COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes

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

Meeting Attendance

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

Absent
Kate Hayes/Jack Teter
Lauren Hughes
Patrick Gordon
John Hannigan
Sonja Madera

DOI
Tara Smith
Deb Judy
Laura Mortimer

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Annual Report Recommendations
4. 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 August and September meeting minutes.

  ACTION ITEM:
  - Meeting minutes for August and September were approved and will be posted as final on the PCPRC website.

- **New member recruitment** - Tara Smith reported that two members - Brandon Arnold and Patricia Valverde - had recently resigned from the Collaborative, due to job changes. She noted that recruitment is ongoing, and openings are available for provider, payer, and consumer representatives. Members are encouraged to send recommendations for potential new members to Tara Smith (tara.smith@state.co.us).

- **PCPRC Sunset Report** - The Colorado Office of Policy, Research, and Regulatory Reform's sunset report for the PCPRC will be released no later than Oct 15. This report will include COPRRR's recommendation as to whether the Collaborative should end as of Sept 1, 2025, based on language included in HB19-1233, or to continue for an extended period of time.
  - The report will be posted on COPRRR's website, and can be accessed at the following link: https://coprrr.colorado.gov/archive-of-reviews.

Federal & state updates

The following federal updates were provided:

- **Advancing Equity through Accountable Care - Lunch & Learn -** Health Affairs will be hosting an upcoming Lunch & Learn webinar **on Oct 17 from 11-12 pm MT**. The event will feature a conversation with Purva Rawal, the Chief Strategy Officer at the CMS Innovation Center (CMMI), focused on CMMI's strategies for addressing equity through accountable care models and policies.
  - Registration is available **HERE**;

- **A Summit on Revitalizing Primary Care to Recenter Relationships and Enhance Health -** The University of California Davis will be hosting a national summit on advancing primary care locally and nationally, with a focus on increasing primary care spending, **on Oct 17 and 18**. The event will feature national leaders in primary care research, policy, and advocacy.
  - Registration is available **HERE**;

- **2024 CMS Optimizing Healthcare Delivery to Improve Patient Lives Conference -** CMS will be hosting a conference on Dec 12 from 9-2 pm MT 31, 2024, to convene change makers from the healthcare community and federal government to share

innovative ideas, lessons learned, and best practices that strengthen patient healthcare delivery and access to high quality care, by reducing the administrative burdens that impact patients and the healthcare workforce.
    - Registration is available **HERE**;

- **CMS - Comprehensive Guidance for Medicaid and CHP** - On September 26, 2024, CMS released the comprehensive guidance on Early and Periodic Screening, Diagnostics, and Treatment (EPSDT), which reinforces EPSDT requirements and highlights strategies and best practices for states in implementing those requirements. The EPSDT guidance also includes information to help address the needs of children with behavioral health conditions.

- **CMS - Notice of Benefit and Payment Parameters** - On October 4, 2024, CMS released the proposed Notice of Benefit and Payment Parameters for the 2026 plan year. CMS also released the Notice of Benefit and Payment Parameters, the annual rule that proposes standards for health insurance marketplaces, carriers, brokers, and agents that connect consumers to ACA coverage. The rule includes several provisions related to affordability and health equity, including: expanding options for carriers to use premium payment thresholds (under which a carrier would not place an individual in a grace period or terminate coverage if the individual fails to pay a de minimis amount); providing incentives to carriers and plans the enroll underserved consumers with high needs; and strengthening enforcement of essential community provider requirements for carrier networks.

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

AHRQ NOFO: State-based Healthcare Extension Cooperatives to Accelerate Implementation of Actionable Knowledge Into Practice - Allyson Gottsman, Practice Innovation Programs at the University of Colorado, Department of Family Medicine

Highlights from Allyson's presentation included:

- The Practice Innovation Program (PIP) at the University of Colorado Department of Family Medicine has been convening the Colorado Health Extension System (CHES), a group of organizations involved in supporting practice transformation, for over a decade; this group was formed in anticipation of this NOFO- when the ACA was passed in 2010, it included a provision to set up State-based Healthcare Extension Cooperatives- funding to establish these cooperatives is now finally becoming available, through this grant opportunity;

- The stated purpose of the State-based Healthcare Extension Cooperatives NOFO is to build a system of state-based health care extension cooperatives to accelerate the implementation of knowledge into practice;
    - Historically, urban legend says that it takes 17 years to get evidence to be universally adopted and distributed in primary care practice; with this funding opportunity, ARHQ is seeking to accelerate this process;

- In Colorado, CHES was set up in anticipation of this funding; in the interim, PIP and CHES have been working collaboratively over the last decade with any organization that has a practice transformation team (practice transformation organizations, or PTOs); CO has an incredible culture of collaboration across partners and across the state;
    - In addition, CO also has Regional Health Connectors that help address health-related social needs;

- Due to Colorado's long-standing history of work in this space, PIP thinks the state is particularly well-suited to apply for this opportunity- it will allow us to take what we have been doing to the next level, and be even more aligned and focused around a common direction to support and advance primary care delivery;

- NOFO/grant purpose: to accelerate the dissemination and implementation of patient-centered outcomes research (PCOR) evidence into healthcare delivery through improvements in healthcare policy, payment, and practice, and to reduce health disparities, especially among medically underserved people;

- While CHES to this point has been focusing on supporting practices to implement evidence and achieve a better result on this quadruple aim, this next opportunity will help the PIP and CHES members to convene a broader array of stakeholders to also address policy and payment reform, all of which we will plan to do in an inclusive, collaborative way;

- NOFO/grant mechanism: AHRQ Is inviting applications to establish and support State-Based Healthcare Extension Cooperatives to conduct an initiative based on PCOR evidence to improve care for medically underserved people; the focus for the initial project must be on behavioral health;

- The State-Based Cooperatives will engage key stakeholders in identifying and addressing barriers/facilitators to build their capacity to implement patient-centered, PCOR evidence-based healthcare delivery improvements;
    - Medicaid is required to be at the table, as well as Medicaid managed care organizations and other organizations that address the health needs of medically underserved people;

- The State-Based Cooperative will work with organizations that serve medically underserved populations to build their capacity to implement patient-centered, PCOR evidence-based healthcare delivery improvements and to support ongoing learning; requires engagement with:
    - Healthcare policy organizations;
    - Healthcare payment organizations;
    - Community organizations;
    - Healthcare delivery organizations;
    - Research organizations;

- This engagement structure, across multiple stakeholders, will allow/require PIP to continue to expand alignment in a more structured fashion;

- In addition, the State-Based Cooperative will:
    - Conduct evaluations of the impacts and refinements of the processes of the Cooperative's activities;
    - Provide the support structure to ensure these activities are integrated and aligned;

- Funded by AHRQ, so the initiative has a large focus on evaluating both the impact of the work on the healthcare delivery side, but also of the functioning of the collaborative and analyzing the impact on policy and payment reform;

- Within RFP, there are requirements to have an "engagement core", which will involve working with healthcare delivery organizations;
    - Each grantee will support 3 cores:
        - Engagement, training, education, and assistance core - transformation work;
        - Monitoring, feedback, and evaluation core;
        - Administrative core - will establish a Multistakeholder Council to provide expert advice and guidance to the Cooperative;

- NOFO/grant awardees must establish a Multistakeholder Council (MSC); the NOFO includes a list of requirements for who must be represented- in CO, we anticipate meeting and exceeding these requirements, by adding groups that are not necessarily named;
    - At a minimum, MSC will:
        - Guide Cooperative's initiatives - the work with the practices;
        - Support implementation of Cooperative's initiatives;
        - Provide guidance and support on state- and local-level barriers and facilitations to improvements that are part of the initiative;

    - Evaluate the cooperative's potential for sustainability, including opportunities for ongoing support for specific Cooperative activities;

- This is a 5-year cooperative agreement (not a grant); this means that CO, if selected, will have a lot of interaction with AHRQ and other state awardees;
    - 15 states will be chosen- optimistic CO has a very strong application; we have been doing a lot of this work, and have participated in several precursors of this with AHRQ;

- MSC member requirements- must have representatives from:
    - Medicaid;
    - Medicaid MCOs;
    - Executive from safety net healthcare delivery organizations (SNHDOs)
    - Clinicians and staff from SNHDOs;
    - Patients, families, caregivers who receive care from SNHDOs or are members of underserve populations;
    - Long list of possible "other" members, many of which are already engaged
        - Plan to include most of state agencies, Academies of Family Physicians and Pediatricians, self-funded employers, community-based organizations, Regional Health Connectors

- Proposal is due January 6; goal is to be ready by mid-December;
    - Up to 15 state awards;
    - 5-year project;
    - Up to $25 million over 5 years (maximum of $6.25 million in any one year); inclusive of indirect costs;

- Steps taken by PIP so far:
    - Believe opportunity is extremely will aligned with how we are already doing work in Colorado, between PTOs and RHCs, and that CHES is optimally positioned to become the fully functioning state-based Cooperative for Colorado
    - Engaged with HCPF leadership (required partner); are supportive and agree PIP is appropriate entity to apply;
    - Started to organize the application proposals (5) and plan for submissions;

- A behavioral health condition has to be the topic of the original focus on engaging the healthcare delivery system; options discussed to date include:
    - Focus on depression and anxiety among those at heightened risk of depression;
        - Adults (+/- children) with chronic condition(s); e.g., diabetes, CHF, obesity;

        - Children: seeing increased anxiety at earlier ages, screening to identify early indications and implement mitigation and prevention;
    - Possibly suicide prevention, by itself or as sub focus within depression;
    - Behavioral health integration - continue current efforts started with HB22-1302, with focus on 1-2 specific conditions with measurable outcomes;
        - BHI is a means, not an end- so using strategies of integration to address whatever conditions we choose;
    - Also interested/intrigued in considering substance use, which would fall within the guidelines of a behavioral health initiatives;
        - Currently shying away from because AHRQ has a heavy data/research component; concerned with angst people have about CFR 42 Part 2 restrictions (HIEs limited in data they have);

- PIP is still in the decision-making phase- interested in feedback/guidance from Collaborative members (from the perspective of payers, providers, or consumers) on the opportunity overall, and the appropriate area of focus within behavioral health.

Discussion:

- A member expressed appreciation the inclusion of pediatrics in this larger initiative; other states don't necessarily have tracks for pediatric patients and families;
    - Prevention and promotion are key to preventing more chronic and long-term issues, so including that within this opportunity is important and innovative;

- Another member noted that their practice is seeing large numbers of alcohol and substance abuse in practice data; the member was not sure how that fits into this opportunity or PIP's work going forward, but it is standing out as a trend;
    - Allyson noted that PIP did a major Unhealthy Alcohol initiative a few years ago under the auspices of AHRQ, but there certainly could be more focus there;
    - She reiterated the concern about SUD as a focus area, due to challenges in getting data, but noted that PIP appreciates and will consider the feedback;

- Tara Smith thanked Allyson for the presentation and outreach, and encouraged members to think about how the AHRQ opportunity can help inform, support and advance the work of the PCPRC, and overall state efforts to strengthen care delivery and payment reform;
    - She noted, for example, that if the AHRQ opportunity would be focused on a specific area or condition, such as substance abuse, that could build practice capacity to collect and report on SUD measures, the PCPRC could then think about including such measures as part of the aligned measure set required by Regulation 4-2-96;

  - Similarly, practice care delivery expectations and competencies developed through work supported by the AHRQ grant could inform future iterations of the aligned core competencies;
  - She also encouraged the group to think more broadly about how to connect the dots between multiple state initiatives, and what will now potentially be an expanding number of multistakeholder tables; how can we best ensure these efforts are coordinated and supportive of one another, and not duplicative and or redundant;

- A meeting participant asked for additional clarification around the data challenges associated with SUD; while they appreciated PIP's hesitancy to focus in that area because of constraints on data collection, they also felt the NOFO might be an opportunity to tackle data-related challenges; the member asked Allyson to expand a little more on the nature of the issues related to obtaining that data- are EHRs not talking with regional health exchanges, it is data that is not being captured? Know what my practice and community has struggled with, but wondering what PIP has been experiencing or seeing;
  - Allyson noted that with many projects, PIP has experienced an angst on the part of the clinics to share behavioral health data because of their largely unfounded fear of 42 CFR Part 2, a federal rule that imposes restrictions upon the use and disclosure of substance use disorder patient records. Providers have often set up a firewall that many organizations but between medical and behavioral health data, even though they don't need to;
    - Under 1302, PIP has contracted with experts to help dispel these fears, and let practices know that sharing data among providers, and coordinating care for a patient, is not only allowed but a good thing to do. However, still see a lot of hesitancy;
    - Have also had HIEs- both QHN and Contexture, which are now merging- talk to the 1302 practices very recently; HIEs are also still not fully up to speed on capturing all the BH data- have had their own lawyers tied up in knots trying to make sure not crossing any barriers;
    - While there has been a loosening of the federal regulations in the last year or 18 months, it hasn't reached the practical level yet;
    - When worked on Unhealthy Alcohol Use program, were able to get data internally from the practices to support, was built on an SBIRT framework, to support that- but it was still quite superficial- how many screens, how many screened positive, and was there a brief intervention or was there a referral; were able to get that from practice, but actually improvement on patient's substance abuse we couldn't get- could get process, but not patient results

    - The participant appreciated the explanation, and noted that in their practice, they have struggled getting data out of EHR; even after updating EHR, still struggled with getting data in right box to get the right report pulled, and having data built into interface- worked with QHN on some of that; so also a challenge in addition to confidentiality and privacy issues/concerns; they noted that locally their practice had been engaged in a couple of grants to look at substance use disorders broadly- and it was really challenging to get the data- it is a part of the infrastructure that definitely needs to be built out and strengthened

- Allyson further noted that PIP is also looking at aligning measures as part of this work- with APM 2, Making Care Primary - want to measure and align with what is happening, and not to create something new;
    - This would be an area where the PCPRC will play a key role and can have a lot of impact;
    - CHES will be more intentionally focused on alignment with payment reform and policy than we have previously (when focus was on care delivery).

Tara Smith again thanked Allyson for the presentation, and encouraged members to reach out with any additional questions, feedback, or input. She then introduced a second guest speaker, Nicole Tuffield, provided an update on HCPF's recent 1115 SUD Waiver Application.

HCPF 1115 Substance Use Disorder (SUD) Continuum of Care Waiver - Nicole Tuffield, Colorado Department of Health Care Policy and Financing

Highlights from Nicole's presentation included:

- Colorado's 115 SUD Waiver was initially approved in Jan 2021; scheduled to last through Dec 31, 2025;

- In 2024, HCPF has submitted two amendments to this waiver, and getting ready to submit renewal or extension request to CMS, to request an additional 5 years, and ultimately with that renewal to move to a comprehensive waiver, since have added additional services:
    - Amendment #1 submitted in April 2024 - related to Re-Entry Services;
    - Amendment #2 submitted in August 2024 - related to Health-Related Social Needs;
    - Renewal request will be submitted in Dec 2024;

- What is an 1115 waiver?

  - A waiver is an agreement between a state and CMS that allows state to waive federal rules; allows more flexibility to offer coverage for individuals, as well as to cover more services that usually aren't covered under Medicaid;
    - 5-year agreement with option to request a renewal;
  - HCPF's current 1115 SUD waiver coverage SUD services in Institutions for Mental Disease and other settings;

- The first amendment submitted in April 2024; key provisions in the proposed amendment include:
  - Continuous eligibility coverage for children 0-3-years;
  - Continuous eligibility coverage for adults released from CO Dept of Corrections;
  - Criminal justice reentry services;
  - Serious mental illness and serious emotional disturbance and inpatient care;
  - STATUS: CMS review will occur between Jan-Mar 2025; HCPF will request effective date of 7/1/25;

- The second amendment submitted in August 2024; key provisions in proposed amendment focus on housing and nutrition;
  - Housing services include: pre-tenancy and housing transition navigation services; rent/temporary housing up to 6 months, including utility costs; one-time transition and moving costs; and tenancy sustaining services;
  - Nutritional services include: nutritional counseling and instruction; medically tailored meals; and home-delivered meals or pantry stocking;
  - STATUS: Federal comment period just closed; HCPF waiting for CMS to review, hopefully concurrently with amendment #1; would also like effective date of 7/1/25;

- Renewal amendment is currently posted on HCPF website, comment period ends today;
  - In addition to SUD waiver authority, would also include presumptive eligibility for long term services and supports, as well as additional amendments submitted this year.

Discussion:

- Tara Smith asked if Colorado's application had similarities to other states that have submitted and received approval of 1115 waivers related to health-related social needs (e.g., New York), and/or if it contained unique features that other states had not included;
  - Nicole noted that CMS released specific HRSN guidance regarding what they would most likely approve, which allowed Colorado to tailor the application to

that, so that we could get specific services covered that have already been approved for other states;
    - There is also a feasibility study, to look at expanding the HRSN even more, about what Colorado could do to meet specific state needs;

- A meeting participant asked if the continuous eligibility waiver will apply to children who get enrolled through Cover All Coloradans?
    - Nicole indicated she could follow up with a response to this question; the waiver will apply to children 0-3 who are enrolled, but she was not sure of the nuances that were potentially involved with Cover All Coloradans;
    - The meeting participant noted that the Cover All Coloradans program will cover undocumented children in Colorado up to age 18; the state authorizing legislation says that they will be covered with the same Medicaid as any other child in Colorado, but federal dollars can't be used for this coverage, so it would be interesting to know whether continuous eligibility under the waiver might apply to this population;

- A member asked via chat if the upcoming election would have implications the waiver approval;
    - Nicole stated that this was still a big unknown; HCPF's waiver is currently under active review, so Colorado is optimistic that the election will not be an impediment to the approval process;

- Tara Smith asked about the housing supports in the waiver application, and the degree to which HCPF was collaborating or coordinating with the BHA, to either align or supplement housing support work that is already underway;
    - Nicole noted that HCPF has been closely collaborating with the BHA across multiple program areas, and could take that question back to find out more information about how the waiver application articulated with other housing programs/proposals.

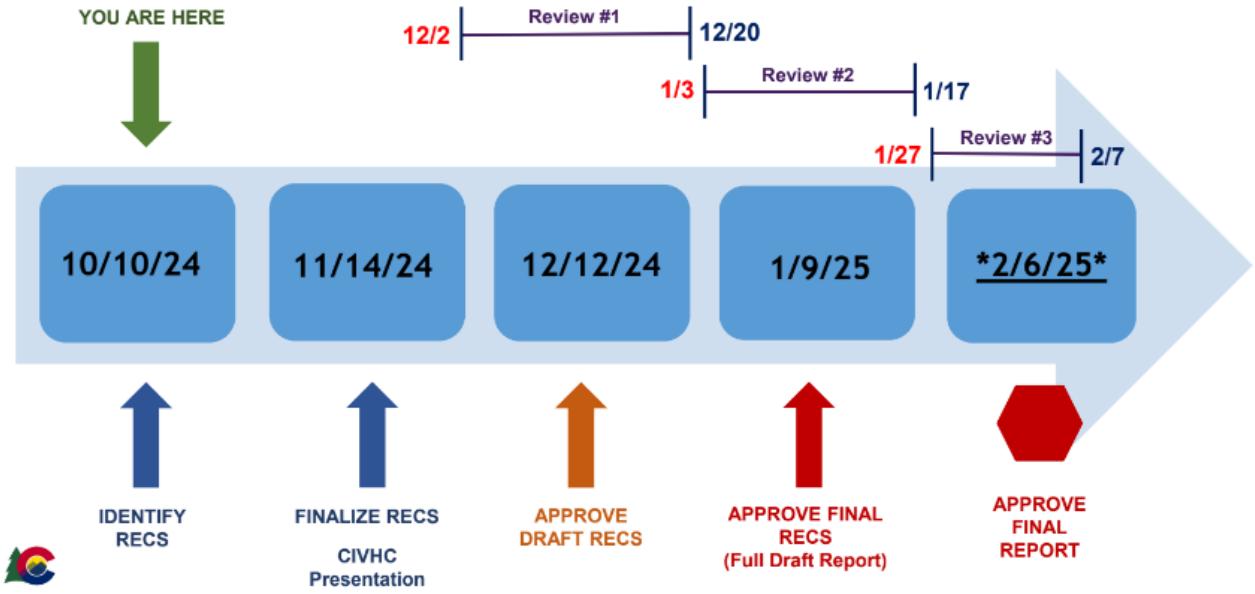
Tara Smith thanked both speakers for their presentations, and welcomed members to send any additional question or comments directly to her, or to reach out to Allyson (allyson.gottsman@cuanschutz.edu) directly, or send questions about the 1115 waiver to hcpf_1115waiver@state.co.us.

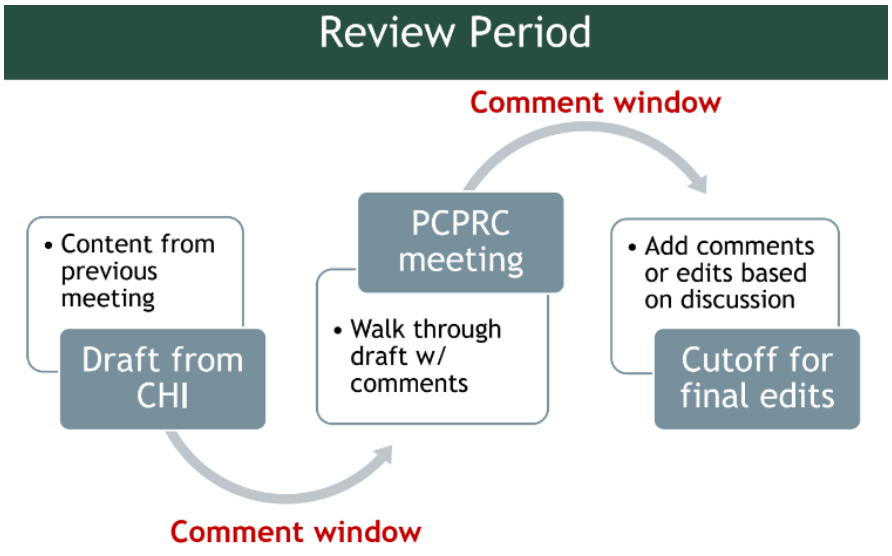
Annual Report Timeline & Process

Tara Smith started a discussion of the annual report writing process and timeline by reviewing feedback that members had provided on last year's process. Members had noted that the "listening sessions" were challenging to attend, due to scheduling conflicts, even when they

were planned in advance. Members expressed appreciation for having clear guidance on sections of draft versions that needed close review, and having structured timelines for feedback. Finally, members had agreed that it was generally beneficial/helpful to have comments/edits attributed to the author, rather than having them anonymized.

The following proposed timeline was presented for the group's consideration, which would include 3 blocks of "review periods", where members could provide written feedback on shared versions of working drafts both prior to and after scheduled meetings.





Discussion:

- A member asked via chat if the schedule for 2025 had been released;
    - Tara Smith stated that the next year's schedule has not been released, but she anticipated Collaborative meetings would continue to be on the second Thursday of the month from 10-12;

- Members generally agreed that the schedule and approach seemed workable;
    - Members felt having an extended time to review and provide written feedback would be beneficial, and were open to using written feedback mechanisms this year, rather than trying to have listening sessions.

Tara Smith thanked members for the input, and indicated the Division would forward with this "review period" approach to the report this year. She noted that the group can remain flexible, and if this approach isn't working well after the first review period, adjustments can be made.

Annual Report Recommendations

Tara Smith briefly reviewed the three major topics that the Collaborative has discussed this year - marketplace dynamics, artificial intelligence (AI), and health equity - and reviewed some of the key issues/themes in each area, which could be developed into report content or recommendations (see slides 24-32, available HERE).

Market Dynamics

- A member noted via chat that an additional impact for patients is decreased access to care as practices close or decrease the number or types of services provided. This may result in or exacerbate existing care deserts. Multiple members agreed with this statement;

- A member asked via chat if the discussion/recommendation should extend beyond private equity, and include a discussion of other commercial entities that are buying primary care practices;
    - Multiple members agreed, with one noting that it is important to speak about general consolidation in primary care;
    - Another member noted that consolidation is having an impact on the primary care landscape in Colorado, both in rural and urban areas; this has implications for patients (where they can seek care), and payers (changing contracts), etc.;

- A member commented via chat that it may be important to call out the role of payment, and payment reform, in contributing to ongoing consolidation; multiple members agreed with this comment;

- Tara Smith asked members if there was interest in having further discussion about: 1) actions being taken, proposed, or considered by other states related to consolidation and acquisitions involving private equity (and/or venture capital); and/or 2) non-compete agreements
    - A meeting participant commented that in their practice's recent experience of being acquired by a hospital, non-compete agreements were incorporated in the legal documents; while Colorado does have some strong protections against the use of non-competes, the continued use of provisions and clauses within legal documents continues to pose a challenge to practice and providers, and can have broader greater detrimental effects on primary care, particularly in rural areas; it is a real disservice to see that these types of agreements or provisions are still being used, especially in light of the struggles and shortages of recruitment and retainment for providers in rural areas; a lot of barriers getting providers to practice in these areas already, so disappointing and disheartening to see they are still being used, and will continue to impact both primary care and specialists whenever consolidation is happening;
    - A member agreed, and expressed concern that non-competes may be a bigger deal than we think; as much as CO may have strong protections, they may not be well known or understood on the ground; if you change jobs and ask "are you going to come after me because I have a non-compete," the answer is generally yes- and not many physicians want to spend the money on a lawyer to figure out what the subtleties are; the fact that the non-compete provisions are there at all probably is have a largely negative effect on the ground; especially in primary care these should not exist;
    - A member noted that a law was passed in Colorado a few years ago (HB22-1317) that makes non-compete clauses in employment contracts illegal; pursuant to 8-2-113, C.R.S., there are only a few instances under CO where a non-compete can be enforced anymore; probably every health professional should have that law in their pocket before they sign a contract; the law is quite explicit, and while still run into employers that put them in, because employer might not know better- and the clinician might sign, also not knowing better- so they find their way into contracts, but per the law are no longer enforceable;
        - A member commented that one of the challenges in this space may be the time it takes for something to be established in law, and the time it takes to filter down and become integrated into practice; if the Collaborative is trying push against and show the harms of market consolidation, part of that effort should be educating people on the ground about what they can and cannot do;

  - A meeting participant noted that as the CO law is structured, non-competes are not enforceable against people who are not considered highly compensated, and the dollar amount that is used to determine highly compensated is less than what most physicians make;
  - A meeting participant commented that based on their recent experience with their practice being acquired, non-compete language appeared not only in employment agreements (which did not have teeth), but was structured in the acquisition itself (the transaction mechanism); as an "asset acquisition," the legal structure allowed for the application of non-compete and non-solicitation clauses that are much stronger, lengthier, etc.; even if one of the clinicians wanted to get out of their employment agreement, there are ways they could do that- but they would still be held to the restrictions in the asset acquisition covenant; if a period is 6 months, that is one thing- if it is 3 years, that is another, and could force someone from a community; it is extremely detrimental to have such mechanisms in place, which have the effect of driving providers from areas where it is challenging to attract and recruit, and causing disruptions and shortages that impact local communities;

- Tara Smith asked members if they would like to include a discussion of how existing systems, both at the state and national level, impact the flow of primary care payments, potentially include:
  - Role of ACOs, and unique considerations related to primary care (benchmarking, attribution, HRSN, pediatrics);
  - Independent primary care;
  - Multiple CMMI models;

- Members seemed to generally agree to these topics, and one member commented that they would love the report to include a run-down/table/matrix of what is at play in Colorado right now, and what we know about it (a summary); it can be a reference, and provides a lot of context to the recommendations
  - Tara Smith agreed, but noted this was an area that would take input/feedback from all members.

Artificial Intelligence

- Members expressed general agreement with including a discussion of the following issues/topics in an AI-related section of the report;
  - Care delivery;
  - Payment; and

- Equity considerations;

- Tara Smith asked if members were interested in including a discussion of patient implications of AI, in relation to the meeting pre-readings related to patient consent (is it needed/desirable or an unnecessary barrier), as well as cost implications (e.g., if AI is capable of identifying risk of conditions/diseases that were not previously available, what are the implications for insurance coverage/payment of following testing and/or treatment);
  - A member expressed support for including these dimensions (consent, affordability) of patient impacts/implications in the report;
  - Another member commented that the reading about insurance coverage of AI-identified risks particularly resonated with them; this is going to be a huge issue not just in this space, but AI in general- AI will be able to do things that we don't understand how and why it happened, but may be more accurate than humans are; don't know if there is a role for the Collaborative in this space, but article raises a lot of important issues/questions.

Health Equity

- Members expressed general agreement with including a discussion of the following issues/topics in an AI-related section of the report:
  - Accountability and infrastructure;
  - Culturally responsive care and cultural concordance; and
  - Data collection and sharing;

- A member commented that in health equity could also be incorporated into the discussion around consolidation/private equity, and how dollars are moving through the system- how dollars are moving through the system is really relevant to some of the challenges around health equity that the articles the Collaborative has been talking about have outlined; perhaps there can be an aspect of the recommendations or themes that we explore in the report with regard to how these examples show that investing more in things that have been underinvested in- and delving into some of the redistributive aspects of an APM.

Potential Additional Topics:

Tara Smith asked members if they were interested in exploring any additional topics in this year's report. She proposed two potential items: 1) communicating the importance of high-quality primary care; and 2) measuring investment and impact on outcomes;

- A member expressed interest in both of those topics/ideas; they noted that the first one (communicating the importance of high-quality primary care) is particularly

important as we are considering the sunset of the PCPRC, and there is really no other place to show that investment in primary care is really important;

- Another member commented via chat that they would love to consider a dashboard, and to see what other states are doing;
    - Multiple members agreed, with one noting the Primary Care Office at CDPHE would have good data for a dashboard;
    - The representative from CDPHE noted that the Primary Care Office is about to release some nice map-based visualizations; CDPHE has a new tool (Power Business Intelligence) that allows real-time visualizations for very large data sets; the PCO is getting ready to make a new request to CIVHC for new claims data for 2022 and 2023; will give us real-time, or near real-time workforce capacity as a measure of community-level access (not just considering the state as a whole, or regions of the state or counties)- actually looking at the community-level to examine what is the capacity and how well does it match to predicted demand; have a statutory direction to look at perinatal health, which certainly has an intersection with primary care conversations; looking forward to understanding a bit more about how people access perinatal health care as revealed in the maps; initial maps are pretty descriptive, in terms of workforce- but it is the initial preview, and how we expect to go much deeper soon;

- Tara Smith asked members about the group's interest in revisiting their initial charges, and developing a graphic or some other summary of the Collaborative's work to date in each area; this could potentially be accompanied by a discussion of what the Collaborative sees as important areas of future focus, as the report may be released concurrently with a bill that would propose to continue the Collaborative for an as-yet unknown period of time;
    - A member commented that it was very important to think about future work, if we are charged with continuing after the sunset review- to show the importance of the things we have done and what can be done in the future- would be awesome;
    - A member was thinking about the recommendations that we have had in the past, and what has happened with those recommendations; have there been any significant changes, based on previous recommendations.

Public comment:

- No public comments were offered.