COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes

Thursday, September 12, 2024; 10:00 - 12:00 pm
Hybrid meeting - 1560 Broadway, Denver CO & Zoom

Meeting Attendance

Attended
Josh Benn
Isabel Cruz
Britta Fuglevand
Steve Holloway
Lauren Hughes
Rajendra Kadari
Cassie Littler
Amanda Massey
Sonja Madera
Amy Scanlan
Gretchen Stasica

Absent
Polly Anderson
Kate Hayes/Jack Teter
Patrick Gordon
John Hannigan
Patricia Valverde

DOI
Tara Smith
Deb Judy
Laura Mortimer

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Annual Review of Aligned APM Parameters
4. Equity, Market Dynamics, Measures
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 the meeting minutes for August had been posted, but the Division is allowing additional time for members to review, and they will be approved at the Oct meeting.

  ACTION ITEM:
  - Meeting minutes from the August meeting will be approved at the September meeting.

- **Primary Care and APM reporting stakeholder meeting** - Tara Smith reported that the Division hosted a stakeholder meeting on August 22 to obtain stakeholder feedback on proposed changes to the primary care and APM reporting requirements included in DOI Regulations 4-2-72 and 4-2-96. The Division is currently reviewing the comments offered, and will be resuming the rulemaking process to update Regulation 4-2-72. As part of this process, the Division will also be releasing an updated reporting template.
  - Updates on this process will be available on the Division's HB22-1325 website, and the Division will also share announcements through the normal rulemaking announcement process (via the DOI stakeholder list).

Federal & state updates

The following federal updates were provided:

- **Future of Telehealth and Its Impact on Primary Care - Upcoming Health Affairs webinar -** Health Affairs will be hosting an upcoming webinar focused on the future of telehealth and its impact on primary care. Panelists will include researchers and other experts in the field to discuss telehealth, primary care, and the policy choices facing lawmakers and health care leaders.
  - The Event will be held on **Tues, Sept 24**, and registration is available at the following link: https://thewebinerd.zoom.us/webinar/register/WN_UALKnwixQji0GAwYYaW2Og#/registration

- **HCP LAN Annual Summit** - Registration is now open for the Annual HCP LAN Summit, which will be held on Nov 14, 2024, in Baltimore, MD. In-person and virtual options are available- registration is available at the following link: https://hcp-lan.us11.list-manage.com/subscribe?u=79339b7f02582ba86a0956046&id=d3d0b5ebbb

- **CMMI Data Sharing Strategy -** On July 31, 2024, CMMI issued an update to its data sharing strategy in a Health Affairs Forefront article (Improving Participation In Value-Based Care—The CMS Innovation Center's Data-Sharing Strategy Initiative). The article

sets forth the goals of the strategy, which include identifying additional data-sharing needs across CMS Innovation Center models to ensure that proper security, risk management, and privacy obligations are employed in tandem with data sharing goals. The data-sharing strategy can also provide a framework that may be useful for other payers, reducing the burden of participating in value-based care overall by facilitating multi-payer alignment.

- **Agency for Healthcare Research and Quality (AHRQ) Notice of Funding Opportunity: Accelerate Implementation of Patient-Centered Outcome Research Evidence into Practice -** AHRQ recently released notice of a funding opportunity that would support states in establishing Cooperatives that would promote and advance the dissemination and implementation of patient-centered outcomes research. Tara Smith was not aware of any formal discussions of Colorado submitting an application, but noted she had heard from several stakeholders that this could be an important opportunity for the state.

The following state updates were provided:

- **HCPF Annual Stakeholder Webinar -** HCPF hosted its Annual Stakeholder Webinar on Aug 27; for those who were unable to attend, meeting materials are available at the following link: https://hcpf.colorado.gov/events/2024-stakeholder-webinar.

- **Making Care Primary** - The Making Care Primary model has started in Colorado, and the state is continuing to have discussions with CMMI and other stakeholders related to both the support of participating practice (through learning design) and to participating payers (through separate, payer specific meetings). Tara Smith will keep the Collaborative informed as these conversations move forward, and there will likely be opportunities for the Collaborative to provide input and insight as the work continues.

Discussion:

- In addition to these updates, a member noted the Standing Committee on Primary Care convened by the National Academy of Science and Medicine (NASEM) will be hosting its next virtual, open public meeting on **Wed, Sept 18**. The three topics that will be addressed include: primary care spend, primary care research, and a discussion of the metrics HHS proposes to use for its primary care dashboard. Interested stakeholders can register at the following link: https://www.nationalacademies.org/event/43570_09-2024_standing-committee-on-primary-care-september-public-meeting.

Review of Aligned APM Parameters

Tara Smith started the discussion of the Division's aligned APM parameters for primary care parameters, as set forth in the Division's Regulation 4-2-96, with a brief overview of the statutory requirements related to the annual review process (found at 10-16-150, C.R.S.). She then briefly reviewed how other states that conduct similar reviews have structured their process, including Massachusetts (see slides 13-19, available here), Rhode Island (see slide 21, available here), and Washington State (see slide 23, available here).

Process/structure of annual review process

Tara Smith posed the following questions group for feedback about potential approaches in Colorado:

- What is the right process?
  - Mechanisms of engagement
  - Stakeholders
- What is the right timing?
  - When?
  - Number/time/format of meetings
- What resources are needed?

Tara Smith also presented a potential timeline for the review process (see slide 26, available here).

Discussion:

- A member commented that hearing the different state approaches was interesting, and of value as we consider how to best structure our processes in Colorado;

- In terms of the timeline, a member asked whether the Collaborative could receive some sort of report that reviewed based on what was done the year before (e.g., the Division made a rule change), so that stakeholders could review prior to the annual review meeting;

- Another member commented in chat that it was helpful to see the timeline, and that it seemed to be at the right pace; they did note it would be helpful to offer up more options during summer months, due to scheduling issues;

- A member asked about the timing of updating parameters, using quality measures as an example; based on the Division's proposed updates to Regulation 4-2-72, carriers would not be submitting data on their use of quality measures until Sept 15 of 2025; so at the time of annual review, the group would not know what the "baseline" is to

make changes to quality measures; from other states, how quickly were they able to get the baseline, and then discuss what future quality measures should look like;
    - Tara Smith noted that she was not familiar with the exact timeline in other states, but it was a good question to look into, and explore in greater detail; the timing and cadence of proposing and implementing measure updates will be an important consideration moving forward;
    - She also noted that when establishing the initial set, the Division had received feedback from a broad range of stakeholders that it was important to allow time for the measures to be fully implemented and in use before making changes. Discussions in early years could likely focus more on measures that stakeholders identify for the future, to address gaps (e.g., patient experience, substance use disorder, health equity) in the current set.

- Several members agreed in chat that providers need stabilization of metrics before changes are considered and ultimately implemented. One noted that some providers may not be able to pull the data to report on the metrics, and a constantly changing landscape exacerbates these challenges;
    - A member agreed that not changing the core measure set makes sense, but also cited a recent JAMA research letter that reported on average physician practices across all of their carriers have 57 quality measures; they noted that an approach like Massachusetts, which has a limited core set and a slightly larger menu set for practices to select might be something for future discussion;
    - Another member echoed this sentiment in chat, noting that their ACO is held accountable for over 100 measures;

- A member also noted in that in regard to quality measures, paying attention to the process of how we develop and monitor measures is as important and intriguing as the measures themselves;
    - They further commented that the categories used by Massachusetts (monitoring set, on deck set, developmental set, and innovation measure set) resonated with them;
    - Agree we need a right cadence moving forward of stability and yet evolution once we understand how these are working in practice, and from a payment perspective;
    - Having these types of groupings might be helpful to categorize potential future measures; to have them in some sort of public database or some other tracking mechanism, so as we learn about what other states are doing, or come up with our own ideas in Colorado, we have a place to safekeep these ideas and information, and not lose it moving forward;

- Another member agreed that the Massachusetts measure set categories and definitions it offers movement forward as we learn more;
    - Building off that, a member commented that depending on the information/resource was organized, structured, placed, and supported, it could provide a forum for ongoing dialogue with different stakeholders- more of a running conversation than an episodic one (if people are able to view, comment, and add to what is in each of these buckets);
    - A member expressed further support for this idea, noting it would also allow payers to offer up measures that may not be in the core set, but they find have value for providers to offer those up;

- A member asked if there was room for conversation around standardizing risk adjustment, in terms of non-Medicare payers;
    - Tara Smith responded affirmatively- that risk adjustment was one of the aligned parameters that would be addressed shortly in the conversation; she also noted that Colorado was a leader in this space, and there are not a lot of other state examples to look at when it comes to alignment or standardization of risk attribution methodologies;

- In rounding out discussion of the annual review process, Tara Smith noted the Division was interested in ongoing feedback on:
    - Mechanisms of stakeholder engagement that the Division could or should consider, outside of an annual meeting structure; are there other forms of outreach, or way of sharing information and getting feedback
    - Stakeholders that are currently missing from the table, that bring an important voice;
    - The proposed timeline for the review process- would it be better to have the annual review meeting in the spring vs the fall? Some other time of year;
    - What resources are needed to support this process (and how can they be obtained, as the Division does not currently have resources set aside in this area that can be tapped);

- A meeting participant (former member) asked in regard to the question of resources whether the Division was seeking input on resources needed to support the review process, or the support that practices need more broadly to deliver advanced care delivery (e.g., setting up and maintaining data systems, etc.);
    - Tara Smith noted that for the purposes of this discussion, the question was more narrowly framed around resources needed to support the annual APM parameter review process;

- The participant noted the importance of additional resources in other aspects, such as the production of the support (the Division's ability to retain CHI as a contact has been of great value), and suggested that it would be likely be useful to have support in the annual review process;
- In relation to additional stakeholders at the table, they noted that it would be valuable for the Division to consider ways to get the perspective of providers in the state who are on the ground, doing the work, as opposed to representatives that may be a few steps removed from day-in, day-out care delivery; this could be accomplished by asking organizations such as the Colorado Academy of Family Physicians or the Colorado Medical Society to collaborate around the circulation of resources, communication, training to providers, to be able to communicate messages to and from the PCPRC;
- Tara Smith agreed that this was an area of future improvement, and noted similar thoughts/conversations about better engaging with patients/consumers to get their voice and perspective;

- A member (payer representative) agreed with the idea of incorporating patient voice, and also noted that from a payer perspective, they are not the person within their organization that is engaged daily in APM contract negotiations;
    - To the degree that the Division can circulate materials in advance of the meeting, so that they can be shared with their internal SMEs and experts, and bring that feedback to the group discussions;

- In terms of resources for the process, a member asked whether a dashboard or some other mechanism that could be used as a way to look back at past work (and progress), and show evolution over time; CIVHC or the Office of Primary Care might be good places to look to and get ideas from about best practices;
    - A member supported this idea, noting that dashboards are effective in visually displaying information, as long as they are designed correctly, clear, and have resources available for updating;
    - When thinking about future quality measure discussions, it is important to have a session dedicated to, or have expertise available in the room, that can speak to measure navigation for practices in rural areas, where low case volumes provide unique challenges.

Current APM parameters (requirements included in 4-2-96)

Tara Smith then shifted the discussion to focus on the existing APM parameters, providing a brief overview of the current requirements for each of the four (4) parameters as contained in Regulation 4-2-96 (see slides 27-31, available here).

Discussion:

- In relation to risk adjustment, a member asked what happens with the detailed descriptions carriers are required to provide to the Division;
    - Tara Smith noted that carriers are allowed to request that the Division keep certain information, which they feel contains proprietary or trade secret information, confidential; this allowance is included in Regulation 4-2-96, and so the Division will need to review the types of information, and any associated confidentiality requests, before determining what (if any) can be shared publicly;
- Several members noted the importance of including risk adjustment and patient attribution as part of future discussions;
    - One member noted via chat the challenges of risk adjustment for pediatric practices;
    - Another noted that value-based payment does not work without correct attribution;
- In relation to core competencies, a meeting participant (former member), noted two issues came to mind:
    - First, providers already have a lot of CME requirements, so if there are ways to either harmonize these activities, to the degree they demonstrate or can be "counted as" achievement of a competency, would be extremely helpful;
    - Second, thinking beyond the provider (staff, medical assistance, other staff), it is important that these individuals have time to meet competency requirements, both in their role in the practice and as a member of a team; for example, if training in certain areas is needed, staff need to have time to complete the training (with the recognition that while they are engaged in the training, they are not checking in patients, etc.)
    - Overall, when looking at competencies, and how they may evolve in the future, it is extremely important that the impact on providers, staff, and practices be considered;
        - A meeting participant added a comment in a similar vein via chat, noting that the CO Medical Board will be conducting a stakeholder process following the passage of HB24-1153 on cultural competence/bias/health disparities requirements for continuing education for physicians in the coming year or so, and that it will be interesting to see how this plays out. They also noted a general sense that this is the only way for the legislature to influence improving cultural competency of providers, and challenged the PCPRC to consider other levers that could be incentivized - workforce pathway programs to further diversify our health care workforce for example - that may get more at the root of this.

- Multiple members expressed excitement/support for this comment.

Centering Equity

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

Discussion:

- A member comment that the articles that were sent were helpful to think about the importance of the infrastructure needed to be able to do the work on the ground level, and how that also needs to be supplemented with the data collection that is needed to support and inform care delivery; for a lot of small practices, it can be hard to collect on a daily basis;
    - The member also noted that infrastructure to connect practices to community resources is also important, so that we aren't exacerbating the "bridge to nowhere"; it is challenging for a practice to keep up with constant changes to the resources that are available, and being paid to develop and maintain that infrastructure, and support that in between work, is really important;
        - Infrastructure is also needed to connect that work back to data;

- Tara Smith asked about the group's experience with health equity plans- have they completed such plans as part of past or current initiatives; are they being required by any payers; are they helpful or valuable to a practice, or more of a burden (check the box exercise);
    - A meeting participant (former member) noted that their small practice in Gunnison has not been asked to prepare such a plan; while they could see potential value, as a practice administrator is not something they have had time to research, and put something together;
    - The participant noted that is such plans become a requirement, like the risk assessment plans that are required when implementing an EHR, it could certainly drive practice behavior, but it would also add to administrative burden, as another document that has to be completed;
        - If a template could be provided, it would help with practice buy- in and enthusiasm to complete such a plan; the template provided for the risk assessment plan for EHR implementation was very helpful, and helped guide and educate providers about issues they might not be aware of;

- A member asked about the use of XX by practices and community organizations; not sure what purposes those serve, or if they could be explored;

- A meeting participant resurfaced the comment from chat about the legislature's reliance on CME as a way to address equity, and how CME requirements, even if well-intentioned, could lead to additional administrative burden for providers. They encouraged the Collaborative to take a broader view of cultural competence, and other mechanisms to support providers in the delivery of culturally competent care, as increasing directives around CME and training are not the most effective mechanisms to address the root of issues around health equity and disparities.
    - A member noted this comment reminded them of a bill that was passed in 2022 (HB22-1267), requiring CDPHE to establish a process to select organizations to provide culturally responsive health care trainings; this work has been going on for the past year, and according to the timeline on CDPHE's Healthcare Provider Training Grant Program website should be finalized this fall , with an evaluation; it will be interesting to see where this investment led, and whether that work results in any recommendations for the Collaborative on what could be part of payment and incentive discussions;

- A member commented that as additional data comes in, both through CDPHE's work, and around culturally responsive provider network requirements associated with Colorado Option plans, it will help inform future work;
    - They noted one of the reading for the meeting included a Blue Cross Blue Shield case study, which contained targeted recommendation about how investments can actually be structured and implemented to support health-related social needs (HRSN); looking at those recommendations in greater depth could be a good next step to follow-up on the Collaborative's recommendations around HRSN in last year's report; based on case studies like BCBS, and what the Collaborative learned last year, the group can potentially come up with a next set of steps/recommendations regarding HRSNs as part of the ongoing equity conversation; this could include exploring some kind of measure set moving forward, to add to the growing conversation, now that we have some really good examples of when that has been effective;

- A member commented that the article about Community Health Workers (CHW) also resonated, and noted support for CHWs was also a topic in last year's report; now that Medicaid will reimburse for CHW, an important next is getting this financial support/payment from all payers; this broader, sustainable support from all payers is particularly important for pediatrics, where patients constantly churn on and off Medicaid- if they are the only payer providing reimbursement, CHW support is hard to sustain;
    - Multiple members supported this comment in chat;

- A meeting participant further reflected on CME requirements, noting the challenges and dangers of burn-out in the health care workforce in general; the addition of requirements (around training, etc.) do incentivize and drive provider action, but we need to be conscientious of adding even one more requirement- it may be a final straw that causes someone to leave the workforce all together, and primary care can't afford that- we have been on a spiral for a while, and we can't afford to keep adding to provider burden.

Colorado Marketplace

Tara Smith transitioned the group into a brief discussion of Colorado marketplace dynamics by reviewing a centering question that has anchored previous Collaborative conversations:

- Are the payments that we are putting forth by changing payment structures getting to the right places?
    - PE entities capitalizing on opportunity to make money off payment changes
    - Our goal: payments to strengthen primary care delivery and workforce
    - Is that happening, and if not, how do we get in front of that?

She asked the group if they had suggestions for information, data, or resources that would help shed light on the major actors and forces impacting market dynamics at the state, regional, and local level, and whether trying to compile this information would be of value.

Discussion:

- A meeting participant shared a personal story about the challenges of sustaining small, independent primary care practices, noting that the practice that she manages on the Western Slope recently was acquired by the local hospitals after over 80 years of operating independently. A story related to the closure is here: https://www.gunnisontimes.com/articles/gvh-to-acquire-gunnison-valley-family-physicians/;
    - She stressed the importance of the Collaborative's work, and the need to remain laser focused on investing in and supporting primary care. If we lose that bedrock, it will be devastating for Colorado and our nation- we have to do something, and we need to do it faster.

Tara Smith asked members to please share any thoughts, suggestions, or resources about how to get a more refined view of the Colorado landscape, to inform future conversations.

Public comment:

- No public comments were offered.