Colorado Coalition for the Medically Underserved

September 14, 2015

Bill Lindsay, Chairman
Colorado Commission on Affordable Health Care

Dear Mr. Chair and members of the Commission,

Thank you for seeking input from stakeholders on the key drivers of health care costs in Colorado, as well as ways to address them. We are proud to support the Commission's important work, and look forward to the results so we can continue to build upon current work being done to address the high costs in health care. Below are our answers to the questions we prioritized from the ones you had publicly released. The hyperlinks below provide links to more information.

1. **What do you think the fundamental cost drivers are and why?**
   Several trusted national publications have discussed this topic, and we find them relevant to the experience in Colorado. We only name a few examples from each of the articles below; though, we strongly recommend reviewing the articles in full.
   - McKinsey Global Institute produced an analysis of what the most high-cost areas of the system are, and such highlights of this analysis include:
     - The United States spends nearly $650 billion more than expected in health care costs. Outpatient care accounts for over two-thirds of this amount, and is the fastest growing category. Inpatient care is the next costliest category, followed by prescription drugs and administrative costs. High-cost technology and use of highly-salaried workforce in what might be inefficient ways contribute to this.
   - A New England Journal of Medicine article published in 2012 discusses a few of the following as cost-drivers and potential solutions to address them:
     - Fee-for-service is costly, as our payment system primarily incentivizes volume over value. A solution would be transitioning to a bundled payment system and/or a global payment system.
     - The cost-sharing in insurance plans doesn't always influence the highest value choices among consumers. Allowing the marketplace to offer specially structured (or "tiered") insurance plans with structured cost-sharing could encourage high-value, low-cost utilization.
     - Much of health care costs are generated by avoidable administrative inefficiencies. We can simplify the administrative system by encouraging further electronic exchange of information, sending explanation of benefits and medical bills electronically to patients, or sending prior authorizations electronically to providers.
     - With the limited information they have, consumers are not empowered to make the most cost-efficient choices. We should require transparency of services, especially to reflect providers' negotiated discounts, estimated out-of-pocket costs for consumers, and the quality of care received.
     - Physicians are the highest trained and the highest paid provider, so we should utilize their skills better for patients who experience complex health issues, and use other non-physician providers whose salaries aren't as high as physicians. By expanding non-physician providers'

scopes of practice, we can better utilize highly-trained, but lower-salaried individuals who can also give high-quality care within the scope of their training. The article references allowing Advance Practice Nurses (APNs) to practice independently, which Colorado already allows, but there are other types of providers we could utilize more (refer to response to question numbers 3 and 4 below).
    - Defensive medicine means that physicians are utilizing the system in more ways than necessary, due to the fear of medical malpractice lawsuits. We should reduce defensive medicine by enacting "safe harbor" laws to protect physicians who used evidence-based medicine that did not reflect defensive medicine and encourage further research and training on evidence-based practices.
- Research demonstrates the high costs that inequalities in care among different racial and ethnic groups yield. Specifically, "among African Americans and Hispanics, the cost burden of three preventable conditions—high blood pressure, diabetes, and stroke—was about $23.9 billion in 2009." Health disparities are complex, but the health care system has a role in reducing unequal approaches to treatment. We recommend a review of the Institute of Medicine's report on this topic for targeted solutions.
- Additionally, there is a lack of coordination of medical services, which causes over-utilization, as well as between medical and non-medical needs that contribute to inappropriate utilization of the system. One such example is highlighted in a National Academies study analyzing potential cost-savings from assisting patients who struggle with transportation. By connecting them with reliable and appropriate transportation options, patients can arrive at their appointments and pick up their prescription medicine in a timely fashion, which will improve their health outcomes and reduce long-term costs. There are many other examples; however, medical homes have the opportunity to improve coordination of medical and non-medical needs of the patient so they are more supported to utilize the system effectively.

3. **Can you list up to three things that you are doing to address costs that are unique?**
4. **Is there any supporting data that demonstrates a reduction in costs?**

As CCMU is not a direct-services provider, we support high-value projects by empowering the work and collaboration of local leaders, in addition to supporting public policies that enable these efforts. The following are the top examples that we perceive as leading the way in reducing health care costs while increasing value and quality of care:

- As alluded to in our response to question 1, we can better utilize non-physician providers to bridge gaps in the system in high-quality, high-value, yet low-cost ways. There are a litany of examples being implemented or piloted in Colorado, including:
    - increasing the number of Advanced Practice Nurses (APNs) by reducing the training barriers for them to gain their prescribing authority,
    - specially training emergency medical technicians and paramedics to provide low-acuity primary care and systems navigation to patients where they are,

    - utilizing community health workers/case workers/patient navigators/case managers to help patients coordinate their medical and non-medical needs, so patients are better linked to the right resources that meet their needs.
- A number of programs in Colorado have been piloted to target "super-utilizers," based on the hypothesis that by targeting the highest-cost consumers of health care who may be incurring the most costs with inappropriate care, we can cut back on health care system costs. These programs have shown great success on a smaller scale, in redirecting these patients to more appropriate, high-value, lower-cost care settings. A great example of how this has made an impact is shown in a recently published Health Affairs article about Denver Health; however, it should be noted that there are a multitude of programs around the state. This initial success behooves us to explore scaling up these programs statewide and connecting them with each other so they can ensure coordination of patients and the resources they need.
- Colorado's Medicaid delivery system through the Accountable Care Collaborative (ACC) is showing some initial cost-savings that we anticipate to continue as the ACC evolves. The ACC is centered on matching a Medicaid patient with a primary care provider and a care coordinator, while incentivizing the providers to meet quality standards and tracking data on utilization. The use of pilot projects to spur innovative approaches to curb inappropriate utilization is also beneficial.

6. What are the principal barriers to make things better related to costs?

- As referenced above, there are many barriers to addressing high health care costs, but there are a few integral barriers that we believe should be tackled first.
    - The biggest barrier is the lack of central responsibility held by a single entity to address costs. The Commission is a step in the right direction; however, the whole health care community has to make a collective commitment that we are all responsible for better understanding health care costs and searching for solutions to lower them. Stating that individual groups are responsible (such as health plans, hospitals, the government, or consumers) is not going to solve anything, as we are all contributing to costs in one way or another, and we can all contribute to the solution. It would be ideal if the Commission could facilitate that collaborative dialogue among key players in the system so we can work from a common agenda. We can follow the example of others who are starting down the path of increasing transparency, much like this hospital in Utah that was recently profiled in this New York Times article.
    - The Colorado All-Payers Claims Database (APCD) is a step in the right direction; however, it is limiting based on the unique consumer experience. Not all possible services rendered can be searched and compared on the tool. It would be powerful if we could expand the APCD further to enable consumers to make the right decisions. Additionally, there is a misconception that high cost is inherently associated with high quality. We should sort through how to include quality markers in the APCD so consumers can weigh both the costs of a service as well as the quality of the service.

- The recently released Colorado Health Access Survey (CHAS) has some interesting data that should inform the work we do in this area. In particular, one in four Coloradans said they had checked if their preferred physician was in-network before getting care. Also, 1.5 million did not check if their health plan covered the benefit before seeking services. We have a great opportunity to increase health literacy and consumer empowerment among Coloradans with the right tools.
- It is crucial that we meet consumers where they are in order to develop the best tools that would be most meaningful for their experience. This Consumers Union focus group report offers great insights on how to best engage them on health care costs.

If there are any questions about our responses, we are happy to share additional information. Again, thank you for your time in reviewing this and your time on the Commission.

Sincerely,

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