

COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Minutes 6-13-2016 COPIC, Founders Room

Commissioners

Present: Commission members: Bill Lindsay (chair), Elizabeth Arenales, Jeffrey Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Dorothy Perry, Cindy Sovine-Miller, Christopher Tholen, Susan Birch, Marguerite Salazar, Jay Want, Larry Wolk

By Phone: Marcy Morrison

Meeting Minutes

I) Approval of the Minutes

- A) The Commission meeting minutes from May 9th, 2016, were approved with one abstention due to a Commissioner's absence from the meeting.

II) Bundled Payment, Peter Hussey & Christine Buttorff, RAND

- A) Christine Buttorff and Peter Hussey with RAND, a non-profit non-partisan organization, presented research on bundled payments. The presentation compared retrospective with prospective pricing and included case studies of bundled pricing. The [presentation](#) can be found on the Commission website.
- B) Commission questions/discussion during the presentation:
- 1) Why did finding consensus in the IHA demonstration take longer than expected?
 - (a) It took longer to define what an episode meant, including what was in and out. Payments were also more difficult than expected.
 - 2) How consistent are the definitions of episodes?
 - (a) At the time of the study, there was no standard. At this point, there are various definitions available with disagreement about what should be actionable versus excluded.
 - 3) With such variability, is it possible to know the impact of bundled payments on quality?
 - (a) The programs are not similar enough to be compared between, and RAND did not see many clinically meaningful differences within the studies.
 - 4) How are physicians motivated to implement this system without a sufficient incentive?
 - (a) There are a number of arrangements between hospitals and physicians. In Medicare, there is gains sharing between the two.
 - (b) Health plans were not as quick as the hospitals to identify a need for change.
 - 5) Did the experience of bundled payments matter for the patient?
 - (a) RAND did not go directly to the patients, as there were so few enrolled, but the providers think the process was essentially invisible to them. The real value to the patient was the ability to be transparent up front on pricing.
 - 6) Historically, disenrollment from Medicare Advantage has been driven by joint replacement. The Comprehensive Care for Joint Replacement program is a cut in payments. How will this study track the patient experience in this case?
 - (a) This trend would be captured by changes in patient satisfaction over time.
 - 7) How does the provider benefit from this savings?

- (a) CMS (Centers for Medicare and Medicaid Services) would say that this system would result in adequate hospitals, physicians, and post-acute care providers to reduce readmission. For the provider, this model loosens regulation, including access to gain share, potentially yielding greater revenues than fee-for-service.
- 8) This budget slide shows a change from baseline increase, not from absolute, so it is unlikely to generate a net decrease in cost, just a leveling off of the increase.
- 9) Actuarial projections show that the current rate of increase is not sustainable. Therefore, this decrease in increase rate is required to maintain the program. The category of joint replacement seemed to have a large amount of variation not matched by a corresponding variation in diagnosis and therefore represented low-hanging fruit for this kind of reform.
- 10) Hospitals could benefit from this program by taking a closer look at where they discharge patients.
- 11) Do the PAPs (Principle Accountable Providers) bear the risk of an episode of care?
 - (a) They are partially but not fully at risk. It is an open question what parts of the episode are entirely under their control.
- 12) Complexity can stifle implementation, but are there positive results coming out of well-considered programs?
 - (a) There is a definite need to focus effort on the few core things that need to be decided, the main body of considerations. There is also a long tail of other considerations that add complexity without generating a return in program success.
- 13) Are bundled payments going to stick around?
 - (a) Some aspects of these programs could take off, especially if Medicare is serious about continuing it.
- C) Commission discussion after the presentation:
 - 1) The data seems slim to justify a recommendation from this body.
 - 2) If the Commission does agree to recommend some version of this, it should have more focus on patient satisfaction metrics, which seem absent here.
 - 3) This presentation is accurate in a number of ways. The administrative complexity is substantial, and it will be difficult to see results in patient outcomes over time.
 - 4) The variation in post-acute care can be large for certain services. It would be best to start applying this method to those services that vary the most.
 - 5) Does it make sense for Colorado to do this? Should we wait for CMS data?
 - 6) Providers are very good at resisting change. The uptake needs to be mandatory and broad-scale.
 - 7) Any recommendation the Commission makes needs to take into account the negative effects of waiting lists. In some countries, waiting list morbidity is a huge issue.

III) Topic Recommendations, Commissioners and CHI

- A) Mara Baer presented a one-pager that offers two recommendations based on the most cost effective procedures for bundled payments, which include hip and knee replacements, back surgery, and congestive heart failure. One recommends a pilot of bundled payments for state employees. A second recommends continuing the existing hip and knee replacement bundled payments for pre-Medicare state retirees, adding the other two procedures as a pilot. Both recommendations would be voluntary for providers and enrollees. The [one-pager](#) can be found on the Commission website.
- B) Commission questions/discussion:
 - 1) Have there been any definite opinions on the program from Colorado employees?
 - (a) Those running the program at the state level are excited, but there has not been data collection on patient satisfaction.

- 2) This kind of program is going to happen somewhere in the U.S. The question is where it happens first. It might be better to have Colorado be an importer of these procedures than an exporter of them.
 - (a) The status quo is not working. As a carrier, I would prefer not to send patients out of state.
 - (b) There are other reasons, for example facility reputation, for patients to seek treatment out of state.
 - 3) Even though this is starting in the private sector, it would be a misrepresentation to say this is a groundswell. It might best be recommended as another pilot, complete with quantitative analysis to objectively evaluate it.
 - 4) Why would a provider voluntarily enter into this program? Rural hospitals especially will struggle with the added administrative burden.
 - (a) This approach would expand on what Colorado PERA is already doing. To recommend another pilot may not seem worthwhile.
 - 5) The average price of joint replacements in the pilot have been halved according to the CHI one-pager.
 - 6) In addition to adding patient satisfaction, the recommendation should include existing definitions of episodes to retain the work that went into defining them.
- C) Commissioners engaged in a straw poll for adding the recommendations to the list under consideration with the clarification of episodes, the addition of patient experience, and additional clarification on the structure of a pilot.
- 1) Nine commissioners voted in the affirmative.
 - 2) One commissioner added that it would be helpful to use the bundle definitions from other pilots where it is possible.
- D) Mara Baer presented a CHI analysis of prescription drug costs. National spending increased greatly in 2014, gradually decreasing in the slope of increase but still increasing at a higher rate than previously. Spending in Colorado in 2013 equaled 354% of 1991 totals. Specialty drugs are a high percentage of total spending, with 2% of patients incurring nearly half of all costs. Recommendations include establishing cost share limits, increasing transparency requirements, and establishing price controls. The [one-pager](#) can be found on the Commission website.
- E) Commissioner questions/discussion:
- 1) Depending on how an insurance company structures its out-of-pocket payments, it could be seen as discriminatory due to demographically specific needs for high cost drugs (e.g. HIV treatments). Transparency seems like the first step in designing a response to this problem.
 - 2) In certain settings populations have access to special pricing through the 340B program, which makes certain drugs more affordable.
 - (a) A recent paper by Dugan points to the program as a cost shift to the private sector.
 - (b) This group might benefit from a deeper dive on both 340B and military pricing.
 - 3) A lot of attention is being spent on multi-State bulk pricing to mitigate costs.
 - (a) This approach would not have much effect on the cost of specialty drugs.
 - 4) Some public education, for example recommending that patients request alternatives to prescribed drugs, may be a useful recommendation.

IV) Total Cost of Care, CIVHC

- A) Jonathan Mathieu presented on the Total Cost of Care project, which has expanded to eleven states. Its aim is to provide the information necessary to shift from fee-for-service to risk-based or pay-for-performance methods. The project has found a large amount of variability in resource use and pricing across Colorado. The [presentation](#) can be found on the Commission website.
- B) Commissioner questions/discussion:

- 1) How does this data fit into the ACC (Accountable Care Collaborative) work?
 - (a) The potential synergy is exciting. It is important to make sure the data are aligned between the two efforts.
- 2) Does this information fit into a potential recommendation?
 - (a) Physicians want to treat patients equivalently but don't have the data to know how to improve. This project will give them the information they need.
- 3) The alignment of the work between the multiple payers seems important.
- 4) Cost needs to be balanced with quality.
- 5) A significant amount of variability will likely make providers look bad one year and good the next.
- 6) The program goals of "attributable, achievable, and useful" seem like good ones.
- 7) What can be generalized from Colorado to other states?
 - (a) The work scheduled for the second grant period will aim to standardize data enough to create a five-state benchmark, but we are not yet able to generate multi-state comparisons.

V) Rural Health Care Access and Affordability Update

- A) Commissioners discussed updates on health care access and affordability.
 - 1) The Commission has felt the need to explore the alternatives.
 - 2) Hospital payments include standby costs, among others. The question up for consideration is whether or not it would be good to separate out those costs to enable different payment options.
 - 3) Additionally, there is a unique challenge for rural hospitals of declining volumes over time. Some of the solutions investigated by the Commission seem too complex to help in this case. The big question is whether to artificially support these hospitals.
 - (a) It can be scary for residents for a local hospital to close.
 - (b) Inaction on this topic amounts to a choice.
 - (c) The State sets urban telephone rates to fund infrastructure in rural areas. A similar system could be set up, with clearly defined essential services funded by the State.

VI) Public Comment

- A) George Swan, retired hospital administrator – I have been doing claims database analysis for four years, and it is not a new concept to bundle things. We already bundle items to budget by department, paying attention to the doctors who order special services. The best practice model is to coordinate between doctors to identify best practices, aiming to generate improvement in the bottom 20% from the practices of the top 20%. Many of the major costs are in critical pathways. Most of the profit is in the first few days of patient care, which influences the "get them well, get them out" principle. More could be uncovered on this subject by looking at Medicare cost share boards – pivot tables I've seen available for California. This data is more useful than the studies we've been looking at today.

VII) General Updates

- A) Bill Lindsay reviewed several logistical updates for the Commission
 - 1) Upcoming state meetings are taking place in Grand Junction, Summit County, and Adams County
 - 2) In Grand Junction, the consortium will host a reception for Commission members, which will hopefully include more discussion about strategies being used locally.
 - (a) A reminder for this meeting will come from Keystone later this week.
 - 3) The Commission's enabling legislation requires advisory committees, due to the perceived need for subject matter experts to inform its decisions. Prior to the next meeting, an outline will be

released on what these committees might look like, with the basic structure of starting with one topic and gradually branching out from there.