COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes
Thursday, April 11, 2024; 10:00 - 12:00 pm
Virtual meeting

Meeting Attendance

Attended
Polly Anderson
Brandon Arnold
Isabel Cruz
Kate Hayes for Jack Teter
Steve Holloway
Lauren Hughes
Cassie Littler
Amanda Massey
Lisa Rothgery
Amy Scanlan
Gretchen Stasica
Patricia Valverde

Absent
Josh Benn
Patrick Gordon
John Hannigan
Rajendra Kadari

Pete Walsh

DOI
Tara Smith
Deb Judy

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. 2024 Priorities & Draft Meeting Schedule
4. Health Equity
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 requested approval of the draft February and March meeting minutes.

  ACTION ITEM:
  - Meeting minutes from the February and March meetings were approved and will be posted on the PCPRC website.

- **Membership update** - Tara Smith noted that the application for new members is open and can be accessed on the PCPRC website; opportunities currently exist for new members in all membership categories. The Division will be circulating a one-pager/flier about the PCPRC that members can share through their networks.

  ACTION ITEM:
  - Tara Smith will circulate a draft one-pager about the PCPRC for members to review, and any revisions/edits can be discussed at future meetings.

- **Website updates** - Tara Smith noted that several updates had been made to several of the Division's websites related to primary care, including the PCPRC website, the HB22-1325 Primary Care APMs website, and the CO APM Alignment Initiative website. Members are encouraged to visit the pages, to see if they are easier to navigate; any suggestions/feedback can be emailed to Tara Smith (tara.smith@state.co.us).

  Member comments/discussion:
  - A meeting participant noted that the annual Primary Care and APM Spending Reports produced by CIVHC are currently included as appendices to the PCPRC's Annual Recommendation Reports but are not directly accessible on the website; they suggested adding direct (separate) links to the Primary Care and APM spending reports.
    - Multiple members agreed with this suggestion.
  - A meeting participant also suggested interlinking the 3 websites, as they interrelate with one another.

Federal & state updates

The following federal updates were provided:

- **Extension of Medicaid Unwinding** - Colorado is extending the Special Enrollment Period (SEP) for those who are being disenrolled from Medicaid due to the end of the COVID-19 public health emergency (the "Medicaid unwind") from July 31, 2024, to November 30, 2024.

- **2024 CMS Health Equity Conference - May 29-30** - Virtual and in-person registration for the 2024 CMS Health Equity Conference, which will be held on May 29-30, 2024, is now open. Interested members can register at the following link:
    - https://cmshealthequityconference.com/register

  In response to a member question, Tara noted that the conference was either being held in Washington DC, or possibly Maryland (at CMS headquarters).

- **ACO Primary Care Flex Model** - In March, CMMI released a new ACO Primary Care Flex Model, which is designed to "empower primary care providers in eligible ACOs to treat people with Medicare using innovative, team-based, person-centered proactive care." The model will provide one-time advanced shared savings payments and monthly prospective primary care payments to selected ACO, with the aim of increasing the number of low revenue ACOs in the Shared Savings Program. CMS currently anticipates releasing a Request for Applications in the second quarter of 2024.

  Member comments/discussion:
  - A meeting participant commented that the focus on low-revenue ACOs sounds like a promising way to look at child health practices.
    - Several members agreed with this comment, although one noted that practices must be MSSP participants to be eligible.

- **Transforming Episode Accountability Model (TEAM)** - In April, CMMI also announced a proposed mandatory Transforming Episode Accountability Model (TEAM), which would require selected acute care hospitals to coordinate care for people with Traditional Medicare who undergo surgical procedures included in the model. The model would launch on January 1, 2026, and run for 5 years.

- **HHS/HRSA - Loan Forgiveness for PCPs/OB-GYNs in Rural Areas** - HHS recently announced that the Health Resources and Service Administration (HRSA) increased by 50% the initial loan repayment amount available to primary care providers—M.D.s and D.O.s, including OB-GYNs and pediatricians; nurse practitioners; certified nurse midwives; and physician assistants— who commit to practicing in areas with significant shortages of primary care providers. As a result, providers could have as much as $75,000 forgiven in exchange for a two-year service commitment. HRSA is also offering up to an additional $5,000 in loan repayment to all National Health Service Corps Loan Repayment Program participants who can demonstrate fluency in Spanish and who commit to practice in a high need area serving patients with limited English proficiency.

Member comments/discussion:

- A member flagged that the deadline for practices to sign up for Making Care Primary has been extended, as CMMI continues to work with practices to get participation agreements in place. The MCP model is still expected to launch on July 1, 2024.

The following state updates were provided:

- **2024 legislative session** - Tara Smith provided a brief update on the current legislative session, and highlighted the following bills, which could have potential relevance to the Collaborative's work:
  - HB24-1005 - Health Insurers Contract with Qualified Providers
  - SB24-080 - Transparency in Coverage
  - HB24-1040 - Gender-Affirming Health Care Study
  - SB24-059 – Children's Behavioral Health Statewide System of Care
  - SB24-175 - Improving Perinatal Outcomes
  - HB24-1149 - Prior Authorization Requirements Alternatives
  - Benefit related
    - Obesity & diabetes; infertility; substance use disorders; biomarker testing
  - SB24-093 - Continuity of care

2024 Priorities & Draft Meeting Schedule

Tara Smith provided a summation of priorities identified by members at the February and March meetings, and offered a draft schedule of discussion topics/presentations for the upcoming year (see slides 10-12, available here). She asked members for feedback on the identified themes/priorities, and the proposed schedule.

Discussion:

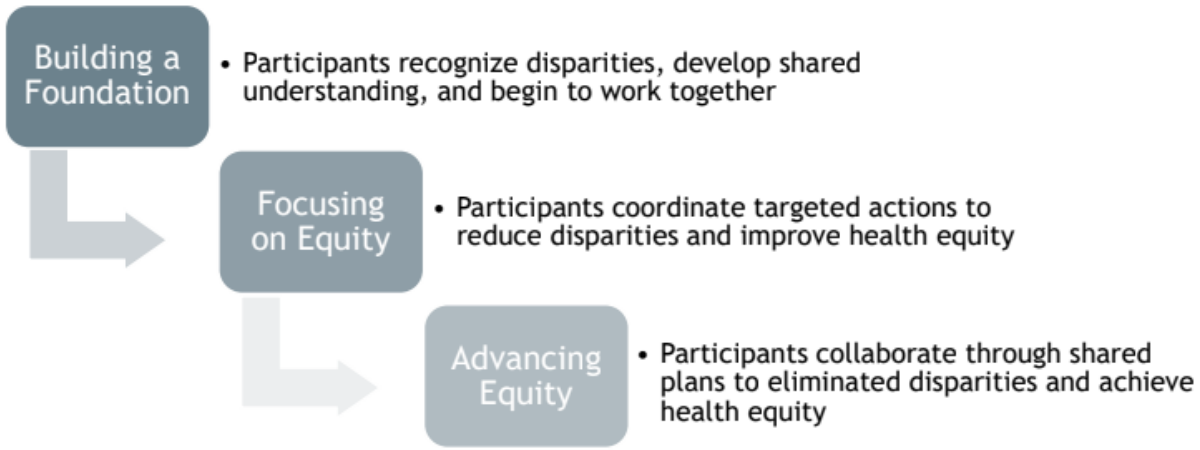
- A meeting participant expressed support for the proposed topics/themes but suggested adding "the role of AI in primary care." They noted that AI is rapidly advancing, and expressed concerns that primary care may struggle to keep up with some of the developments, both good (e.g., payments) and potentially negative (e.g. use of AI to ramp up pre-authorizations, denials).
  - Multiple members agreed with the addition of this topic, with one citing in particular the use of AI in developing risk algorithms.

- Members expressed general agreement with the proposed schedule, commenting that it looked robust, and represented a good array of topics.

- A meeting participant noted that the CIVHC Primary Care & APM Spending Report gets to the Collaborative relatively late in the process of developing recommendation, and wondered if it would be helpful to invite CIVHC to give a "preview", prior to the release of the report, reminding the Collaborative about the data that will be available to them to inform recommendations. While specific results will not be available, they could inform the group of any issues or trends they are seeing (e.g., if certain gaps exist, or if any of the methodologies have been changed/revised).
    - Multiple members supported this suggestion.

Equity in APMs

Tara Smith started a discussion of health equity in APMs by presenting an overview of the various national and state frameworks and initiatives that are focused on incorporating equity into APMs, including several efforts in Colorado. To further frame the conversation, she also reminded members of previous Collaborative recommendations on this topic, focusing on the Third Annual Recommendations Report (see slides 16-27, available here), and the "step-by-step" approach to centering equity put forward in that document:



The following questions were then offered to start group discussion:

- Do you still support a step-by-step approach to health equity, or should this frame/framework be revised?
    - If so, where are we in the process, and what are the next steps?
    - If not, how would you like to proceed?
- Follow-up activities around Step 1?
    - Roles & responsibilities
    - Data collection
    - Summary of activities to date (follow-up reports, HB22-1325)

- What would be included in Step 2?
    - Specific questions for: CMMI, other states, payers?

Discussion:

- A member asked if the Collaborative had reviewed literature or research examining the impact of different payment mechanisms on reducing or exacerbating disparities?
    - Tara Smith noted that the Collaborative has reviewed articles in the past looking at the implications of alternative payment models on health equity, and the potential unintended negative consequences; she offered to try to gather and re-circulate some of these resources;
    - A member entered the following resource into chat: https://drive.google.com/file/d/1v4J2N7Jkr3llfRASbPKDfi9ZNSlNg9e8/view.

- A member noted two words that come to mind when they think about equitable APMs are accountability and infrastructure. They felt the Health Affairs article circulated as pre-reading for this meeting - which noted that it is important to pay more than lip service to equity, and actually built teeth into models - offered a rich area of discussion for the Collaborative.

- A member commented via chat that they felt that Step 2 seemed like the right step, both time wise and strategy wise.
    - Multiple members agreed.

- A meeting participant commented that while a lot of work had been done around a shared understanding of definitions in Step 1, they felt that additional clarity was needed when it comes to data, including how data is collected and displayed. They felt work was still needed to arrive at a common understanding of how data related to health equity is being collected, who is collecting it, and what is being collected. This work could potentially be categorized as a "step 2" activity, but that it is still an important issue to address.
    - Multiple members agreed via chat, and a meeting participant noted their organization (a payer) is still working on this issue. They highlighted that the collection of this data is still difficult, and when it comes to providing interventions for patients or getting them to the right resources to focus on equity, there is still some disagreement over where that responsibility lies with the plan or the provider (more so or entirety to one party or the other). They noted additional challenges that arise when a member has needs in an area that doesn't have resources available for referral. Based on this, they felt that a lot of foundational work (step 1) is still needed.

- Another member commented that the literature in this area has grown and evolved over the last few years, and that it would be helpful to aggregate and review the current body of work as a group. They noted that the current APM landscape is different than when the 2021 report was produced, with regard to data around some of the outcomes of some of these models- and issues highlighted in the article that was circulated about the gains and gaps with the Making Care Primary model. The member also pointed out that it is unlikely that Step 1 will ever be perfectly complete- the foundation of how we talk about things and what we are learning and what the challenges are is never going to be totally settled - but it is important to move us forward, into what does operationalizing this look like, what are good examples, what are bad examples, and what does that mean about what we can collectively agree on recommending for moving this forward. The member expressed strong interest in continuing to have this conversation, and making sure that as some of this work around equitable APMs continue that we have some shared understanding and goals beyond just that we agree that this is important and that it should be part of the conversation. We have moved the ball forward with the regulations from HB22-1325, but there is more work to be done.
    - Multiple members agreed, with one noting that because we may never have the super solid foundation that we would want, it may be helpful to reframe the focus to finding the right balance to strike between building/strengthening necessary infrastructure elements (especially data collection/analytics) and a bridge to step 2.

- Tara Smith asked if there were specific topics or issues that come to mind that additional information or resources would be particularly helpful? For example, regarding the issue of data collection - is the group interested in looking at specific examples of where/how this data is being collected, and/or touching base with NAIC group examining race/ethnicity (referenced in the previous PCPRC report), and/or asking payers about their methods? Or are there other areas in the recent literature that stand out, to help guide efforts?
    - A member commented that it might be helpful to connect with some of the larger payers in Colorado to find out if, where, when, and how they are collecting this data. It would be great to build on what the majority of patient or covered lives are using or thinking about as a place to start. For example, Medicaid has a strong equity focus, and a health equity plan, that could be leveraged. From the perspective of a Federally Qualified Health Center (FQHC), collecting this data is part of enrollment and must be reported federally, but the average provider in Colorado might not have developed systems/capacity to view the race/ethnicity of their patients.

- Tara Smith next asked the group if they had any thoughts or ideas about cultural competency/responsiveness, and interest in having further discussions in this area.
    - One member noted that the U.S. of Care just released a report on culturally responsive networks and policies unique to Colorado that included recommendations. While the recommendations are broad, they nevertheless speak to the measurement and other pieces of cultural competency, and offer examples of what the measures can look like (U.S. of Care report available at: https://unitedstatesofcare.org/new-report-culturally-responsive-care/).
    - A member noted that payers have been engaged with the Division around some of the cultural competency requirements in the CO Option, so maybe further discussions on foundational definitions could potentially help ease those conversations and provide a better understanding of some of these concepts that bleed into other areas.
    - Another member commented that they didn't know from a provider perspective, what kind of education currently exists. Are there trainings in Colorado that providers can access? It would be helpful to get a better sense of the current landscape.

- A member noted that payment (and its limitations) has been central in many conversations they have had around cultural responsiveness and how it is used to both support a more culturally responsive workforce. Important features of payment structure include: what types of providers are included in payment models; how team-based care can reduce some of the barriers to entering the workforce; and how can payment models reflect these training and learning goals as part of the capacity for folks- what does that look like for payers, for provider, and for patients in terms of asking for what they need. The payment model as a facilitator of making this a reality is an important part of the conversation on culturally responsive care.

- A meeting participant via chat noted their dislike of cultural competency as a construct- they felt it was too binary, and that cultural humility and cultural responsiveness are more useful concepts.
    - Multiple members agreed, with one noting when using words like cultural competency, it is too easy to get drawn into a check the box mentality; as we learn, it is helpful to evolve our terms. It's not realistic to become competent after a training or two or three - but demonstrating humility and responsiveness as one continues to learn and grow goes a long way. It is important to avoid reductionistic words and thinking when talking about and implementing these types of programs.
    - A meeting participant noted that their institution has several training programs in communication, have a standardized patient program with the Black

Women's Health Initiative that has been amazingly power; somehow trying to capitalize on initiatives at various organizations would be helpful;

- A member noted that disability competency in primary care should also be part of the Collaborative's thinking and discussion.
    - Multiple members agreed with this comment.

- A member elevated the concept and goals of racial cultural concordance in this conversation. They noted that while cultural competency is essential to a high functioning, successful, high quality, equitable system of care, we are still sometimes (oftentimes) taking the dominant culture of the system and trying to make it more accessible to non-dominant cultures and experience. The next level of our obligation is to move even more deeply into creating a more diverse primary care workforce, so there is actual cultural concordance with the communities that we intend to serve. The Office of Primary Care at CDPHE has done a lot of work in trying to understand racial and ethnic dimensions of the PC workforce over the last several years- and while this work is getting better, it reveals lots of what we already knew intuitively about our workforce- that it is not very diverse, not growing from all the communities we want to serve. It is important that the goal of cultural concordance is part of this dialogue.
    - A member noted via chat that diversifying the workforce is a long -term solution, while building the capacity of our current workforce to be culturally humble/responsive is a short- to medium-term solution.

- Tara Smith asked members about the "guiding principles" that the Collaborative had included in the Third Annual Report, which included: 1) elevating the voice of individuals and families alongside experts in the healthcare field; 2) incentivizing action to reduce health disparities; and 3) focusing on whole-person care.
    - A member commented that since this principle was put forward, the conversation around this issue has evolved fairly significantly. More recent thinking has been examining various approaches - such as bringing people into this (policy) space versus meeting people where they are at, versus how these conversations are already happening. It would again be helpful to review some of the more current literature; for example, U.S. of Care produced a messaging guide on VBC/APMs and how patients do or do not respond to talking about payment models, and how such conversation can be made more accessible to people. HCPF is also doing work right now to bring more people into their payment model design, and it would be interesting to explore some of their new strategies and learnings in this space. (U.S. of Care report available at: https://unitedstatesofcare.org/the-latest/value-based-care-patient-first-care/).

- Tara Smith next asked members about some of the previous recommendations around guarding against the exacerbation of disparities in APM model design, and if there were any new threads of the conversation they wanted to pursue.
    - A meeting participant noted that from the payer perspective, the ability to guard against disparities relies on the quality of the data, which goes back to Steps 1 and 2 in this conversation. They also cautioned that the more stipulations and parameters that are put on APMs, the less flexibility payers will have to be able to target some of these issues. While payers want to work toward these goals, requirements to adhere to a specific set of measures, or limits on the measures that can be collected, may reduce payer's ability to select measures that can target specific populations. While we want to do these things, we also need to make sure that we are providing the flexibility to do them and do them well, without increasing the burden on any particular party to try to achieve those goals.
    - A member noted that from the Medicare data on early APMs, there have been a handful of articles that have found pretty harmful impacts for providers that are serving patients that have prior barriers to care, without intentionally thinking about the upside and downside risk questions. It would be helpful to review the growing literature on this, particularly in the Medicare space, which can help us ask some of the right questions.

- In closing, a member reflected that while the step-by-step approach is still useful, centering equity is never going to be a completely linear process, where any one step will remain static and can be considered fully complete. They supported going back and reviewing some of the more recent literature as a good next step in advancing this discussion.

Public comment:

- No public comments were offered.