

**DRAFT**  
**COLORADO COMMISSION ON AFFORDABLE HEALTH CARE**

**Meeting Minutes**  
**9-12-2016**  
**COPIC, Founders Room**

**Commissioner Members**

**Present:** Elisabeth Arsenales, John Bartholomew, Susan Birch, Jeffrey Cain, Alicia Caldwell, Rebecca Cordes, Ira Gorman, Linda Gorman, Bill Lindsay, Marguerite Salazar, Cindy Sovine-Miller, Christopher Tholen, Larry Wolk

**On the Phone:** Steve ErkenBrack, Dorothy Perry, Jay Want

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**Meeting Minutes**

**I) Approval of the Minutes**

- A) Chris Tholen motioned to approve the August meeting minutes. Elisabeth seconded the motion. The minutes were approved unanimously.

**II) Social Determinants**

- A) Bill introduced Cindy to provide an update on the smaller group meeting to discuss social determinants. The Committee had a preliminary discussion on prioritizing some of those issues.
- B) The Committee focused on the issues raised by the Children’s Campaign, but also raised other issues, including:
- 1) Universal child care
  - 2) Potential to use Medicaid funds for purposes of enhancing access to affordable housing for homeless, seniors, people with disabilities
  - 3) Intersection of criminal justice system and health care – utilizing health care earlier on for incarcerated individuals
  - 4) Housing and location in general – communities, neighborhoods, urban design, safety
  - 5) The Committee recommended discussing social determinants during the October meeting, particularly in the healthy living space. CALPHO may also eventually have some recommendations in this arena.
  - 6) Jeffrey noted that it can be useful to break down social determinants on short-, medium-, and long-term impacts.
  - 7) Linda suggested exploring how these efforts have worked (or not worked) in the past; without an examination of how efforts have failed in the past, it could be difficult to get taxpayer dollars for work on social determinants.
- C) Colorado Children’s Campaign, Erin Miller
- 1) Erin reviewed CCC’s recommendations to prevent and mitigate adverse childhood experiences (ACEs) for Colorado children, thereby reducing the long-term costs of chronic disease:
    - (a) Increase funding to allow the Nurse-Family Partnership and other evidence-based home visiting programs to serve, first, all familiar expecting their first child and living under 200% of the TPL and second, expand access to at-risk second-time parents.
      - (i) Questions and comments from the Commission:

- There is a large body of data on the first-time parent work. I agree that it should be expanded, but what kind of evidence is there for expanding beyond first-time mothers?
    - ◊ The emphasis is still on the first-time birth, but CCC does have some evidence on expanding to share with the Commission.
  - What are the barriers?
    - ◊ The main barrier right now is funding.
- (b) Expand access to screening and services for developmental and behavioral concerns, ACEs, and maternal depression
- (i) Questions and comments from the Commission:
- Can you help us understand what's getting in the way?
    - ◊ There's reimbursement rates to consider
    - ◊ There are divergent recommendations from the Preventative Task Force and AAP (examine if parent notices concern versus universal screening)
    - ◊ Colorado has really poor and deteriorating rates for screening and there is not a ton of evidence on what has led to that
  - I'm interested in toxic stress. You can really change the trajectory of a child by intervening with parents who were abused early on.
  - Kids who are behind in socio-emotional development have health problems down the line. We know ACEs contribute to those delays
  - You have a lot of access to data. Can we demonstrate a return on investment on those early interventions, or do we have info from other states that would help motivate that investment?
  - There is significant and innovative work being done in this area, but the answer is really in retooling the systems to get folks aligned.
  - Have you thought about what needs to happen with child services to prevent fears about children being taken away by child services?
    - ◊ The majority of the data comes from people who sought out the services voluntary. We already barely have the capacity to serve the families who seek out these services.
  - Do you have data about why screening for kids drops off so precipitously after age one?
    - ◊ No, but CCC can look into it.
  - When it comes to maternal depression, Colorado is really innovative in allowing women to get services through their child's Medicaid ID so that screening and treatment can happen in the child's provider office. Unfortunately, right now that screening is only allowed once a year, which does not always catch the issues. The U.S. Preventative Services Task Force just made the recommendation that this screening be universal. This is one of the few services where simply getting screened can actually reduce the rate of incidents.
- (c) Invest in programs to prevent unintended pregnancies, especially among teens.
- (i) Questions and comments from the Commission:
- Cory Gardner suggested making birth control an OTC drug.
  - Teenagers frequently say that birth control is widely available and that's not an issue.
    - ◊ But before the privately funded project, teens were on waitlists to access birth control.

- Other states also saw rates of unwanted teen pregnancy drop in the same time frame, some higher than Colorado.
    - ◊ But CO was still among the greatest decreases
- 2) Expand access to high quality child care and preschool.
    - (i) Questions and comments from the Commission:
      - Do you have data on the countries that provide extended paid parental leave? Any longitudinal evidence on the long-term impact on the child?
      - Hoping to have the statewide public health organization present to the Commission in October.

### III) Rural/Hospital Conversation

- A) Single Geographic Region Report, Commissioner Salazar and Michael Muldoon, DORA
  - 1) Focuses on cost differentials of the different areas.
  - 2) The study was performed by an outside organization, Lewis & Ellis.
  - 3) Used APCD data, which is mainly commercial.
  - 4) The nine rating areas including the seven MSAs and the non-MSAs in the west and east, which cover the large areas of smaller towns.
  - 5) Why is the Denver range for insurers so tight?
    - (a) These rating factors are the actual individual market.
  - 6) What is a rating factor?
    - (a) When insurers develop their rates, they are very limited by the ACA. Every insurer develops an index rate and then they can develop adjustments to it. Then they consider rating factors: age, geographic area rating factor, smoking factor, etc. Those are the very restrictive rating factors that are allowed to adjust any individual's rates.
      - (i) Most carriers don't even take the smoking rate into consideration because it's too hard to determine if those rates are accurate.
  - 7) These factors are for 2017, and they were based on 2015 calendar year data and other restrictions from CMS.
  - 8) Does morbidity show up in total spending?
    - (a) Yes
  - 9) It's clear that insurance does not necessarily reflect the cost of care provided.
  - 10) Has anyone compared these rates to the housing index or other things like that?
    - (a) Not yet, but that data is being gathered right now.
  - 11) Are there plans to include a breakdown of the demographics in certain areas?
    - (a) There is no county by county rating factor because some of the counties have such low populations that there is no credibility factor.
  - 12) The ultimate recommendation was not to make any changes.
  - 13) Additional questions and comments from Commissioners:
    - (a) It seems that if we looked at rating factors differently, we might be able to square the risk (put in bands).
      - (i) Right, we've looked at this. Do you move the countries around so that everyone has the same rating factor? The problem is that you really need to handle all the area factors and the rating factors.
    - (b) If rating factors get capped, then someone else (other regions) have to absorb the rates?
      - (i) This study is for a specific purpose and dedicated to insurance ratings. What we are supposed to get at is the cost, and why that cost differential is there.
    - (c) How much have you looked at how people migrate for care?
      - (i) We do look at that, but it's not a high amount.

- (d) When you look at the high level delivery on mental health delivery, the per person total is a lot higher for Region 9 than across all other regions.
  - (i) Agreed. It gives us a lot more questions to ask.
- B) CICP Report, John Bartholomew
  - 1) Actually started in the CO indigent care program back in 1999. Back then, it started as a reimbursement program.
  - 2) The program is \$100-115,000,000. It's not an insurance program; it's more of a reimbursement mechanism.
  - 3) The overarching takeaway is that we are really starting to get to some good questions.
  - 4) Some of the CICP takeaways for the Commission to consider:
    - (a) Increasing the FPL level in the CICP
    - (b) Lowering the copayments for hospital services
    - (c) Recruit more CICP eligible providers in areas of the state that may have gaps in care
  - 5) There could be thousands of folks who should have bought silver plans although they bought bronze plans.
  - 6) Overall, there's about a 6.4% uninsured rate; that's about 350,000 uninsured people.
  - 7) There are not great variations between costs for the bronze and silver plans, and in fact you usually save money in the long run (at certain FPL levels) if you get a slightly more expensive plan. This could be something to do a better job advertising.
  - 8) Most of the variation in regional cost is on the outpatient side. Acuity, cost difference at facility, other utilization that is not acuity based, and higher cost services.
  - 9) Alignment of public and private payers of health care is vital in order to advance delivery system transformation and improve population health for all Coloradoans.
  - 10) Questions and comments from the Commission:
    - (a) There are a number of states that have expanded Medicaid. What does the comparison look like with respect to rising costs of Medicare and Medicaid?
      - (i) When we focus on how much of compensated care went to Medicaid, we aren't looking at the whole picture. At the same time as that, utilization increased significantly. When you look at uncompensated reimbursement for hospital, and then account for Medicare/Medicaid offsets, you actually don't see huge differences. It's just being offset to different categories.
      - (ii) When we push on cost, they say that in those areas, they struggle with even being able to contract with those providers.
    - (b) I appreciate that utilization is an issue, but I don't think that's the end of the story. We really do see radically different charges. So for me, the question is what is the core differences across hospitals when it comes to all these fees? Is it true that we don't know how to compare across the hospitals nor across the states?
    - (c) The European observatories face the same things. None of these things have to do with costs. Europe set six vignettes of standard treatments and went and looked at all these countries. The charges differed by up to 400%. It's all administrative pricing, not cost in the economic sense. You can only really examine it when you look at cash payments, and you don't have all these cross reimbursements muddying things.
    - (d) We know that the costs can be different even among different hospitals in the same community when you account for acuity, etc.
  - 11) Can we have a conversation about having a deeper dive?
- C) Dan Gibbs, Summit County Commissioner:
  - 1) It's really important that when we are talking about the cost of services of health care, we are talking about the negotiated rates between the payers and the providers. Until we understand

why there are these differences between objectively the same care in two places, we are going to be swimming upstream. I encourage you to take a close look at the other areas where region 9 is much cheaper than other regions. For instance, newborn and delivery – why is that so much cheaper? Why is it that mental health services and office surgical visits are cheaper? Everything isn't more expensive in the mountains.

D) CMMI Opportunity

- 1) We were approached by CMS about doing a pilot. We have a follow up with CMS next week to talk about what other states are doing. There can be disproportionate reimbursement for similar sources just based on the payer source. If Medicare payed more per unit but capped the total costs, is that something that would have some merit? CMS is just considering the cost, not the demand.
- 2) Questions and comments from the Commission:
  - (a) As we continue in these conversations, we need to be mindful of the bandwidth we have.
  - (b) The Planning Committee doesn't have the ability to make any decisions; it's just there to gather information.

#### IV) Updates

A) Report Outline

- 1) Staff and the Planning Committee came up with a timeline for the report and then did a backout schedule to determine how much time we have for each task. Bill strongly encouraged Commissioners to review the backout schedule and provide any feedback to him and Lorez. He also asked for feedback at the meeting.

B) Budget Update

- 1) The Commission has encumbered all of its contract responsibilities through May. It sunsets in June. That means the Commission is on budget through then, but it is not at a point where it can add any more activities.

C) List of Topics to Be Addressed by Commission

- 1) The Commission discussed additional topics that could be addressed by an Advisory Committee. Commissioners expressed interest in rural areas and market competition/market regulation (which was deemed particularly helpful for the legislature). It was suggested that the Commission could take up both topics.
- 2) Bill made clear that this work wouldn't be done in time for November, just in time for the final report in June. He would appoint the chair of the Advisory Committee from one of the directors and hope to involve other members of the community in the process.

D) Medicaid Concept Paper (Cindy Sovine Miller)

- 1) Cindy presented on a concept paper that she shared with the Commission. She noted that we have seen a decrease in the uninsured, and most of that population has gone into the Medicaid population. This is bad because we haven't doubled the number of providers for the Medicaid population. Cindy noted that she has talked to a number of Medicaid patients in her community about their needs and their struggles, and that she feels strongly that this trend cannot continue into the future. Her concept paper proposes that the Medicaid population be offered subsidies to access private care.
- 2) Questions and comments from the Commission:
  - (a) I am not aware that the federal government is willing to shift a Medicaid eligible person to a private plan for eligibility. The states that have done something along these lines have taken Medicaid dollars and used them. Structurally, are there states that have done this that you're aware of?

- Arkansas (which didn't want to expand eligibility) was allowed to do this through a waiver. With the new president, we could be allowed to move the needle forward.
- (ii) I am familiar with the Arkansas waiver. The challenge is that at bottom: When GAO and others have assessed this, you're really just taking Medicaid dollars and putting them to a more expensive purpose. Payment incentives designed to entice providers will not sustain.
- I don't envision that Medicaid would pay for this. The patient would make the choice and have access to Medicaid as it exists today, and all of the cost sharing responsibilities that go with that choice would be there.
- (iii) Specialty care across the state is an issue.
- (iv) Could there be a public buy in for Medicaid? Could Medicaid have a different fee schedule? It seems hard to pull this off, but I'm open.
- (v) I think some of the bullets under "Medicaid expansion has left most vulnerable..." are inaccurate; there seem to be contradictions in the paper. What do we want to fix? Is it less wait times/access? Do we have a big or a small issue to solve for?
- To be clear on the summary: folks that have access to Medicaid should also have access to the above 133% subsidy level – it's either way; it's a choice, especially for 2019 when we are on the hook for everything. I'm more interested in the human element of this and access to providers. It was really when we heard these issues at the statewide meetings that I was motivated to work on this. And it seems like there might be cost savings for the state
- (vi) The bigger questions seems to be that you have to give people a separate course of action in order to determine whether the current system is actually working. Why can't you say in the report that this just isn't working? Why do we have to work within the current federal boxes?
- (vii) On the 208 Commission, when we recommended an expansion of Medicaid, we said do it when, but not until, there is a fix to the payment for Medicaid. I support the idea of giving folks a choice. At the end of the day, there are commercial networks that are broader.
- (viii) Could the Planning Committee better flesh out this idea? Could we present it to CMS?
- We are not ready to present to CMS. We lack evidence and data. You risk conveying something that just may not be true.
  - I would agree that this isn't quite ready to be presented. We need to come up with a better sense of how the whole Commission feels about this.
  - It makes most sense to have the Planning Committee take up this issue.
- (b) Public Comments
- (i) William Eric Dickman: I grew up an Air Force Brat, dad was a commander. I did well in school, got a football scholarship and stayed in school and earned a B.S. in finance. Early on, I was running five branches of a credit union and moved to Southern California. When my chronic pain started happening, I was considered top ten of Chase earners and earnings. Needless to say, I had full on insurance that whole time. When the pain started, I kept trying to work, and started learning about the system. Early on, my doctor wrote a prescription for a wheelchair. Then I didn't hear anything for three months. So my wife testified before a Senate Committee, and I got the wheelchair the next day. Then I had an abscessed tooth. You can't get a root canal on Medicaid.

- On Medicaid, you really are lucky to get an appointment the next month. When that's the case, I can understand why they end up missing their appointments because they have to plan out so far in advance.
- When the pain started, I tried to get on regular insurance. You're really treated like less of a person. Right now, I technically don't have insurance because my social Security disability was just approved.
- I've made it 45 years being able to make my own medical decisions, and now on Medicaid I basically can't do that.
- When I switched from private insurance to Medicaid, my pain doctor ended up dropping me. It's extremely frustrating.
- When you're used to regular insurance your whole life, it's jarring to go into these substandard deals.
- We could afford and want to pay for private insurance, but we were forced onto Medicaid because disability is non-taxable income.

E) The meeting was adjourned.