COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes
Thursday, February 8, 2024; 10:00 - 12:00 pm
Virtual meeting

Meeting Attendance

Attended
Brandon Arnold
Isabel Cruz
Steve Holloway
Lauren Hughes
David Keller (proxy for Cassie Littler)
Miranda Ross
Lisa Rothgery
Amy Scanlan
Patricia Valverde

Absent
Polly Anderson
Josh Benn
Patrick Gordon
John Hannigan
Rajendra Kadari
Anne Ladd
Cassie Littler
Amanda Massey
Kate Hayes for Jack Teter
Pete Walsh

DOI
Tara Smith
Laura Mortimer
Cara Cheevers

Agenda:

1. Housekeeping & Announcements
2. Annual Report Recommendations
3. Public comment

Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda. The primary objective of the meeting was to finalize and formally approve the recommendations for the Fifth Annual Recommendations report, which must be posted by Feb 15, 2024.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith requested approval of the draft Jan meeting minutes.

ACTION ITEM:

- Meeting minutes from the Jan meeting were approved and will be posted on the PCPRC website.

- **Meeting schedule** - The PCPRC meeting schedule for 2024 has been posted on the website, and members were reminded to check their calendars to make sure meeting dates/times are populated on their calendars. Anyone with technical issues should reach out to Tara Smith (tara.smith@state.co.us).

  ACTION ITEM:

  - Members should ensure they are properly registered for all PCPRC meetings in 2024, and contact Tara Smith with any issues.

- **2024 legislative session** - The 2024 legislative session started on January 10, and approximately 376 bills have been introduced to date. Tara Smith highlighted the following bills, which may have potential relevance to the Collaborative's work, and invited members to also bring bills to the attention of the group as the session progresses:
  - HB24-1005 - Health Insurers Contract with Qualified Providers
  - SB24-093 - Continuity of care
  - SB24-080 - Transparency in Coverage
  - Benefit related
    - Obesity & diabetes; infertility; substance use disorders; biomarker testing
  - HB24-1040 - Gender-affirming health care study
  - SB24-059 – Children's Behavioral Health Statewide System of Care

  ACTION ITEM:

  - Members should email their name, credentials, and organizational affiliation, as they would like to have it listed in the report, to Tara Smith (tara.smith@state.co.us) by EOD on 1/15/24.

Annual Report Recommendations

Tara Smith briefly reviewed the goals for today's meeting, which included finalizing and voting to formally approve the Annual Recommendations Report. She briefly reviewed the voting process, as outlined in the PCPRC Standard Operating Procedures and Rules of Order. At the start of the meeting, nine members were present, which was a sufficient number to vote on approval.

Tara Smith led members through a section-by-section discussion of the report, reviewing feedback that had been received prior to today's meeting, and requesting any additional feedback or edits.

Executive Summary

Tara Smith reviewed the key discussion points in this section (see slide 10, available here), then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

Discussion:

- In the opening paragraph, the following adjustments were made to the second sentence:
  - "Since its creation in 2019, the Collaborative has remained focused on the goal of strengthening Colorado's primary care infrastructure and care delivery system through increased investment and the adoption of value-based payment models, also known as alternative payment models (APMs), that drive value, not volume, and improve health outcomes."
  - The intent was to mirror the distinction between "financing for infrastructure" (a systems-level investment) and "payments for care delivery" (a payer-level investment) in the first in the first recommendation, so that the report is consistent. The addition of the phrase "also known as alternative payment models" was meant to signal to the reader that the terms value-based payment and APMs are used interchangeably in the report.

- The following language was also added to the Executive Summary of the document that ties the report back to several of the Collaborative's statutory charges, as delineated in HB 19-1233:
  - "[The recommendations] are offered in accordance with the Collaborative's statutory charge to develop recommendations to advance the use of APMs to increase investment in advanced primary care delivery, which the Collaborative has previously defined to include comprehensive care that focuses on behavioral health integration. In addition, the report discusses current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation, and identifies barriers and opportunities around the adoption of APMs by health insurers and providers to support integrated care delivery."

- The definition of "integrated care" in the Executive Summary was changed from the CDC definition included in previous draft to the definition put forward by the Agency for Healthcare Research and Quality; this change was made to align with the definition of integrated care in HCPF's Request for Applications for HB22-1302 grants.

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- "Integrated care is defined as the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

- A footnote was added to this section to recognize that the term "payer", as used in the report, refers primarily to insurers or health plans that are regulated by the Division of Insurance, recognizing this is one of the primary levers of the Collaborative for recommending action; the importance and support for multi-payer alignment around the recommendations, however is still included:
  - "The term payer, as used in this report, refers primarily to health insurers regulated by the Division of Insurance. However, the Collaborative has consistently recognized the importance of private and public payer alignment to the success of APMs, and continues to support and advocate for multi-payer alignment around the recommendations in this report and additional strategies to strengthen primary care."

- The language of the recommendations in each section (payment, workforce, health-related social needs, medication-assisted treatment) has been streamlined and simplified; the goal of these revisions was to make sure the recommendation was clear and concise, and framed in the active not passive voice.

Colorado's Primary Care Payment Reform Collaborative Section

Tara Smith reviewed the key discussion points in this section (see slide 14, available here), pausing for feedback/discussion.

- Members did not have questions or feedback on this section.
- **DECISION/ACTION:** No changes will be made to this section of the report.

Introduction/Framing Section

Tara Smith reviewed the key discussion points in this section (see slide 16, available here), then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

- The 2021 Colorado Health Access Survey (CHAS) data regarding stigma was updated to include figures from the 2023 survey;

- The following sentence regarding the benefits of behavioral integration was edited for clarification:
    - "Behavioral health integration can also increase access to care by reducing logistical burdens on patients, such as managing multiple appointments, disjointed medical records systems that don't communicate with one another, and keeping various care teams informed about their care plan ~~communication with various care teams~~."

- A definition of value-based payments was added into the "Update on Investments in Primary Care Spending Through Alternative Payment Models" subsection:
    - "An underlying tenet of these recommendations has been that while increased investment in primary care is needed regardless of the payment type, primary care can be better supported and sustained by shifting away from fee-for-service reimbursement structures to value based payments, which use financial incentives and other payment mechanisms to reward providers for delivering high quality and high value care."
    - To distinguish this general definition of value-based care from CIVHC's methodology for reporting value-based payment arrangement spending, a clarification was also added to footnote 5: "Value based APM arrangements, as operationalized in CIVHC's reporting methodology, do not include risk-based payments and capitation payments not linked to quality (3N and 4N HCP LAN categories respectively). Please see Appendix C for the full CIVHC report on primary care spending and alternative payment model use."
- For the recommendation related to health-related social needs (HRSN), the following language was added to clarify the footnote explaining the PCPRC's decision to use this term:
    - "For the purposes of this report, the Collaborative is using the term health-related social needs due to its wide use in the field at the time of publishing. However, the Collaborative recognizes that this is evolving terminology and that there may be different preferences to refer to these types of needs, services, and supports, including interest in moving towards less deficit-based frameworks."

Payment Section

Tara Smith reviewed the overall recommendation language (see slide 18, available here) and the key discussion points in this section (see slide 19). She then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

- The "Challenges and Opportunities" subsection starts with the sentence: "Challenges, gaps, and needs within behavioral health integration in Colorado include sustainability, support for practice integration, and unclear mandates for large

employers and self-funded plans." Tara Smith asked for clarification about what the group meant by "unclear mandates for large employers and self-funded plans."

- One member suggested the language could be added noting that while the Collaborative's recommendations can influence DOI-regulated plans and Medicaid, no mechanism currently exists to address or suggest requirements for the rest of the health insurance ecosystem, including self-funded plans. This gap makes alignment challenging- it is difficult to know who needs to be aligned with, or what alignment at an ecosystem level should/could look like.
- Tara Smith asked if part of the difficulty that members are expressing is challenging in engaging this sector in alignment discussions.
- A member suggested changing the language from "unclear mandates" to "an unclear path for alignment."
- Multiple members agreed with the importance of calling out the types of plans that are not regulated by DOI, and liked the idea of adding a graphic showing the various plans in the marketplace (DOI regulated vs self-funded vs public).
- DECISION/ACTION:
  - The Division/CHI will explore options for creating a graphic, but it may be too late to add this into the report (based on the design timeline)
  - The language in the report will be changed from "unclear mandates" to "unclear path for alignment"

- In the "Supporting Team-Based Care" subsection, the following edits were madeK
  - Kaiser provided the following language to describe the Collaborative Care approach: "Kaiser Permanente's Collaborative Care approach is a team-based, patient-centered model of care that has shown to be effective in supporting individuals with a diagnosis of depression and/or anxiety within the primary care setting. Collaborative care uses a registry to identify and outreach patients who are not improving or have disengaged from treatment. Team members include the patient, primary care provider, a care manager working closely with the patient for follow up, and a psychiatric consultant."
  - The following qualification was added to the following sentence in paragraph 2: "For value based payments to support improvements in primary care, ~~possible future service additions should be taken into account~~ careful consideration should be paid to how payments are structured in advance of services being added."

- In the "Keeping Track of Billing Codes and Investments" subsection, the following edits were made in the second paragraph:
  - "The Collaborative recognizes that payers currently report on certain behavioral health measures through mechanisms including the Healthcare Effective Data and Information Set, and existing reporting should be leveraged

whenever possible to minimize administrative burden. To better inform strategies to increase investment in behavioral health integration, and to identify opportunities for payer alignment, limited additional reporting on the types of integrated behavioral health programs payers currently have in place, as well as the percentage of members eligible to participate in such programs, and/or the percentage of members served, will also be valuable."

Workforce:

Tara Smith reviewed the overall recommendation language (see slide 22, available here), the definitions in this section (see slide 24), and the key discussion points (see slide 25). She then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

- The definition of "whole-person and whole-family care", drawn from John Snow International, was updated as follows:
  - "Whole-person care and whole-family care. Whole person-care and whole-family care [is] the coordination of health, behavioral health, and social services in a patient- and family-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. - adapted from JSI"

- In the "Community Health Workers and Other Non-Clinician Providers" subsection, the following edits were made to paragraph 2:
  - Supporting a strong non-clinician workforce means not only establishing payment for current non-clinician roles, but also bolstering the overall development pipeline of this workforce. Peer support specialists, community health professionals, and non-clinical social workers are vital to ensuring whole-person health care is not only attainable, but sustainable. Additionally, ~~S~~systemic investments in recruitment and training programs — such as the behavioral health micro-credentialing work currently underway at the BHA and the creation of new roles like the qualified behavioral health assistant role — are needed to enhance the workforce in this field."
  - An edit was also made in the "Current Payment Support Landscape" subsection to refer to the qualified behavioral health assistant role, which is the correct terminology.

- In the "Examples of Non-Clinician Providers" break out box, the following language was added to more explicitly reference the work by HCPF and CDPHE:
  - "Note: While these terms describe the roles of various non-clinician providers, the Collaborative supports the community health initiatives underway at the Colorado Department of Public and Health Environment (CDPHE) and the Colorado Department of Health Policy and Financing (HCPF). These agencies

are aligned around a definition of community health worker that is based on the American Public Health definition (above), but are using "community health worker" as an umbrella term for individuals who may go by many names, such as: health promoters; community outreach workers; promotores de salud; health navigators; patient navigators. The Collaborative appreciates and reinforces the use of "community health worker" as an inclusive term to refer to additional, related non-clinician roles within a care team."

- The following context was added to "The Role of Telehealth" subsection:
  - "Consumer advocates have heard from patients and providers that an over-reliance on telehealth can have adverse impacts for clients in mental and behavioral health care crises. On-the-ground resources must be available for the most vulnerable patients to access in-person care for conditions such as SUDs, eating disorders, and other matters. Patients should be able to make informed decisions with their providers about which option (telehealth, in-person, or a combination) works best to address their needs."

Health-Related Social Needs Screening and Referrals Section

Tara Smith reviewed the overall recommendation language (see slide 27, available here), the definitions in this section (see slide 29), and the key discussion points (see slide 30). She then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

- In the "Challenges and Opportunities" subsection, the following sentence was added to the second paragraph:
  - "Provider education around stigma and bias is equally important, to confront and reduce the structural and social barriers often experienced by those with social and behavioral health needs."

- In the "Spotlight on Housing" call-out box, the following corrections were made:
  - "This work includes integrating tenancy supportive services as an option into BHA's new contracting model for behavioral health safety net service delivery, the Behavioral Health Administration Service Organizations (BHASOs).

- In the "Health-Related Social Needs Data Considerations" subsect, the following data was added from the 2023 CHAS survey:
  - "In the 2023 Colorado Health Access Survey, people of color were more likely than white Coloradans to report being treated disrespectfully when getting care (7.7% versus 4.4%, respectively)."

Medication Assisted Treatment (MAT)

Tara Smith reviewed the overall recommendation language (see slide 32, available here), the definitions in this section (see slide 34), and the key discussion points (see slide 35). The Division did not receive or make any edits to this section of the report.

Conclusion:

Tara Smith reviewed the key discussion points in this section (see slide 37, available here), then walked the group through proposed final edits and revisions, pausing for feedback/discussion.

- The following sentence was added to the first paragraph of the conclusion:
  - "The Collaborative focused much of its discussion on areas for support and investment, but less time discussing how to measure whether the outcomes for individuals are improved as a result of that investment. Given the goals of the Collaborative include ensuring payers are able to see the benefits of their investments in the form of health outcomes and member experience, future work should include ensuring providers are accountable for improving outcomes and experience for Coloradans."

- A member liked taking this concept full circle in the report, noting that the report is focused on end goal (integrating behavioral health) and offers a series of recommendations on how to get to that end goal, but that it is also important to put mechanisms in place to make sure that actions taken to implement the recommendations are actually having the desired impact (and achieving the end goal);

- Another member questioned the lack of clarity in the final sentence- as currently worded, it includes health outcomes as an outcome of interest, but the references to "experiences for Coloradans" could include member experiences, or experiences of patients and families, or of providers; it may be important to be more specific;

- Another member raised the importance of referencing the need for systems changes, if this additional language is included; providers and payers don't have full control over all the changes that are needed to support integrated care delivery- they can take specific actions, some of it is truly is dependent on system changes; earlier in the report, we call out these structural issues, and if we are going to do a "full circle" in the conclusions, it would be important to reiterate those here;

- A member agreed, but expressed concerns that systemic changes are beyond the scope of what the Collaborative can do; they are something the group can explore, but it is hard to describe that role in this section;

- Another member comments on the parallels between this discussion and the earlier conversation about the plans that the DOI has regulatory authority over; it may be worth including a reminder that there are plans outside of the scope of these recommendations;
    - On a broader level, this statement is about acknowledging there are things the Collaborative can impact (through the recommendations), but there still needs to be broader systems change; so while this report is focused on the levers that the PCPRC has, it is a reminder of the bigger picture;

- A comment was entered in the chat about the addition of potential language about "encouraging partnerships with community organizations working for necessary systemic changes";

- A member voiced concern about the inclusion of a sentence holding providers accountable, without the recognition that there are things that are not within their control that impact outcomes that need to be acknowledged;
    - A member agreed, but noted that an emphasis on this point could potentially undermine the recommendations and the report; in a sense, the Collaborative would be putting forth recommendations that investments and payments are needed to get to certain outcomes, but at the same time saying that the recommendations might not work because of all these systemic issues- therefore the investments/payments should only be made if all of these other things happen;

- A member offered the perspective that the intention behind the additional language was to note that it is important to collect and assess data to ensure that the investments and payments recommended in the report, based on the actions that are within the purview of payers and providers, are having the desired impact on outcomes;

- A member questioned whether the word "accountable" was the source of tension, noting that the investments recommended in the report actually extend beyond providers, and include things like infrastructure and non-clinician roles; perhaps the language here can speak to that more holistic picture;
    - Members agreed that it could be helpful to make a distinction between the systemic investments and specific payments to providers, which would be to pay for actions that they could control, provided they are given the necessary support, tools, etc.;

- Members generally agree that clinicians should be held accountable for outcomes, but there is a limit to which clinicians and care teams can be held accountable due to broader, market and delivery system dynamics;

- Members also supported including language that makes it "yes/and" statement- there should be accountability, but future conversations must recognize and define what is the realistic limit of what that accountability is, and system level factors do put natural limits on accountability; various suggestions about language regarding future conversations included:
    - "Future conversations are needed about how to measure success in this space…"
    - "The Collaborative can also use future reports to encourage (conversations about measuring impact of investments, provider accountability)
    - "Future work should include the definition of measures to ensure providers are held accountable…"

- DECISION/ACTION: The Division/CHI will workshop language to be included in the conclusion, and email to members on 2/9 for approval.
    - A member emphasized this language should simply state further conversation is needed, and does not put forth a values statement.

VOTE:

During the PCPRC meeting, the 8 members in attendance voted to approve this year's annual recommendations report as follows:

- 6 votes - full approval of report in its entirety (pending a final review of added conclusion language);
- 2 votes - provisional approval (pending a final review added conclusion language and full set of revisions made during the meeting discussion).

After the meeting, the report was approved in its entirety by 12 members, via email.

Next Steps:

- DOI/CHI draft and circulate language for the conclusion section to members; all members are asked to vote by COB on 2/9;

- The final report will be published on Feb 15 on the PCPRC website.

Goals and Priorities for 2024

Tara Smith started a discussion of potential PCPRC goals and priorities for 2024. To frame this conversation she reminded members of actions that Collaborative has taken since its creation, reviewing the group's statutory charges (see slide 40, available here) and the two DOI regulations, 4-2-72 and 4-2-96, that have been informed by PCPRC recommendations. She then asked members for ideas about what they would like to see the PCPRC accomplish in

2024 (and 2025), and how group members would like to contribute. Some ideas from the Division included: 1) improving the primary care/APM reporting methodology; 2) continued collaboration with the BHA, other state initiatives; 3) connection with other state/national primary care initiatives; and 4) staying informed on the implementation of the Making Care Primary CMM model.

Discussion/Suggested ideas:

- Measuring how the investments are actually improving health outcomes;
- With that, there are also the limitations and structural issues that are plaguing primary care in other areas; since we have addressed many of the statutory requirements, the Collaborative could explore emerging topics and challenges;
- Two thoughts: 1) the impact of venture capital on primary care; venture capital goes where the money goes, so by directing more money toward primary care are we making it a more attractive target, and what the implications of that the both for health care systems and the payment models we are talking about; 2) this group will want to pay attention to HCPF's Payment Alternative for Colorado Kids (PACK) initiative, which kicked off yesterday, and is an attempt to develop a child-specific APM in the level 3 or 4 category;
- When it comes to team-based care, do we really have a good grasp on how much that costs- how do you recruit, how do you retain, how do you train, how do you select the right types of primary care team members based on the population; have some colleagues at OHSU that are beginning a research study to examine some of those questions; to drill in a bit more about what we mean by team-based care- what is the infrastructure needed, how to finance it, how to do that well, might be an area of interest;
- Agree with comment on venture capital, also impacts of system consolidation on primary care, what that looks like; this may be further afield, but all things AI and primary care; how to wrap our hands around this massive, nebulous elephant in the room that absolutely will have impacts on training and retention and potentially making clinicians lives easier but also for the organization, financing and delivery of health and health care; lots of legal issues, liability, and other issues involved;
- Are the payments that are put in place going to the right places? They are going to the places to support team-based care; seeing in small practices, that they have money to support team-based care, but still don't have money to hire a new doctor; worry that are all of the new primary care doctors that are coming out into the world, will there be any of them going into small independent practice, or will 80% of them be going to

big systems; how do we as people who influence policy-makers need to change how we think about

- Echo interest in consolidation and particularly its relationship to APMs and following that money; would also like to pick up on some of the threads that we talked about in a previous report about what makes an equitable APM; continues to be concerning data about how risk-based models in particular impact patients of color and other types of low-income communities, so we need to dig more into what an equitable APM looks like;

- From NASEM perspective, challenges we have in helping lawmakers understand really tangibly what is high quality primary care; a lot of the work we try to move forward depends on that; the other component too is helping to draw the connections between bigger issues and public health trends - like BHI, pandemic preparedness, maternal morbidity and mortality, mental/emotional/behavioral health challenges that we are all experiences with the opioid/heroin epidemic - PC is a part of not the full solution, but a very important part of solving those bigger issues and public health trends that we are experiencing right now, and making those connections.

Public Comment:

- No public comments were offered.