) The funds for the study come from a hospital analytics bucket at HCPF. The idea is that CICP has changed and population has decreased; how it was previously funding is outdated and there may be an opportunity now to look at how we finance this program. There are some constraints because CICP is a reimbursement program only for hospitals which would create guardrails to the outcomes that can come from this study. The money expires June 30th for the 2015/16 FY and must be allocated by that time.
2) Why is it better for the Cost Commission to do this rather than HCPF send this off on their own?
   (a) What attracted HCPF was the diverse people around the Commission table to give input into the money spent.
3) Would the Commission need to go through state contracting process?

(a) No

E) Public Comment
   1) George Swan, retired hospital administrator: On All Payer System and study of hospitals, haven't heard any mention of Medicare cost reports. California has used pivot tables to look at all the data around hospital cost reports and it is very amazing – great, simple resource to look at data developed over the last 30 years. You shouldn't neglect that. Its interesting Colorado is 8th on cost care, obviously there are some interesting disparities to look at. The LPHA view of a county is interesting place to start with county health rankings. Another great pivot table is the BRSS which has a beautiful system about life course. Should use data in context with cost reports.
   2) Dan Gibbs, Summit County Commissioner: Update on HB15-1336, the bill directs DOI to study 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. The bill passed out of house last week 54-11. Six different western slope commissioners, Club 20, CCI, CML, Chronic Care Collaborative, etc. were all very supportive. The bill was modified with an amendment to add specificity. Very supportive of you examining rural areas, and want to encourage you not to just look at different MSAs in the state. There could be a county with federal definition of rural but might be listed in a Denver MSA region; Clear Creek County is one example of this. The bill will be in the Senate this week and I encourage the Commission to support the bill. It's not just rural areas experiencing challenges, this is why CCI and CML are broadly supportive of the bill. More analysis to figure out true cost drivers is a real positive.
   3) Amy Downs, CHI: Very interesting discussion looking at cost drivers in rural areas. Commissioner Salazar did do a study on this a few years back. Should look at this study and make sure what the Commission does is not duplicative as there are some interesting findings from the study.

F) Action Item:
   1) Should the Commission make a formal ask of HCPF to fund a study up to $100K to look at health care cost drivers in rural areas?
      (a) The motion was approved by voting Commissioners 9-1.

IV) Topic Recommendations, CHI and Commissioners

A) CHI provided a presentation on potential Payment and Delivery Reform recommendations for the Commission to take a deeper dive into. The Payment and Delivery Reform options included:
   1) Bundled Payments
   2) Blended and Braided Funding
   3) Rate-Setting and Global Budgets
   4) Value-Based Insurance Design (VBID)

B) Commission discussion:
   1) With respect to VBID are they having a positive effect on health plans?
      (a) Unaware if anything has shown impact or having a lot of positive results.
   2) There has been a lot of work in Colorado around value based benefit design, wondering where that is and what the benefit has been?
      (a) The challenge was there were not enough lives in the study to show statistical change; it looked more at key takeaways and how to make the program better next time. The next pilot will be in Grand Junction.
   3) We don't want to limit ourselves to just PERA and want to look at things aside from state based systems.

C) The Commission did a straw poll on Payment and Delivery Reform recommendations for CHI to further study and develop:

1) The results of the poll were not provided during the meeting. CHI and Keystone will report back with the tally after gathering votes from Dorothy and Cindy who were participating on the phone.

V) Statewide Meetings

A) A list of dates and locations for the statewide meetings have been sent to Commissioners which will occur in May and June. Keystone will be working with Commissioners on finding meeting locations in the various areas.

VI) Planning Group Update, Bill Lindsay

A) Chris Tholen provided a financial update to the Commission. The Commission's cash fund shows there is almost $47K left in the budget. The JBC has approved an additional $178K for the Commission. In total the Commission will have approximately $225K. This funding will bring the Commission to the end of March 2017.