COLORADO
Department of Regulatory Agencies
Division of Insurance

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

Meeting Attendance

Attended
Polly Anderson
Brandon Arnold
Josh Benn
Isabel Cruz
Britta Fuglevand
Steve Holloway
Cassie Littler
Amanda Massey
Amy Scanlan
Gretchen Stasica

Absent
Kate Hayes/Jack Teter
Patrick Gordon
John Hannigan
Lauren Hughes
Rajendra Kadari
Patricia Valverde

DOI
Tara Smith
Deb Judy
Jill Mullen

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. AI in Primary Care
4. Colorado Market Dynamics
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 May meeting minutes.

  ACTION ITEM:
  - Meeting minutes from the May meeting were approved and will be posted as final on the PCPRC website.

- **Scheduling updates** - Tara Smith announced that the PCPRC meeting in September will be hybrid- with participants having the opportunity to participate either in person or virtually. The in-person location will be at the Division (1560 Broadway)- additional details will be forthcoming.

- **Primary Care and APM reporting stakeholder meeting** - Tara Smith also announced that the Division will be hosting an upcoming meeting to discuss proposed changes to the primary care and APM reporting requirements included in DOI regulations 4-2-72 and 4-2-96. The DOI is targeting **August 22, from 10-11 am**; an invitation with confirmation of the date, time, and registration link will be sent out shortly.

Federal & state updates

The following federal updates were provided:

- **Transforming Episode Accountability Model (TEAM) finalized** - CMS announced the finalization of TEAMl, a 5-year mandatory model to incentivize care coordination between providers during surgery and services provided 30 days post-surgery. While the model is focused on acute care hospitals, it does include requirements for referrals to primary care to support continuity of care, to help drive positive long-term outcomes.

- **Final Rule - 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS)** - On August 1, 2024, CMS issued the fiscal year (FY) 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule, which updates Medicare fee-for-service payment rates and policies for inpatient hospitals and LTCHs for fiscal year (FY) 2025. Provisions relevant to the work of the Collaborative include:
  - Higher payments to hospitals for furnishing care to individuals experiencing homelessness and housing insecurity;
  - Promote access to treatments for rural and underserved communities; increased new technology add-on payments to improve access to new gene therapy for sickle cell disease; and

  - Separate payment to small independent hospitals, including rural hospitals, for establishing/maintaining access to buffer stock of essential medicines.

- **Final Rule – 2025 Skilled Nursing Facility Prospective Payment System (SNF PPS) -** On July 31, 2024, CMS issued a final rule updating Medicare payment policies and rates for skilled nursing facilities under the Skilled Nursing Facility Prospective Payment System (SNF PPS) for fiscal year (FY) 2025. Provisions relevant to the work of the Collaborative include:
  - Updates SNF Quality Reporting Programs (QRP) to better account for adverse social conditions that impact health; and
  - Adding 4 new social determinants of health items (one for living situation, two for food, one for utilities) and modifying one SDOH assessment (transportation).

- **Final Rule – Updates to Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) -** On July 31, 2024, CMS also released a final rule (CMS-1804-F) that provides policy updates for the fiscal year (FY) 2028 Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP). This rule, similar to the SNF PPS, includes the addition of four new assessment items in the Social Determinants of Health (SDOH) category: Living Situation, Food, and Utilities to the IRF-Patient Assessment Instrument (PAI).

Discussion:

- A meeting participant asked whether the TEAM model was a multi-payer model, or was specific to Medicare.
  - Tara Smith noted that the model was focused primarily on acute care hospitals, and the payments were specific to Medicare (it was not a multi-payer model).

The following state updates were provided:

- **Senate Bill 21-169 Stakeholder Meetings** - Tara Smith provided an update on the Division's implementation of SB21-169 - a Colorado law that protects consumers from insurance practices that result in unfair discrimination on the basis of race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identify, or gender expression - noting that the DOI hosted a stakeholder meeting related to health insurance on July 30, 2024. At this meeting, consumer advocates expressed their perspectives and concerns about the utilization of big data and artificial intelligence tools by health insurers. Meeting materials, including a recording, are available on the Division's SB21-169 - Protecting Consumers from Unfair Discrimination in Insurance Practices website. Stakeholders who are interested in following the Division's activities related to SB21-169 can sign up for updates on the Sign-Up for Division of Insurance Email Lists website.

- **HCPF Annual Stakeholder Webinar** - HCPF will be hosting its Annual Stakeholder Webinar on August 27, from 8-11 am. This event will review HCPF major initiatives for fiscal year 2023-2024, priority initiatives for fiscal year 2024-2025, and Public Health Emergency Unwind insights and opportunities going forward. Register at the following link: https://us02web.zoom.us/webinar/register/WN_yr1yodo2Txa10zITMSc-Mg.

AI in Primary Care

Tara Smith started the discussion of AI in primary care by reviewing key themes surfaced during the presentations on AI that were provided by Dr. James Barry and Jason Lapham at the July PCPRC meeting. Both the presentations and the articles that were distributed as pre-meeting materials dealt with several dimensions of AI, including: 1) care delivery; 2) payment; and 3) ethics. To help frame the discussion of each of these topic areas, she offered the following questions:

- How are you seeing AI impact primary care in Colorado?
  - Impacts on your practice (adoption/workflow)?
  - Impacts on your payments/reimbursements/costs)?
  - Impacts on patients?

- What are the key implications for primary care and the work of the Collaborative?
  - Payment or other policy levers that you would elevate?
  - Other strategies, considerations
  - Resource allocation

- Specific questions for: federal partners, other states, payers?

Care Delivery

Tara Smith briefly reviewed the issues/topics raised in the pre-reading materials related to care delivery (see slides 16-22, available here).

Discussion:

- A member noted they had recently attended a value-based care conference, with other primary care associations, and AI in primary care- particularly uses around predictive and prescriptive analytics- were a significant topic of discussion; while the member had not hear a lot about clinical applications of AI in health centers here in Colorado, the use of AI is nevertheless hear and spreading;

- Another member commented they are seeing AI starting to be used in the health systems they are working with, largely in relation to administrative tasks (inbox management, documentation help, voice recognition and large language processing

models), and has been received positively by providers; however, this use has also raised fears about new expectations around productivity, and the need to do more in the time that is now freed from administrative tasks;

- A member noted they had received an email this week about a new pilot for an AI technology that transcribes notes during a patient visit; providers who participate in the effort are expected to see additional patients each month, and so it has been a hard sell for providers who already feel they are overstretched;

- A meeting participant offered a perspective from the Western Slope, noting that AI is not in wise use in their area, in terms of some of the tools and devices and were referenced in the pre-reading materials;
    - The practice they work in did transition to an EHR that includes better algorithms and computing capabilities, but outside of that, they are not using AI tools widely, principally due to the costs of paying for keeping up on the technology required;
    - The financial burdens associated with IT, including EHRs, are a real struggle in rural areas, which limits the capacity to adopt and implement new tools or devices;
    - In terms of billing, and some of the CPT codes that were listed for the AI devices in the pre-reading materials, their practice is not using them in the outpatient setting, but the participant was not sure if that was the case for the hospital in their area; a CEO that joined the hospital recently is very interested in and excited about AI, and is working to get EPIC implemented in the next year (to consolidate the 4 or 5 EHS systems they are currently using);
        - The hospital in Gunnison has a new automated breast ultrasound, which is supported by AI, and according the the radiology director at the facility, has been a real benefit to providers;
    - Anecdotally, the participant was aware that another another family practice provider in the community is currently piloting an AI scribe tool on his own- it is a software application on a mobile device that is integrated with EHR, and populates the chart during the patient visit; the software can recognize clinical/medical components of discussion from casual conversation; this capability, if the automation is done accurately, could be a huge benefit to providers; providers would still have the responsibility to review the output, to make sure it is complete and accurate, but it has the potential to be a large time saver;
    - On the flip side, however, there is fear about what will be expected in the "time saved" through the use of these tools;

  - Our group has not done any special billing for AI codes; don't know if transcription piece is something that would have its own billing code or not; not sure of billing being done by hospital;

- A member commented that one of the health systems they are working with is using AI tools (ambient dictation that uses AI to populate notes) to reduce documentation burden; a pilot is also underway to use AI to respond to patient emails; a key unanswered question to date is whether these tools can successfully reduce the documentation burden that is primary care, which is the focus of efforts within this member's sphere, and actually bring the joy back into medicine, by allowing providers to spend more time interacting with patients;

- A meeting participant inquired via chat whether providers were disclosing the use of such tools to patients; responses to this question were:
  - In the case of the pilot using AI to respond to emails, the response to the patient discloses that the message was generated with the help of a chat bot;
  - In the anecdote from the Western slope provider, the story was actually told by the patient in that interaction, so they were aware that the technology was being used (and were asking if the meeting participant's practice was using something similar);

- A member reflected that one of the articles in the pre-reading noting the higher use of AI in academic centers raised concerns about the future workforce; if residents are being trained in environments where they are seeing and using this technology, and it is then not available in the communities where they end up practicing, it raises two concerns: 1) how do we recruit people to areas that really need primary care but may not have the resources to have these kinds of tools that residents "grow up with"; and 2) how do we teach them to practice without these tools, if they go somewhere where these tools don't exist? This discrepancy between training and practice needs to be called out and addressed somehow, as we ultimately want practice and care delivery to be similar across settings;

- A meeting participant suggested that medical schools and residencies could potentially partner with practices and support the provision/maintenance of these tools at practice sites that are hosting medical students or residents for clinical rotations;
  - Smaller practices in rural areas face significant financial barriers to procuring and utilizing AI tools, and a partnership with residencies or academic centers to pay for or provide these technologies could serve as a bridge to help meet that need, while supporting clinical rotations in areas that are in high need of primary care;

- Such practices already struggle to take new residents, as it limits their ability to see and take on new patients (providers aren't able to see as many patients when the are precepting); partnerships that would allow for the expansion of AI tools in rural areas could create a pathway for providers to train and then work in rural areas;

- Tara Smith asked if members had any additional concerns, raised by the pre-reading materials or their personal experience, about the impact of AI on the physician-patient relationship, which at the heart of primary care;
  - A member commented that they are concerned one of the points made by a speaker at the July meeting- that "garbage in is garbage out" for these models and tools; in the case of large language processing, the models are pulling form data that is already in the chart, which may not always reflect an accurate picture of the patient; the member noted they could foresee "garbage in garbage out" becoming increasingly problematic if we are not careful about how these tools are used, how their output is monitored, used, and presented to patients;
  - They further noted some of these issues are already being seen in relation to note transparency; if a clinical includes a note about chronic kidney disease in a patient chare, but no one has told or explained to the patient what that means, it leads to a panicked or angry call from the patient saying I didn't know I had kidney disease;
  - The member also raised concerns that AI may tend to promote the biases that are already built into the data and models, which we need to be thoughtful about, especially if we are going to be starting to use this technology in terms of predictive analytics;

- Another member expressed similar comments concerns, noting that AI can be a double-edged sword. They reflected that one of the presenters at the July meeting had highlighted instances where AI and large language models had helped uncover systematic biases in some of the clinical notes and and other source, so it has the potential to "root out" and help us better understand sources of bias or discrimination, and improve health equity and care delivery; on the other side, if the notes and outputs of AI tools and models are incorporated into care delivery in a way that continues to reinforce these biases, it can actually serve to perpetuate discrimination and disparities- in some of the ways we have seen medical devices and other technologies make prejudiced decisions- so AI needs to be used carefully, and with an equity lens;

- A member commented that AI is a topic that CDPHE and the Office of Primary Care has been thinking about for a host of non-clinically focused reasons; questions of interest include:
    - Any time you use an AI assistant at CDPHE you are creating a record that potentially is subject to open records act requests; imagine analogous problems with AI generation in a clinical setting- how does that documentation become part of the medical record- is it fully integrated, is it simply an aide that then gets edited and translated by the clinician?
    - The member noted that while they are not familiar enough to know how those questions are being handled in the clinical settings, it is an important consideration; in their personal experimentation with AI note-takers, or meeting summarizers, they have found pretty consistent inaccuracies, with the tools getting it right about 70% of the time- so what are the implications for the times it doesn't get right;
    - The member cautioned that sometimes tools can make us lazy, and we need to guard against this tendency- if we are carefully editing the work of the AI charting tool, it can be good mechanism to save time; however, if the use of a tool starts to make us increasingly lazy, and errors start to creep into the record- what are the implications for patient care quality, liability, error rates. Also, what is discoverable in a legal case- how might that make the work harder? These are challenges in non-clinical settings, but are likely applicable in that context as well.

Payment

Tara Smith briefly reviewed the issues/topics raised in the pre-reading materials related to payment (see slides 23-31, available here).

Discussion:

- A meeting participant commented that it would make sense for the PCPRC to consider payments and payment structures that would support uses of AI that can directly benefit primary care delivery (e.g. care coordination, continuity of care, message management), as opposed to use cases centered on a specific device, or specific subpopulation;
    - When thinking more globally about population health, and primary care providers' population management of the patients on their panel, APMs - either via additional payments or percentage on a PMPM basis - are a more viable mechanism to support the use of AI tools;
    - For providers, it is taxing and time consuming to have to add additional codes to a claim, and be paid on a FFS basis; if costs are passed on to patients, it can

also be detrimental- they may not want to pay a fee, and it could end up causing more burden and/or harm to patient's care,

- A member commented that payment is a challenging issue to tackle when it comes to AI, due to uncertainty about the behavior that we might want to incent in this space; how we pay for something drives behavior, and the jury is not yet in on what we are we trying to incent with AI vs without AI;
    - Payment structures are difficult to determine when we don't have a clear cut "this is exactly what I want to do or promote,"-and we don't know enough about AI yet (no one has clear answers about whether we are getting what we think we are getting, and whether we want to incent that.

Ethics

Tara Smith briefly reviewed the issues/topics raised in the pre-reading materials related to ethical considerations around the use of AI (see slides 32-35, available here).

Discussion:

- A member noted that the point made in one of the pre-reading articles about include the patient perspective in the development and use of AI tools and models was an interesting and important one; this perspective might be the part that is missed when we are thinking about big data and what is already out there;
    - The member further noted that from a pediatric point of view, confidentiality is also very important; teenage confidentiality is a hard topic- what are the impacts and implications of these tools in this space?
    - It is also important to include a wide variety of patient perspectives, not just adult patient perspectives; when thinking about children, there are also implications for parents, making decisions about data/privacy for their kids;

- Another member agreed that including patient perspectives is important, but also a challenge- there are so many different groups of patients, and so many factors that would make people more or less comfortable with the idea of their data being used in these ways- or how is the data being incorporated in tools and models, and translated into practice and care delivery? How does this impact the doctor-patient relationship? it is extremely important, but also really hard- how can these systems be designed in a way that people have ownership and autonomy over their own data, which is a struggle in all types of AI and data systems in general;
    - In terms of ethical frameworks, they can be valuable- but it can also be helpful to connect ethical challenges within existing frames; connecting discussions of AI with some of the challenges that people have in seeking primary care and medical care in general that has relatively well-studied, and drawing on lessons

learned from that research can provide some level of insight into guiding practices of how best to think about AI from a patient centered lens.

Colorado Marketplace

Tara Smith provided a brief review of the Collaborative's recent discussions exploring some of the broader, system-wide market dynamics - including private equity, consolidation, and venture capital - that impact the flow of dollars in the health care system, including dollars flowing to primary care. A centering question coming from those conversations: are the payments that we are putting forth by changing payment structures getting to the right places? Our goal is to strengthen primary care delivery and workforce- is that happening, and if not, how do we get in front of that?

In looking at that question in the context of Colorado, Tara Smith highlighted the range of payers (public and private) and providers (integrated care delivery systems, safety net provider, small and large practices, and urban and rural practices). She also noted that the dollars flowing between those two entities are mediated through various systems or structural arrangements- including CMMI models, ACOs, and various network arrangements. To provide additional details about Making Care Primary, the newest CMMI primary care model, Tara introduced Nick Minter, the Director of the Division of Advanced Primary Care in the Patient Care Models Group at CMMI.

Making Care Primary

- Making Care Primary is a 10-year model structured with 3 tracks to meet providers where they are, to provide them with additional upfront support in the beginning of the model for those that are least advanced;
    - The upfront support for newer providers is more generous, and does not require providers to hit certain performance measures; as time goes on, and they become more competent in a value-based care environment, the model will transition payment to prospective basis- start to provide more funding but require that to be contingent on hitting certain performance benchmarks;
    - Idea is over 10 years organizations that are wary of going into VBC develop competencies to sustain and thrive in that environment;

- Potential revenue in model, when looking at all the different payment types (care management fee, performance-based payments, payments to support specialty), is near to double what the revenue is for current, traditional Medicare patients on a per-annum basis;

- Additional data on model participants, both nationally and in Colorado, is summarized on slides XX-XX, available here.

Discussion:

- A member commented that while it is exciting to have so many models in Colorado, the number of models can also be really confusing for providers, and highlights the need for payer alignment. Providers, particularly those in smaller practices that don't have the capacity to analyze data, have a hard time understanding the risks and opportunities involved in different models; payer contracts are nuanced, and different skills are needed to "win" in different contracts, and it can be hard for the practices on the ground to chart the right course;
    - Nick agreed, noting that CMS was sympathetic to the difficulties providers face in navigating the primary care landscape alone; he highlight the resource How the CMS Innovation Center is Supporting Primary Care, which outlines the various primary care models currently in place, and their interactions with each other;
    - Nick noted CMMI's goal is to provide pathways, so that organizations with different preferences, affinities, philosophies, and specialties can get into value-based care, gain the skills to be accountable for patient outcomes, and rewarded for that;
    - Within the 5 current models, some overlap, some don't; some overlap unless you join a 3rd model then no longer overlap- that is tough for providers to navigate; in addition, CMS isn't able to give providers a "calculator" that can tell them their exact payments, and figure out what will best for them- but they are always willing to engage in conversations and answer questions to the best of their ability;

- A member noted that CMMI is using these models to get more resources into primary care, and asked if the markets that have adopted these models are seeing an increase in the number of primary care providers;
    - Nick noted that workforce changes are not something CMMI's evaluations have looked at very strongly; the evaluations largely focus on impacts at patient level- Congress says the must must look at and try to detect improvement in patient outcomes and cost;
    - Workforce is an important outcome, but is not often prioritized in the same way; he did acknowledge the statistics that show a shortage of primary care physicians in the coming years, and appreciated it was a very relevant and important question;

- The member commented that they were specifically thinking about Asaf Britton, and research demonstrating that increasing primary care physician supply can reduce mortality and have positive impacts on population health. If we are using payment models to drive change, are we driving the kind of change we want to see?

- Nick appreciated the question, and noted that CMMI is always trying to balance a certain duality based on their statutory charge from Congress- they are working to create a cogent, coherent primary care landscape that allows providers to opt into model that make most sense to them, but at the same time they must fulfill mission their mission as an agency to test different types of primary care reform to determine which ones work;
- In trying to build a landscape of different options, it can be easy to forget that CMMI doesn't know what the best option is going to be- part of their mission is testing different approaches, determining what works best, applying those lessons, retiring approaches that don't work, and trying something new;
- He acknowledge this process can be disruptive- once providers adjust to a certain way of providing care, hearing that didn't save money and having to adapt to something else is difficult;
- As an agency, CMMI is thinking through how to make that easier; how to make progression into VBC something that doesn't necessarily abruptly end with conclusion of a model, and is open to feedback on how to accomplish that, and how to balance the duality of their mission.

- A member commented via chat that the work CMMI and CMS have done around measure alignment has been very valuable, and multiple members agreed. They also expressed appreciation for the additional information on Making Care Primary.

Public comment:

- No public comments were offered.