COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes

Thursday, May 9, 2024; 10:00 - 12:00 pm
Virtual meeting

Meeting Attendance

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

Absent
Polly Anderson
Brandon Arnold
Patrick Gordon
John Hannigan
Rajendra Kadari
Pete Walsh

DOI
Tara Smith
Deb Judy

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Market Dynamics - Private Equity
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 noted a delay in getting the draft meeting minute for April posted online prior to today's meeting. The draft April minutes should be posted on the PCPRC website shortly, for approval at the June meeting.

  ACTION ITEM:
  - Meeting minutes from the April meeting will be posted shortly and approved at the June meeting.

- **Website updates** - Tara Smith reminded members about updates 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.
  - She noted that draft reporting guidance related to HB22-1325 and Division Regulation 4-2-94 has been posted on that website, and comments due tomorrow. If anyone needs more time to provide feedback, they should contact Tara Smith (tara.smith@state.co.us).
  - Any suggestions or feedback on any of the primary care or APM websites can also be directed to Tara Smith (tara.smith@state.co.us).

- **Membership update** - Tara Smith noted the Division had very recently circulated a one-page recruitment flier about the PCPRC that members can share through their networks to members. She asked members for any immediate feedback, but noted any specific comments or suggestions could also be sent to her via email.

  A new PCPRC member, Gretchen Stasica, was introduced. Gretchen is the Executive Director of Actuarial Services for Kaiser Permanente and will be replacing Miranda Ross. Welcome Gretchen!!!

  ACTION ITEM:
  - Members should email any comments or feedback on the proposed recruitment flier to Tara Smith (tara.smith@state.co.us).

Federal & state updates

The following federal updates were provided:

- **Final Rule - Nondiscrimination Protections, Section 1557 of ACA** - CMS released a final rule related to nondiscrimination protections under Section 1557 of the Affordable Care Act (ACA), clarifying several key provisions including:
  - Health care providers, insurers, grantees, others must proactively notify patients that language assistance services are available at no cost, and accessibility services are available at no cost;
  - Coverage health programs/activities offered via telehealth must be accessible to individuals with limited English proficiency and/or disabilities; and

- Prohibitions of discrimination based on sex includes LGTBQI+ patients.

- **Final Rule - Health Coverage for DACA Recipients** - CMS also released a final rule related to health insurance coverage for DACA recipients. Under the rule, DACA recipients and other newly eligible individuals will qualify for a special enrollment period for 60 days following the rule's 11/1/24 effective date. In addition, individuals that qualify to enroll in the Marketplace plan may also qualify for advance premium tax credit and cost-sharing reductions.

- **CMS National Strategy - Quality in Motion** - CMS released Quality in Motion: Acting on the CMS National Quality Strategy, an update to the 2022 National Quality Strategy, an initiative aimed at improving the quality and safety of health care for everyone, with a focus on those from underserved and/or under-resourced communities. The report includes a three-part call to action to: 1) adopt Universal Foundation measures; 2) commit to improving safety and reducing harm; 3) advance health equity in all quality and value-based programs

- **Office of Minority Health - Health Equity Data Resource** -The CMS Office of Minority Health released the 2024 Health Equity Data Definitions, Standards, and Stratification Practices, which includes guidance for providers, states, community organizers, and others to improve their health equity-related data collection and analysis. The report includes suggested definitions, standards, and stratification practices for various sociodemographic elements including, race, ethnicity, sex, and others.

Discussion:

- A Collaborative member offered another upcoming opportunity related to the National Academy of Medicine's Standing Committee on Primary Care. The member, Dr. Lauren Hughes, is a Co-Chair of this committee, and Dr. Stephanie Gold, a former PCPRC member, is currently a fellow with the NAM. On May 21-22, the Standing Committee on Primary Care will be hosting its first public meeting, focused on issues of financing, workforce, and payment in primary care. Members of the public can register at the following link: https://www.nationalacademies.org/event/42471_05-2024_standing-committee-on-primary-care-may-meeting.

  ACTION ITEM:
  - Tara Smith will circulate the link to the Division's primary care and APM stakeholder distribution list after the meeting.

The following state updates were provided:

- **2024 legislative session** - Tara Smith noted that the 2024 legislative session recently concluded, with a total of around 778 introduced bills (including joint resolutions, etc.). She introduced Deb Judy, a Deputy Commissioner at the Division, to highlight a few bills of particular relevance to the Collaborative's work. A more comprehensive list is available here (see slides 10-11).
    - HB24-1149 Prior Authorization Requirements Alternatives - this bill passed this year, after 3 years of previous efforts, with the intent of streamlining and addressing some of the administrative burdens providers face as the result of prior authorization requirements; specific elements include: required data reporting to the DOI related to PA practices, for public posting; carrier's annual review of prior authorizations; extending some of the times for how long prior authorizations last (up to one year); requiring carriers to work with provider to set up a program to modify or eliminate PA requirements (by 1/1/26);
    - SB24-093 Continuity of Coverage - this was one of the Division's priority bills, and applies when a person changes insurance source (e.g., rolls off Medicaid, changes insurance carrier in the middle of the years); it adds and strengthens consumer protections around continuing to receive care in certain circumstances;
    - SB24-080 Transparency in Coverage - this was also a Division priority bill, and allows the Division to enforce the requirement that carrier's have tools to help consumers understand cost-sharing elements; includes broader elements about getting data for the state (using reporting carriers are already responsible for reporting federally or posting- this bill will make it more usable for the state);
    - HB24-1045 Treatment for Substance Use Disorder, SB24-037 Prevention of Substance Use Disorders, SB24-048 Substance Use Disorders Recovery - three bills that came out of the Interim Committee; HB24-1045 initially had the Division doing some work around network adequacy, but they were removed due to fiscal implications- it does include elements around MAT coverage and prior authorization, as well as reimbursing pharmacists for providing MAT services;
    - SB24-205 Consumer Protections for Artificial Intelligence - this bill was introduced at the end of the session; the Division was engaged around how this bill might interact the DOI's current work to implement SB21-169; this bill is very broad, and applies to developers and deployers of certain Artificial Intelligence systems, which are defined to include health care services, as well as insurance; if signed into law, will be enforced by the Attorney General's office; will require the development of risk management systems and testing those systems to make sure they don't result in algorithmic discrimination for consumers; this bill was crafted along with a bill that was also in the Connecticut legislature;

- SB24-175 Improving Perinatal Outcomes, HB24-1392 Insurance Coverage Pediatric Neuropsychiatric Syndrome, SB24-124 Health-Care Coverage for Biomarker Testing - these three bills all require commercial insurance companies to cover benefits in health benefit plans; HB24-175 requires coverage of doula services, HB22-1392 requires coverage of services related to Pediatric Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcus (PANS/PANDAS), and SB24-124 requires coverage of biomarker testing; the Division worked with sponsors around these bills because of concerns around potential state defrayals, and included language as the Division try to assess the impacts if the benefits are considered in addition to essential health benefits; actuarial analyses were conducted for all 3, and are available on the Division's Actuarial Review of Health Benefit Coverage Legislative Proposals website;
- In addition to the bills reviewed above, there were several bills that garnered significant discussion, and that the Collaborative had been tracking, that did not pass, including:
  - HB24-1005 Health Insurers Contract with Qualified Providers - this bill started out requiring health plans to include primary care providers in their networks if they met certain conditions; it evolved significantly as it worked its way through the legislature, and by the time it went to the Senate, was focused non-compete clauses; it did die in committee in the Senate;
  - SB24-059 Children's Behavioral Health Statewide System of Care - this bill also went through an extensive process as it worked its way through the legislature; it looked at creating a statewide system of care for children and behavioral health, and involved of discussion between the agencies and bill proponents; ultimately failed in the House Committee, but on a related bill, HB 24-1038 High Acuity Care for Kids, they ran an amendment about creating a leadership team that will look and evaluate developing a system of care for kids with high behavioral health needs;
  - HB24-1040 Gender-Affirming Health Care Study - this was a bill the Collaborative had been tracking, but Division staff were not familiar with why it did not pass; a PCPRC member noted in chat that it was due to challenges in balancing privacy concerns with the need for data to study and understand how to expand access to care;
  - SB24-163 Arbitration of Health Insurance Claims - this bill related to out-of-network coverage, which providers were interested in- they wanted to be able to batch insurance claims, but it did not pass;

        - HB24-1028 Overdose Prevention Centers - this bill not surprisingly did not pass; has been introduced in previous sessions, and will likely be introduced again in future years;
    - Deb Judy noted that many of the bills discussed today are still waiting for the Governor's signature, and the Division is still working through final amendments, as the last day of session was just yesterday (May 8) but looks forward to seeing where things sort out and starting to work on next steps.

Discussion:

- A meeting participant asked in the chat if the Division could provide information about SB24-221 Funding for Rural Health Care
    - Tara Smith noted this was not one of the bills the Division closely tracked, and in a quick review it appeared to focus on workforce and involves the Department of Higher Education.
- A meeting participant noted that in the discussion around gender-affirming care, bill proponents were able to get a line added to the long bill (the state budget) for funding to support an education program around gender-affirming care through the statewide ECHO system.
- A meeting participant also inquired about the statewide system of care bill, and how that relates to the settlement with HCPF; does the bill impact the efforts that are coming out of the EPSDT lawsuit settlement;
    - Deb Judy noted that settlement was part of the conversation around the bill; concerns were expressed around the multiple pieces in play in relation to the settlement, in addition to the concerns about the fiscal impact;
- A meeting participant asked in the chat about the final outcome of SB24-130 Noneconomic Damages Cap Medical Malpractice Actions;
    - A meeting participant commented that the bill ended up turning into a different bill, HB22-1472, that included both the non-economic damages caps for malpractice liability as well as a general liability agreement with the trial lawyers and the business and provider communities;
    - The non-economic damages caps were raised to $875,000, phased in over 5 years; a separate wrongful death cap implemented around $1.575 million, also phased in over 5 years.
    - The meeting participant also asked if there were going to be any ballot initiatives this fall; no, as part of the agreement that was struck, the ballot initiatives will be withdrawn

Tara Smith ended this section of the meeting by noting some "state update" topics that will be scheduled at future meetings, including:

- Updates on the integrated behavioral health grants and legislative report that are associated with HB22-1302;
- Updates from CIVHC on potential revisions to the format of the annual primary care and APM spending reports.

Market Dynamics

Tara Smith provided a high-level overview of market trends and dynamics that impact primary care, including market consolidation, and private equity and venture capital investments (see slides 13-27, available here), and then set up the following questions for discussion:

- How have you seen financialization/private equity playing out in Colorado?
    - Impacts on your practice/community?
    - Impacts on your network(s)?
    - 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?

Discussion:

- One member commented via chat that it was remarkable that the extraction of wealth associated with PE acquisitions (20% of annual returns) could be done within healthcare entities;

- A meeting participant from Gunnison (Western Slope) noted that in general, from the rural perspective in Colorado, they have not seen a lot of activity with private equity buying up practices; however, these areas definitely feel the financial strain of running a practice- discounts aren't necessarily available for IT, software, EHRs, the security measures that need to be in place, and are not getting consistent increases in payment from payers; are having to negotiate and re-negotiate contracts, and payments are not keeping up with inflation, which makes it difficult to keep the doors open. So, it makes sense that practices would turn to private equity as a financing mechanism as an option, even if it might not be the best or most desirable option. In rural areas, workforce challenges also may compound this trend- as physicians are retiring and finding others aren't willing to buy into private practices anymore, due to all of the business and administrative challenges. They posed a question about practices that may have been bought by private equity in the past, and flipped a

couple of times, and the impacts on workforce- are any of the same people still at the practice, and/or are they still financially on the hook for paying off the debt?

- Tara Smith noted that some of the literature indicates that over 60% of practice acquisitions by private equity are followed by another private equity transaction, which indicates that scenario is likely happening.

- A member noted that from an ACO perspective, where existence is rooted in trying to get more money into primary care- we are still not getting enough money into primary care, not matter how hard we work, how well are doing and adding to teams; we are giving them a little on the top, but it is absolutely not enough, and the real problem is we have a generation of physicians who are about to retire; recently had a conversation with second year medical school student and asked how much salary plays into decisions about specialty- and all of them said 100%, it always comes into play; even when you look at medical schools with free tuition, they are not increasing the number of primary care doctors; while we are getting more money into primary care in terms of rewarding quality and coordination, it is not enough to actually replace the workforce; small, independent practices cannot afford to compete with the hospital systems who can put forward $250,000 and float somebody's cashflow while they build up their practice. There is always going to be a market for actors with big cash pockets coming in and buying up these practices- that is what we have seen over the last two years, and what I have seen in my career;
  - A member commented via chat that they agreed with these comments, noting that pediatrics doesn't get many inquiries from PE because pediatricians don't get paid enough in prevention and promotion to be on their radar; in relation to workforce, the member noted that this year close to 30% of pediatric residency programs did not fill their residency positions, with the total number of graduates applying to pediatrics declining by 6.1% over last year. This is the largest single drop in the past decade;
  - Several members expressed concerns at this trend, with one noting that at the rate we are going, we will have no physicians in primary care (General IM, FP, peds) in 10 years.

- Another member offered notes from a recent Board on Health Care Services meeting (this is an advisory Board that suggests to the NAM what types of studies, workshops, forums, etc. they need to host next in terms of identifying and curating evidence for a variety of stakeholders), which was focused on private equity. One of the first speakers was Dr. Zuri Song, MD, PhD, general internist that focuses his research on healthcare financing, payment, broader health economics (based at Harvard, frequent collaborator with some of the articles shared for today)- some highlights from his presentation, both fascinating and frightening:

- Dr. Song reiterated that private equity entered healthcare in the mid-2000s, initially focused on the acquisition of brick-and-mortar types of practices, but now the major focus has shifted to different types of physician practices, largely with the gaming of the "add on" model;
- Dr. Song also talked about rates of complications and readmission rates after a practice is acquired or invested in by PE- ED inpatient readmission rates tend to increase after acquisitions;
- Relative to the workforce, Dr. Song noted that after acquisitions practices see decreases in salaries, and decreases in staffing ratios, which further compounds issues, particularly in regard to primary care and rural health.
- Dr. Song did reiterate that primary care is not a monolith intervention- there is a great deal of heterogeneity, so that in thinking about policy levers that are available at the state and federal levels, we should be mindful of that;
- Dr. Song also mentioned that horizontal acquisition is far outpacing vertical acquisition at this time relative to private equity; two clinical areas that are leading the way: 1) dentistry, given its procedural nature; 2) fertility chains - PE is currently investing in 8 out of 11 fertility chains in the country;

- A meeting participant noticed they had just been to a pediatric meeting in Toronto, and chaired a panel on "Who Owns Child Health", which included a speaker talking about private equity;
  - In the pediatric world, pediatric primary care is the last pot, because the ways you can make the 20% margin are fewer, but neonatology is being gobbled up across the country, as is pediatric oncology;
  - The pediatric space is a little protected, because 75% of subspecialty practices are in academic centers, as opposed to the adult space where only about 20-25% of sub-specialties are in academic centers, and the academic centers have been a little slower to be acquired;
  - The speaker also reviewed collective meta-analyses of impact of PE on quality of care- most of the studies show an increase in cost of care, particularly in NICUs, and most of the harmful outcomes were seen in nursing homes and psychiatric practices; interesting in the context of the data around consolidation of mental health practices in Colorado; it appeared that one of the higher areas was also in Mesa County;
  - Overall, the presentation was fairly depressing- one of the key challenges in the pediatric space is that most of these acquisitions are under the radar because they are small and gradually accumulated, and by the time you have an accumulation, it is too late to do anything about it; the impacts this will have on workforce is not clear, but hard to imagine it will be positive;

- A member commented from the patient perspective, we are increasingly concerned about the role of PE, and the overall trend of financialization- things like medical credit cards, and other pieces that continue to cement racial wealth gaps and divides and challenges with medical debt; these forces are not only driving folks seeking care into debt, but also making people afraid to interact with the healthcare system until they desperately need to, which creates a vicious cycle of who gets to be healthy. The consumer community is concerned about these trends- the top questions people have are "why does everything cost so much" and "why do I get so little time with my provider", and many of these trends really answer those questions. We are trying to dig in from the patient perspective on what can be done to ensure that profits are not being put over patients, which is the goal of the PE model.
    - A member agreed with this comment via chat, noting they are starting to see some of the same patterns around cost and access that existed before the Affordable Care Act (ACA) came into existence.
    - Another member commented that for another project they are reading Michael Fine's book On Medicine and Colonialism, and he talks about the extraction of wealth through the health care system from communities to the owners or the equity shareholders, and likens it to colonialism; we are hearing that this process has reduced quality of care, reduced access, and will exacerbate health disparities while making communities poorer;

- A chat thread started a discussion of the role of noncompetes in the current market dynamics, with one member noting that non-competes are no longer legal for more professionals;
    - A meeting participant noted they had heard mixed messages about whether non-profit hospitals are exempt, and whether that was true;
    - The member noted that they didn't believe non-profit hospitals were exempt in Colorado law, which has been in effect for several years. Colorado's law now essentially outlaws all noncompetes in contracts, with a very few highly technical positions in research and technology. The FTC in the last few weeks issued a ruling that made noncompetes much more difficult to create and enforce nationally, so that they are nearly impossible to enforce in the health sector. https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes
    - Any of the contracts CDPHE has written for clinicians for center programs have insisted that employers exclude a noncompete, even if it was otherwise standard practice, because our goal is to attract clinicians into communities and do everything we can to help them stay.

- A member commented they were struck by the term "stealth consolidation", and noted that one of the things that made them so angry about this topic is how PE is so

good at applying their leverage in a ways that are so hard to identify and track; shedding light and bringing visibility to the issue is worthy of the Collaborative's time; there are benefits to shining light on things that are murky and harmful. Another frustration is what feels like completely inadequate state and federal policy levers that are so behind right now, relative to this issue, and where there might be opportunities to intervene. While not sure what to do with that, it highlights the need to shed light on this, so the Collaborative can continue to think creatively about other opportunities to intervene, particularly on the state level, and have another opportunity for Colorado to be a leader in thinking about these issues.

  - Multiple members agreed with these comments, with one member noting that an additional theme from the articles is looking at the role or the ways that alternative payment models have been designed that have incentivized the way that PE has played out in certain spaces; how we can be thoughtful in thinking through what an equitable APM is, or how to respond to concerns about how/why the money is not getting where it needs to go in primary care, and how we can prevent against or mitigate some of these unintended consequences through APM design- so that we are not playing into a model of care that is potentially integrated but is actually resulting in consolidation.

- A member commented that from a payer perspective, we are definitely seeing the impacts of PE and consolidation; when it comes to investment in primary care, a lot of payers would like to invest more, but we also have to deal with all of the other pieces of the system that we are paying for- in those areas where costs are being driven up specifically because of PE, a lot of this comes to a head; when you look at anesthesiology or ER where some of the PE investment firms have taken hold; while there is consternation about network adequacy rules, when you see consolidation in a certain area then there is excessive leverage on the provider side to demand certain reimbursements in order to get them in the network and be able to offer a plan, and that does drive costs pretty significantly;

- A member asked about the status of the anesthesiology litigation, and if that was a mechanism to "shine a light" on anti-competitive practices in other areas of the healthcare field;
  - Tara Smith noted that she wasn't sure about the impact or implications of the litigation on other areas in healthcare, but the case, particularly the complaint, provided a very detailed description of how the entire process of acquisitions took place over a period of time in Texas; the FTC deliberately tracked and documented the process "across the lifecycle", and the complaint is based on multiple small transactions, rather than one large one, which is a new approach by the agency;

    - A member entered the following link into chat, related to a victory by the Colorado Attorney General in a case against the U.S. Anesthesia Partners: https://coag.gov/press-releases/usap-health-care-monopoly-attorney-general-phil-weiser-2-27-2024/.

- Tara Smith asked member how they would like to continue this conversation- is this a topic that you would like to include in a future recommendation, would it be beneficial to hear from other states, are people interested in bringing in additional expertise;
    - Multiple members expressed interest in all of the above via chat, with one member noting that there is a deep need for education and awareness, and to "shine light", at least as a starting point;
    - Another member commented via chat that for a next meeting, a comparison of how other states are responding to PE impacts on primary care would be useful;
    - A member noted that as long as this discussion aligns with the Collaborative's mission of investing in primary care, and the downstream impacts; just looking at why specialist groups are getting bought up is less fruitful, but to the degree it is impacting primary care spending and payment flows, and the role of APMs in influencing (either driving or mitigating) these trends;
        - Multiple members agreed with this statement, noting that the Collaborative will need to be mindful of scope and purpose;

- A member highlighted this comment, by noting that a central question is "Are the payments that we are putting forth by changing the payment structures getting to the right places"; what we are seeing with PE entities is that they see an opportunity to make money off of some of these payment changes, and we are trying to put payments in place in order to affect the primary care workforce. Is that really happening? And if not, how do we get in front of that?

Public comment:

- No public comments were offered.