COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes

Thursday, December 12, 2024; 10:00 - 12:00 pm
Virtual meeting via Zoom

Meeting Attendance

Attended
Isabel Cruz
Britta Fuglevand
Steve Holloway
Lauren Hughes
Alex Hulst
Cassie Littler
Sonja Madera
Amanda Massey
Kevin McFatridge
Amy Scanlan
Gretchen Stasica

Absent
Polly Anderson
Josh Benn
Kate Hayes/Jack Teter
Patrick Gordon
John Hannigan
Rajendra Kadari

DOI
Tara Smith
Deb Judy

Agenda:

1. Housekeeping & Announcements
2. Primary Care & APM Spending Report
3. Update on Standing Committee on Primary Care
4. Annual Report Recommendations
5. Public Comment

Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith noted that the Division will be posting abbreviated meeting minutes for the months of Nov, Dec, and Jan, as the content of member discussions will be reflected in edits and revisions to draft versions of the report.

  ACTION ITEM:
  - Abbreviated meeting minutes for November and December will be posted on the PCPRC prior to the January meeting.

- **New member announcement** - Tara Smith introduced Kevin McFatridge, the Executive Director of the Colorado Association of Health Plans, as a new payer representative. Kevin was previously the ED of Colorado Healing Fund, and prior to that was CEO for the Michigan State Medical Society. Welcome Kevin!!

- **2025 PCPRC schedule finalized** - Tara Smith announced that the PCPRC schedule for 2025 has been finalized and posted on the PCPRC website, along with the registration link. Based on member feedback, the PCPRC will continue to meet monthly, on the second Thursday of the month, from 10-noon MT. The Collaborative will NOT meet in July, giving members a summer break.
  - Members and stakeholders can register for 2025 meetings at the following link: https://us06web.zoom.us/meeting/register/tZMkdequrT4vHtX-7DQb0V8UY2Y7pW1ljRL4

Federal & state updates

The following federal updates were provided:

- **CMMI - Seventh Report to Congress** - On December 11, CMMI published its 2024 Report to Congress. The report highlights strategic accomplishments, updates on 37 models and initiatives (9 new models, including Making Care Primary), 52 evaluations, and additional activities between Oct 2022 and Sept 2024.

- **Open Enrollment for 2025 Marketplace coverage** - CMS recently announced that as of December 5, nearly 988,00 new customers have enrolled nationally in health insurance coverage through state Marketplaces (in ACA plans). Open enrollment in Colorado will extend through January 15, 2025.

To provide state updates, Tara Smith introduced two guest speakers. The first speaker, Allyson Gottsman, provided an update on a Notice of Funding Opportunity recently released by the Agency for Healthcare Quality and Research (AHRQ), related to state-based healthcare extension cooperatives.

Primary Care & Alternative Payment Model (APM) Spending Report - *Dagmar Velez, Lead Intake Data Analyst, Center for Improving Value in Health Care (CIVHC)*

Tara Smith introduced Dagmar Velez from CIVHC to provide an overview of the Primary Care Spending and Alternative Payment Model Use in Colorado, 2021-2023 report (see slides 8-23, available HERE). Highlights from Dagmar's presentation included:

- The current report includes an analysis of primary care and APM spending data submitted by 13 carriers for the years 2021, 2022, and 2023;
- Overall, primary care spending as a total of medical spending increased across all lines of business between 2021-2023 from 15% to 18%;
    - Spending increased for Medicare Advantage (MA) and Medicaid, and decreased for commercial payers and CHP+ plans;
- Payments under value-based APMs accounted for 34.8% of total medical spending in 2023; excluding Denver Health and Kaiser (integrated delivery systems), the percentage of payments through value-based APMs was 28.7% in 2023;
- Payments under value-based APMs accounted for 60.7% of primary care spending in 2023; excluding Denver Health and Kaiser, the percentage of payments through value-based APMs was 54.1% in 2023;
- Prospective payments under APMs accounted for 52% of total medical spending in 2023; excluding Denver Health and Kaiser, prospective payments accounted for 42.5% of total medical spending in 2023.

Discussion:

- A member asked in chat about the potential to include age banding categories in the future;
    - Dagmar noted that it would challenging to add age bands to APM reporting because such reporting is on a contract basis; currently, CHP+ is broken out as a line of business, which includes only 18 and under, but adding additional categories to each line of business may not be feasible right now; one option to

consider would be to create age categories for primary care claims data only (not including APMs), but that would take additional time and resources;

- A meeting participant commented that the figures reported for the percentage of primary care payments throwing through APMs still seem very high, and does not reflect the experience of many primary care practices; they noted that their practice, based on their internal analysis, showed about 20% of payments through APMs; while the bulk of their practice payments are Medicaid FFS, which are technically part of an APM because the rate is adjusted based on performance, the payments are really just FFS- something that the methodology for this report may not reflect; it is hard to reconcile the data in the report with on-the-ground experience;
    - A meeting participant agreed with this comment, noting that the numbers in the report seem higher than what primary care practices experience;
    - Tara Smith noted that trying to get at the correct categorization of payments, in a way that is standardized across multiple payers, has been an ongoing challenge, and has been part of the iterative process of making improvements to the reporting over the last several years; CIVHC is continuing to work with payers and the DOI to get higher quality and more nuanced data, but it will continue to be an evolving process;
    - Meeting participants acknowledged and understood these challenges, but noted it was important to continue to try to get data so that we can get a better answer to the question: how much of your book of business needs to be in value-based payment before you change how you practice to reflect value-based payment; at 20%, it isn't enough- providers pay a little attention to value, but they mostly pay attention to the patient in front of them;
    - Dagmar noted that the APM spending percentages are reported across all lines of business, and in the future CIVHC could break those numbers out by specific line of business, to get a better understand of the differences seen across different payer types (which may be a better reflection of practice level experience);

- A meeting participant asked if it was explored why primary care spending decreased from 2022 to 2023, and wondered if market dynamics and consolidation may have contributed to this trend;
    - Tara Smith noted that the data indicate that while spending increased across certain lines of business, it decreased in others, including among commercial payers that are subject to the primary care investment target set by the Division; she noted that there could be several reasons for this- certain payers have updated or revised the way they pull and report data from their systems from year to year, and while the Division has allowed these revisions to improve data quality, it makes measurement from year to year challenging; the

Division will be following up with individual payers to better understand their primary care spending, and determine appropriate next steps.

Tara Smith thanked Dagmar for the presentation, and the entire CIVHC team for their work on this year's report. Multiple members also thanked the CIVHC team via chat. Members can send any additional questions to Tara Smith (tara.smith@state.co.us), and she will relay them to CIVHC.
A meeting participant asked a final question about whether the findings from the report would be incorporated into this year's recommendations. Tara Smith indicated that the current draft of the report included a placeholder for a discussion of the CIVHC data, and that this is an issue slated for today's discussion.

Update on NASEM Standing Committee on Primary Care - *Lauren Hughes, State Policy Director, Farley Health Policy Center, Associate Professor, Department of Family Medicine, University of Colorado Anschutz Medical Campus*

Tara Smith next introduced Lauren Hughes, a PCPRC member who is also a co-chair of the National Academies of Sciences, Engineering, and Medicine (NASEM) Standing Committee on Primary Care, to provide an overview of the Committee's work to date (see slides 25-55, available HERE). Highlights from Lauren's presentation included:

- The National Academies are private, nonprofit institutions that provide independent, objection analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine;
    - Established by President Lincoln in the 1860s, with the idea that government could benefit from advice from non-governmental entities;

- In May 2021, NASEM released the Implementing High-Quality Primary Care Report to serve as a roadmap to action around primary care at the federal level; the report included objectives to achieve high-quality primary care:
    - Objective 1: Pay for primary care teams to care for people, not doctors to deliver services;
    - Objective 2: Ensure that high-quality primary care is available to every individual and family in every community;
    - Objective 3: Train primary care teams where people live and work;
    - Objective 4: Design information technology that serves the patient, family, and interprofessional care team;
    - Objective 5: Ensure that high-quality primary care is implemented in the United States;

- The work of the Standing Committee is based on Object 5; since the release of the report 3 years ago, the most movement has occurred around Objectives 1 & 5;

- Actions taken around Objective 1 include:
    - Introduction of Making Care Primary and AHEAD models; both of these CMMI models include components of the NASEM report actions related to payment;
    - Last summer, US Senators Whitehouse and Cassidy introduced the bipartisan "Pay PCPs Act of 2024", which calls upon CMS to do 3 things: 1) Establish hybrid payments for primary care; 2) Reduce cost-sharing for Medicare beneficiaries; and 3) Establish a new technical advisory committee to help CMS more accurately determine physician fee schedule (PFS) rates for primary care
    - Recent CY 2025 Medicare Physician Fee Schedule Rule includes Advance Primary Care Management Services billing codes;
    - Standing Committee on Primary Care will be releasing a report by the end of the first quarter of 2025 with recommended actions to address primary care valuation decisions for the PFS by CMS;
    - AHRQ issued a technical brief on primary care spend that included recommendations on how to improve primary care spending estimates;

- Actions taken around Objective 5
    - In September 2021, the Assistant Secretary for Health within HHS established the Initiative to Strengthen Primary Health Care
    - NASEM Standing Committee on Primary Care established;
    - HHS released an Issue Brief in November 2023 which includes a compilation of actions, as well as goals and priorities, related to primary care;
        - One activity was to create a primary care dashboard project; on Sept 18, 2024, the Standing Committee hosted a virtual public meeting and heard an update on the dashboard; metrics include: 1) increasing overall investment in primary care; 2) expanding and supporting the primary care workforce; 3) improving access to primary care; 4) develop HIT to support primary care; and 5) enhanced primary care research;

- Standing Committee on Primary Care exists to advise federal agencies in HHS, USDA, VA on a wide variety of primary care policy issues; in last calendar year have chosen to focus on payment and workforce priorities and objective from the Implementing High-Quality Primary Care report, currently finalizing priorities for 2025;
    - Standing Committee currently has 20 members from across the country, none employed by federal government;

- Standing Committee does its work through 2 public work streams: meetings and publications focused on advising federal actions; work is funded for 3 years, with 2-4 public meetings each year;

- Needs around **payment** that have been identified in panel discussions:
    - What do primary care providers and practices, especially small and rural practices, need to join value-based models?
    - Medicare Advantage is not half of the program- more data is needed on all front, including:
        - Cost, quality and access for beneficiaries;
        - Marketing practices;
        - Delays and denials;
    - As more states are looking at primary care spending, a common definition would be welcome (this topic was discussed at the Sept public meeting);
    - Metrics alignment across payers is paramount;
    - Work is needed on evaluating the valuation process for primary care, including a better understanding of the limitations of the current approach, and identifying the time and effort required for interprofessional teams to deliver high-quality advanced primary care-
        - What are principles and processes for alternative inputs that still meet statutory requirements?
        - A publication is in process, and anticipated in first quarter of 2025
    - Scaling and spreading of care models and new codes;
        - Parts of (or entire) CMMI demonstrations;
        - How to capitalize on VA, payer learnings;
        - Education about new G codes for health-related social needs

- Needs around **workforce** that have been identified in panel discussions:
    - Improving graduate medical education;
        - CMS authority to track outcomes and how these dollars are spent;
        - Funding that follows trainees, rather than institutions;
        - Sharing teaching health center CMS results (and finding permanent funding) (discussed at Nov public meeting);
        - Identifying community-based sites with enough capacity to welcome learners (discussed at Nov public meeting);
    - Interprofessional primary care teams - HRSA Administrator asked committee for help around the following components of primary care teams:
        - Composition;
        - Training;
        - Payment (form, amount, and flow);
        - Data clarity and comprehensiveness;

- On NASEM Standing Committee on Primary Care website, can find information from meetings and publications; two publications of note in 2024:
    - Response to the Pay PCPs Act of 2024 RFI;
    - Response to the CMS CY 2025 Advanced Primary Care Hybrid Payment RFI;

- Additional associated activities:
    - AHRQ's National Center for Excellence in Primary Care Research received its first funding ever in FY22 of $2 million;
    - HHS Primary Care Dashboard proposes two measures regarding NIH and federal dollars going into primary care research;
    - CARE for Health Initiative launched by NIH; goal is to conduct research addressing issues important to diverse communities, particularly those underrepresented in biomedical research;
    - SCORECARDS:
        - Milbank Memorial Fund in partnership with Physicians Foundation and Robert Graham Center released 2nd scorecard earlier this year: "No One Can See You Now: Five Reasons Why Access to Primary Care is Getting Worse (and What Needs to Change"; currently working on 3rd scorecard;
        - Other state examples of primary care dashboards: Virginia, Massachusetts.

Discussion:

- A member commented on the similarities between the work that was underway in Colorado and other states, and the work that is happening at the national level, including the work of the Standing Committee, and wondered about the best use of time and resources at both levels; they questioned if there were certain areas that states could focus on, and move efforts forward in a way that was complementary, and not duplicative, of work happening at the federal level;
    - Laruen noted that in her work with the Standing Committee, Colorado stands out as an exemplary state in addressing many of the topics that the Committee is grappling with; she encouraged PCPRC members to continue to push forward in areas around adequate payment and multi-payer alignment, and doing the work that is currently underway, as it is important in informing the work of the Standing Committee; to date, it is not duplicative- rather, state examples of successes and failures can help inform the Standing Committee's recommendations to federal partners. Experimentation across states is important in the federalist approach to policymaking, and is not at cross-purposes.

Annual Report Recommendations

Tara Smith briefly reviewed the timeline for the annual recommendations report (see slide 57, available HERE), and the upcoming review periods that members would have to make comments on report drafts (see slide 58 available HERE).

Tara Smith briefly reviewed the organizational structure of the report (see slide 60, available HERE), then walked members through each section of the working draft circulated to members in advance of the meeting.

Executive Summary

Tara Smith provided a brief summary of the content in the Executive Summary section of the draft report (see slide 61, available HERE) and asked for comments or feedback.

Discussion:

- Members did not offer any immediate comments or feedback on this section of the report.

PCPRC Background

Tara Smith provided a brief summary of the content in the PCPRC Background section of the draft report (see slide 62, available HERE) and asked for comments or feedback. She specifically asked members about the level of detail that should be included related to the Collaborative's sunset and the COPRRR report.

Discussion:

- A member noted that the COPRRR report was also mentioned in a different section of the report, but thought that it would be appropriate to include one or two sentences describing what the summary of the report is related to the continuation of this work, and to signpost that recommendation.
    - A member agreed with this comment, and suggested including a link to the COPRRR report, in addition to the high-level summary, so that people could read more if they were interested.
    - Multiple members agreed with these comments/suggestions via chat.

Introduction and Key Context:

Tara Smith provided a brief summary of the content in the Introduction and Key Context section of the draft report (see slide 63, available HERE) and asked for comments or feedback. She specifically asked if members would like to have previous recommendations listed out in this section, or included as an appendix to the report, to save space in the narrative.

Discussion:

- A member liked the idea of including an appendix with the full list of report recommendations, but suggested included a shorter bulleted list, or a prose description of the range of topics that have been addressed in previous reports;
    - A member agreed with this suggestion, and supported the inclusion of a paragraph summary, with a one-sentence overview per report; it is important to have some sort of summary at the start, but the details can be in an appendix;
    - Multiple members agreed with these comments via chat;

- Tara Smith noted that the introduction section began with a statement that "additional investment in primary care is needed because", then went on to list a series of reasons, including: workforce challenges, affordability and access challenges, continued need to address health equity, and the tenuous financial state of rural and independent practices. During the review period, a member had suggested adding the additional expectation placed on primary care providers as an additional reason increased investment is needed. She asked members if there was anything that should be added or subtracted from this "list" of reasons.
    - A member suggested adding small practices in the bullet about the tenuous state of practices; multiple members agreed with this comment via chat;
    - A member commented in chat that safety net clinics have also expressed a lot of concerns regarding their financial stability, and could also be mentioned in the bullet about the tenuous state of practices; multiple members agreed with this suggestion.

Marketplace Dynamics

Tara Smith provided a brief summary of the content in the Marketplace Dynamics section of the draft report, including the wording of the overarching recommendation (see slides 64-66, available HERE) and asked for comments or feedback.

Discussion:

- Members expressed general agreement with the wording of the recommendation, including the words "monitor" and "impact";

- A member commented that while consolidation and private equity are certainly prevalent in discussions around marketplace dynamics, it would be helpful to distinguish venture capital from private equity in the report; this could be done in a few sentences in the narrative;
    - Meeting participants agreed with this comment;

- Tara Smith noted that the current draft includes a section of definitions, and an introductory paragraph that addresses "Consolidation and Private Equity", and that there is currently some overlap between these two; she noted that the Division and CHI would highlight these sections for future member comments and suggestions on how to incorporate the discussion without overlap;
- One member suggested via chat that the narrative include separate paragraphs about consolidation and private equity, followed by a paragraph about the intersection of the two;

- Another member commented that the report refers briefly to the COVID Public Health Emergency (PHE) unwind, and noted that it was a major issue impacting practices right now;
  - Multiple members agreed that this was a significant issue that is important to raise this year, given the impacts on 2024 and 2025; one noted that the report didn't need to do a deep dive, but should be included in the discussion.

Artificial Intelligence:

Tara Smith provided a brief summary of the content in the Artificial Intelligence section of the draft report, including the wording of the overarching recommendation (see slides 69-70, available HERE) and asked for comments or feedback.

Discussion:

- Regarding the wording of the recommendation:
  - A member suggested ending the second sentence of the recommendation with the word "implemented", rather than "adopted" or "incorporated";
  - Another member suggested ending the sentence after the words "meaningfully addressed"; multiple members agreed with this suggestion;

- Members agreed that definitions of AI, and the different types of AI (generative, etc.) are important in this section;

- Regarding the subsection discussion "Accuracy and Bias", Tara Smith noted that Collaborative's discussions had primarily focused on AI uses in a practice setting (tools that reduce administrative burden, etc.), and less on the use of AI by health insurance companies; the Collaborative did hear about and briefly discuss state actions related to AI in other contexts, including the Division's work around SB21-169; she asked members if/how they would like to reference this other work;
  - Members generally agreed references to SB21-169 and work by the NAIC should be mentioned in the report.

Health Equity:

Tara Smith provided a brief summary of the content in the Health Equity section of the draft report, including the wording of the overarching recommendation (see slides 67-68, available HERE) and asked for comments or feedback.

Discussion:

- Members had no immediate feedback on the wording of the recommendation;
- Members like the idea of linking the section on whole-person and whole-family care back to last year's report.

Future Work and Additional/Miscellaneous Topics:

Tara Smith briefly outlined potential areas for future work, and additional miscellaneous topics that could be incorporated into the report narrative (see slides 71-72, available HERE) and asked for comments or feedback

Discussion:

- A member commented that while questions about how the flow of dollars are getting to providers is important, the larger and equally (if not more) important question is whether we are getting to the outcomes we want to be getting; ultimately, the goal of strengthening primary care and improved care delivery is about improving patient outcomes, which shouldn't be lost in the discussion;
- Another member agreed with this comment, and noted that access is another really important piece, even though it is challenging to measure; they noted that the Office of Primary Care at CDPHE has done a lot of work in this area, which could potentially be leveraged, but a key question is if increasing the spend on primary care you are also increasing access to care;

Graphics Check-In:

Tara Smith briefly outlined the current list of suggested graphics for this year's report (see slide 73, available HERE), noting that not all of them may be possible. If members have suggestions for what should be removed or added, they should let Tara Smith (tara.smith@state.co.us) know as soon as possible.

Public comment:

- No public comments were offered.