

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

**Meeting Minutes**  
**10-10-2016**  
**COPIC, Founders Room**

**Commissioner Members**

**Present:** Elisabeth Arenales, Peg Brown (as a proxy for Marguerite Salazar), Jeffrey Cain, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Bill Lindsay, Marcy Morrison, Dorothy Perry, Cindy Sovine-Miller, Christopher Tholen, Jay Want, Larry Wolk

**On the Phone:** John Bartholomew

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**Meeting Minutes**

**I) Approval of the Minutes**

- A) Ira motioned to approve the September meeting minutes. Cindy seconded the motion. The minutes were approved with one abstention from Marcy, who was not in attendance at the September meeting.

**II) Social Determinants**

- A) Recommendations from the Social Determinants Workgroup
- 1) Cindy presented on the Social Determinants Workgroup's discussions, which resulted in recommendations to expand access to high quality child care and preschool and expand access to screening and services for developmental and behavioral concerns, ACEs, and maternal depression to address toxic stress. On behalf of the Workgroup, she asked that these recommendations be taken up by the Commission in November.
  - 2) Questions and comments from the Commission:
    - (a) Elisabeth emphasized that a considerable amount of background and research supports these recommendations.
    - (b) Are there other social determinants of health that the Workgroup would also take up?
      - (i) Yes, the complete list includes work/wages, unemployment, early life events, addiction, education, housing, food/nutrition, transportation, stress, social exclusion, and social support and social gradient.
      - (ii) The Workgroup/Commission will continue to consider these options for being addressed more formally in the future.
    - (c) Was there any effort to determine how much it will cost and who will pay?
      - (i) There is some data from the Colorado Child Care Assistance program. It would need to be taken up as a bill.
    - (d) There are results in Tennessee that suggest that preschool does harm to children or that children who don't have preschool catch up by first grade. How can you ensure that preschool will be high quality? How do you handle the costs of the sickness spread in preschool with children with weakened immune systems in a big group?
      - (i) There are different ways of interpreting the research; some kids do well and then they are lost in the public education system. We have a very robust preschool quality system in Colorado – it is outcome-based and measurable.

- (e) One of the struggles is that this is such a huge topic, and it's hard to wrap our minds around social determinants. Take employment: We are very passionate about employment, but you can't get someone employment if they're homeless. And getting someone a home doesn't matter if they don't have food. It's very hard to tackle and fund this enormous issue.
  - (f) The recommendations seem to be at the level of the individual rather than the population, and I'd like to see more of a focus on population health – clean water infrastructure, clean air, etc. And there actually are studies that show that it's actually good to children to be exposed to disease early on because it strengthens their immune systems and saves money in the future.
  - (g) Funding and cost remain major challenges in social determinants. How can we prioritize based on ROI? Are all the recommendations at risk if we can't prioritize because the whole thing just seems too expensive?
  - (h) A lot of the preschool studies have focused on disadvantaged children, and there are many more variables involved there – for instance, disadvantaged children also don't have as many books in the home.
  - (i) The conversation seems to have expanded much beyond health, and we need to make sure that we are focused on health care costs. To me, social determinants are very important (and for me, it all starts with housing), but we need to make sure the discussion remains focused.
  - (j) I would like to see all social determinants go into the Commission's recommendations/reporting at the same time; we should include all of them if we are going to include any of them.
  - (k) If you include this, you need to be careful about causation versus correlation.
  - (l) Is there a way to frame this not as "the" list, but as a list of possible things to consider because the most important social determinants are different for each individual? For instance, investments in a middle class community are not going to need to be the same as for a low-income community.
  - (m) The draft report does already include some discussion of social determinants. The Workgroup was charged with coming up with additional recommendations because additional social determinants kept coming up in the Commission meetings.
- 3) Elisabeth made a motion to include the social determinant recommendations (on preschool and toxic stress) in the November report. Cindy seconded the motion.
- (a) Questions and comments from the Commission:
    - (i) I don't see how universal preschool reduces health care costs.
    - (ii) I struggle with this, but we don't have a lot of background information in front of us to support these recommendations.
    - (iii) The Children's Campaign has presented on this; the Commission has received a few presentations on the topic.
- 4) Cindy proposed a modification of Elisabeth's motion to separate the two recommendations and present only the toxic stress item for consideration.
- (a) Questions and comments from the Commission:
    - (i) There still is not enough background on this; most of the data comes from interest groups.
    - (ii) There was discussion of whether screening for toxic stress issues is already in place. It was determined that while there is statewide screening, we don't know exactly how much and who is reached.
  - (b) Bill put the motion to include a recommendation on screening for toxic stress (*Expand access to screening and services for developmental and behavioral concerns, ACEs, and maternal depression to*

*address toxic stress*) to a vote. 6 Commissioners voted in favor; 4 voted against. The motion did not pass.

- (c) Bill emphasized that no one is saying that social determinants aren't important; the Commission is just saying that right now, there isn't enough information or agreement to put forward the recommendations suggested by the Social Determinants Workgroup.
- B) Health Living Investments, Kyle Legleiter, Colorado Health Foundation
  - 1) Presentation: <https://www.colorado.gov/pacific/sites/default/files/10.10.2016%20Cost%20commission%20presentation.pdf>
    - (a) Part of the working theory is that if we have a healthier population in Colorado, our health costs will decrease. Research suggests that a lot of the things that make people healthy actually lie outside the formal health system.
    - (b) Colorado is not so unique that research from other places isn't relevant to Colorado. We have a lot in common with people in other places.
    - (c) There is a great deal of evidence that suggests that there are options that actually make people healthier.
    - (d) Our resources as a state are fewer than what it might take to implement all 14 of the proven effective techniques. For instance, putting up reminders to take the stairs by elevators isn't as effective in a small Eastern Colorado city that doesn't have many multistory buildings.
    - (e) How do you decide what public health interventions to use? Evidence-based public health.
    - (f) Lessons from two HI-5s in Colorado:
      - (i) School-based programs to increase physical activity
      - (ii) Safe routes to school
    - (g) While we do have some excellent evidence of interventions that work, innovation is important.
  - 2) Questions and comments from the Commission:
    - (a) Of the things on the list that we aren't doing, what would you prioritize?
      - (i) Kyle: Reducing tobacco (still leading cause of preventable death); school-based programs to increase physical activity/safe routes to school
    - (b) Why was brain-based mental illness not included on the CDC's list?
      - (i) Kyle: There may simply not have been enough studies to support its inclusion.
    - (c) Why are there so few recommendations related to homelessness?
      - (i) Kyle: One of the problems with the existing scientific literature is that it focuses more on the housed than the homeless.
- C) Importance of Employment, Bill Lindsay
  - 1) Summary of issue: <https://www.colorado.gov/pacific/sites/default/files/092016%20wnl%20Social%20Determinates%20of%20Health.pdf>
    - (a) In behavioral health, we tend to focus on employment, housing, and food.
    - (b) One of the original doubts about the Commission was that the ocean is too big and we can't possibly boil it. I fear that the social determinants conversation is making the ocean even bigger.
- D) There were no public comments on the discussion of social determinants.

### III) Freestanding EDs

- A) Presentation on Community Clinics and Emergency Centers (CCECs), Randy Kuykendall, CDPHE
  - 1) Presentation: [https://www.colorado.gov/pacific/sites/default/files/CCECs\\_Final\\_091316.pdf](https://www.colorado.gov/pacific/sites/default/files/CCECs_Final_091316.pdf)

- (a) There are 40 CCECs in Colorado. 15 are certified and 7 are pending licensure. They are concentrated in urban areas. There are frequently cases where a patient is taken to a freestanding ED and needs to be escalated to a higher level trauma center.
- 2) Questions and comments from the Commission:
  - (a) Are these centers responding to a specific need?
    - (i) Randy: In our state, if you can build it and meeting the safety standards, it will move forward. You don't need to prove a need.
  - (b) Is there evidence that the delay in treatment has led to more negative outcomes for patients?
    - (i) Randy: I think that what we're seeing in this data is a phenomenon that is new – patients being taken to freestanding EDs that cannot always adequately treat them – and that's what we are trying to point out. This undermines the parallel efforts that we've done in trauma to get patients to the right place at the right time.
  - (c) Are FSEDs good or bad?
    - (i) Randy: We are just observing the unintended consequences of the proliferation of FSEDs. It is a model of care that is new; it is promulgating at a high speed.
  - (d) What about Medicare/Medicaid?
    - (i) Randy: Many of the facilities are independently operated and do not accept Medicare/Medicaid.
  - (e) Do you see Medicare/Medicaid patients being turned away from the FSEDs?
    - (i) Randy: We do.
  - (f) A year ago, Arvada had no FSED and now there are 5. I have heard it defended as a requirement to put in a certain size footprint for urgent care.
    - (i) Randy: There are no requirements along those lines.
  - (g) Is it true that there is no licensing for urgent cares?
    - (i) Randy: Yes, there is no regulatory body for urgent care facilities.
- B) Colorado's Freestanding EDs, Katherine Mulready, Colorado Hospital Association,
  - 1) Presentation: <https://www.colorado.gov/pacific/sites/default/files/FSED%20Overview%20-%20Oct%202016.pdf>
    - (a) There are a number of challenges emerging from the proliferation of freestanding EDs, but also some solutions to address those challenges. One emerging model is having FSEDs bill true emergency scenarios at the emergency rates; patients who come in because they have an after-hours issue or couldn't get in to see their doctor will just be billed at an urgent care rate.
    - (b) Education about the proper use of EDs is essential, but EMTALA does make that difficult.
  - 2) Questions and comments from the Commission:
    - (a) You said that some FSEDs contract with insurers. What percentage of visits end up being out of network?
      - (i) Katherine: At the affiliated FSEDs, the billing tracks with the main hospital. But with the independent EDs, I don't know.
    - (b) How do you educate on use of EDs when you have to treat someone once they're on the property?
      - (i) Katherine: The EMTALA requirement is that when anyone arrives on the ED property, they are required to have a medical screening exam, and their medical issue must be stabilized before they are discharged. So how can you give the right amount of information without violating EMTALA? You can't do anything to deter a person from seeking care.
    - (c) EMTALA is federal and only applies if the facility takes Medicare and Medicaid. Is the state EMTALA similar?

- (i) Randy: Yes, it's very similar.
  - (d) Where is there money to be made here?
    - (i) Katherine: There is opportunity to capture market share where there are not hospital facilities nearby (or even where there are). The proliferation of FSEDs is not driving more visits; but it is dispersing visits at a greater number of facilities.
  - (e) The problem doesn't seem to be patients understanding the difference between EDs and urgent care, but rather a lack of understanding of the services available inside each of those facilities.
  - (f) It is not clear that FSEDs are actually increasing costs.
    - (i) I believe the cost impact is on consumers: They are paying facility fees for incomplete facilities; they might be able to pay much less if they went to an urgent care or a doctor's office.
  - (g) Has there been a decrease in visits to hospital-affiliated EDs?
    - (i) Katherine: We can't differentiate between FSEDs and hospital-affiliated EDs.
    - (ii) The real benefit is in wait times; you don't have 2-3 hour waits anymore because there are more facilities available.
  - (h) What we are leaving out is the fact that many of these people are probably going to these facilities because they cannot get in to see their regular doctor. There is also the issue of doctors who won't treat Medicare/Medicaid patients.
  - (i) Does the Commission think that it is important to add standards for FSEDs to set forth minimum clinical and procedural requirements that a facility must meet before it is licensed?
  - (j) I heard Randy say "we don't do money." Is it possible to have the CDPHE regulations consider cost?
    - (i) Randy: Our authority does not extend to the financial side of the house. We could partner with those who do consider financial issues. The regulatory set was not designed for this model of care. We are, at this point, primarily concerned with safety.
  - (k) If you are worried about the facilities fee issue, could you also put a moratorium on hospital that buy physicians practices?
  - (l) Katherine: There actually isn't a huge difference between the staff available at hospital-affiliated EDs and FSEDs. Hospital-affiliated EDs do vary widely as well.
- C) Bill observed that there was not enough momentum to put forward a recommendation on this issue.

#### IV) Cost Shifting and Uncompensated Care, CHI and Chris Tholen

- A) In the interest of time, this topic was shifted to the November meeting.

#### V) Updates

- A) Medicaid Private Option Proposal
  - 1) Proposal:
    - <https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Private%20Option%20-%20Issue%20Paper%20and%20FAQ.pdf>
  - 2) Cindy put forward the recommendation that she took to the Planning Committee: *Ask the legislature to run legislation during the 2017 General Assembly directing the Colorado Department of Health Care and Financing to work with the Centers for Medicare and Medicaid on a waiver to section 1115 of the Social Security Act, to allow individuals whom are eligible for Medicaid under expansion, to have the choice to be able to also access premium subsidies, in lieu Medicaid, for the purchase of a Federally Qualified Health Plan on Colorado's Exchange.*
    - (a) Individuals within this population may not need the Medicaid benefit package, and this proposal would simply allow them to put their own money up to purchase private health

insurance. This could benefit the people who want private insurance options, but also increase the pools of money available for the individuals who do stay in the Medicare population.

- 3) Questions and comments from the Commission:
    - (a) I am intrigued by the proposal, but would they be able to switch back and forth between Medicaid and private insurance?
      - (i) You could switch only during the annual reenrollment period.
    - (b) I can see why this has potential for people struggling with the Medicaid program, but to move everyone into the exchange could raise rates for everybody.
    - (c) These individuals could, at this point, choose to buy private insurance – just without subsidies.
    - (d) We should be more proactive than just having the legislature explore it.
    - (e) It would save the state money.
    - (f) Medicaid does get a lot of complaints, and that’s in part because there is no competition. So this could build in competition for Medicaid.
    - (g) There was a suggestion that this proposal be shopped with insurance carriers before any decisions are made.
  - 4) The Commission determined that it would try to solicit additional carrier input by the end of the year. Commissioners also noted that the public should be solicited for additional feedback.
- B) November Report
- 1) Draft report:  
<https://www.colorado.gov/pacific/sites/default/files/Cost%20Commission%20November%202016%20draft%20v3.2%20clean.pdf>
  - 2) Commissioners should submit feedback on the draft report to Lorez by noon on October 14. The emphasis is on content, not wordsmithing or minor edits.
- C) Advisory Group Recommendations
- 1) Advisory Committee process:  
<https://www.colorado.gov/pacific/sites/default/files/100516%20wnl%20Advisory%20Committee%20Membership%20and%20Participation%20-%20Rev.pdf>
  - 2) During the last meeting, the Commission discussed developing an advisory group focused on market forces v. regulation.
  - 3) Elisabeth volunteered to be the chair of the group. Bill noted that the group would also be populated by interested outside stakeholders.
- D) CMMI Update
- 1) Summary of discussion:  
<https://www.colorado.gov/pacific/sites/default/files/100516%20CMMI%20Discussion%20Cost%20Commission.pdf>
  - 2) In September, members of the Planning Committee and Commissioner Salazar met with representatives from CMMS to learn about the results of the Center for Medicare and Medicaid Innovation’s recent RFI to states and efforts on innovation and experimentation.
  - 3) Bill pointed out some of the main questions related to this work: Is it possible for state/feds to participate on a pilot project? Could it focus on a geographic area? Could it be focused on providers in addition to hospitals? He noted that this probably will need to be longer-term in nature.
  - 4) Questions and comments from the Commission:
    - (a) Won’t Vermont do this, and can’t we let them experiment and see how it goes?
- E) Financials

- 1) Chris noted that the Commission has funds to last through April 2017. These means that there are no additional funds beyond what the Commission already has planned.
  - 2) The statutory mandate ends in June.
- F) Other
- 1) A set of recommendations on the ACA will be discussed in November.

**VI) Adjourn**

- A) The meeting was adjourned.