COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, September 18, 2025; 10:00 - 12:00 pm

Meeting Attendance

Attended
Polly Anderson
Josh Benn
Steve Holloway
Cassie Littler
Amanda Massey
Erin McCreary
Kevin McFatridge
Dana Pepper
Amy Scanlan
Mannat Singh
Kevin Stansbury
Gretchen Stasica

Absent
Alex Hulst
Britta Fuglevand
John Hannigan
Kate Hayes/Jack Teter
Lauren Hughes
Rajendra Kadari
Patrick Gordon
Sonja Madera

DOI
Tara Smith
Jill Mullen
Debra Judy
Matt Voss

Agenda:

1. Welcome & Introductions
2. Annual Review of Aligned Alternative Payment Model Parameters
3. Housekeeping & Announcements
4. Federal & State Updates
5. Annual Recommendation Report Topics – Discussion
6. Public Comment

Introduction:

Tara Smith welcomed participants and briefly outlined the meeting agenda, goals and desired feedback. She noted that the first hour of the meeting would be devoted to the annual review of Colorado's aligned APM parameters, pursuant to § 10-16-150, C.R.S., and the second hour would focus on topics for the Collaborative's upcoming annual recommendations report.

Annual Review of Aligned Alternative Payment Model Parameters

Tara Smith briefly reviewed the statutory directives related to aligned parameters for primary care APMs, and the annual review requirements. Prior to today's meeting, the Division posted surveys/comment forms on the HB25-1325 Primary Care Alternative Payment Models website to obtain stakeholder input/comments on each of the four parameters: patient attribution, risk adjustment, quality measures, and core competencies. As this year (2025) is the first year of implementation for parameters, the Division is seeking feedback on the following questions:

- What changed for you across the past year, if anything, in your contracting process, whether you're a provider or a payer or a consumer, due to increased transparency requirements?
- Would you rate that change as positive or negative?
- Based on your experience of it, do you have any recommendations for further change?

Tara Smith noted that any next steps coming out of this review session would depend on the nature of the comments received but reviewed a potential timeline for updates to Regulation 4-2-96, if needed (see slide 7, available here). This would likely include stakeholder discussions starting early next year (Jan-March 2026), with the formal rulemaking process starting in May/June 2026. The effective date of the rule would then either be Jan 1 of 2026 or 2027, depending on the nature of the revisions.

The current requirements for each parameter were reviewed and followed by open discussion from meeting participants.

Risk adjustment *- see slide 8 for current requirements, available here*

- A member who serves on the PCPRC as a consumer representative but works closely with the Clinically Integrated Network (CIN) affiliated with Children's Hospital Colorado in Colorado Springs, which includes 36 primary care and pediatric practices, shared comments she received from colleagues at the CIN:
    - The Medical Director commented that risk adjustment is always a grey area in contracts, and payers often respond "it's proprietary" when answering questions in this area. They noted the current regulation does not specify what information payers need to share, and wondered if other provider organizations felt that payers are fulfilling the risk adjust requirements;
    - The Managed Care Contracting Director liked the language around risk adjustment transparency but thought it would be helpful if carriers were required to share the diagnoses that they are considering in the methodology, such as whether a developmental delay is included or excluded.

- A meeting participant, a former PCPRC member and practice manager in Gunnison County for the last 15 years, noted their practice experiences corroborated the comments around transparency; their practices felt their experience with different payers was mixed:
    - Medicaid was able to share some good data, and through working with the Regional Accountable Entity (RAE), they were able to provide some nice reports; in Gunnison County, the RAE was through Rocky Mountain Health Plans, which was bought out by United; United as a whole was not as good in sharing, but it was through the Medicaid program, and we still received a lot of data;
    - With other commercial payers, risk adjustment was just a "big black hole" for any kind of information we were sharing with them for different programs; even with the ACOs they participated in over the years, they didn't get good data- it may have been because the practices were too small, and were a zero so to speak with any shared savings for these different reports;

- A member (provider representative) commented there is not enough transparency around risk adjustment in the commercial space, and it can be very frustrating;
    - Multiple members agreed with this comment via chat;

- A member (provider representative) echoed all of the previous comments, and noted from a pediatric perspective, the challenges are even more complex; there aren't good risk adjustment methodologies for pediatrics, and it is hard to get information about how an adult risk stratification platform (often proprietary) crosswalks to a pediatric population- no one seems to know how that looks;
    - The member noted that Medicaid RAEs have been better this year about trying to show practices what that crosswalk entails, but it is still difficult to know what diagnoses are included, and how to better tier patients in your practice;
    - Challenges in this space are particularly acute with private payers, and there is still a lack of information on how that is happening at the ground level;

- A member (consumer representative) commented that having the requirements and opening the conversation is important, and it is beneficial to have the regulation in place; operationally, however, it's still hard for providers to work around, and it almost feels like a shell of a parameter, with bumpers in place but no data behind it;
    - A member agreed with this comment in chat;

- A member (payer representative) noted that from a RAE perspective, the requirements are helpful; as a RAE, the member's organization works in an integrated way with HCPF (the state Medicaid agency), as the physical data comes from HCPF, and the behavioral health data comes from the RAE- and in getting that data, it is often correct, and sometimes can be very delayed. So, in considering the transparency

and/or data gaps, the RAEs feel that as well. It is a real challenge to try to figure out how to either integrate that data- get the provider level data, put it all together, send it back to HPCF, then back to the RAE before it is shared with providers. The requirements are important and guide all of those activities, but there are complications because of the way data flows;

- A member (provider representative) thought this was a very fair and accurate assessment and appreciated the challenges, but noted from a provider perspective, it then becomes a matter of looking back, and the data is not actionable in the moment; it would be great if there was a better platform or method for sharing.

Tara Smith summarized the discussion around risk adjustment by noting that stakeholders generally seem supportive of the current transparency requirements and view them as a necessary step in opening conversations between payers and providers. In terms of key takeaways, she noted the suggestion to add diagnoses codes as part of the description of risk adjustment methodologies that carriers must share with providers was something the Division would take back and consider.

She then asked meeting participants if there were any additional comments, and specifically if there were any recommendations for suggested changes to the current risk adjustment requirements, as contained in Regulation 4-2-96. Tara noted that social risk adjustment has been an important part of the Collaborative's conversations about risk adjustment, and right now the regulation requires carriers to provide the Division with information about how they are approaching (or intending to approach) the incorporation of social risk- but wanted to know if meeting participants had any thoughts on this topic as well.

- A member (payer representative) noted their organization, a RAE, is collecting data in a much more intentional way than in the past. Previously, it was dependent on how claims were coded, how things were identified- and the RAE had to try to extract that information. Today that has improved, due in part to provider support, and having conversations with providers about ways to obtain that information, and in a large enough sample size to actually be able to use;
  - The member appreciated the inclusion of social risk adjustment in the regulation, and noted that as a RAE, they look at this type of data from multiple levels, as it is tied to so many funding streams, waivers, etc.
  - From the member's perspective, this data is getting better all the time- for providers, it is getting easier to extract data around housing, food insecurity, and other stressors, etc., in whatever EHR system or other method they are using;
  - While we are still a long way from having enough data for people to feel satisfied, we are at least making a start and seeing improvement.

***Patient attribution** - see slide 9 for current requirements, available here:*

- A member who serves on the PCPRC as a consumer representative but works closely with the Clinically Integrated Network (CIN) affiliated with Children's Hospital Colorado in CO Springs (which includes 36 primary care practices), shared comments both on behalf of herself as a consumer, and on behalf of colleagues at the CIN:
    - From the member's perspective as a consumer:
        - Attribution is important for consumers, but it can be very confusing at times, due to the different methodologies that carriers might use; it can also be burdensome for consumers/patients to reattribute themselves- they are pointed to provider directories for a list of PCPs that they can select, but those directories are flawed, and they may end up selecting a PCP that isn't available (accepting new patients), or who may be erroneously listed as in- or out-of-network, when that is not the case;
        - The process of selection has nuances that consumer/patients may not understand, and there is a need for thoughtful education;
    - From the member's colleagues at the CIN:
        - Both the Medical Director and the Managed Care Contracting Director commented that providers seem to lack any knowledge of how to deal with misattributed patients; although the regulation requires payers to have a formal process that much be communicated to providers, the differences in payer methodologies to select PCPs (sometimes patient selection, sometimes claims) aren't always transparent;
        - The Medical Director commented that it would be helpful to have more detail about what was meant by the terms "meaningful payments" in Sections (8)(B) and (9)(A)(1) of the regulation;
    - Additionally, from a consumer perspective, the member expressed concerns that consumers don't fully understand how PCP selection may affect providers' payments, or how they might impact that patient's in- or out-of-network status; for consumers, PCP selection seems like a bunch of hoops to jump through, without any larger awareness of the larger implications (including benefits for them, their provider, etc.);

- A meeting participant, a former PCPRC member and practice manager of two clinics in Gunnison County, appreciated those comments, and shared reflections on their experience with attribution:
    - Both clinics experienced claim denials for patients who were receiving services in Colorado, but their home base was in Texas, and they were assigned to a PCP in Texas; when the clinics would submit claims for services rendered, they were denied- which was an interesting learning;

- Patient attribution is incredibly confusing and onerous for the provider, and affects things like PA, referrals, etc.;
  - If a provider was not listed as the patient's PCP, the practice/provider was not able to change it, only the plan member could- and the process for doing that can be all over the board (some payers require forms, others a phone call);
  - This is onerous, confusing, frustrating, and time consuming for patients, and results in delays in care- for example, when the practice could not obtain prior authorization or a referral to make an appointment with a specialist due to a hang up with attribution;
- In one instance, the clinics had around 100 claims that were not being processed, and subsequently denied, and even the payer couldn't understand why; after extensive investigation, the payer discovered a computer program was auto-assigning patients based on zip code to providers within a certain radius around Gunnison County was the source of the issue- and no one realized that was happening;
- Despite the clinic's efforts to be diligent and update provider rosters and directories, errors are still occurring (e.g., retired doctors showing up on patient cards);
- In addition to the administrative frustrations, it also has a real impact on payment- when participating in APMs that include shared savings, inaccuracies in attribution, and/or a lack of awareness among patients (going back and forth between practices without realizing the consequences), can cause providers and practices to lose out on savings that they helped generate;

- A member (provider representative) commented that they recognized the importance of patient attribution from a payer's perspective, as a way to ensure providers can't just "cherry pick" patients, but they also echoed the difficulties around changing attribution even it is obvious it has been done incorrectly;
  - The member emphasized that we need to come to some agreement between payers and providers of how to fix attribution when everyone knows it's wrong; that is difficult to do, but if we're going to base payment on attribution in any way, it has be to process that is transparent, very clearly defined, with a very clear process around how to fix it, and a timeframe around that process;
  - The member also appreciated the previous comment about the lack of consumer awareness or understanding of the importance and implications of picking a PCP or pediatrician- this is an area where providers could use payer assistance, so that we are working collaboratively to drive people to primary care as a gateway to good care overall;

- A member (provider representative) agreed with the need/importance of a clear process for reattribution, and noted that in previous discussions around reattribution, the PCPRC had talked about developing a shared metric for payers and providers to actually measure/track improvement in attribution process (whether payer systems are in place, whether conversations between payers/providers are actually happening, whether attribution is actually improving); reattribution is so important, and having some accountability, in the form of metric, could provide structure and substance around the requirement, rather than just saying "is there a way to put in some accountability, and structure/substance behind reattribution processes, rather than just saying "it should happen";
    - Tara Smith noted that the regulation requires carriers to submit a signed attestation that they have: a) established or maintained a process for providers to submit reattribution requests for misattributed patients to be added or removed from attribution lists, and b) established and clearly communicated to providers a process for regularly reviewing, no less than quarterly, a provider's patient attribution list and provider attribution requests. The regulation stops short of defining what that process must be, but provides a basic level of accountability that systems are in place and are being communicated- additional details could be added in the future, as needed;

- A meeting participant, a former PCPRC member who has supported an attribution measure in the past, expressed continued support for this idea, noting that it will be impossible to improve the attribution process without some sort of metric- if you can't measure it, you can't improve it. This could be done through some sort of sampling, where we ask payers and some large provider groups to develop a metric that compares "who we think your patients are" vs "who you think your patients are", and that should be something we monitor to make sure it stays within an acceptable limit (it will likely never be 100% correspondence, but we can likely do better than 50% correspondence). Right now, there is no national benchmark, so we don't know what that percentage should be- but we need some way to measure, and track, if we are going to actually see improvement;

- A member (consumer representative) asked if there were current regulations that defined, more granularly, different attribution methodologies that payers should select from, or is each payer developing their own? Right now, payers are using things like claims data, patient selection, geographic location- and the conversation seems to be stuck in the phase of "which methodology are you using" for a specific plan, a specific network, or member type, etc. The member wondered if there are any more granular regulations on how payers should select those methodologies;
    - Tara Smith explained that the current regulation stops short of identify a specific method or list of methods that carriers must use; however, based on

past discussions of attribution, many carriers use methodologies that have similar hierarchies, with patient designation being the first (and most important) method, when it is available, then turning to claims to see where patient has utilized services. Some payers, in the absence of a patient designation or claims use geographic attribution, are assigning the patient to the closest PCP.

Tara Smith asked for any additional comments or feedback related to patient attribution, particularly from payers, related to operationalizing and implementing the requirements.

- A meeting participant asked a question to payers as to whether claims data could be used for attribution, and basing a PCP on the volume of claims for a specific provider or practice;
- A member (payer represented) noted that on the Medicaid side it is prescribed by HCPF and is based on claims; member choice can shift attribution, but it is initially based on claims data;
- A member (provider representative) also noted via chat that HCPF removed geographic attribution from Medicaid in ACC 3.0.

Tara Smith summarized the discussion around patient attribution by noting that stakeholders see transparency as important, and having clearly defined reattribution processes are essential, particularly when attribution serves as the basis for payment. In terms of key take-aways, she noted the suggestion to develop a metric to measure attribution was something the Division would take back and consider.

Aligned Core Competencies *- see slide 10 for current requirements, available here*

To frame the discussion of aligned core competencies, Tara Smith noted that in the annual primary care and APM reporting carriers are required to submit (pursuant to Amended Regulation 4-2-72), carriers generally reported using the core competencies as currently set forth in the regulation. Most carriers did not report using many additional competencies or care delivery expectations in their primary care APMs.

She also noted that this was one area where the Division did receive comments prior to the meeting. A suggestion was made to potentially align the core competencies with the Advanced Primary Care Management (APCM) codes that are used in Medicare. APCM codes are a set of 3 codes (G0556, G0557, G055), included in last year's Physician Fee Schedule (PFS), which combine elements of existing services for primary care (care management and communication technology-based services) into a bundled payment that can billed monthly by providers. In this year's proposed PFS rule, CMS is proposing to expand on APCM codes by allowing the addition of integrated behavioral health services.

Tara Smith invited Stephanie Gold, a family physician who practices at Denver Health and Scholar at the Farley Policy Center at the University of Colorado, and a former member of the PCPRC, to provide additional context around the APCM codes, and outline some key questions that would be involved in a decision to potentially align the core competencies framework with Medicare's APCM approach. Highlights from Dr. Gold's remarks (see slides XX-XX, available here) include:

- Medicare has certain requirements for providers to be able to bill for APCM codes, and the subsequent tiering, which determines payment amounts;
    - This payment structure is new as of January 1, 2025, and represents a big shift in how Medicare is paying for primary care services;
    - To bill these codes, it is not required for an individual patient to receive all required services (listed below) in a given month; rather, it is a shift toward more of a hybrid payment structure, so payment is flexible to allow for the infrastructure and care capacity to deliver services at the time it is clinically appropriate and makes sense;

- Current requirements to bill APCM codes include:
    - Get patient consent;
    - Conduct an initiating visit;
    - Provide 24/7 access and continuity of care;
    - Provide comprehensive care management;
    - Develop, implement, revise and maintain an electronic patient-centered comprehensive care plan that is updated;
    - Coordinate care transitions;
    - Coordinate practitioner, home- and community-based care;
    - Provide enhanced communication opportunities, like asynchronous communication through portals;
    - Conduct patient population-level management, including risk stratification and care-gap identification and management; and
    - Measure and report performance;

- APCM codes are tiered into 3 different levels of payment (how Medicare is risk adjusting):
    - Level 1 (G0556): One chronic condition - $15/mo.;
    - Level 2 (G0557): Two or more chronic conditions - $50/mo.;
    - Level 3 (G0558): Two or more chronic conditions and Qualified Medicare Beneficiary status (dual eligible) - $110/mo.;

- In considering whether to move toward alignment with the APCM code billing requirements, some important things to note:

- Cost sharing may be a significant barrier in uptake of these codes; currently Level 1 and Level 2 APCM services are subject to standard Medicare Part B cost-sharing rules, which means patients are typically responsible for the 20% coinsurance, unless they have supplemental coverage; Level 3 APCM services for patients with more complex needs are excluded from patient cost-sharing;
- In the CY 2026 PFS Proposed rule, CMS is considering the following changes:
  - Looking at whether some or all of these services are preventive, and therefore could have cost sharing removed;
  - Allowing behavioral health integration add-ons; this would allow existing Medicare codes for behavioral health integration, including the Collaborative Care Model and general behavioral health integration care management, and letting practices that are billing APCM also bill those codes as an add-on, without requirements for time-based billing;

- Some potential benefits of aligning the core competencies with APCM codes include:
  - An opportunity to shift not only required competencies to greater alignment, but also to shift payment toward a hybrid approach;
  - A potential for greater national multi-payer alignment; and
  - The APCM billing requirements include a lot of overlap with the current core competencies;

- Some potential benefits of continuing with the existing core competency requirements include:
  - Current competencies are based on extensive past multi-stakeholder work;
  - They align with Medicaid's ACC 3.0;
  - Tiering structure allows for practices to progress;
  - Core competencies include a stronger emphasis on behavioral health integration.

Tara Smith thanked Dr. Gold for bringing this idea to the Division, and the information, and asked for reaction/feedback from meeting participants.

Discussion:

- A member (provider representative) offered the following comments, from a pediatric perspective:
  - The APCM requirements don't really correlate well with pediatric care, and are more focused on payment for chronic disease, as opposed to prevention, promotion, and other focuses in pediatrics; if we move toward this model, how do we also provide opportunities for pediatrics;

  - Behavioral health is important in youth, and the integration of physical and behavioral health has been an important part of the work we have done in Colorado- would hate to lose that effort and focus;
  - Dr. Gold expressed agreement with these comments, and encouraged discussion of how to make sure Colorado's work about behavioral health integration and other areas is not lost, but could be used to supplement the APCM framework;

- A meeting participant appreciated the information about APCM codes, noted this framework seemed to be a step in the right direction in terms providing prospective payment, and payments that are more meaningful to practices; however, if this is a first step, it would be important to build on and be able to expand to all providers, including pediatrics, and something would be adopted by all payers;

- A member (payer representative), who leads a payer association in Colorado, noted a shift to APCM would be something their members would need to discuss offline, but thought generally insurance carriers would support aligning on clinical and functional definitions of advanced primary care, including behavioral health integration, which is consistent with Medicare's APCM framework; they thought carriers would likely caution against adoption of Medicare's payment structure wholesale, as flexibility is essential in allowing carriers and providers to design models that reward outcomes;

- A meeting participant echoed the concerns raised about the applicability of APCM codes to pediatrics, and also noted that cost sharing may present large challenges with implementation; it may be hard to sell to patients about what they are getting with this type of payment- it is almost like setting up a subscription service for their doctors - and that will be a real shift in how they think about payment; if that challenge/issues isn't addressed, it will be hard for this to work, and the idea of implementing this across different types of plans should be approached with caution; co-payments, even a small amount, are a big deal for patients, in terms of selecting and using coverage;

- Dr. Gold appreciated this comment, and 100% agreed with the other comments and concerns raised in the discussion; she agreed that if the Division were to move away from the current core competencies toward multi-payer adoption of the APCM framework, cost-sharing could post a huge barrier to implementation;
  - She did note that CMS may hopefully be moving in the direction of not having cost-sharing requirements for APCM, and that the Farley Center and other organizations had submitted comments on the CY 2026 PFS rule to suggest that there should be no cost sharing;

- In terms of whether or not such a change would require Congressional action (as suggested by the meeting participant), Dr. Gold noted that the proposed rule was asking for feedback on whether any or all of the APCM services could be considered preventive, and therefore would have no cost-sharing under existing rules in the ACA; Farley and others presented the case that they care capacities themselves support the delivery of preventive care, and it is impossible tease out where those care capacities are used for preventive vs other services.

Tara Smith thanked Dr. Gold for the presentation and information, and meeting participants for the discussion. She indicated that it will be important to see where CMS lands in the CY 2026 PFS Final Rule, and that this may be a topic that the Division would be interested in hosting additional stakeholder meetings in early 2026 to further explore.

Aligned Quality Measures *- see slide 10 for current requirements, available here*

- A member (payer representative) commented that some of the measures posed difficulty for their organization, particularly those that relied on clinical data - they did not have enough data for some of these measures to make them statistically valid; in addition, most of their organization's measures are aligned with HEDIS, and some of the aligned measures are not; for their organizations, deviations from HEDIS specifications are difficult to implement;
  - The member did not immediately have a list of suggestions for different measures or proposed changes, but did relay that implementation of the existing sets has posed difficulties in this first year, and they would be providing additional feedback to the Division after the meeting;

- A member raised a technical question about the measure sets, and whether updates to existing measures were automatically included (for example, the current well-child check measure is old, and the screening for depression and follow-up measures has been updated); it would be helpful if the Division could post the most updated versions on their website;
  - Tara Smith noted that while the intent in establishing the measure sets was not to lock them in place at a certain time, but to allow for any updates that were adopted by the measure steward, this is actually challenging due to the way rules are promulgated;
  - Administrative rules required the Division to incorporate standards, such as measure specifications, by reference at the time the rule is adopted, and don't generally allow flexibility about including "future updates"; however, the Division can work with their Attorney General partners to see if there is way to accomplish this;

- A member (payer representative) commented that alignment with national standards, such as HEDIS, NCQA, or CMS, to the greatest degree possible is better for carriers, and makes implementation much simpler administratively;
    - Tara Smith noted that alignment with national standards is part of the statutory requirement around aligned quality measures, and was an important consideration in the rulemaking process establishing the current measure sets, but appreciated the feedback;

- A member who serves on the PCPRC as a consumer representative but works closely with the Clinically Integrated Network (CIN) affiliated with Children's Hospital Colorado in CO Springs (which includes 36 primary care practices), shared comments on behalf of colleagues at the CIN:
    - The Managed Care Contracting Director felt some sections of the requirements are vague, in terms of referring to "appropriate thresholds" and "mutual agreement";
    - The Medical Director felt greater alignment was needed- the current regulations seem to be "focusing on certain things over here," and the requirements could be more aligned across commercial carriers;

- Tara Smith appreciated this comment, noting it gets at the heart of what the Division is trying to accomplish in establishing aligned parameters- the need to have standard requirements to streamline and reduce administrative burden, but also allow flexibility for payers and providers.

In closing out the review/discussion of the aligned APM parameters, Tara Smith noted the Division is considering two areas for stakeholder discussion in the next year:

1. The development of additional categories of measures that would be included as part of the Division's annual review, such as an "on deck" measure set, that included measures that have been recommended for use and will be moved into the required sets in 2-3 years (for additional examples, see slide 14, available here); and

2. Additional discussion related to aligning the aligned core competencies with Medicare's APCM codes.

She thanked all attendees for their participation and comments and noted the Division will keep the comment forms for all parameters - risk adjustment, patient attribution, aligned core competencies, and aligned quality measures - open through October 31. Stakeholders can also contact Tara Smith directly (tara.smith@state.co.us or 720-701-0081) with questions or comments.

Housekeeping & Announcements

The following housekeeping issues were addressed:

- **Meeting minutes:** Tara Smith noted that September meeting minutes were posted on the PCPRC website yesterday and will be approved at the November meeting. revisions.

  ACTION ITEM: Meeting minutes for September will be approved at the November meeting.

- **Meeting attendance:** Tara Smith briefly reviewed the upcoming meeting schedule, noting that attendance will be important at the next several meetings, as the group will be developing the recommendations for the annual report;
  - She reminded members that proxies are allowed for meetings, and are also allowed to vote on behalf of members;
  - If members know they will miss a meeting and are interested in appointing a proxy, they should contact Tara Smith (tara.smith@state.co.us).

Federal & State Updates

Due to time constraints, the majority of federal and state updates were skipped, but members are encouraged to look at slides 19-22, available here. Tara Smith did highlight that Medicare open enrollment starts on October 15, 2025, and the Division has resources and assistance available for those with questions about plan options: 1-800-503-5190; dora_seniormedicarepatrol@state.co.us.

Annual Recommendation Report Topics

To begin discussion around potential report topics, Tara Smith invited Kevin Stansbury, the CEO at Lincoln Community Hospital and Health Care Center, to share his perspective on the impact of changes in the federal and state landscape. Highlights from Kevin's remarks and the discussion included:

- The passage of HR1 is a big deal, and will disproportionately impact rural hospitals, at a time when many were already worried;
  - 12 Colorado hospitals were on a list compiled by the University of North Carolina identified at risk of imminent closure;
  - The combination of cuts to Medicaid, the end of enhanced premium tax credits (ePTCs, set to expire at end of year), and upcoming changes in eligibility requirements will come together to disproportionately impact rural hospitals;

- Rural independent hospitals are also struggling with lower payments from commercial payers, relative to system-affiliated rural hospitals and urban hospitals, and need to figure out a way to adjust that to make sure we are generating enough revenue;
    - For Lincoln Community, 75% of patients are Medicaid or Medicare, so there is not a lot of commercial volume- but for what volume does exist, need to be able to make some margin on it to make up for the losses;

- In terms of Medicaid cuts specifically, the Colorado Hospital Association (CHA) is estimating they will reduce revenue for each hospital in the state by around 25%;
    - For Lincoln Community, that will be about a $1.5M loss per year, which we have no way to make up;
    - Are trying to plan for that, but for a hospital like Lincoln Community, and they have no way to make that up;
    - Trying to plan for that hit, and how to maintain essential services for the community while remaining solvent;

- Right now, there is a lot of misinformation circulating about Medicaid reimbursement for immigrants without documentation is incredibly harmful;
    - Emergency laws are required by law to see every patient, with some basic screening, and to provide care regardless of the patient's ability to pay;
    - So, all the discussion around documentation, and who has it and who doesn't, in the end doesn't matter from the perspective of the hospital- it ends up paying;
    - The issue of uncompensated care, when there is no other payment source and the hospital pays the costs, also disproportionately impacts rural hospitals;

- In terms of ePTC, the failure to extend existing subsidies, which will expire at the end of the year, is also a source of concern;
    - At a meeting with Representative Taggart last week, information was shared that in Mesa County (Taggart's district), some premiums will increase to $50k per year without the extension of ePTCs;
        - Those types of increases are just completely unaffordable- for example, the median income in Lincoln County is $49K;

- Kevin noted he was somewhat less worried about eligibility requirements; it will be an issue, but people in his area, and in many rural areas, understand that they will have to reapply every 6 months to have a redetermination;
    - The worry is less about people knowing it is something they will have to do, and more about the distance they may have to travel;

  - Although still researching the exact requirements, some of Lincoln Community's patients will have to travel to Ft. Morgan for a redetermination, which is over an hour's drive away;

- A member jumped in, to follow-up on a comment entered in chat, to comment that the changes in HR 1 are just as relevant for the Children's Health Insurance Program (CHIP) as they are for Medicaid, and will also impact rural hospitals and health clinics; they noted their organization, one of the RAEs, had over 65,000 members enrolled in CHP+, and in rural areas, the hospital constitutes the entirety of the rural health network; for non-urban areas, the network is often the rural hospital and/or the rural health clinic;

- Kevin appreciated this comment, noting it also raises the important question of "what is a rural health network";
  - He noted that in talking with policymakers, he often reminds them that if you travel east on I-70, you care about his hospital, as it is the only hospital between Denver and Burlington, Kansas;
  - This is the case for many rural hospitals in the state, whether in Gunnison, Craig, or Cortez - there are either long distances between many of our hospitals, or roads that may be impassable during the winter months- something many people forget;

- Circling back to Medicaid, it is true when policymakers argue that they are not cutting benefits; however, Kevin said what he fears most is the changes in the provider tax;
  - It is the reduction in the provider tax (something Colorado calls the Hospital Provider Fee), which reduces the state's ability to get the federal match, and then reimburse hospitals using supplemental payments;
  - That is how Lincoln Community and other rural hospitals can almost break even on Medicaid; through the supplemental payments and the formula we have through CHASE fund;
  - Without that, hospitals will see the estimated 25% cuts in Medicaid payments;

- It is critical to maintain access to public health insurance, as that is the source of access for patients in Lincoln County;
  - Again, 75% of Lincoln Community's patients are on Medicare or Medicaid;
  - Right now Lincoln Community operates an extended care unit for long-term care for patients, and 98% of residents those are Medicaid beneficiaries; the closest nursing home facility is about 80 miles away, and it is not appropriate care to tell an elderly patient that we no longer offer that service and you will have to have your family take you to Denver or elsewhere;

- In terms of the Rural Health Transformation Program, the pleas that rural hospitals would make to policymakers are:
    - Many believe that independent rural hospitals should be prioritized benefits under the RHTP;
    - Hospitals should be evaluated for their financial stress; mentioned previously that 12 rural hospitals are at imminent risk of closing, but 50% are not making a margin right now, let alone when the Medicaid cuts start to happen;
    - Hospitals should also be evaluated based on their rurality; Lincoln Community, for example, is 80 miles from any other source of care, and the population density in the area they serve is roughly 2 people per square mile; that makes for very low volumes, but the hospital needs to maintain a level of intensity of services to meet patient needs;
    - Finally, when you have seen one rural hospital, you have seen one rural hospital; so, it is important to have community orientation in how the money is invested, as every community is different;
        - While it is important to meet the Governor's goals, and the parameters set out by CMS, there is also a lot of value and innovative systems that could be developed if we allow communities to make decisions about how the money is invested.

Discussion:

- A member commented via chat that she appreciated the reinforcement regarding the immigrant access messaging/issue, and the premium hikes that will result if ePTCs are not extended. They noted their organization (consumer advocacy) is watching those two issues very closely, and note that if they could be helpful in terms of policy or the amplification of consumer voices, they would be happy to do so;

- Tara Smith asked a question related to the RHTP, and using community as a way to drive that investment, with an eye toward sustainability; in thinking about the acute needs of rural hospitals that were just outlined, within the application there also seems to be space for investments that are sustainable community infrastructure, which could include things like primary care- what role, if any, do you see for primary care or those broader investments?
    - Kevin started by noting his answer might be counterintuitive, but this was an important issue that was being actively and deliberately discussed;
    - From his perspective, the financial stress on hospitals right now is the most acute need- for example, he is likely not going to be able to give his staff a raise this year, and that's hard, with inflation, etc.;
    - He would personally advocate for a two-tier solution: first, bolster hospitals that are in financial distress right now, which could likely be done with a

relatively small amount of money; second, once we are able to get everyone level-set to survive, then we can start to get innovative with more remote patient monitoring, remote services, leveraging technology investments, leveraging investments in EHRs, how to optimize the use of those records, and working most closely with urban systems to ensure rural areas have access to specialty care to support primary care;
    - Kevin highlighted Aspen Valley Health, and Dave Ressler's work, as an example of a rural system that is more advanced (and stable); so, in that area, they will be able to jump right into the innovative pieces, some of which they have already done;
    - But in other areas of the state, rural hospitals need money just to survive, and the immediate priority is to ensure they stay solvent;

- A meeting participant asked if Kevin could talk about the realities of what a $50B program actually looks like at the state level- how much money is it likely to be per year for one state or one system, given the competition across all 50 states, and how it is spread out over several years?
    - Kevin explained that the legislation is designed so that one-half of the money goes to all states equally, so long as they have submitted an approved application; there is prescriptive direction within the notice of funding opportunity, but if that is followed, those funds should be attainable; inside the state, HCPF has established a steering committee to decide how that half will be distributed, consistent with Governor's goals;
    - The other half of the money has to be distributed to at least 25% of the states (so 13 or 14 states), but CMS has provided less criteria on how those funds will be awarded; states are counting on CMS guidance for that half, to understand the non-clinical issues that will be considered on awarding that money, and relying on federal legislators to lobby for their hospitals;

- A member asked whether any groups have been able to quantify how much farther a dollar goes in rural independent hospitals, versus in consolidated systems and practices; such an analysis would be a powerful way to ensure dollars, even if they are only going to be a fraction of what is getting lost with cuts, are going to the places where they will have the greatest impact; rural is forced to make a dollar go further than their urban and big system counterparts, but has that difference been quantified?
    - Kevin noted that he and many independent rural hospitals have been relying on the transparency data they are required to post on their websites;
        - Through that data, and data that the National Rural Health Association captures, which measures rural hospitals across the country against each other, he knows that that Lincoln Community's charges are in the 10th percentile; Lincoln keeps them low purposefully, as their patients

otherwise wouldn't be able to afford care (does no good to increase charges when they know they won't be paid);

- Additional work has been done around insurance dynamics, with imperfect numbers but for purposes of getting a comparison, showing that in urban areas average commercial reimbursement is 240% of Medicare, in Ft Collins it is 290% of Medicare (the highest in the state), while on the Eastern Plains it is the lowest in the state at 139% of Medicare;
  - So, we know there are disparities, and yet rural hospitals are still able to operate their services, although they struggle a lot of the time;
- Numbers that would quantify how much good a dollar does in each system would be welcome;
  - Rural areas consistently wrestle with the comment "it's more expensive to get health care in rural areas," which is not helpful, and doesn't give a full or accurate picture;
  - When looking at the numbers, Lincoln Community's ED sees on average 10 patients per day, but there are fixed costs associated with maintaining an ED; so, when you look at the per patient costs of an ED for Lincoln compared to a system like UCHealth or HealthOne, which sees hundreds of ED patients a day, Lincoln's is higher;
  - We need to figure out how to level that, to tell the true story, that rural health is one of the best bargains in health care;
    - Kevin noted that he has long advocated for rural areas as the best place to test new delivery systems, which have homogenous populations that we really know; it makes more sense to test in rural areas, and if it works there scale to urban, rather than the other way around; would be more effective to test in rural, and if it works there, scale to urban; right now, we test in urban, then try to squeeze that model in rural, and too often say it can't work in rural because the population is too small- we should flip that script;

- Another member asked about the lower commercial rates for rural health, and whether that has always been the case, or if it was a more recent phenomenon; in thinking through the incentives for payers, and why they would want them to be lower- are they trying to drive referral patterns, or to trying to send a message to members? They noted from an urban point of view, their organization (a RAE, which also has a lot of rural counties) is constantly balancing the referral patterns, and trying to keep everyone in their communities- do commercial payers have a different perspective, and if so, why?

- Kevin appreciated the question, and noted this is an area where we need to have more dialogue; he shared the story that a former head of a large system in CO argued that he paid rural hospitals more because it was a better bargain;
- Studies show, however, that patients get better when they are cared for closer to home; so, while it doesn't make sense to offer certain services in rural facilities (e.g., complex heart surgeries), there are a lot of services, like orthopedic surgeries, where Lincoln Community has had great success;
- A lot of the current dynamics seem to be driven by market power; as the larger systems have integrated more, there has become more of a balance in market power between large systems and large commercial payers; within that context, rural hospitals just aren't big players, and not a priority;
- A key question is how small providers can develop partnerships with innovative delivery care systems, but to do that, they need the attention of those systems, which will take speaking collectively and with a louder voice to say, "we can save you money."

Tara Smith thanked Kevin for his comments, and the good discussion, and noting the short time left in the meeting briefly walked members through an outline of the topics/issues that members had expressed interest in including in this year's annual report (see slides XX, available here). She asked members to review the slides in greater detail after the meeting, but most indicated general support of organizing the report around the topics of payment, data, and developing a comprehensive primary care strategy.

An outstanding question remains around the development of a primary care scorecard, and whether it is something the Collaborative would like to pursue. A member asked if the idea would be to create a scorecard and have it ready as part of the report, or whether the Collaborative would put forth its thoughts and recommendations around what a scorecard for primary care should include. Tara Smith responded that it was ultimately a question for Collaborative members but did indicate it would be very challenging to have a full-blown scorecard ready to go by next February.

Tara Smith ended the meeting by reminding members that CIVHC would be at the November meeting, to present the latest primary care and APM spending data, and that the rest of the agenda would be devoted to workshopping report topics. The Division is going to try to frontload the report writing process this year, in the absence of contractor support, to maximize flexibility if Collaborative members need to pivot as things unfold.

Public comment

- No public comments were offered.