Department of Family Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

COLORADO
Department of Regulatory Agencies
Division of Insurance

2023 Multi-Stakeholder Symposium

Final Report

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Prepared by Practice Innovation Program
University of Colorado Department of Family Medicine

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Executive Summary

The **2023 Multi-Stakeholder Symposium** is a step in the ongoing statewide process to build relationships, find common values, and work toward **healthcare payment models** that work for all stakeholders – patients, physicians, advanced practice providers, health systems, payers, employers and patients. The goal is to align payers, both public and private, around alternative payment models that enable primary care to deliver Advanced Primary Care. To achieve the goal of improved care at a lower cost with an improved experience of care by patients and health care teams, extensive collaboration will be essential. The Multi-Stakeholder Symposium is one medium among others to foster collaboration across the stakeholders.

The Multi-Stakeholder Symposium brings together payers, providers and practice staff to build relationships and find common ground. The origin of the Symposium has long history in Colorado, starting in 2010 as part of the Multi-Payer Patient Centered Medical Home Demonstration Pilot. As other models rolled out in Colorado, they incorporated the opportunity to facilitate dialogue among payers and physicians, including the Comprehensive Primary Care Initiative beginning in 2012, then Comprehensive Primary Care Plus and State Innovation Model in 2016, and incorporating the Transforming Clinical Practice Initiative in 2018. Evaluations following each gathering of patients, payers, physicians, and practice members have always been positive, stressing the value of having a venue in which to build relationships and come to understanding of common interests. Building on the success of the past, the 2023 Multi-Stakeholder Symposium was incorporated into HB 22-1325, Primary Care Alternative Payment Models (https://leg.colorado.gov/bills/hb22-1325/.) Details of the 2023 Multi-Stakeholder Symposium (date, location, attendees) appear in the Appendix.

The Practice Innovation Program (PIP) of the University of Colorado Department of Family Medicine was contracted by the Colorado Division of Insurance to convene the 2023 Multi-Stakeholder Symposium. PIP convenes and coordinates the Colorado Health Extension System (CHES), a cooperative of more than 20 Practice Transformation Organizations and multiple state agencies and other partners. PIP has an over 20 year relationship with practices, practice transformation organizations, and payers across Colorado and has been a trusted partner for multiple large scale practice transformation and improvement initiatives.

Background

Colorado law HB22-1325 Primary Care Alternative Payment Models requires the Colorado Division of Insurance to collaborate with the Department of Health Care Policy and Financing, the Department of Personnel, the Department of Public Health and Environment, and the Primary Care Payment Reform Collaborative to develop and promulgate rules for alternative payment model parameters for primary care services offered through health benefit plans. By December 1, 2023, the Commissioner of Insurance must promulgate rules detailing the requirements for alternative payment model parameters alignment. The 2023 Multi-Stakeholder Symposium was conducted as part of compliance with this bill and to learn from stakeholders to inform future policies.

Healthcare payments can be thought of along a continuum. As defined by the *Alternative Payment Models Framework* developed by Health Care Payment Learning & Action Network, there are four categories of payment:

Category 1: Fee-for-service (with **no link** to quality and value)
Category 2: Fee-for-service (**linked** to quality and value)
Category 3: Alternative Payment Models Built on Fee-For-Service Architecture
Category 4: Population-based Payment

These categories represent a continuum of clinical and financial risk for provider organizations. The participants in the Multi-Stakeholder Symposium discussed progression toward categories 3 and 4 through various efforts going on at the level of individual practices, practice organizations, healthcare payers, statewide and national projects.

Definitions:

The following definitions apply to this report:

- **Alternative Payment Models** – a healthcare payment method that uses financial incentives, including shared-risk payments, population-based payments, and other payment mechanisms, to reward providers for delivering high-quality and high-value care, that includes better care for individuals, better health for populations, and a positive experience for the healthcare teams and lower cost. "Alternative" as opposed to paying for activities in the traditional fee for service model.

- **Value-based payment models** are broadly categorized as those models on which payment is calculated on demonstrated value, i.e., improved outcomes, reduced cost and better patient experience.

- **Population-based payment** means a provider or practice is paid to manage the health of specific people, and with that payment they are then able to use their judgment regarding what care and support each patient needs, based on their understanding and relationships with their patient. Population based payments, provided they are paid a specific dollar amount for each person, generally on a monthly basis, are often referred to as "per member per month (PMPM)" or "per beneficiary per month." The dollar about per member/beneficiary is generally calculated by actuaries using formulas that consider how sick the patients are and their history of using healthcare resources. This includes the number of chronic conditions, the amount of medications, and the history of hospitalizations and emergency departments, and, more recently, also considering health related social needs.

- **Population management**, when practiced to the fullest potential, is delivered by a diverse team of people led by a physician who has access to robust information systems and solid relationships with, and knowledge of, their patients, including knowledge of their families, culture, and community. When practices have sufficient resources to engage in excellent population management, they have a comprehensive team that may include a medical assistant, a social worker, a care manager, a community health worker

and lists of subsets of patients. The support staff run reports to identify which patients are due for which services, ranging from services related to recommended screenings and immunizations as a part of prevention or services appropriate for follow up for chronic conditions. Most importantly, population-based payments enable a provider, supported by a strong care team, to manage the care of far more patients in a day than can be seen in a fee-for-service model.

Key Themes

Common values across all stakeholders:

- Payment reform that includes an opportunity to direct more resources to primary care is viewed positively.
- Paying for results, i.e. improved health and reduced costs, as opposed to for paying for "activity" (fee-for-service) is viewed positively.
- Primary care that is well funded and supported is central to both high quality health care and appropriate payment.
- Advanced primary care means a focus on the patient, not the disease, including the context of their environment, family, and community.
- Advanced Primary Care includes a robust team of caring people with diverse training and skills working collaboratively to address prevention, acute care, and chronic conditions and that includes behavioral health integration and attention to health-related social needs, health literacy, language preferences, and cultural norms.
- In considering payment reform, it is important to recognize that primary care deals with complexity.
- To achieve better health, we need to address underlying public health needs, including addressing "upstream" root causes of disease, and engage with community resources. Healthcare can't and shouldn't improve health on its own.

Payers' Perspectives

- Payers hear that providers wish to have alignment among the health plans.
- Payers are very interested in working with other insurers on alignment of quality measures. In at least the short term, there will be some programmatic requirements that may limit their ability to exactly and completely align, but there is will to move in that direction.
- To the extent they can, payers want to decrease administrative burden. We need to create a system that wraps around primary care providers to help them do all the things we need them to do.
- As a health organization, payers want to be innovative and helpful. They want to drive toward quality rather than quantity.
- If we can have a healthier population, then premiums should decline because healthier people cost less to care for. If we can lower an employers' costs because their employees are healthier, then everyone is happy.

- Improving healthcare outcomes all drive a healthier population that lowers costs.
- Patient activation is critical to success.
- Primary care is making up for gaps in the human services system. These issues are from culture decisions we made in our country years ago about what health care is supposed to look like. Meanwhile we have very adverse public health trends. We have medicalized all our social issues. Primary care is carrying much more of the burden than they are in other countries because of the lack of investment in social resources.

Patient Perspectives

- Patients want to be more than a number. They want dignity, kindness, and compassion.
- Paperwork has taken over.
- Patients desire coordination, so that when they arrive for care the people and systems know their story. They desire better communication – between providers and also between providers and patients.
- In moving toward advanced primary care, patients want to feel like they have a partner in the provider and the team.
- Patients don't trust their health plan or insurance company. The plans are so complicated it is difficult to understand what is covered and what is not.
- People are very price sensitive.
- Patients should be asked more often "how was your experience?"
- Patients should be asked more often "what matters to you?" Not "what's the matter with you?"
- Patients are getting to used to and like care provided by teams.

Provider Perspective Regarding Advanced Primary Care:

Essential components that need to be in place to deliver, and pay for, Advanced Primary Care:

- Sufficient payments that enable primary care clinicians to see 18 patients a day instead of 30 and have a robust team to support care coordination, address health related social needs, and do appropriate proactive outreach to manage prevention and chronic conditions.
- Behavioral Health Integration is an essential core of advanced primary care.
- It is critical to have a robust team with diverse training and skill sets.
- Having Practice Transformation Support is extremely beneficial when making substantial and sustainable changes. An outside practice facilitator keeps a practice focused and moving forward. Peer to peer learning and sharing is very helpful.
- Measure what matters – for example, the Person Centered Primary Care Measure, not a huge range of clinical quality measures.
- Actionable data is necessary; preferably a database that aggregates data across multiple sources to enable primary care practices to **easily** understand their patients' experiences across multiple sectors – other healthcare settings, human services, and community organizations. Incorporate Health Information Exchanges as well as Social Health Information Exchanges.

- All payers need to provide prospective population management payments to assure sufficient revenue to build and sustain a robust team-based care approach.
- To reduce administrative burden and make it possible to deliver advanced primary care, payer alignment is needed on measures, attribution, and actionable data delivered in an aggregated useful format.
- Hospitals need to be at the table, given that 70% of physicians in Colorado are employed by a health system.

A concern about population-based payments for practices is that they can't afford to take the risk that the payment may be less than the Relative Value Unit (RVU) generated by fee-for-service. Private practices need sufficient prospective payments that cover a vast majority, preferably all, of their patients and are consistent over time. They need to be able to count on prospective payments that can support an infrastructure that includes behavioral health integration and other team members such as health coaches, community health workers, social workers, and other support services essential to deliver advanced primary care, which includes comprehensive, whole person care that addresses health-related social needs. It is much harder for smaller private practices to have the resources needed to provide population management to address prevention, chronic conditions, and health-related social needs.

In terms of measurement, the system needs to evolve to more meaningful measurement of primary care. Current clinical quality measures are too narrowly focused to be reflective of value in primary care. They serve a purpose in helping a team do quality improvement and provide population management among sub-sets of patients, for example, those with diabetes, hypertension, or asthma. Until the system evolves to more meaningful measures, the clinics resoundingly advocated for alignment and uniformity of measures.

There is a lot of enthusiasm for the idea of population-based payments that enable doctors to spend 45 minutes to an hour with complex patients who need the benefit of complex clinical judgement, and help others with other forms of care that may or may not involve a visit to the practice. Population-based payments enable a practice to "touch" and manage the care for far more patients in a day than if they are only compensated if they see the patient and have a diagnosis and a code for the service provided. When they are paid to manage health of people, they can be more responsive to more people. For instance, in a fee-for-service payment approach, "seeing" 25 or 30 patients, which is what it takes for financial viability, leads to burnout because it is not satisfying, patients don't feel they received the care they deserved, and the visits are so short there is little time for meaningful patient engagement. When there is population-based payment, providers can use their discretion on which patients to spend more time with and which patients will do fine with a brief text and a link to information and resources. It also enables practice team members to provide outreach to manage prevention and chronic condition support.

Evaluation results:

MSS evaluation: 53 total responses

35 responses from people in person (36% response rate)

18 responses for people participating virtually (rate unknown, number of participants was variable throughout the day)

100 % of people participating in-person indicated that the Symposium was worth their time.

67 % of the people participating virtually indicated the Symposium was worth their time.

All the speakers and panel discussions got strong positive responses.

Hybrid meetings are challenging for the people participating virtually; we have an opportunity to improve their experience in future Symposia.

The free text comments reaffirmed what we have heard from past evaluations Multi-Stakeholder Symposia, there is a strong appreciation for the opportunity to have dialogue at the tables among providers, practice teams and payers, with an added appreciation for the 2023 Symposium for having patients participate, both on the panel and at the tables.

Below are a few of the comments that represented the sentiment of many responses to the question: What did you value most at the Symposium:

The symposium has the right idea--a diverse spectrum of providers and payors along with key government contacts from CMS and the State of CO. It also has the correct format of time for the presentations and I think overall the correct chosen topics from the presentation.

Interactive tables, breadth of speakers, providers, patients. CMS presentation, all was most helpful.

Time in person to network across multi-stakeholder group is really valuable.

Next Steps

The Division of Insurance will be informed by the perspectives of participants at the Multi-Stakeholder Symposium as they collaborate with the Department of Health Care Policy and Financing, the Department of Personnel, the Department of Public Health and Environment, and the Primary Care Payment Reform Collaborative to develop and promulgate rules for alternative payment model parameters for primary care services offered through health benefit plans. Multi-Stakeholder Symposia are helpful to promote understanding and collaboration among all the stakeholders: payers (public and commercial), employers, providers, patients, and practice transformation organizations. Future Symposia are desirable, but may depend on the availability of funding. The Primary Care Payment Reform Collaborative will continue to provide a forum for collaboration in moving this important work forward.

Appendix. Details of the 2023 Multi-Stakeholder Symposium

June 23, 2023, 9:30am-3:00pm, Anschutz Medical Campus

Symposium Venue: Anschutz Health Sciences Center, 1890 N Revere Ct, Aurora, CO 80045

The Symposium was sponsored by the Colorado Division of Insurance with funding from the state legislature (HB 22-1325)

Time Allotted	Agenda topic
9:00 – 9:30	• **Registration** • **Coffee and Networking**
9:30 – 9:50	**Vision for Multi-Payer alignment for Value-Based Care** • *Representative Chris deGruy Kennedy*
9:50 – 10:15	**Making Care Primary** • *Kate Davidson. LCSW CMS/CMMI. Director of Learning and Diffusion* • *Sarah Fogler, PhD CMS/CMMI Director of Patient Care Model Group* • *Questions and Answers*
10:15 – 10:30	Break

10:30-11:45	**Panel: Advanced Primary Care: what is it and how does it benefit stakeholders**
	• *Moderator: Dr. Perry Dickinson, Practice Innovation Program*
	  • *Health Plan: Dr. Jonathan Sollender, Medical Director, Anthem*
	  • *Employer: Dr. Raymond Tsai, VP Of Advanced Primary Care, Purchasers Business Group on Health*
	  • *Family Practice: Dr. Whitney Kennedy, Highlands Health for Life*
	  • *Pediatric Practice: Dr. Lauren Luzietti, Every Child Pediatrics*
	  • *Patient: Mari Plaza Munet*

11:45 – 12:15	**Table discussion:** • **Advanced Primary Care: Multiple Perspectives** ○ What does Advanced Primary Care mean and how does it benefit each stakeholder group?
12:15 – 1:15	**Lunch**
1:15 – 2:30	**Panel: Aligned payer collaboration to support Advanced Primary Care** **Moderator: Ashlie Brown, Colorado Health Institute** • *Commercial Payer: Patrick Gordon, CEO Rocky Mountain Health Plan* • *Public Payer: Dr. Peter Walsh, Chief Medical Director Colorado Department of Health Care Policy and Finance* • *Family Practice: Dr. Rick Vu, Mathews-Vu Medical Group* • *Pediatric practice: Dr. Brian Gablehouse, Peak Pediatrics* • *Patient: Carol Pace*
2:30 – 3:00	**Table discussion: Considerations from multiple perspectives regarding value-based payments**
3:00 - 3:15	• **Summary** • **Next Steps** • **Adjourn**

Attendees:

- Participants in person (96)
- People registered for virtual participation (85)
  (Virtual participation was variable throughout the program)

In-person Participant by stakeholder type:

- Patients: (8)
- Provider/practice: (36)
- Payers: 11 organizations, (21 people)
  - Anthem
  - Carelon (RAE* 2 and 4)
  - Center for Medicare and Medicaid Services (CMS/CMMI)
  - Colorado Access (RAE 3 and 5)
  - Colorado Association of Health Plans
  - Community Care Alliance (RAE 6 and 7)
  - CVS/Aetna
  - Health Care Policy and Finance
  - Humana
  - Rocky Mtn Health Plans (also RAE 1)
  - United Health Care
- Purchasers Business Group on Health: 1
- State agencies: 2
  - Colorado Department of Public Health and Environment (1)
  - Division of Insurance (1)
- Practice Transformation Organizations: 12
- Department of Family Medicine: Practice Innovation Program: 12

Other: 4

Colorado Health Institute (1)
Colorado Medical Society (1)
Independent Consultants (2)

RAE: Regional Accountable Entity:
RAEs are organizations under contract with Health First Colorado, Colorado's Medicaid program. They are responsible for coordinating members' care, ensuring they are connecting with primary and behavioral health care, and developing regional strategies to serve Health First Colorado members.

Virtual participants (80)

Participants by Stakeholder type:

- State Legislator: 1
- Provider/Practice: 53
- Payer: 3
  Colorado Association of Health Plans (1)
  Health Care Policy and Finance (1)
  United Health Care (1)

- Employer 3
  - Colorado Association of Health Plans (1)
  - Purchasers Business Group on Health (1)
  - Boeing (1)

Practice Transformation Organizations: 15

Deloitte Consulting: 5