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Thank you for the opportunity to submit comments to the Colorado Commission on Affordable Health Care. Community Health Centers provide a health care home for more than 650,000 of their community members – more than one in eight people in Colorado – from 51 of the state's 64 counties. Over 90% of those patients are at or below 200% of the Federal Poverty Level, which is $48,500 for a family of four.

As the membership organization representing Colorado's 19 Community Health Centers (CHCs) and their patients, we are acutely interested in how the cost of health care impacts access to care for those in need. The CHC model provides many examples of how high quality care can be provided at a lower cost. By design, CHCs target patient populations which are traditionally underserved and deemed at-risk for health problems, but they still continue to meet or exceed national practice standards for chronic condition treatment. Further discussion of this is included in our responses below.

CHC's are among the largest care providers for Colorado's Medicaid population, and as a result there are many questions about how we are paid. FQHCs receive federal funding to support service provision to the uninsured, but the majority of our budgets come from local and state sources, with one of those being Medicaid. In order to protect our ability to provide care to the under- and uninsured, federal regulations require CHCs to be reimbursed for the full cost of providing care to Medicaid patients. This is accomplished in Colorado through a reimbursement that pays CHCs per visit based on the average cost of care provided the previous year. These rates are reset annually, which encourages CHCs to provide the highest level of care to the patient at each visit.

CCHN and our members have been following the cost commission discussions closely, and we have already shared thoughts about drivers of health care costs related to workforce, which are integrated here. We look forward to your continued conversations and welcome any follow up questions regarding our responses.

1. **What do you think are the fundamental cost drivers and why?**
    a. 1 in 5 Coloradans are currently enrolled in Medicaid, making it a large player in health care spending in Colorado.[1] With over 90% of CHC patients at or below 200% of the Federal Poverty Level, Medicaid is also the health payment system with which CHCs are most familiar. As a result, many of our comments come from our experience with that program, but may be transferable to the system as a whole.
    b. The current way that reimbursement is structured for health care is a fundamental cost driver for the following reasons:
        i. Nearly all reimbursement is based on volume of care rather than quality, regardless of payer.

[1] 2015 Colorado Health Access Survey, http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf

1. Volume based payment systems focus on units of service provided, incenting providers to provide more of those units of care without regard for outcomes.
2. Preventing and managing diseases often involves non-medical interventions such as care coordination, which are not reimbursed in the current volume based payment model, disincentiving their use.
3. Other provider payment structures provide opportunities to utilize additional interventions and population health interventions to promote health and decrease costs.

ii. Payment systems are divided in ways that discourages treatment of patients comprehensively.
1. In Medicaid, medical, dental and behavioral health care are each administered separately with different payment structures. Data is not shared across systems, and the responsible entities (RCCOs, HCPF, BHOs, etc.) do not share data readily across systems, nor typically coordinate care for patients across the systems.
2. These systems maintain separation between care providers and cause large system inefficiencies.
    a. For example, CHCs often have separate electronic records or patient billing systems for medical, dental, and behavioral health because systems have to be structured differently to seek reimbursement.

iii. Payment currently incentivizes provision of care in more costly settings than is necessary.
1. Primary care services provided in emergency department settings are reimbursed at higher amounts than when provided in the more appropriate setting of a primary care outpatient clinic.
2. Services can often be provided by providers other than physicians, such as nurses, but those services are not reimbursable for CHCs without a face-to-face interaction with the more expensive provider.

c. In Medicaid, Primary Care Providers (PCPs) have limited ability to control total cost of care of their patients for several reasons:
    i. There is no opportunity to steer patients to hospitals or specialists based on quality or cost.
    ii. Patients assigned to the PCP have no obligation to see that provider, meaning they can seek care from any provider at their desired frequency.
    iii. PCPs are not consistently notified of patient interaction with other forms of care, such as the emergency department, prohibiting them from providing appropriate follow up care.

d. Medicaid and other providers place extensive focus on controlling the cost of primary care, while the more expensive parts of the health care system involve hospitals and specialists. These more expensive interactions could be reduced with increased focus on and access to comprehensive, culturally appropriate primary care.

2. What are the barriers to reducing cost?

a. The biggest barrier to reducing costs are systems and organizations that have been built to survive or profit off the current system, which, as discussed in our response to question one above, incentivizes volume of care over quality.

b. CHCs are ready and exploring opportunities to test innovative payment systems which support practice level changes focused on outcomes and patient health.

3. Can you list up to three things that you are doing to address cost that are unique?

a. The success of the CHC model is based on three components:
    i. Providing comprehensive and integrated primary care that includes behavioral and oral health
        1. This is accomplished through a team based approach that encourages using less costly providers to the full extent of their licensed ability.
        2. There is also a strong focus on quality. In Colorado, the CHCs jointly track quality measures and are working to improve on key indicators beyond those defined by Medicaid.
    ii. Providing care to individuals and families regardless of insurance coverage
        1. CHCs are non-profit health care providers focused on mission, not profit, which allows us to maintain focus on expanding access to care regardless of ability to pay. Additionally, focusing on mission rather than profit creates space for innovation and problem solving around how to help patients and communities have better health.
    iii. Focusing on preventive care and providing additional services, such as care coordination, physical and occupational therapy, pharmacy, group visits, and nutrition classes, in order to reduce the need for more costly interventions long term.

b. Mountain Family Health Center is participating in the state's PRIME payment reform pilot population which is based on payment and quality improvement. Leadership from all CHCs in the state has been actively engaged in learning about the PRIME pilot, as well as pilots and innovations from other states.

4. Is there any supporting data that demonstrates a reduction in cost?

a. CHCs target patient populations which are traditionally underserved and deemed at-risk for health problems, but they still continue to meet or exceed national practice standards for chronic condition treatment. The most recent study found that patients at Colorado CHCs had one-third fewer emergency room visits, hospital admissions, and primary care preventable hospital admissions than private fee-for-service providers.[2]

b. The coordination of care, use of evidence-based practices, behavior change coaching and partnerships with other local health care organization that happen daily in CHCs yield sizable saving in health expenditures - $1,262 per patient annually according to one study.[3] The ability of CHCs to innovate in how care is provided because of our non-profit status has demonstrated that caring for the whole person and focusing on primary and preventative care is cost effective.

5. Where do you see waste in the system?

a. Payment of higher rates for primary care services provided in the emergency department wastes funds that would go farther in an outpatient, primary care setting and discourages providers from working with outpatient primary care clinics to provide those services.

b. Low reimbursement from Medicaid reduces available providers and restricts access to care, such as occupational and physical therapy and chiropractic

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[2] Jennifer Rothkopf et al., "Medicaid Patients Seen At Federally Qualified Health Centers Use Hospital Services Less Than Those Seen By Private Providers," *Health Affairs 30:7 (July 2011).*

[3] NACHC analysis based on Ku L et al. "Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs," GWU Department of Health Policy. *Policy Research Brief No. 14. (September 2009).*

services that can reduce the need for more expensive services, such as surgery and medicated pain management, over the long term.

c. Payment systems are tied to face-to-face, one-on-one visits with providers, which in some cases is a more expensive and less effective form of care. This is particularly the case with patients managing a chronic condition. The use of group visits has been demonstrated to improve patient ability to control diseases, such as diabetes, at least as well, if not better, than traditional care.[4] However, payment systems focus only on traditional care models, thereby prohibiting the ability of providers to fully implement this modality of care provision as an option for patients.

6. What are the principal barriers to transparency?

a. There is a great deal of focus on primary care, but primary care providers have little information on what happens outside of their four walls, particularly regarding patient involvement with hospitals. Primary care providers' inability to access timely actionable patient data prohibits them from doing proactive follow-up, and having a complete understanding of their patient's experience.

b. IT structures and communication of data between providers is restricted by both structural issues, such as proprietary systems which do not communicate with each other, and regulations, such as 42 CFR.

7. What would you change to make things better related to cost?

a. Payment reform that rewards increasing quality outcomes and controlling the total cost of care.

b. Integrated Medicaid mental and physical health funding to make primary, preventative and behavioral health services more efficient and patient centric.

c. Limits on and transparency regarding administrative costs for entities providing administrative services to Medicaid.

d. Medicaid consideration of hospital and provider costs and outcomes in development of narrow networks where possible.

[4] Simmons, C. and Kapustin, J.F. "Diabetes Group Visits: An Alternative to Managing Chronic Disease Outcomes." *The Journal for Nurse Practitioners, 2011i*