Colorado's Primary Care Payment Reform Collaborative

Seventh Annual Recommendations Report

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The recommendations in this report are a product of the Collaborative and should not be construed as recommendations or specific opinions of the Division of Insurance (DOI) or the Department of Regulatory Agencies (DORA).

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Executive Summary

The Primary Care Payment Reform Collaborative (the Collaborative) is pleased to present this Seventh Annual Recommendations report. Since its creation in 2019, the Collaborative has remained focused on the goal of strengthening Colorado's primary care infrastructure and care delivery system through increased investment and the adoption of value-based payment models, also known as alternative payment models, that drive value, not volume, and improve health outcomes.

This year's report comes at a unique moment — both in the history of the Collaborative and in the health care landscape in Colorado and the United States. In 2025, the Colorado General Assembly passed legislation extending the Collaborative for an additional seven years, through September 1, 2032. The year 2025 also brought the passage of H.R. 1, a federal budget reconciliation bill signed into law on July 4, 2025, which is fundamentally reshaping the health care landscape in the U.S. These federal changes are interacting with other market forces, including increased consolidation, to bring issues of health care access and affordability to a head. Within this context, the Collaborative reasserts its commitment to increasing investment in primary care to improve patient outcomes, increase health equity, and reduce health care costs. The recommendations in this report are divided into two parts:

Part 1:
Payment.

In Part One, the Collaborative addresses key issues related to payment and strategies to support primary care in the face of reduced resources and increasingly complex market dynamics and disruptions.

Part 2:
Comprehensive Primary Care Strategy.

In Part Two, the Collaborative proposes a framework for the development of a comprehensive primary care strategy to provide the state with a shared understanding of the current status of primary care in Colorado and to support the collective movement of practices, payers, and purchasers toward advanced primary care.

Colorado's Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative was established by House Bill 19-1233 (HB19-1233) and charged with developing recommendations and strategies for payment system reforms to reduce health care costs by increasing the use of primary care. Colorado has been a national leader in primary care payment reform; when the Collaborative was established in 2019, Colorado was one of only a handful of states engaged in strategies to increase investment in primary care. Now, more than 20 states are working on a range of activities, including setting spending targets, measuring and reporting on primary care spend and outcomes, and establishing primary care task forces.[1]

The Collaborative is statutorily tasked with the following:

Recommend a definition of primary care to the Insurance Commissioner.

Advise in the development of broad-based affordability standards and targets for commercial payer investment in primary care.

Coordinate with the Colorado All Payer Claims Database (APCD) to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado's Medicaid program), and Child Health Plan *Plus* (CHP+).

Partner with the Department of Health Care Policy and Financing (HCPF) to align primary care quality models with the Collaborative's recommendations through the Accountable Care Collaborative and other alternative payment models (APMs).

Report on current health insurer practices and methods of reimbursement that direct greater resources and investment toward health care innovation and care improvement in primary care.

Identify barriers to the adoption of APMs by health insurers and providers and develop recommendations to address these barriers.

Develop recommendations to increase the use of APMs that are not fee-for-service in order to:

- Increase investment in advanced primary care models;
- Align primary care reimbursement models across payers; and
- Direct investment toward higher-value primary care services with the aim of reducing health disparities.

Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care.

Develop and share best practices and technical assistance with health insurers and consumers.

Historical information about the Collaborative — including previous recommendation reports, meeting materials, and Standard Operating Procedures and Rules of Order — is available on the Colorado Division of Insurance (DOI)'s Primary Care Payment Reform Collaborative website. Each year, the Collaborative's primary care recommendations report is made available electronically to the public on the DOI website.

The Collaborative reached the findings and recommendations in this report through iterative discussion during 10 public meetings in 2025. All Collaborative meetings are open to the public, with meeting times posted in advance on the Collaborative's website. Time for public comments is reserved during each meeting.

The DOI selects members of the Collaborative through an open application process. Each member serves a one-year term with the opportunity for reappointment, for additional terms. Collaborative members represent a diversity of perspectives, including:

- Health care providers;
- Health care consumers;
- Health insurance carriers;
- Employers;
- U.S. Centers for Medicare and Medicaid Services (CMS);
- Experts in health insurance actuarial analysis;
- Primary Care Office, Colorado Department of Public Health and Environment (CDPHE); and
- HCPF.

Introduction and Key Context

Primary care lies at the nexus of health care access and affordability. Research shows that health systems with a strong primary care foundation provide better access to health care, improved health outcomes, enhanced life expectancy, more equity, and lower health care costs.[2,3] Primary care serves as a key point of access into the health care system and can improve both individual and population health through the provision of preventive services, care coordination, and chronic disease prevention.[4] Primary care is also one of the most cost-effective investments, with evidence pointing to savings of $13 for every $1 invested, and fewer hospitalizations for patients with complex, high-cost conditions.[5,6]

Over the past six years, the Collaborative has worked to strengthen the primary care system in Colorado. This Seventh Annual Report, like its predecessors, builds on recommendations from previous years, but also marks a unique moment — both in the history of the Collaborative and in the health care landscape in Colorado and the United States.

The legislation establishing the Collaborative in 2019 included a sunset clause, which would have ended the group's work on September 1, 2025, absent legislative action. In 2024, the Colorado Office of Policy, Research and Regulatory Reform conducted a sunset review of the Collaborative's activities to date and issued a report recommending that the Collaborative be continued for an additional seven years.[7] This recommendation gave rise to Senate Bill 25-193, which was signed into law and extends the Collaborative through September 1, 2032, while adding language to ensure the unique needs of primary care delivery in pediatrics are considered in discussions of APMs.

This reaffirmation of the Collaborative's work, and the foundational role of primary care, could not come at a more crucial time. Many of the challenges currently facing primary care are familiar: chronic, decades-long underinvestment; administrative burdens leading to clinician burnout; an aging and shrinking workforce; the inability of fee-for-service (FFS) payments to sustain advanced primary care delivery; increasing demands on providers to address social and behavioral health needs; and shorter visits and larger panel sizes. The Collaborative will continue to prioritize answers to these issues. Yet recent events at the national and state level stand to not only exacerbate existing problems, but create new and significant threats to the accessibility and affordability of health care.

Federal and State Policy Changes

Health policy at the state and federal levels is undergoing rapid change. Policy information in this report is current as of February 12, 2026.

H.R. 1, signed into law on July 4, 2025, is fundamentally reshaping the health care landscape in the U.S. Over the next two to eight years, the federal law will impose new Medicaid eligibility and coverage provisions — including mandatory work requirements, biannual eligibility redeterminations, and cost-sharing for certain members — which are projected to affect hundreds of thousands of Coloradans.[8] The law's elimination of eligibility for certain legal immigrants will result in coverage losses for both Medicaid and Medicare enrollees and restrict premium tax credits for those enrolled in coverage through Affordable Care Act (ACA) Marketplaces. The enactment of H.R. 1's ACA Marketplace provisions in future years — such as bans on automatic reenrollment and new pre-enrollment verifications — will result in additional coverage losses.

Even for those who remain covered under public or private insurance, H.R. 1 includes provisions that impact health care access and affordability. The law immediately threatened access to critical primary care and preventive services by forbidding Medicaid payments to certain "prohibited entities," including Planned Parenthood and other providers offering abortion services, for a one-year period starting on July 4, 2025.[9] Colorado has been able to maintain payments to such providers through a joint state attorneys general lawsuit[10] and the passage of Senate Bill 25B-002. However, access to preventive and reproductive services remains a concern.

For ACA Marketplace enrollees, H.R. 1 expands access to Health Savings Accounts (HSAs), which are tax-advantaged savings accounts traditionally designed to help enrollees in high-deductible health plans pay for out-of-pocket medical expenses. Starting on January 1, 2026, the law makes key changes to allow people receiving care through a direct primary care (DPC) arrangement, in which patients pay a periodic (usually monthly) fee to a provider and receive unlimited access to a set of primary care services, to contribute to HSA accounts and to use HSA funds to pay DPC membership fees.[11] While it is difficult to predict how this change may affect where and how people access care, growth of the DPC model both nationally and in Colorado has important implications for primary care (discussed in detail in the Direct Primary Care section of this report).

Finally, H.R. 1 will ratchet down Colorado's use of provider fees beginning in 2027. Colorado currently uses a hospital provider fee to draw down federal funding to enhance hospital payments and to help finance Medicaid coverage for several populations, including adults without disabilities (the ACA expansion population), a buy-in program for adults and children with disabilities, and other expansions. Colorado stands to lose between $900 million and $2.5 billion annually by federal fiscal year 2032 due to the reduction in provider fees and corresponding federal matching funds through this provision. These changes are expected to erode coverage, increase the number of uninsured in the state, and put further strains on the safety net.

Additional actions by the Trump administration, related to the health care workforce and the availability of federal health datasets, also will have significant impacts for primary care and the primary care workforce pipeline.

Restrictions on Immigrant Work Visas

A Presidential Proclamation issued in September 2025 increased the fee for H-1B visa petitions, a temporary visa for foreign professionals, from $3,500 to $100,000.[12] Research shows that physicians practicing in the U.S. through the H-1B visa program have been "far more likely than their domestic counterparts to fill critical gaps in health care delivery systems, such as primary care and psychiatry," and the increase in H-1B application fees will disproportionately affect rural and socioeconomically disadvantaged communities, which already experience the greatest health care workforce shortages.[13,14]

Student Loan Caps

Starting in July 2026, H.R. 1 will impose a $200,000 lifetime cap on loans for professional students, including doctors, and a $100,000 lifetime cap for graduate students, including advanced practice registered nurses.[15] Without financial support, students may decide not to go to medical school, and those who do attend may choose higher-paying specialties over primary care, exacerbating existing provider shortages. The diversity of the future primary care workforce also may suffer if only the wealthiest students can afford medical school and advanced nursing degrees, which has important downstream implications on patient care and health disparities, particularly in rural and underserved areas.[16,17]

Federal Data Sources

A set of Executive Orders signed in January 2025 related to gender ideology[18] and diversity, equity, and inclusion[19] led federal agencies to pull multiple federal government websites and datasets offline on January 31, 2025, including national health surveys, indices, and data dashboards used by providers, researchers, and policymakers.[20,21] A series of lawsuits over the ensuing months has led to the partial restoration of data on websites maintained by the Department of Health and Human Services, the National Institutes of Health, and the Centers for Disease Control and Prevention,[22,23] but questions and concerns remain about the integrity of key federal data sources.[24,25]

Health System Funding

Overall, the Congressional Budget Office estimates H.R. 1 will increase the number of uninsured people in the U.S. by 10 million by 2034. When combined with the expiration of the enhanced premium tax credits, the number rises to more than 14 million.[26] While devastating to affected individuals and families, these coverage losses will also lead to increased uncompensated care, putting critical strain on community health centers, rural hospitals, and other safety net providers.

These changes in the federal landscape are occurring in the midst of increasing health care affordability challenges in Colorado. Rising health care costs, inflation (both medical and general), workforce shortages, provider consolidation, and increasing drug costs are pressing both private and public insurers.[27] In the private market, these trends, coupled with the Congressional failure to extend enhanced premium tax credits,[28] resulted in an average 101% increase in premiums in 2026 for the approximately 225,000 Coloradans enrolled in Colorado's individual marketplace.[29]

In terms of public insurance, Colorado's Medicaid program costs have increased by an average of 8% a year since 2018, driven by a combination of medical price growth and program enrollment. While this represents about half of the member cost growth rate of private insurance plans and is comparable to Medicaid spending in other states, Colorado is nevertheless facing significant challenges in managing Medicaid costs.[30] These challenges are being compounded not only by reductions in federal funding (and increased administrative burdens) associated with H.R. 1, but also by the Taxpayer's Bill of Rights (TABOR), which has limited state revenue growth to an average of 4.4% a year over the past decade.[31]

Investing in Primary Care

At a time of shrinking state and federal resources, as insurers and providers are simultaneously experiencing higher costs, higher utilization, and higher-need patients, the question of how to support the continued viability of primary care has taken on increased urgency. In the face of strong headwinds, the Collaborative reasserts its commitment to increasing investment in primary care to improve patient outcomes, increase health equity, and reduce health care costs. The recommendations in this report are divided into two parts:

Part 1: Payment. In Part One, the Collaborative addresses key issues related to payment and strategies to support primary care in the face of reduced resources and increasingly complex market dynamics and disruptions.

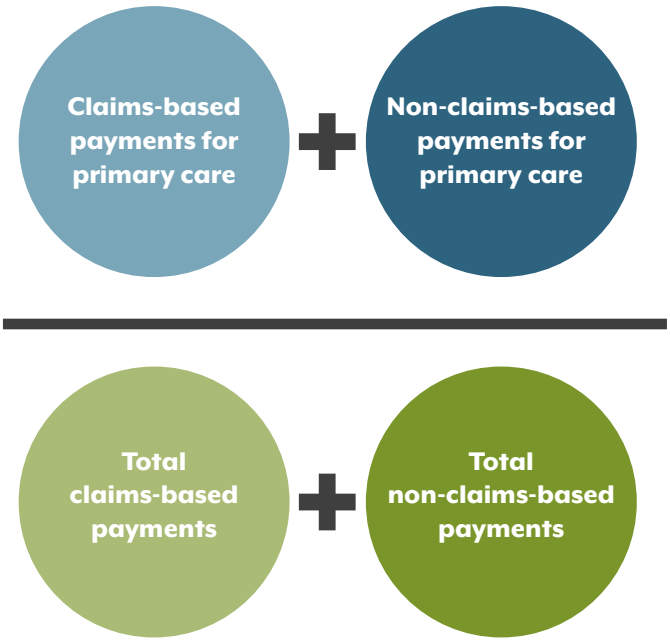
Part 2: State Comprehensive Primary Care Strategy. In Part Two, the Collaborative proposes a framework for the development of a comprehensive primary care strategy to provide a shared understanding of the current state of primary care in Colorado and to support the collective movement of practices, payers, and purchasers toward advanced primary care.

Update on Primary Care and Alternative Payment Model Spending

To understand spending on primary care in Colorado and to track changes in investment over time, the Collaborative receives annual reports on primary care spending and APM use in Colorado from the Center for Improving Value in Health Care (CIVHC). The report is based on annual information submitted by health insurance payers to CIVHC about primary care and total medical spending from claims and non-claims payments under FFS and APMs (see Figure 1).

Figure 1. Colorado Annual Primary Care and APM Spending Reports

Primary care spending is calculated as a percentage of total medical spending and includes claims-based and non-claims-based spending:



In November 2025, CIVHC presented the most recent findings of spending based on data from the Colorado APCD for calendar years 2022 – 2024. The Primary Care and Alternative Payment Model Use in Colorado, 2022-2024 report includes an analysis of data reported by commercial, Medicaid, and Medicare Advantage payers. Importantly, the primary care spending data does not include data from self-funded employer plans. Self-funded plans, in which employers pay for their employee health claims directly, are estimated to make up around 50% of what most Coloradans think of as the "insurance market" (coverage that is not obtained through a public source such as Medicaid, Medicare, or the Veterans Administration). Self-funded plans are not subject to state regulation and therefore are not required to report data to CIVHC.

Total Primary Care Spending

Primary care spending across all reporting payer types increased from 15% in 2022 to 16% in 2024, according to the CIVHC data. This is down from a peak of 17% in 2023. Most payer types reported modest changes in primary care spending between 2023 and 2024 (see Figure 2). In general, Medicare Advantage and Medicaid dedicated a higher proportion of their medical spending to primary care than commercial insurers. However, there are structural differences across payer types — including mployee Retirement Income Security Act (ERISA) protections, employer benefit design, risk adjustment, and Medicaid rate constraints — that naturally produce variation in primary care investment and APM adoption. Also, increases in hospital spending can decrease the proportion of primary care spending, even if the dollar amount of primary care spending is rising. For these reasons, comparisons across payers or over time should be made cautiously.

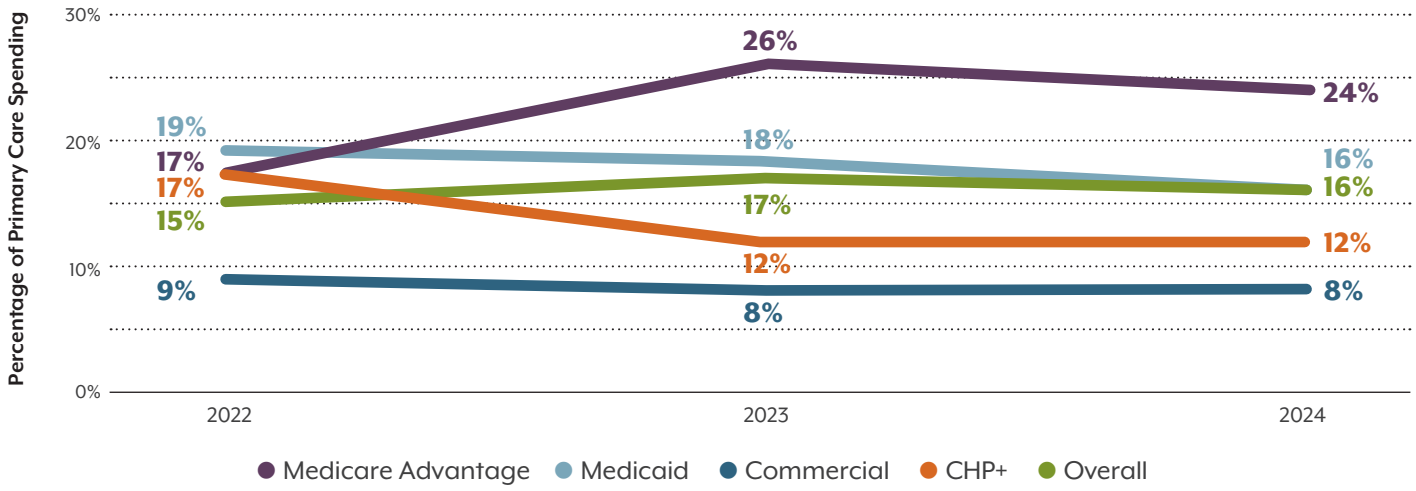
Value-Based Payment Model Spending

In addition to overall primary care spending, CIVHC reports on the percentage of primary care spending that is flowing through APMs, both as a percentage of total medical expenditures and as a percentage of primary care spending. In 2024, value-based APMs (which, for the purposes of this report, exclude risk-based payments and capitated payments not linked to quality) accounted for 27.5% of total medical spending and 50.8% of total primary care spending across all reported payer types.[32] This represents a slight decrease from 2023, when payers reported 28.7% of total medical spending and 54.1% of primary care spending flowed through value-based APMs.[33]

Prospective Payments

The Collaborative has consistently recognized the importance of prospective payments to support primary care providers' capacity to deliver high-

Figure 2. Percentage of Primary Care Spending by Payer Over Time, 2022-2024



quality, advanced primary care.[34] Prospective payments offer greater flexibility for providers to deliver care responsive to their patients' needs. In 2024, 47.6% of all medical spending made through APMs across all reported payer types was paid on a prospective basis.[35] Of total primary care spending made through APMs in 2024, 82.2% was paid on a prospective basis.

Data over the past three years have shown high proportions of prospective payments in primary care APMs (over 80%), but this does not match what providers say they are receiving. The way the data are collected might be inflating the numbers, but the full explanation is not clear. The Collaborative will continue to work with CIVHC to better understand data that carriers are reporting as prospective spending, and potentially explore different methodologies for collecting these data. Any new methodologies should rely primarily on existing APCD reporting or other established state or federal data sources and should not create new payer or provider reporting requirements absent legislative direction.

The Collaborative also acknowledges that the high proportion of prospective payments reported in the APCD data may be influenced by a small number of fully integrated systems that are not reflective of the broader commercial market. To account for this, CIVHC reports on the share of prospective payments out of primary care APM spending separately for all payers, including the two fully integrated systems in the state, and for payers excluding the integrated delivery systems. For the past two years, the difference has averaged around 2 percentage points; in 2024, 84.4% of all APM primary care spending flowed through prospective payments when all payers were included, and 82.2% was prospective when integrated systems were excluded.

Improving Data Quality

Tracking primary care and APM spending over time is essential for understanding payer investments in primary care. Clear definitions that establish a common understanding of what is included in the reporting of specific data elements are also crucial to generating high-quality data and ensuring primary care and APM spending results are not reported inconsistently or misinterpreted.

Data from the Colorado APCD provide valuable insights, but certain data challenges remain. Changes in payers' data and accounting systems, and in the individuals or teams responsible for data submissions to CIVHC, make it difficult to compile spending data consistently year-over-year. The complexities and nuances of value-based payment arrangements can also make it difficult to capture and appropriately categorize spending.

This year CIVHC also implemented a new method of categorizing payments for APM submissions, switching from the Health Care Payment and Learning Action Network (HCP-LAN) categories to the Expanded Non-Claims Payment Framework (or Expanded Framework). While the HCP-LAN categories have been helpful, certain features of this framework make it challenging to discern the amount of FFS versus non-claims-based dollars that may be included in a payer contract. For example, if a contract includes both FFS and non-claims-based components, under the HCP-LAN framework the total dollars in the contract are all counted as non-claims-based spending. The Expanded Framework will allow for increased specificity in reporting and provide greater insight into the structure of various payment arrangements. However, many payers reported this change caused them to revisit their previous APM classifications, and in some instances to make adjustments to more accurately represent the payment mechanisms involved. While such modifications overall serve to improve data quality and integrity, they make it difficult to directly trend investment levels within and across categories over time.

Future Priorities

CIVHC currently does not collect data in a way that allows primary care and APM spending to be broken out by age bands (e.g., 0-4 years old, 5-10 years old, and 11-21 years old); therefore, it is not possible to determine the amount of spending on children or aging adults. Understanding the flow of resources to patient populations by age group continues to be a priority for the Collaborative and an area of focus for future data collection. Additional data on the number of self-insured lives and the impact this current gap in reporting has on observed primary care spend also continues to be of interest. The Collaborative looks forward to continued work with CIVHC and other partners to ensure the data is as timely and actionable as possible.

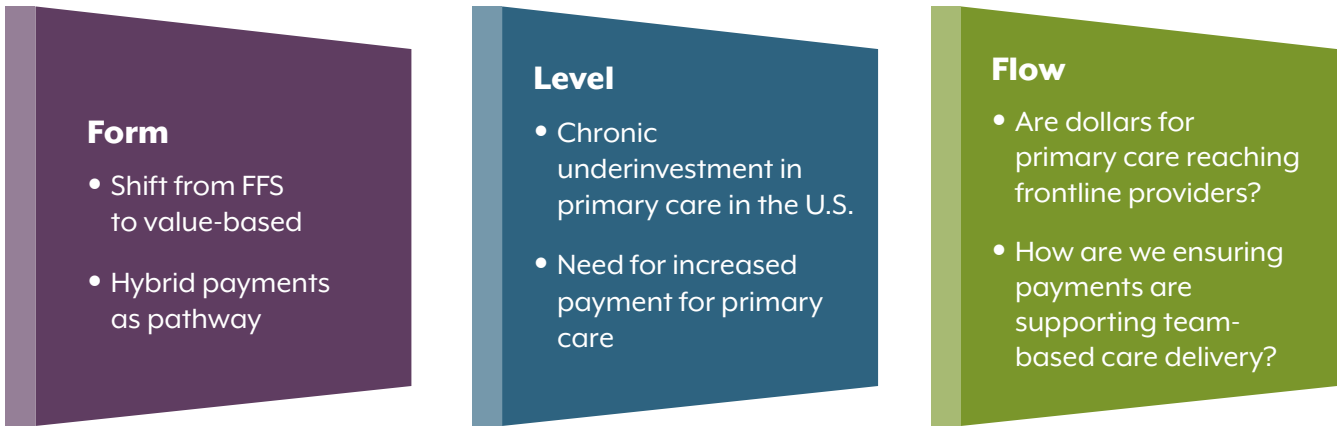
Recommendations Part 1 — Payment

In the First Annual Report, the Collaborative laid the groundwork for payment strategies that best support advanced primary care delivery by recommending that increased investments in primary care should: 1) be offered primarily through infrastructure investments and APMs that offer prospective funding and incentives for improving quality; and 2) support providers' adoption of advanced primary care models that build core competencies for whole-person care. The Collaborative has built on these core tenets in subsequent reports, offering a series of recommendations related to multi-payer alignment, behavioral health integration, support of care delivery teams, and other key topics (see Appendix A for a complete list of previous report recommendations).

In the Third and Fifth Annual Reports, the Collaborative further distinguished between two interrelated dimensions of payments needed to support primary care. The first involves direct payments to providers and care teams for care delivery; the second involves investments in the primary care infrastructure, financed through joint, systemic efforts that may include governments, payers, and other stakeholders. Infrastructure investments include workforce development incentives, system transformation initiatives, quality improvement initiatives, broadband access and data interoperability (i.e., the ability to access, exchange, and cooperatively use data), and other tools needed to deliver high-quality, whole-person and whole-family care.

In Part 1 of this Seventh Annual Report, the Collaborative focuses on recommendations specific to payments to providers and care teams. Recognizing the impact of shifting market dynamics on primary care practices, the Collaborative explores three facets of payments: their form, level, and flow (see Figure 3). The Collaborative also elevates recommendations related to three groups that face unique challenges with value-based payments: rural providers, pediatric providers and practices, and safety net providers.

Figure 3. Three Dimensions of Primary Care Payments



Source:
Derived from the work of Asaf Bitton; see Primary Care Needs a Triple Double: A Call to Action, Milbank Memorial Fund Blog Post, November 19, 2025

Form of Payment

FFS payment structures, which reward distinct services, are incompatible with the complex, coordinated, and comprehensive care that is the hallmark of advanced primary care delivery.[36] The Collaborative has consistently stressed the need to move away from FFS payment structures and strongly advocated for increased investment in primary care to flow mainly through APMs. Such payments must be structured to meet the realities of today's health care landscape and the unique needs of providers that are most threatened by impending resource cuts.

The form or structure of payments is particularly important in reducing provider administrative burden. A recent Commonwealth Fund survey found that two in five primary care providers in the U.S. report feeling "burned out," more than nearly every other country, and that more than two in five reported administrative burden as the primary reason.[37]

While APMs can reduce certain burdens associated with coding, billing, prior authorization and other tasks, without intentional structuring and alignment across payers, they can also increase provider workloads. For example, payment models that rely on process-centered quality metrics can become "check the box" exercises that take provider time and focus away from care delivery, whereas models that offer overall outcomes-based payments can allow for more clinical independence and innovation. Both payers and providers require a degree of flexibility to structure APMs to meet the needs of specific populations, yet these types of adjustments can lead to increased model complexity. The Collaborative continues to work to find a balance between these competing priorities.

Prospective Payments to Support Care Delivery

The Collaborative advocates for prospective payments to support the delivery of comprehensive, whole-person and whole-family care that improves patient outcomes.

Definitions

Team-based care. "Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care." — National Academy of Medicine

Whole-person care and whole-family care. Whole person-care and whole-family care are the coordination of health, behavioral health, and social services in a patient- and family-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. — adapted from JSI

Prospective payment. Prospective payment means a payment made in advance of services that is determined using a methodology intended to facilitate care delivery transformation by paying providers according to a formula based on an attributed patient population to provide predictable revenue and flexibility to manage care within a budget to optimize patient outcomes and better manage population health. — § 10-16-157(2)(f), C.R.S.

Payments to primary care teams must be adequate, flexible, and prospective so that providers and practices can make decisions to best meet the needs of their patients and local communities in terms of care coordination, education, virtual care, and other services that are needed outside of discrete visits. Prospective payments and up-front investments are also crucial in allowing practices to build the competencies needed to deliver such care and succeed in value-based payments.

Total cost of care contracts that involve prospective payments raise unique considerations around the use of retrospective adjustments, in which providers must return a portion of the up-front payment if they fail to meet cost, quality, or outcome targets. This return or "clawback" of prospective payments classified as expenses can exacerbate, rather than mitigate, provider concerns around revenue stability and predictability, and limit innovation and flexibility. Payers need mechanisms to hold providers accountable for advanced care delivery that improves patient outcomes, and retrospective adjustments may be appropriate in certain arrangements, particularly with providers who have extensive experience participating in APMs. However, the Collaborative continues to encourage payers and providers to work together to determine provider readiness and to consider guardrails that limit retrospective adjustments as appropriate.

The Collaborative also acknowledges that variations in the form of primary care payments across different lines of business are structural as well as discretionary. Commercial benefit designs, employer purchaser constraints, and federal rating rules all affect insurance carriers' ability to deploy prospective models at scale, and should not be interpreted as insufficient carrier investment. In addition, many independent and multispecialty practices cannot operationalize prospective payments without significant investment and multi-payer alignment.

Takeaways and Recommendations: **Prospective Payments**

- The Collaborative continues to advocate for prospective payment models that allow for flexibility in care delivery and provide revenue stability for providers.
- The Collaborative will continue to work with CIVHC and payers to better understand the scope and use of prospective payments in Colorado.

Payer Alignment

Since its inception, the Collaborative has stressed the need for alignment across the various payer APMs used to support primary care. As noted in the Second Annual Report, providers and practices need common goals and expectations across payers to transform care delivery. Alignment across payers "improves efficiency, increases the potential for change and reduces administrative burden."

Based on feedback from the Collaborative and other stakeholders, the DOI implemented aligned parameters for primary care APMs used by commercial payers through Colorado Insurance Regulation 4-2-96, which went into effect on January 1, 2025.[38] After one year of implementation, it is still too early to tell how the aligned parameters are impacting APM adoption and participation, or whether they are meeting intended goals to increase transparency, reduce administrative burden, and improve health care quality and outcomes.

While the DOI's regulation applies to commercial payers, the Collaborative recognizes the importance of market-wide alignment, including Medicare and Medicaid. Colorado was one of eight states selected to participate in Making Care Primary (MCP), a 10.5-year Center for Medicare and Medicaid Innovation model focused on primary care, which would have provided an opportunity to include Medicare in the state's primary care alignment efforts. The Trump Administration ended MCP early (in September 2025), and while Colorado initially had low enrollment in the model, it was nevertheless a disappointing loss. The Collaborative remains interested in exploring avenues for alignment with both Medicare and Medicaid, as well as self-funded employers. Current and future opportunities are highlighted below.

Medicare Advanced Primary Care Management and Integrated Behavioral Health Codes

In 2025, CMS added Advanced Primary Care Management (APCM) services to Medicare's Physician Fee Schedule. APCM services are billed using codes that bundle existing care

management and communication services into a single payment that can be billed monthly.[39] CMS added three new behavioral health codes that can be billed as add-on services in 2026.

With the cancellation of MCP, the APCM and behavioral health add-on codes may offer a potential framework for alignment by commercial payers and Medicaid. While the Collaborative is interested in exploring alignment opportunities, several key issues will need to be evaluated:

- Colorado has been a leader in integrated behavioral health, and requirements around integrated care delivery are currently included in the aligned core competencies in Regulation 4-2-96. Movement toward alignment with Medicare's framework should not weaken existing structures.
- APCM codes are currently subject to cost-sharing requirements, which may serve as a barrier to adoption across other payers.
- Pediatric and other providers who do not have Medicare as a significant part of their payer mix would not benefit from alignment, and any movement in this direction would need to be weighed to ensure it does not cause harm.

Health First Colorado Accountable Care Collaborative Phase III

In 2025, Health First Colorado launched a new phase of the Accountable Care Collaborative, the state's primary care delivery system for Medicaid. Known as ACC Phase III, it was designed to align with Regulation 4-2-96. It also contains policy and payment provisions designed to address historical barriers to APM participation and integrated care delivery, including:

- **Access Stabilization Payments.** Under ACC Phase III, HCPF will provide an Access Stabilization Payment for practices that have had a hard time participating in APMs. Per-member-per-month (PMPM) payments will be made to eligible Primary Care Medical Providers (PCMPs),[40] including pediatric, rural, and small independent providers.
- **Support for Integrated Behavioral Health.** In 2025, HCPF also implemented an Integrated Care Sustainability Policy to build a sustainable reimbursement model for primary care providers who incorporate behavioral health services into their practices.

The Collaborative applauds the innovative payment structures included in ACC Phase III and is interested in exploring opportunities to expand such approaches more broadly across payers. Conversations about this began during the development of the Integrated Care Sustainability Policy, when HCPF, in partnership with the DOI, reached out to commercial payers to identify potential areas of alignment around the use of codes, PMPM payments, and other design features. Revisiting these discussions, while simultaneously learning lessons and best practices as ACC Phase III is fully implemented, will help ensure solutions to chronic challenges to APM participation — related to practice size, location, and ownership, as well

Takeaways and Recommendations: **Payer Alignment**

- The Collaborative reaffirms that multi-payer alignment is crucial to the success of APMs, and Colorado should continue to build on prior and ongoing work of payers and providers to advance high-quality, value-based care.
- The Collaborative supports the continued development and refinement of the aligned APM parameters established by the DOI through Insurance Regulation 4-2-96.
- The Collaborative would like to pursue opportunities to engage large self-funded employers in voluntary discussions regarding primary care investment, integration, and value-based payments to improve collaboration between public and private health care sectors that will ultimately benefit patients and health care delivery in the state.

as payment for behavioral health integration — are implemented on a market-wide scale, maximizing their success and sustainability.

Rural Providers

Rural providers and communities face unique challenges related to health care access and affordability. Rural areas have 15% fewer primary care clinicians on a population basis than urban and suburban areas, and the current supply of primary care physicians in rural areas is expected to meet only 68% of demand.[41,42] Geographic distances in rural areas also pose challenges, and transportation options are often more limited.[43] While telehealth can offer opportunities to increase access, limited access to broadband and high-speed internet continues to pose a barrier.[44] As a result, rural residents suffer from higher rates of chronic conditions, poorer behavioral health, greater risk of opioid overdoses, and higher mortality than their urban counterparts.[45]

Nearly half of U.S. residents in rural areas are uninsured or are covered by public payers, which puts unique strains on rural health providers. As highlighted in a recent Commonwealth Fund issue brief, "[t]his limited payer mix, coupled with relatively low reimbursement rates and high provision of uncompensated care compared to nonrural areas, poses challenges to the financial stability of rural primary care."[46] Health centers form a central point of access, with rural health clinics providing care for nearly one-third of rural residents, and health centers funded by the federal government caring for one in five residents.[47] Due to the large role that Medicaid plays in funding health care in rural areas, these communities and providers are likely to be hardest hit by the impending Medicaid cuts imposed by H.R. 1.

While many components of value-based payments could benefit rural providers, in recent years there has been growing recognition that APMs often fail to account for the realities of rural primary care practices. Many are designed for high service volume areas and don't work well in rural areas with fewer patients, fewer specialists, and higher operating costs.[55] But this does not have to be the case; as highlighted in the recent report Closing the Distance in Primary Care: Evidence, Stories, and Solutions, rural providers are pursuing a number of innovative strategies to provide high-quality, advanced primary care, including participating in a variety of Accountable Care Organizations (ACOs). Clinically integrated networks (CINs) have also been highlighted as a mechanism to increase rural participation in APMs. CINs, which are structured collaborations between physicians and hospitals, support rural providers in APM adoption by aggregating patient populations, allowing for shared use and investment in data infrastructure, and facilitating shared clinical expertise, while still allowing for independent practice ownership.[48] (CINs are discussed in greater detail in the Flow of Payments section of this report.)

Ongoing federal and state funding for rural primary care workforce education and training is also essential. This includes sustained funding for Colorado's Regional Health Connector Program, which creates partnerships between physician offices, public health, and community organizations that lead to healthier communities across the state. The Collaborative also continues to encourage all payers to support Community Health Workers as part of APM payment structures. The important role that Community Health Workers play in team-based, integrated care delivery — such as connecting patients with behavioral health and social services — was highlighted in the Fifth Annual Report, and these benefits are particularly crucial in bridging care needs in rural areas.

Takeaways and Recommendations: **Rural Providers**

- The Collaborative recommends that payers consider the unique needs of rural providers, including Rural Health Clinics and Federally Qualified Health Centers in rural areas, in the design and implementation of APMs. Examples of such needs include:
  - Factors such as hospital closures and long travel distances may limit options for provider collaboration, and smaller patient panels in rural areas may make it challenging for providers to meet minimum attribution thresholds to participate in APMs.
  - Metrics used in rural APMs should account for the characteristics of rural patients, who have higher rates of chronic diseases, and rural care delivery, which often prioritizes comprehensiveness.
- The Collaborative encourages rural providers and payers to explore the formation of clinically integrated networks (CINs) in rural areas, which could support provider participation in APMs.
- The Collaborative strongly advocates for federal and state funding for rural primary care workforce education and training. This includes sustained funding for Colorado's Regional Health Connector Program and support for Community Health Workers as part of APM payment structures.
- The Collaborative encourages all payers, when possible, to align with strategies included in HCPF's ACC Phase III care delivery model that are designed to support rural practices, including:
  - Access stabilization payments, which support practices in delivering care and maintaining access for patients, families, and communities; and
  - Integrated behavioral health payments, which include a combination of FFS and PMPM payments.
- The Collaborative recognizes the importance of analyzing primary care and APM spending data across different regions in Colorado to better understand geographic variances and identify potential gaps and will work with CIVHC to determine how this might be accomplished using current reporting mechanisms.

Pediatric Providers

The Collaborative has consistently elevated the unique needs of pediatric providers related to value-based payments for primary care. The Second and Fourth Annual Reports highlighted issues related to risk adjustment. Current risk adjustment models are often developed using standard populations that include adults and children, which do not translate well to pediatric-only populations and fail to account for social drivers of health, which are particularly important to predicting near-term risk for pediatric populations. The Fourth Annual Report also discussed concerns about patient attribution, which can be hampered by delays in attributing newborns, as well as quality measures and the need for the development and research of additional pediatric measures. In the Fifth Annual Report, the Collaborative highlighted some of the challenges prospective payments and shared savings models pose for pediatrics practices, due to fluctuations in patient populations.

Medicaid covers approximately 40% of children and more than 40% of births in Colorado.[49] This makes pediatric providers, and their patients and families, particularly vulnerable to the Medicaid cuts included in H.R. 1. As noted in a recent Health Affairs article, "Medicaid serves as the backbone of the pediatric health care system, funding hospitals, preventive services, community health centers, and community health programs that provide healthy food and safe housing. Legislation that defunds coverage will have inevitable downstream consequences on all children."[50]

Additional provisions in H.R.1 — including work requirements, increased frequency of eligibility checks, the reduction of retroactive coverage to 60 days, the end of HCPF's implementation of continuous eligibility for children ages 0-3 — are expected to increase churn and reduce coverage. Other actions by the Trump administration to prohibit evidence-based

gender-affirming care for youth and to revise vaccine schedules are also impacting the ability of clinicians who care for children to deliver high-quality, evidence-based, and needed care. In 2025, Colorado passed House Bill 25-1027 and Senate Bill 25-196, which allow the State Board of Health to adopt rules for the state's school and child care immunization requirements. Additionally, the legislation authorizes the Commissioner of Insurance to adopt rules requiring insurance coverage for immunization recommendations in effect as of January 1, 2025, in the event modifications are made to the Advisory Committee on Immunization Practices (ACIP) vaccine schedule. The Collaborative is interested in working with CDPHE and other stakeholders around vaccine education to ensure Coloradans have access to information that is grounded in long-standing science, expert consensus, and transparency, and that individuals and families can make informed decisions.

Takeaways and Recommendations: **Pediatric Providers**

- The Collaborative recommends that payers consider the unique needs of pediatric practices in the design and implementation of APMs. Examples of such needs include:
  - Payments must be structured to support preventive care, a hallmark of pediatric care that is ill-suited for models geared toward chronic care (such as shared savings);
  - Quality measures such as immunizations may be hard to meet in the face of increased vaccine hesitancy and the confusion caused by federal changes in vaccine recommendations, which is further eroding trust in vaccines;
  - Pediatric APMs should include age ranges in their design; for example, PMPMs should be higher in the first three years of life to support the frequency of visits during this time; and
  - Current risk stratification methods, based on Hierarchical Condition Categories, are not well suited for pediatric practices.
- The Collaborative is interested in exploring opportunities to partner with CDPHE and other stakeholders around vaccine education.
- The Collaborative encourages all payers, when possible, to align with strategies included in HCPF's ACC Phase III care delivery model that are designed to support pediatric practices, including:
  - Access stabilization payments, which support practices in delivering care and maintaining access for patients, families, and communities; and
  - Integrated behavioral health payments, which include a combination of FFS and PMPM payments.
- The Collaborative recognizes the importance of having primary care and APM spending data for different age bands to better understand the level of investment in pediatric care and will continue to work with CIVHC and payers to be able to stratify data that is currently collected by age.

Safety-Net Providers

The term "safety-net providers" is used generally to describe clinicians, provider organizations, and health systems that disproportionately serve low-income, underinsured, and uninsured patients.[51] Safety-net providers are a foundational component of primary care in the U.S. and Colorado, serving mostly lower-income populations in rural and urban communities.

Colorado Safety-Net Providers

- **Community Health Centers**, also known as **Federally Qualified Health Center** : Primary care, including preventive physical, dental, and behavioral health services. Located in medically underserved areas and among medically underserved populations.
- **Community Safety Net Clinics**: Free, low-cost, or sliding-fee primary care services for people who have low incomes and/or do not have insurance. These can include faith-based clinics, facilities staffed by volunteer clinicians, and family medicine residency clinics.
- **Rural Health Clinics**: Primary care services, differing by clinic. Located in non-urban areas with documented shortages of health care providers and/or medically underserved populations.

Source: Colorado's Health Care Safety Net: A Primer, Colorado Health Institute, September 2021

In 2024, community health centers (CHCs) served 32 million patients nationally, including one in six Medicaid beneficiaries.[52] Colorado's 21 CHCs provide a health care home for over 850,000 Coloradans (one in seven people in the state), including one-quarter (24%) of Medicaid and CHP+ enrollees and half of all uninsured Coloradans.[53] In 2024, Colorado CHCs provided almost 2.8 million clinical and virtual visits at over 250 locations across the state's rural, frontier, and urban communities, including clinics, mobile units, and school-based health centers.[54]

Safety-net providers often operate on very slim, if not negative, margins. They went through significant strain in the Medicaid "unwinding" following the COVID-19 pandemic. Nationally, an estimated 25 million people lost coverage as of August 2024 due to the unwind, when eligibility requirements frozen during the pandemic came back into force. That loss of coverage contributed to CHCs reporting average net financial margins of -2.4% in 2024.[55] In Colorado, the number of uninsured patients seen at CHCs increased by 29% (38,000 people) between 2021 and 2024, due in large part to the Medicaid unwind.[56] Two-thirds of the state's CHCs reported having negative operating margins in 2024, a trend that was expected to continue in 2025.

Similar to pediatric providers, safety-net providers also see a large percentage of Medicaid patients and are equally vulnerable to H.R. 1's impending funding cuts. The National Association of Community Health Centers has estimated the implementation of the law will increase uncompensated care costs by nearly $7 billion at CHCs alone and will cause 1,800 care sites to close, resulting in 34,000 lost jobs.[57]

Takeaways and Recommendations: **Safety-Net Providers**

- The Collaborative recommends that payers consider the unique needs of safety-net providers in the design and implementation of APMs. Examples of such needs include:
  - CHCs and other safety net providers report substantial administrative burden in dealing with differing quality measures across payers and APMs. Quality measures and contracting approaches should be harmonized whenever possible;
  - Patient churn and loss of coverage pose special challenges for safety-net providers. If a patient loses coverage and is no longer attributed to a clinic, it limits the clinic's access to timely information and therefore its capacity to effectively manage the patient's care;
  - CHCs are required by federal law to provide care for uninsured patients, yet any improved care or reduced costs for those patients isn't counted under value-based contracts and therefore doesn't result in shared savings.
- The Collaborative encourages government and payer investment in data infrastructure and staffing that will allow CHCs and other safety-net providers to identify, track, and efficiently manage the care of high-risk, high-cost patients.

Level of Payment

The 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) report Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care called for the measurement and tracking of progress in five key objectives: payment, access, workforce, digital health, and accountability. Since 2023, the Milbank Memorial Fund, in partnership with The Physician's Foundation and the Robert Graham Center, has produced an Annual Scorecard Report examining various dimensions of primary care payment. Over the past two years, this Scorecard has reported historically low levels of investment in primary care, regardless of payer type.[58] The 2025 Scorecard reported primary care spending decreased across all payer types (commercial payers, Medicare, and Medicaid) between 2021 and 2022 to an insurance-wide average of just 4.6% of total medical spending, and less than half of primary care physicians reported receiving any revenue through value-based payment models.[59]

Colorado is among a handful of states that has the capacity to collect and analyze both claims and non-claims-based spending in its annual reporting of primary care spending. Colorado's reporting methodology is based on the Collaborative's broad definition of primary care[60] and is therefore higher than national data reported in the Scorecard (which uses a narrow definition, confined to fewer primary care provider types), but nevertheless shows similar trends of reduced primary care spending across multiple lines of business.

While variances in data reporting from year to year affect the Collaborative's ability to assess detailed trends over time, some general observations can nevertheless be made. Since 2021, primary care spending for commercial payers has hovered near 8% of total medical spending. When integrated care delivery systems are excluded, that number falls to approximately 5%. Between 2023 and 2024, payers reported decreases in spending for commercial, Medicaid, and Medicare Advantage lines of business. These decreases are troubling and deserve further exploration. Without an increased, sustained investment in primary care systemwide, Colorado will not be able to achieve the desired impacts of improved care delivery and patient outcomes.

Takeaways and Recommendations: **Level of Payment**

- In a time of constricting resources, investment in primary care must remain a central priority for Colorado. Primary care plays a crucial role in health care access and affordability. As the one area of the health system where investment produces better health outcomes at a sustainable cost, it can and must play a fundamental role as the state navigates an increasingly challenging health care landscape.
- While tracking primary care investment is important, spending levels alone do not indicate success. Measures of access, utilization, and patient outcomes should be used alongside spending data to assess whether payment reforms are improving care delivery and population health.
- To better understand the level of investment needed to adequately resource, support, and sustain primary care, the Collaborative is interested in data and resources that can answer key questions, including:
  - What is the current level of financial stability/instability for primary care practices in the state?
  - How much are administrative burdens adding to the cost of running a practice and impeding patient access to care?

Flow of Payment

In the Sixth Annual Report, the Collaborative highlighted the impact of marketplace dynamics — including increased consolidation and private equity and venture capital investments — on the quality and cost of health care. While the lack of transparency around mergers and acquisitions can make these trends hard to track, the Collaborative remains interested in observing and understanding their influence on primary care. A summary of recent research detailing consolidation trends in health care and primary care is included in Appendix B.

The Collaborative also raised significant concerns about the negative impacts that consolidation, private equity, and the financialization of the health care sector can have on patients, providers, and payers. Increased health care costs, decreases in care quality, and the extraction of wealth and resources from primary care practices remain salient concerns. In this year's report, the Collaborative is expanding its lens to examine two features in the primary care landscape that are not new in terms of their appearance, but have particular relevance in the wake of H.R. 1's passage: 1) direct primary care; and 2) "soft consolidation" trends that have the potential to help (or harm) provider participation in APMs.

The Collaborative also raises key questions about research and data needed to better understand the flow of payments to primary care providers in the context of larger health system dynamics. As noted in the NASEM report, "… how primary care payments flow through organizations to reach and influence primary care delivery, and whether they are aligned with overall intent, remains a critical issue." Understanding these trends is important not just in terms of understanding the flow of payments but in gaining insight into how and why people are choosing these points of access. Ensuring that primary care investment reaches providers on the front lines is a shared responsibility across payers, providers, systems, and policymakers. Collaboration — rather than payer-specific mandates — will be essential to achieving sustainable improvements.

Direct Primary Care

Direct primary care (DPC) is a business and care delivery model in which clinicians charge patients a flat monthly or annual "membership" fee for unlimited access to a defined set of primary care services. Rather than billing commercial health insurance, Medicare, or Medicaid, DPC providers rely on patient membership fees as their primary source of revenue; patients, in turn, are able to access care without paying anything at the time of service delivery. Some DPC arrangements allow patients to access additional services, such as imaging, prescription drugs, or lab services, for an additional flat fee, often at reduced prices negotiated by DPC providers. The DPC model is similar to concierge medicine, in that both charge patients a fee to support operations, which allows for smaller patient panel sizes than in traditional fee-for-service practices. But DPC is distinguished by not accepting insurance, charging smaller membership fees, and focusing on saving money by providing a select set of services (see Figure 4).[61]

Data regarding DPC practices is challenging to collect, as these models by design exist outside of billing and other reporting systems, but a developing body of research is starting to provide insights into the scope and characteristics of this workforce. One recent study found the number of total concierge and DPC practices increased by 83.1% between 2018 and 2023, growing from 1,658 to 3,036, and the number of clinicians in such practices similarly increased from 3,935 to 7,021 (a 74.8% increase) during this time frame.[62] The majority of practices were small, with fewer than five clinicians, and were located throughout the U.S., with the greatest concentrations in the Northeast and Southeast (see Figure 5).

Self-reported data on DPC participation, tracked through DPCFrontier.com, also indicates an increasing number of DPC practices in Colorado. Using data from this website, a 2018 report by the Colorado Health Institute (CHI) estimated roughly 90 DPC clinics were operating in the state, accounting for roughly 10% of the nation's clinics at that time, and served around 63,000 patients.[63] As of December 2025, DPCFrontier.com data indicates the number of Colorado DPC practices has increased to roughly 144, now accounting for just over 5% of practices across the nation, with the majority (around 80%) located along the Front Range.[64] Assuming a panel size of 700 patients (the number used in the CHI study), this equates to just over 100,000 patients currently served.

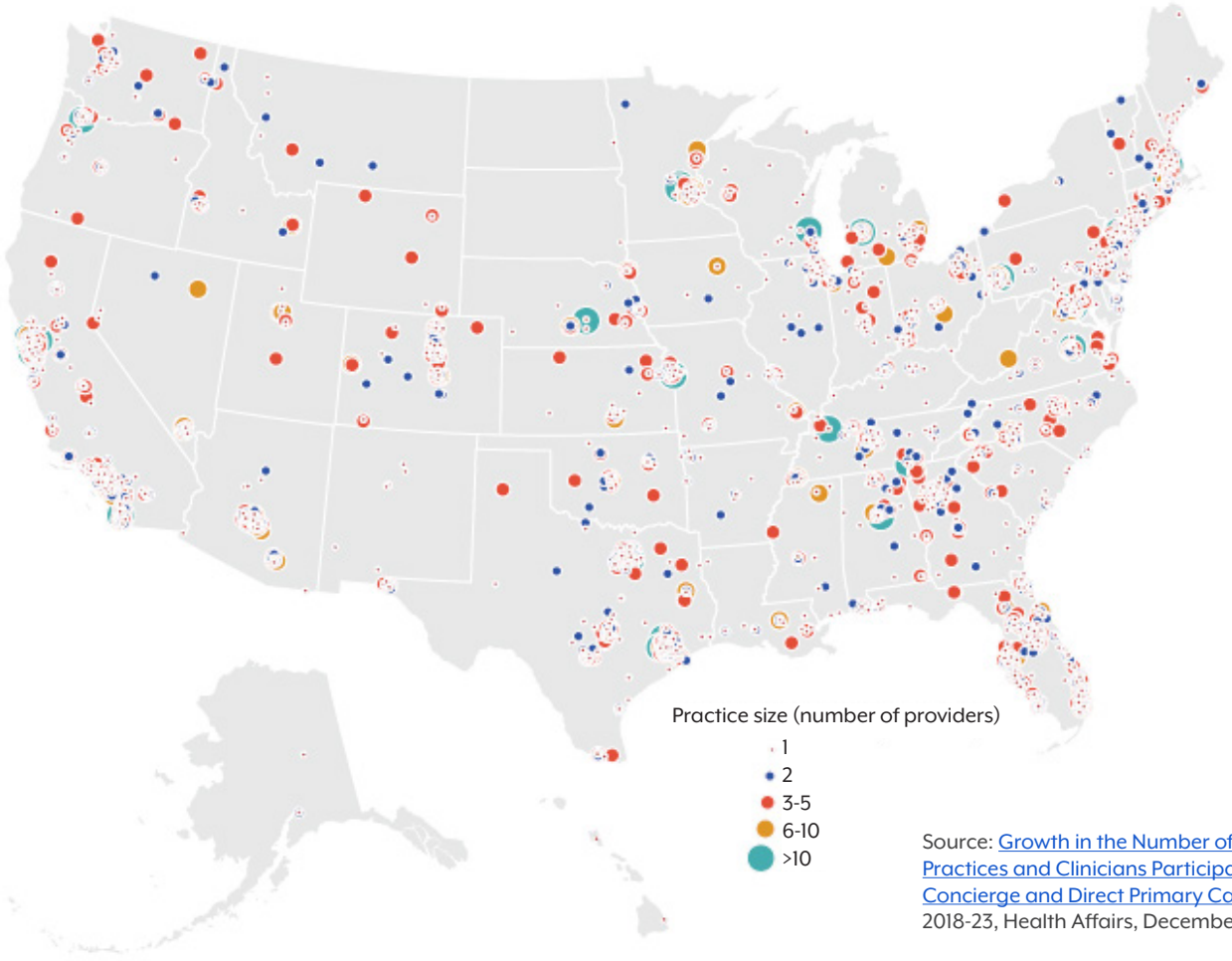
H.R. 1 significantly boosts the DPC model by allowing people who participate in DPC to use HSA funds to pay DPC membership fees, as long as monthly fees are under $150 (individual) or $300 (family).

Figure 4. Difference between DPC and Concierge Practices

Direct Primary Care	Concierge Medicine
▸ Generally do not accept insurance or bill any third parties (Medicare, Medicaid, commercial insurance) for services provided	▸ Often accept insurance and bill third parties for office visits and procedures
▸ Often rely on fees of less than $100 per month	▸ Charge higher monthly fees than DPC practices in addition to insurance collection
▸ Patient panel sizes are between 400 and 800 per provider	▸ Patient panel sizes are relatively small, between 200 and 300 per provider
▸ Focus on providing core services and saving patients money, rather than on offering premium services	▸ Often focus on providing "premium" services (e.g., vascular scans, "executive" lab panels, extended office visits, etc.)

Source: Difference between concierge and direct care, Medical Economics Blog, February 18, 2025

Figure 5. Practice Locations of Concierge and Direct Primary Care Practices, 2023



Source: Growth in the Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018-23, Health Affairs, December 2025

Collaborative members appreciate many of the components that make the DPC model attractive to clinicians and patients. For clinicians, benefits include smaller and regular panel sizes, freedom from the administrative burdens and reporting requirements associated with billing third-party payers, and a pathway for physicians in employment situations to regain autonomy and devote more time to direct patient care. For patients, DPC offers longer visit times, increased continuity of care with a single provider, and in certain circumstances may make care more accessible and affordable.

Moving forward, the Collaborative is interested in continuing to explore and understand DPC's implications for the following key issues:

Access to care. How is the DPC model impacting how and where people are seeking primary care services in Colorado? What makes it most attractive to individuals and families?

Affordability. Does DPC make care more or less affordable, from both a patient and a systems perspective?

Quality of care. How can the quality of care be evaluated? What is currently known, and what research may be needed?

Workforce. How is DPC affecting the primary care workforce? What are the current and future implications for the primary care pipeline?

Takeaways and Recommendations: **Direct Primary Care**

- The Collaborative recommends continued monitoring of the DPC landscape, both nationally and in Colorado, to better understand not only the qualities and characteristics of practices and providers but also the reasons people and clinicians are turning to DPC.
- The Collaborative is interested in exploring strategies for payers to incorporate some of the principles of the DPC models into APMs, which ideally can maintain incentives for access and still drive population health changes.

'Soft Consolidation' Trends and Integrated Provider Systems

In addition to the acquisitions and mergers that often characterize vertical and horizontal consolidation, other less formal types of provider integration that do not involve changes in ownership (sometimes referred to as "soft consolidation") are also transforming the primary care landscape, both nationally and in Colorado. Entities such as Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), and Independent Physician Associations (IPAs) — arrangements in which groups of providers voluntarily join together to improve care delivery and reduce costs — have existed for decades, but they entered a period of rapid growth following the passage of the ACA.

As many as 1,800 ACOs are currently operating in the US, with the top 25 alone serving nearly 15 million patients.[65] Data on the number of CINs are harder to find, as such entities are not monitored at the federal or state level and do not need to seek approval prior to formation. But a 2015 white paper estimated around 500 CINs were operating in the U.S. at that time.[66,67] The Collaborative is not aware of any publicly available data sources that include the number of ACOs or CINs operating within Colorado, but member experience, combined with national data and trends, indicates such arrangements are likely very prevalent in the state and have a significant impact on how primary care payments are flowing to practices on the ground.

ACOs and CINs can facilitate the adoption of and administration of APM payments by creating a central location for payers and providers to develop strategies and obtain feedback around key elements (e.g., panel size or quality metrics) and to implement models that impact more providers than a payer may be able to reach individually. They can also provide an operational and organizing structure for hospitals and other participating providers to more efficiently navigate the "in-between" spaces in a patient's care journey, to ensure people are getting the right care, at the right time, by the right person.

Yet the presence of integrated provider networks including ACOs and CINs can also pose challenges to the flow of payments and APM participation.

- **Accountable Care Organization (ACO)**: Defined by CMS as "a legal entity recognized and authorized under applicable federal or state laws, made up of eligible groups of providers that work together to manage and coordinate care for a payer-specific population."
- **Clinically Integrated Networks (CINs)**: Defined by the Federal Trade Commission as a "structured collaboration between physicians and hospitals to develop clinical initiatives designed to improve the quality and efficiency of healthcare services."
- **Independent Physician Association (IPA):** Defined by the American Academy of Family Physicians as "a business entity organized and owned by a network of independent physician practices to reduce overhead or pursue business ventures such as contracts with employers, ACOs and/or managed care organizations."

While ACOs or CINs can streamline payer negotiations for participating providers, this centralized structure can serve as a barrier for payer communication with specific providers (as they may be referred back to the ACO administrators). This dynamic is particularly acute as relationships are forming between payers and these entities and may improve over time as ACO models grow.

Participation in ACOs or CINs can also be onerous for small practices, which are less likely to have resources available to meet reporting requirements or attend required meetings, and may not be able to meet minimum thresholds for participation. In addition, although a small practice may be successful in meeting required metrics, it still may not be large enough to receive shared savings or other incentive payments. Small practices may also struggle with the contracting nuances of ACO or CIN arrangements.

The Collaborative recognizes that provider integration arrangements, including ACOs and CINs, constitute a significant and growing feature of Colorado's primary care landscape, and as such should be included in state efforts to increase alignment across payers and providers. Duplicative work is likely happening around administrative and operational functions within APMs — at the practice level, the ACO level, and the system level — and in the absence of an identified team leader to help streamline work and assume responsibility, ACOs and CINs are less effective in reducing administrative burdens, particularly for small practices.

The presence of ACOs and CINs in Colorado, combined with ongoing consolidation trends, has important implications for primary care payments (whether payments for care delivery are reaching primary care providers) and investments

(whether system investments in data sharing or other infrastructure components are benefiting primary care practices). The flow of dollars through health systems is complex and difficult to trace, but it is crucial to understand whether dollars intended to support advanced primary care delivery are actually reaching primary care teams on the front lines. Other states are starting to take action to ensure payments intended to support primary care are reaching their intended target. The Maryland Health Care Commission recently recommended the state conduct a focused review on how health systems are investing in their owned and affiliated primary care teams to identify gaps and determine if additional accountability mechanisms are needed.[68] Rhode Island has established expectations that payers may make PMPM payments to a primary care practice that is part of an Integrated System of Care only in situations where the Integrated System of Care "is contractually obligated to use the PMPM payment to finance care management services at the primary care practice earning the payment."[69]

The Collaborative is interested in learning lessons from other states and in working with payers, health systems, and ACO and CIN leaders to better understand how dollars intended to support primary care are flowing through systems in Colorado. Key areas of interest include:

- **Prospective payments.** Prospective payments play a crucial role in supporting providers in ACOs/CINs, and meaningful conversations are needed between payers and these organizations about where those payments go, and what they look like across different ACO structures (e.g., physician group ACOs vs. hospital ACOs), as well as small practices.
- **Data exchange.** Data exchange is fundamental to the success of APMs, as practices need to have visibility around where attributed patients are seeking care outside of the office in order to get in front of those needs and effectively manage patient care. Prospective payments and systemic investments are needed to support infrastructure changes that will allow for improved data exchange, both at the practice level and within and across integrated provider systems.
- **Additional system disruptors.** The Collaborative is interested in gaining a better understanding of how organizations offering weight loss or other health care services — such as hims and hers, Midi, Inc., and Ro — may be influencing how and where people are accessing care. The use of such services may be impacting health outcomes, but often with little accountability or coordination of care.

Takeaways and Recommendations: **Soft Consolidation and Integrated Provider Systems**

- Ensuring primary care investment reaches providers on the front lines is a shared responsibility across payers, providers, systems, and policymakers. Collaboration will be essential to achieving sustainable improvements.
- The Collaborative recommends establishing relationships and/or partnerships with ACO and CIN leaders who design the incentives and value-based payment models for their employed PCPs. Partnering with these leaders will facilitate greater alignment across payment approaches.
- To better inform recommendations and strategies for increasing investment in primary care, the Collaborative will continue to seek data from researchers, other states, payers, providers, health systems, and employers to better understand the following questions:
  - Where are patients getting primary care, and what is driving them to those sources?
  - How many providers in Colorado are independent versus system-owned or affiliated?
  - How much money in health systems is actually flowing to primary care providers on the front lines?

Recommendations Part 2 — Comprehensive Primary Care Strategy

The Collaborative remains committed, statutorily and philosophically, to advancing strategies to increase investment in primary care. Colorado will require systemic investments and cross-sector strategies to truly support and sustain a robust primary care infrastructure that can meet the needs of all Coloradans — and serve a pivotal role in ensuring care remains accessible and affordable. Therefore, in addition to the recommendations on payment offered in Part 1 of this report, the Collaborative is dedicating Part 2 to the discussion of a comprehensive, statewide primary care strategy.

Vision and Goals

The Collaborative's vision for a comprehensive primary care strategy in Colorado is grounded in the belief that primary care is a common good and is instrumental in creating healthy communities. As such, a statewide strategy should be focused on the goal of ensuring all community members — across disparate community settings — have reliable access to high-quality, person-centered, team-based care that measurably improves population health and truly advances equity.

A comprehensive strategy should create a clear, shared understanding of the current state of primary care in Colorado and support the collective movement of practices, payers, and purchasers toward advanced primary care. Such a strategy — organized by the Collaborative — can be a powerful tool for promoting shared accountability for developing impactful primary care policies across multiple state agencies and other key stakeholders. While this strategy must emphasize payment, a focus on this alone would not be sufficient to ensure that high-quality primary care is readily available for all Coloradans as a common good. The scope of a comprehensive strategy could also include initiatives to strengthen the interprofessional primary care workforce,[70] reduce administrative burden, streamline health insurance requirements and practices, and advance other efforts that improve patient access and affordability.

Related to payment, a comprehensive statewide strategy should meaningfully involve all payers and support accountability to multi-payer alignment. Absent multi-payer alignment, incentives to improve care may only cover a small proportion of a practice's patients and not enable significant changes. Multi-payer alignment moves incentives in the right direction, while still recognizing differences across commercial, Medicaid, and Medicare populations.

A comprehensive state-level strategy can establish goals for Colorado's primary care system, as well as metrics to assess progress toward those goals. The strategy should rely on transparent claims-based and other high-quality data and focus on identifying system gaps and aligning efforts where feasible and beneficial. As a shared mechanism for transparency, measurement, and alignment, the strategy could inform future policymaking, but it is not intended to serve as a regulatory or enforcement structure, or a vehicle for establishing payment mandates, spending benchmarks, or other directives absent legislative authority. It must also be manageable, so that it remains both actionable and sustainable.

Example goals include:

- Enhance access to high-quality primary care, including for different populations with specific medical needs, such as the growing percentage of older Coloradans who need help navigating frailty or dementia.
- Invest sustainably in the state's primary care infrastructure, including information technology, the interprofessional workforce, and practice facilitation, so that the system is better equipped to deliver on the promise of high-quality, whole-person, team-based care in diverse settings across the state.
- Design improvements to Colorado's primary care system in partnership with patients and providers who have lived experience and rich perspectives about what changes need to be made.

- Create interoperable data systems with appropriate patient protections that allow primary care teams to connect to the broader health care system to provide more seamless care across different settings and conditions. Data shared should be clear, accurate, and actionable.
- Improve integration of primary care with behavioral health, social services, and public health to enhance the whole health of individuals and populations.

Measures selected to track implementation of goals should be clinically relevant, important to patients, and not administratively burdensome to primary care practices.

At present, the state's primary care workforce is stressed and navigating profound burnout related to chronic underinvestment, more complex patient care needs, and increasing burdens made worse by our fragmented health care system. As a result, many providers are choosing to leave traditional primary care roles, reduce their hours, retire early, or leave medicine altogether, leading to substantial challenges for timely access. The current state of primary care also influences the career choices trainees make, and the sector is witnessing declining interest in primary care across several professions. A comprehensive, state-level strategy can inform needed changes to strengthen Colorado's primary care system so that it is a healthier environment for patients, providers, and practices and more attractive to students in the pipeline.

Potential Partners

The Collaborative includes a diverse set of partners across the state. A comprehensive state strategy would draw on all these perspectives, pull in additional stakeholders for input, and consider accountability structures for other agencies and groups. These partners may include:

- State agencies, including CDPHE, HCPF, the Behavioral Health Administration, and the Department of Personnel and Administration;
- Additional state partners may include the Department of Education and Department of Early Childhood for strategies and metrics related to pediatric primary care;
- Policymakers;
- Professional clinical societies;
- Health professions training programs;
- Primary care nonprofit and health care advocacy organizations;
- Patients and families who depend on and use primary care;
- Primary care providers;
- Public and private payers;
- Health care purchasers, including large employers offering self-funded plans;
- Health systems, CINs, and ACOs, including the leaders and organizations who influence or design value-based models or provider incentives; and
- Health information technology/data organizations.

The partners involved in the creation of the state strategy would also serve as key audiences. A successful strategy would identify and inform policy development and implementation across multiple domains, serve as a mechanism for keeping all stakeholders engaged in primary care, and keep all stakeholders informed of actions and activities related to primary care. The strategy could also serve as a useful tool for educating new partners and members of the public about the value of primary care and the consequences of underfunding it.

State Primary Care Scorecard

To support a comprehensive primary care strategy, the Collaborative proposes the creation of a state primary care scorecard to measure and track primary care across multiple domains. Such a tool would encourage transparency and accountability, creating a mechanism to promote alignment where it makes sense and to evaluate the implementation of current or future primary care legislation and regulation. It could also help identify areas of need and guide the most effective use of resources to address critical gaps by collating data from multiple sources and locations into a single resource.

In considering a primary care scorecard for Colorado, the Collaborative has reviewed similar efforts in other states, including Massachusetts, New York, and Virginia. Most existing state scorecards are dashboards that include a combination of federal and state data sources with measures related to payment/financing, workforce, access, health outcomes, and equity. Several national organizations have also developed mechanisms for tracking key health care measures that include primary care data.

National Primary Care Scorecards and Health Rankings

The Milbank Memorial Fund and The Physicians Foundation, in partnership with the Robert Graham Center and HealthLandscape, developed a Primary Care Scorecard Data Dashboard to measure key primary care indicators across the nation and in states identified in NASEM's 2021 report, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.

Other national sources include The Commonwealth Fund's annual Scorecard on State Health System Performance, the University of Wisconsin Population Health Institute's County Health Rankings and Roadmaps, and the UnitedHealth Foundation's America's Health Rankings.

The Collaborative puts forth the following recommendations for a Colorado Primary Care Scorecard, with full acknowledgement that further development of this proposed framework should involve an array of stakeholders to inform the specific domains, measures, and data sources. The Collaborative is also cognizant of the resources needed for the development and ongoing maintenance of such a tool and is interested in exploring partnerships with other state agencies and organizations to assist in this effort. A scorecard is only useful to the degree that it effectively captures relevant metrics and engages and focuses policymakers, consumers, and other stakeholders on what is most important to ensure the viability and sustainability of primary care in Colorado.

Data Sources

A wide range of state and federal data sources can be leveraged to inform the creation of the Colorado Primary Care Scorecard, including:

State

- Colorado Health Access Survey
- CIVHC/APCD data
- Colorado Health Systems Directory

National/Federal

- Agency for Healthcare Research and Quality (AHRQ) Primary-Care Related Data Resources
- County Health Rankings and Roadmaps
- America's Health Rankings

Using existing state and federal data reduces the burden of gathering and analyzing data and allows for comparison with other states. Over time, the state can identify data gaps and explore potential new data sources, keeping in mind any associated burdens or costs. Using state-level data is also prudent given concerns about reliable, ongoing access to federal data.

Potential Domains and Metrics

The Collaborative recognizes the development of domains and metrics included in the scorecard should be determined in partnership with other stakeholders. The following proposed domains and suggested metrics are intended to serve as a starting point for further stakeholder conversations.

Access and Utilization

The Collaborative recommends identifying a set of metrics to track access to and utilization of primary care. Such metrics should leverage state data resources, such as the Colorado Health Access Survey and the Colorado Health Systems Directory, when possible, but may also include state metrics that are compiled by national organizations to provide some level of comparability.

Potential metrics compiled by national organizations include:

- Percentage of adults and children without a usual source of care;
- Primary care clinicians (physicians, nurse practitioners, and physician associates) in Colorado per 100,000 population.

Additional metrics of interest for the Collaborative, which would require further research into available data sources and existing reporting mechanisms, include:

- Percentage of residents using primary care and primary care use trends;
- The amount of care avoided due to cost.

Financing and Payment

The Collaborative recommends identifying a set of metrics to track financing and payment for primary care. The annual Primary Care and APM Spending reports produced by CIVHC should serve as a backbone for this reporting, but additional metrics may be added to capture different dimensions of spending and infrastructure investments that are outside of the scope of that report. Members are curious about the idea of tracking how underinvestment in primary care raises costs elsewhere in the health care system.

Potential metrics from the CIVHC annual Primary Care and APM Spending report include:

- Primary care spending as a share of total health care spending by all payers, commercial health insurance, Medicare, and Medicaid; and
- Total medical spending and primary care spending flowing through APMs.

Training and Workforce

The Collaborative recommends identifying a set of metrics to track primary care workforce and training programs. The Colorado Health Systems Directory maintained by the Office of Primary Care offers a rich source of data about primary care clinicians in Colorado and allows for the analysis of clinicians by provider type (e.g., family medicine, internal medicine, pediatrics), provider profession (e.g., MD/DO, nurse practitioner, physician associate), geographic distribution, demographics, and other characteristics.

Potential metrics compiled by national organizations include:

- Percentage of clinicians (physician, nurse practitioners, and physician associates) working in primary care;
- Percentage of physicians entering and leaving the primary care workforce;
- Percentage of residents trained in community-based settings and in rural or medically underserved areas;

Additional metrics of interest for the Collaborative, which would require further research into available data sources and existing reporting mechanisms, include:

- Age of the primary care workforce in Colorado (e.g., number of physicians over 65);
- Provider satisfaction;
- Primary care provider shortages, based on supply and demand projections.

Performance and Health Outcomes

The Collaborative recommends identifying a set of metrics to track primary care services' performance and population health outcomes. This could include analysis into how populations' health-related social needs are being met in conjunction with primary care, potentially through using the Behavioral Health Administration's care access programs.

Metrics of interest for the Collaborative, which would require further research into available data sources and reporting mechanisms, include:

- Patient satisfaction and experience of care;
- Preventable hospitalizations and preventive screenings (e.g., breast, cervical, colorectal cancer screenings);
- Additional population health metrics, such as the prevalence of low birth weight, uncontrolled diabetes, substance abuse, avoidable premature mortality, and immunizations.

Practice Readiness

The Collaborative recommends identifying a set of metrics to track provider and practice readiness for value-based care to help ensure scorecard measures reflect operational feasibility, not just aspirational design. In developing such metrics, payer alignment and administrative burden must be considered to ensure scorecard elements do not duplicate any existing reporting or exceed practice or payer capacity.

Metrics of interest for the Collaborative, which would require further research into available data sources and reporting mechanisms, include:

- Attribution stability;
- Practice reporting capability;
- Panel continuity; and
- Data infrastructure — interoperability and data sharing.

Equity

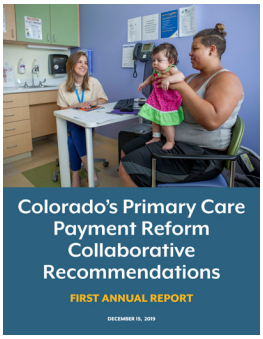
The Collaborative recommends identifying a set of metrics to track inequities in the primary care system and care delivery. This includes analysis across populations with specific health needs, including but extending beyond standard population demographics (such as racial inequities).

Conclusion and Future Work

Colorado has taken important steps to strengthen primary care in the seven years that the Collaborative has existed. As the Collaborative now looks forward to an additional seven years, shifts in the federal and state landscape have given increased urgency to questions of how to support, sustain, and advance primary care in Colorado. Primary care lies at the nexus of health care access and affordability, and the Collaborative is resolved to continue efforts to increase investment in primary care. The strategies and recommendations in this report reflect the nuances and complexities associated with payments to primary care providers, involving the form, level, and flow of such payments, as well as unique considerations for providers and populations that are most vulnerable to resource reductions related to H.R. 1. Market dynamics and provider consolidation add additional complexities. Addressing the challenges and seizing the opportunities will require ongoing collaboration across payers, providers, and consumers, and the Collaborative remains committed to leading this work.

The Collaborative also looks forward to engaging with an array of stakeholders to explore the development of a comprehensive primary care strategy. Such a strategy could create a clear, shared understanding of the current state of primary care in Colorado and be a powerful tool for promoting shared accountability for developing impactful primary care policies across multiple state agencies and other key stakeholders. Whether through a comprehensive primary care strategy, continued recommendations, or both, the Collaborative remains focused on the goal of ensuring all community members — across disparate community settings — have reliable access to high quality, person-centered, team-based care that measurably improves population health and truly advances equity.

Appendix A: Previous Report Recommendations



First Annual Report 2019

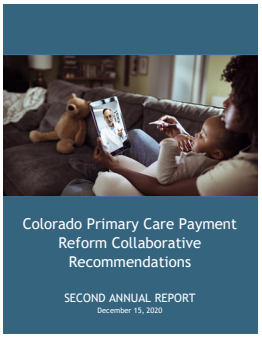
Definition of primary care. The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both fee-for-service and alternative payment models.

Primary care investment target. All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least one percentage point annually through 2022.

Measuring the impact of increased primary care spending. The state should identify and track short-, medium-, and long-term metrics that are expected to be improved by increased investment in primary care.

Investing in advanced primary care models. Increased investment in primary care should support providers' adoption of advanced primary care models that build core competencies for whole-person care.

Increasing investment through alternative payment models. Increased investment in primary care should be offered primarily through infrastructure investment and alternative payment models that offer prospective funding and incentives for improving quality.



Second Annual Report 2020

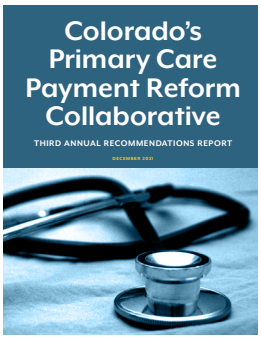
Multi-payer alignment. Multi-payer alignment is crucial to the success of alternative payment models, and Colorado should build upon the prior and ongoing work of payers and providers to advance high-quality, value-based care. Practices need common goals and expectations across payers. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices.

Measuring primary care capacity and performance. Measures used to evaluate primary care alternative payment models should be aligned across public and private payers and reflect a holistic evaluation of practice capacity and performance.

Measuring system-level success. Measures to determine whether increased investment in primary care and increased use of alternative payment models are achieving positive effects on the health care system should examine various aspects of care and value.

Incorporating equity in the governance of health reform initiatives. The governance of initiatives to support and enhance primary care services should reflect the diversity of the population of Colorado.

Data collection to address health equity. Data collection at the plan, health system, and practice levels should allow for analysis of racial and ethnic disparities.



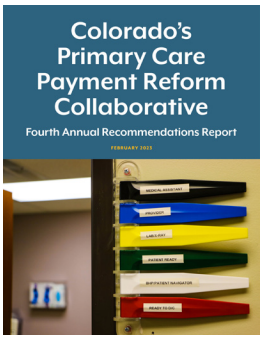
Third Annual Report 2021

Guiding increased investment in primary care. Investment in primary care should be offered primarily through value-based payments and infrastructure investment. Value-based payments include alternative payment models that offer prospective funding, provide incentives for improving quality, and improve the accessibility and affordability of primary care services for all Coloradans.

Centering health equity in primary care. Health equity must be a central consideration in the design of any alternative payment model. Value-based payment arrangements should provide resources to support providers and patients in achieving better care and more equitable outcomes.

Integrating behavioral health care within the primary care setting. A variety of effective models for the integration and coordination of behavioral health and primary care should be encouraged and supported through alternative payment models and other strategies.

Increasing collaboration between primary care and public health. Increased investment in primary care should support collaboration with public health agencies to advance prevention and health promotion to improve population health.



Fourth Annual Report 2022

Aligning quality measures. Quality measures should be aligned across payers to ensure accountability, standardization, and continuous improvement of primary care alternative payment models. Aligned quality measure sets may include a menu of optional measures, reducing the administrative burden while still allowing for flexibility.

Improving patient attribution. Patient attribution methodologies for primary care alternative payment models should be patient-focused, clearly communicated to providers, and include transparent processes for assigning and adding or removing patients from a practice's patient attribution list.

Improving risk adjustment. Incorporating social factors into risk adjustment models as a tool to advance health equity is essential to ensure providers have adequate support to treat high-need populations. An evidence-based, proven social risk adjustment model is needed. Additionally, increased transparency is needed around the components of current payer-level risk adjustment models.

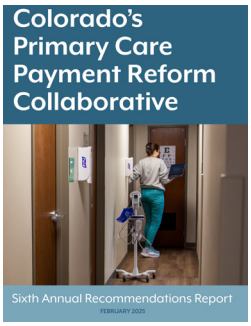
Fifth Annual Report 2023

Payment for behavioral health integration. Behavioral health integration should be intentionally supported as a key component of increased investment in primary care.

Workforce for behavioral health integration. Payers should support and promote care delivery strategies that incorporate nonclinical providers as part of the care delivery team to holistically address whole-person and whole-family health needs.

Health-related social needs screening. Payers should support and incentivize clinician and nonclinician providers working on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services.

Medication-assisted treatment. Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment services through adequate payment that reflects the additional time and training needed to address complex patient needs.



Sixth Annual Report 2024

Monitoring the impact of marketplace dynamics on Colorado's primary care practices. Marketplace dynamics of primary care practices, particularly consolidation and private equity investment, should be monitored in Colorado. These dynamics have a direct impact on the quality and cost of health care. An understanding of marketplace trends is necessary to support the primary care workforce and inform future investment in primary care infrastructure.

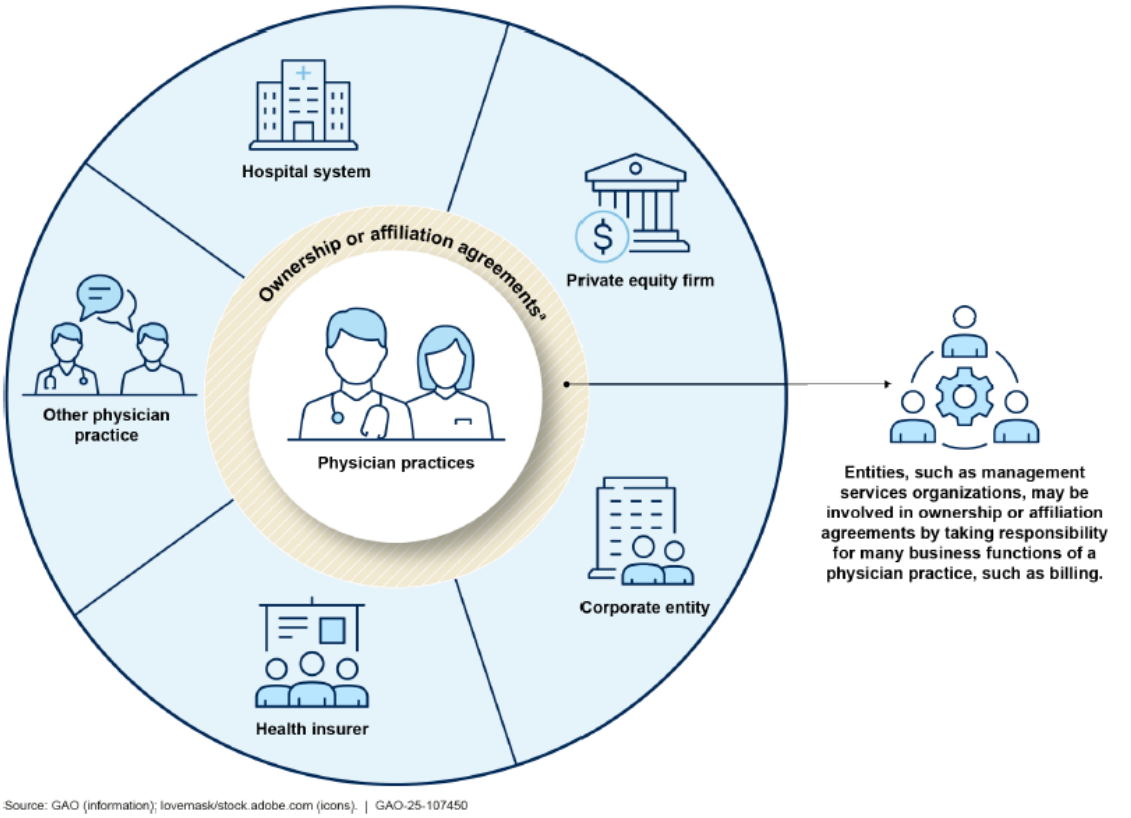
Promoting ethical and equitable adoption of AI. New technology, including artificial intelligence (AI) tools, should be thoughtfully adopted into the primary care setting. Valid concerns about AI accuracy, impacts on practice workflow, and consent regarding the rapid adoption of this technology should be meaningfully addressed.

Evaluating the progress of payment models in driving health equity. Payment models should drive meaningful actions to address health equity. This includes incentivizing evidence-informed actions that improve the quality of care and lead to a reduction in disparate health outcomes. The extent to which payment models are successful in addressing disparities and directing quality improvements in health care should be tracked and used to inform model adjustments.

Appendix B: Consolidation Trends in Health Care and Primary Care

The complexity of interactions contributing to increased physician consolidation was recently underscored in a U.S. Government Accountability Office report, Health Care Consolidation: Published Estimates and Effects of Physician Consolidation (GAO Report). As illustrated in Figure 6, physician consolidation can occur both horizontally, when physician practices merge with one another, and vertically, when practices are acquired by a range of other entities, including hospital systems, health insurance companies, corporate entities (such as retail or medical supply companies), and private equity firms.

Figure 6. Entities That May Consolidate with Physician Practices



Source: GAO (information); lovemask/stock.adobe.com (icons). | GAO-25-107450

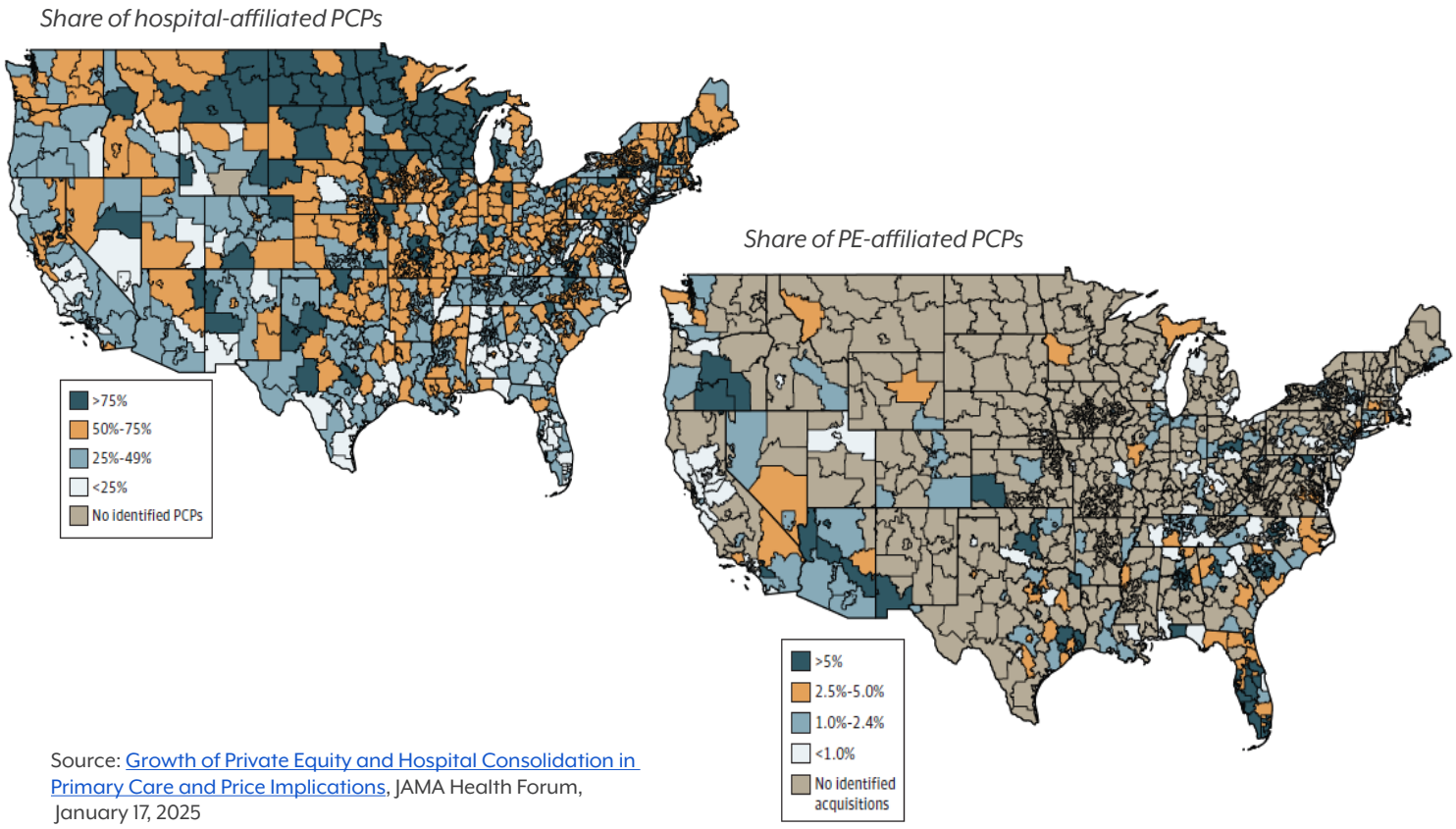
[a]Physician consolidation can occur through acquisitions of physician practices by other entities, as well as affiliation agreements between physician practices and other organizations.

No single data source is currently available to identify physicians who work in consolidated practice environments versus those who remain independent, and estimates vary based on how researchers define and measure physician affiliations and practice ownership. Yet recent studies indicate that the number of physicians working in independent, privately owned practices continues to decline. For example:

- An American Medical Association Physician Practice Benchmark Survey found that in 2024, only 42% of physicians were in private practice, an 18 percentage point drop from 2012, while 47% of physicians reported working in practices that were owned by a hospital, hospital system, or health system, or were directly employed (or contracted with) a hospital;[71] and
- A study by the Physician Advocacy Institute examining hospital and corporate ownership found that 58.5% of physician practices in the U.S. were owned by hospitals or corporate entities (including private equity firms, insurers, and other businesses such as CVS and Amazon) in January 2024, an increase of 9.2% over the past two years. The study found that over three-fourths of physicians, or 77.6%, were hospital- or corporate-employed in January 2024.[72]

Primary care practices have been subject to increased acquisitions by hospitals, private equity firms, and other corporate investors over the past decade. A recent study found that the share of hospital-affiliated primary care physicians increased from 25.2% in 2009 to 47.8% in 2022, while the number of private equity-affiliated primary care physicians increased to 1.5%.[73] The concentration of hospital and private equity affiliation varied by geography, and states with higher rates of hospital affiliation generally showed lower rates of private equity affiliation (see Figure 7).

Figure 7. Geographic Variation in Hospital-Affiliated and Private Equity-Affiliated Primary Care Physicians in 2022

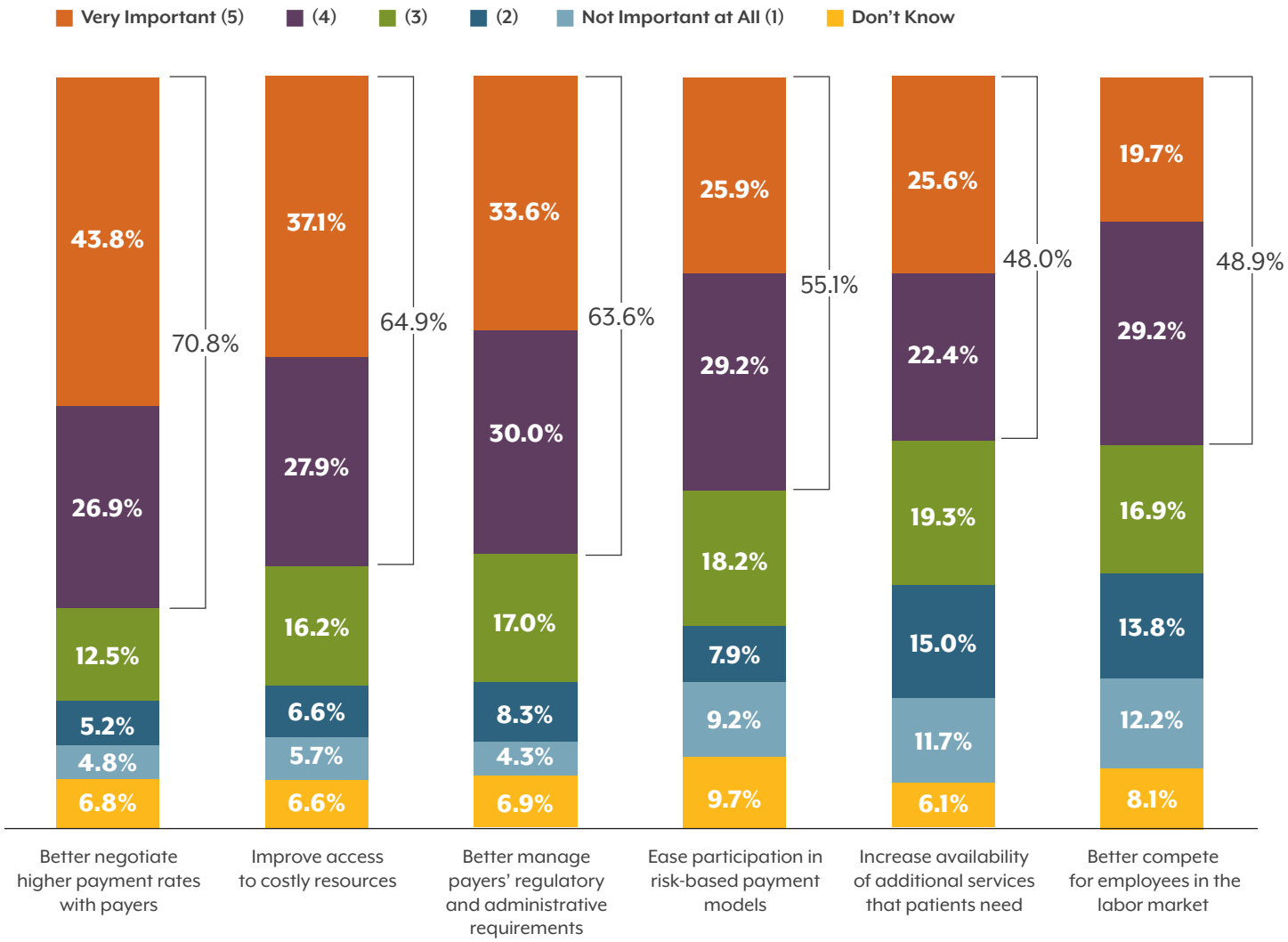


Source: Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications, JAMA Health Forum, January 17, 2025

Data indicate that within primary care, both nationally and in Colorado, vertical integration with health systems is the primary driver of consolidation. Private equity affiliation, while increasing, is a more recent phenomena and to date it remains concentrated in local and regional markets. These trends have important implications for affordability, as prices in hospital- and private equity-affiliated settings are higher relative to care provided in independent settings. One study recently found that for primary care office visits, negotiated prices were 10.7% higher for hospital-affiliated PCPs and 7.8% higher for private equity-affiliated PCPs, compared to independent physicians.[74]

The ability to negotiate higher fees is consistently cited as a reason that primary care physicians may opt for (or are being pushed to) corporate ownership; 70.8% of physicians responding to the AMA Survey cited the need to "better negotiate higher payment rates with payers" as "very important" or "important" in their decision to sell their practice, followed by the need to "improve access to costly resources" and to "better manage payers' regulatory and administrative requirements" (see Figure 8).

Figure 8. Reasons Why Private Practices Were Sold

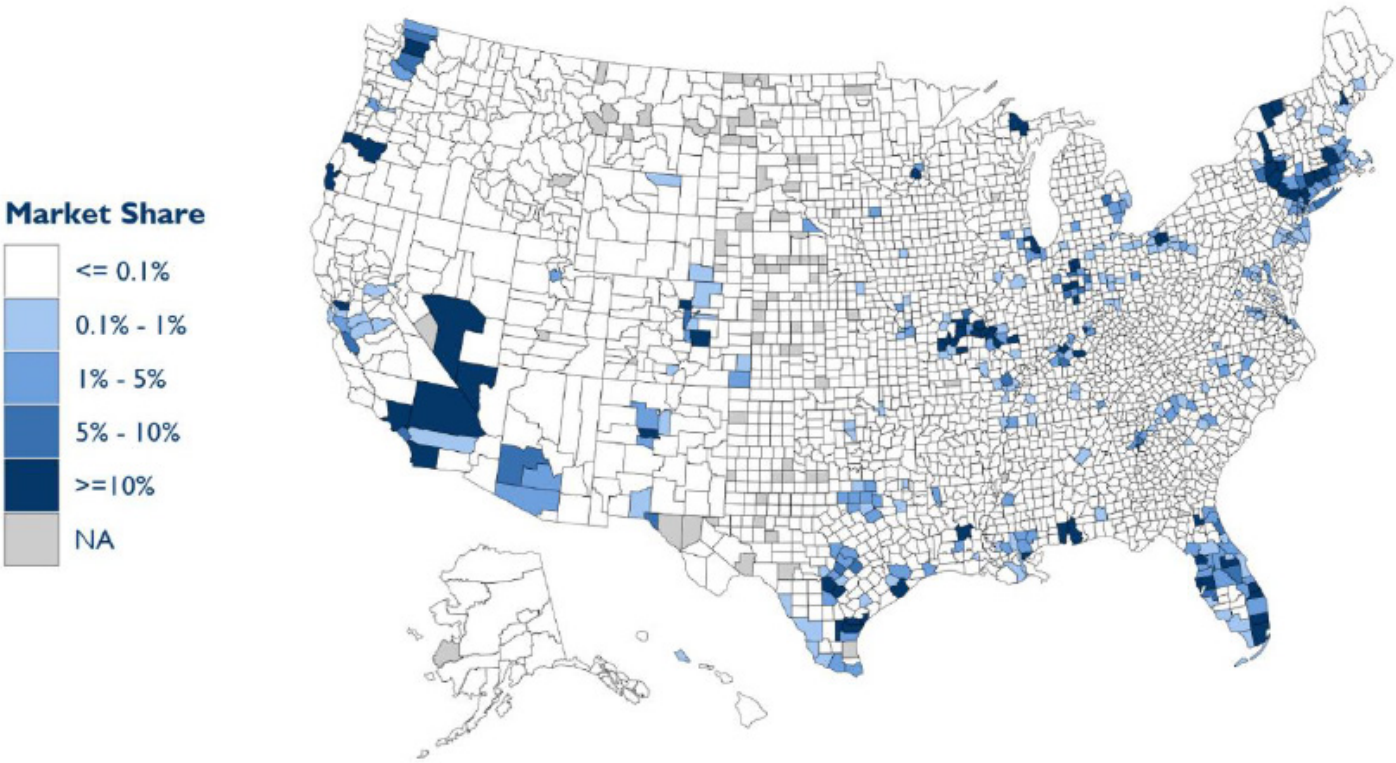


Totals and subtotals might not sum perfectly due to rounding.

Source: Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties, American Medical Association Policy Research Perspective, 2025

In addition to hospital and corporate acquisitions, health insurance company ownership of primary care practices is also playing an increasing role in health care consolidation. To date, studies in this area have been more limited, but one recent analysis found that the share of the national primary care market operated by insurers increased from 0.78% in 2016 to 4.2% in 2023.[75] Optum, a subsidiary of the UnitedHealth Group, was the primary driver of this growth, increasing its share of the primary care market from 0.55% in 2016 to 2.71% in 2023. In 2023, 15.1% of the U.S. population lived in counties where an insurer controlled more than 10% of the primary care market, and 10.1% lived in counties where Optum alone was above this threshold (see Figure 9).[76] In Colorado in 2023, insurers controlled over 10% of the primary care market in two counties — Boulder and El Paso — with Optum alone controlling 20% of the market in El Paso County.

Figure 9. All Insurer Primary Care Market Share by County, 2023



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