COLORADO
Department of Regulatory Agencies
Division of Insurance

# Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, November 13, 2025; 10:00 - 12:00 pm

## Meeting Attendance

*Attended*
Polly Anderson
Britta Fuglevand
Steve Holloway
Lauren Hughes
Cassie Littler
Amanda Massey
Erin McCreary
Kevin McFatridge
Dana Pepper
Amy Scanlan
Mannat Singh
Kevin Stansbury
Gretchen Stasica

*DOI*
Tara Smith
Matt Voss

*Absent*
Josh Benn
Alex Hulst
Patrick Gordon
John Hannigan
Kate Hayes/Jack Teter
Rajendra Kadari
Sonja Madera
Kevin Stansbury

*Guests*
Trang Giang
Amanda Kim
Alice Aguirre
Stephanie Gold





## Agenda:

1. Welcome & Introductions
2. Primary Care & APM Spending Report from CIVHC
3. Housekeeping & Announcements
4. Federal & State Updates
5. Annual Report Recommendations
6. Public Comment

## Introduction:

Tara Smith welcomed participants and briefly outlined the meeting agenda, goals and desired feedback. She noted that the first half hour of the meeting would be devoted to the annual presentation from CIVHC about their data on primary care spending, and the rest would focus on topics for the Collaborative's upcoming annual recommendations report.

## Primary Care & APM Spending Report from CIVHC

Tara Smith welcomed the team from the Centers for Improving Value in Health Care (CIVHC) to present top level findings from this year's annual primary care & APM spending report. She noted that due to delays in payers' data submissions, the full report and associated data tables are still being finalized but will be circulated to members via email and posted to the Division's website as soon as they are available (likely next week). The Division will set aside time at the December meetings to answer any additional questions, after members have had a chance to review the report and data in full.

Sarah Barkley and Trang Giang briefly reviewed the purpose and methodology of the primary care & APM spending reports that CIVHC prepares annually, pursuant to §25.5-1-204(3)(c)(II), C.R.S. (see slides 4-6, available HERE). Sarah noted one change to this year's reporting was that payers submitted APM data using the Expanded Non-Claims Payment Framework, rather than the Health Care Payment and Learning Action Network (HCP LAN) (see slides 7-9, available HERE). The Expanded Framework builds off the HCP LAN and Milbank models for collecting and measuring non-claims-based spending and aligns with the Common Data Layout for Non-Claims Payment (CDL-NCP), which has been increasingly adopted by state APCDs to harmonize data collection across states.

This year's report includes data from 2022-2024, and high level findings (see slides 10-20, available HERE) include:



- Primary care spending as a percentage of total medical spending by line of business, 2022-2024:
    - Overall, across all lines of business, we have seen a 1% increase from 15% to 16% over 2022 to 2024, but down from a peak of 18% in 2023;
    - Medicare Advantage reported a decrease from 26% in 2023 to 24% in 2024, but remained higher than the 17% reported in 2022;
    - Medicaid reported a slight decrease, from nearly 19% in 2022, to 18% in 2023, to around 16% in 2024;
    - CHP+ showed a small increase from 11% in 2023 to 12% in 2024, but is still down from the 17% reported in 2022;
    - Commercial remained steady at 8%, with no change reported between 2023 and 2024;
    - Sara noted that one payer, Carelon, has only submitted non-claims expenditures in their APM files, all of which are behavioral health and have been categorized as primary care; while some of the data in the submission may not actually be primary care only, this is consistent with how the payer has reported in previous years- and since they will be offloading next year, CIVHC did not make adjustments to the data;

- Primary care spending as a percentage of total medical spending in 2024:
  - For all payers, the share of primary care spending was 15.7%, about a 2% decrease from 2024;
  - For all payers excluding Denver Health and Kaiser, the share of primary care spending was 15.8%, also about a 2% decrease from 2023;

- APMs as a percentage of primary care spending in 2024:
  - Out of primary care spending, about 89% was made through an APM, including both value-based APMs and APMs not linked to quality; this is a slight decrease from last year, which was 91%;
  - Payments through value-based APMs were 58.0% in 2024, a slight decrease from last year;
  - Payments through APMs not linked to quality were 31.2% in 2024, slight increase from last year;
  - Predominant types of APMs were 4N, 4A, 4C, and 2C, similar to last year;

- APMs as a percentage of primary care spending in 2024, excluding Kaiser and Denver Health:
  - Out of primary care spending, 88% was through an APM, about 1% decrease from 2023;
  - Payments through value-based APMs were 50.8% in 2024;
  - Predominant types of APMs in 2024 were 4N, 4A, and 2C, similar to last year;



- APM spending as a percentage of all medical spending in 2024:
  - For all payers, payments under value-based arrangements accounted for 33.5% of total medical spending, a slight decrease from last year;
  - For all payers excluding Kaiser and Denver Health, payments under value-based arrangements accounted for 27.5% of total medical spending, also a slight decrease from last year;

- Prospective payments as a percentage of **APM** primary care spending in 2024:
  - For all payers, 84.4% of total **APM** primary care spending was through prospective payments; this is about a 1% increase since last year;
    - Predominant APM types were 4N, 4C, and 4A, the same as last year;
  - For all payers excluding Kaiser and Denver Health, 82.2% of total **APM** primary care spending was through prospective payments; this is about a 1.5% increase from last year;
    - Predominant APM types were 4N, 4A, and 2C, the same as last year;

- Prospective payments as a percentage of total medical spending in 2024:
  - For all payers, 47.6% of total medical spending was through prospective payments made through an APM; this is about a 4.5% decrease from last year;

  - For all payers excluding Kaiser and Denver Health, 36.3% of total medical spending was through prospective payments through an APM; this is about a 6% decrease from last year;

- Limitations of the study this year similar to previous years and include:
  - Resource constraints from payers, challenges with submission logic and validation feedback;
  - Changing hands with multiple teams at payer organizations causes timeline issues; difficulty for payers with new APMs categories/ criteria/ PMPM calculations to figure out;
  - Challenges for intake team to validate APM data with APCD data;
  - Primary care definition is a bit tricky, no clear methodology to identify portion of capitation payments designated for primary care, primary care designation varies by payer;
  - Medicaid- payers only reported payments made directly to providers, to avoid duplicating payments going from HCPF to RAE/MCO organizations;

- Next Steps: CIVHC will continue working with payer representatives to ensure accurate reporting; investigate and add/remove as needed new primary codes; and plan for incorporating Capitation File data into the annual reporting.



***Discussion:***

- In opening the discussion, Tara Smith briefly reviewed why Kaiser and Denver Health are broken out of several data elements- state statute added through HB19-1233 and HB22-1325 included certain exclusions for "nonprofit, nongovernmental health maintenance organizations with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group"; practically, this exclusion applies to Kaiser and Denver Health in Colorado, and members have said it is helpful to see and understand primary care and APM data with and without these systems included;

- A member asked for clarification around the prospective payment figures included in the report, wondering what was counted in these payments as 84.4% seems like a very high number; multiple members agreed via chat that this number seemed large;
  - Sarah explained that prospective payments are payments made to providers ahead of a service; for this specific number, it is for payments that are also made through an APM, and it has always been around this high; she also noted that CIVHC receives data from payers in certain "buckets" - for prospective payments, for primary care spending, and for APM spending, and while it is a little challenging to unpack the methodology behind each of those categories, she could respond in greater detail in an email;

- Trang further explained that in the APM submission, there is a field for payers to indicate prospective payments, by marking a flag "Yes" or "No"; to calculate this field, if the flag is a "Yes", it is counted toward a prospective payment;
- The PCPRC member appreciated the explanation, and indicated they would like to get a better understanding of what is included in this calculation, as it doesn't match their reality in practice;
    - Multiple members agreed with this statement via chat;
- Tara Smith noted that the prospective payment flag was one of the newer fields that had been added to the report, and there is always a learning curve for payers when new requirements are added; she did explain that CIVHC had also added other fields, which ask payers to provide a written description of the APM- and CIVHC can use that to cross-check certain responses; she also noted that one of the challenges with this report is how different payers may be interpreting/categorizing payments- the purpose of the report is to try to get an "apples to apples" comparison across payers, but sometimes the categories don't line up with payer's internal systems, and can result in unique incongruencies;
- Trang asked the member what a more "reasonable" or normal percentage would be, if 84% seems high;
    - The member did not have an immediate number in mind, but said they could check with their organization, or other clinicians, to see what that number might be;
    - Trang appreciated this, and noted that if the Collaborative had a more typical or reasonable percentage in mind, CIVHC could add a check during the data validation processes, and ask payers if they report values that significantly deviated from that number;

- A meeting participant echoed the sentiments around the high number reported for prospective payments;
    - They noted that none of the primary care practices associated with CU Medicine were taking prospective payments, at the last financial meeting their practice decided not to, so it seemed odd that so many others would be accepting, when such a large system is not;
    - A PCPRC meeting concurred, noting their CIN just had a conversation about the movement of funds away from prospective payments and toward shared savings; they didn't have a specific number to report, but also questioned the high number in the report;
    - A meeting participant noted via chat that if an APM included a small prospective component but all dollars in that APM are being counted as prospective, that would inflate the figure- but even then, it still seems high;

  - Another meeting participant, who formerly managed primary care clinics on the Western slope, noted that the practices received monthly APM payments, but none were prospective;

- A member asked via chat about the guidance that was provided to payers regarding reporting;
  - Tara Smith noted that reporting requirements and guidance for APCD submissions was done through a rulemaking process; HCPF is the state entity that has authority, and each year the Data Submission Guide (DSG), which includes detailed reporting instructions, is released for comment, then goes through formal rulemaking;
  - The next rulemaking hearing will be on November 20, 2025, from 10 am- noon, and is open to the public; stakeholders can register HERE;
  - Information for submitters, including a copy of the current DSG, is available on CIVHC's website HERE;

- A meeting participant also asked for clarification around payments related to HCPF and the RAEs- it appeared payments to the RAEs were being excluded, and questioned if that was correct;
  - Tara Smith noted that in the first year of collecting and reporting this data, the payments from HCPF to the RAEs, and the RAEs to providers, were both included, which resulted in double counting, so CIVHC has put processes in place to prevent that from happening;
  - Trang noted that when HCPF sends data, it is split into different files; one of the files (the production file) includes payment HCPF made directly to providers, and is included in the report; the other file (the supplemental file) includes payments HCPF made to the RAEs/MCOs, but because CIVHC collects this data from the RAEs/MCOs, HCPF's supplement file is not included the report (to avoid double counting);
  - The meeting participant appreciated this explanation, but noted that only ⅓ of the payment that HCPF makes to the RAEs goes to primary care practices, and questioned whether these dollars were included in the report;
  - Trang noted this data was collected from the RAEs directly, and is included in the report, it is just not done through the HCPF files;

- Tara thanked CIVHC for the report, and all the work, and again noted that the full report would be distributed to members and stakeholders as soon as it is available; the Division will hold time at the December meeting for any additional questions- members can submit questions in advance to Tara Smith via email (tara.smith@state.co.us), so that the DOI and CIVHC can be prepared to respond; as members review the data, some high-level takeaways to keep in mind include:

- Multiple payers reported looking more closely at their APM classifications this year, due in part to the shift in reporting categories; several made changes to previous classifications, based on this review; the Division and CIVHC allowed these changes to improve data quality- but it does result in variances in payer's reporting over the years;
- Several payers reported that declines in this year's reporting were due to the Medicaid unwind; and
- While CHP+ reporting did have a slight uptick this year, the Division and CIVHC are still trying to understand the overall decline in spending.

## Annual Recommendation Report Topics: Presentation

Tara Smith noted that due to schedules, she was shifting the agenda slightly to make room for a brief presentation related to potential report topics, before diving into Housekeeping and State & Federal Updates. She noted that Collaborative members have expressed interest in 3 related topics for this year's report: first, tracking how payments are flowing through systems, and whether they are reaching primary care providers on the front lines; second, how alignment can be reached across the entire market, including self-funded employers; and third, developing a comprehensive primary care strategy. Earlier this year (April 2025), the Eugene S. Farley, Jr. Health Policy Center issued a report and playbook, Advancing Primary Care Payment Reform in the Commercial Sector: A Report and State Policy Playbook, that includes information and recommendations specific to those three issues. She introduced Stephanie Gold, a co-author of the report and a former PCPRC member, to discuss several recommendations in the Farley report that may be relevant to the Collaborative's discussion/conversations. (see slides 37-51, available HERE).



- Project overview & scope of work:
  - The project examined state policy levers to better understand how they advanced the adoption of primary care APMs in the commercial sector, supported multi-payer alignment, and ensured monitoring and enforcement;
- Report authors did an environmental scan, reviewing state reports and policies, and interviewed 50 stakeholders across 5 states, with deep dives in Washington, Colorado, Arkansas, Rhode Island and Delaware;
  - Talked to a broad swath of stakeholders
- Findings were turned into a report and policy playbook; major takeaways from the work include:
  - APMs must provide a meaningful amount of payment delivered through non-fee-for-service mechanisms, including prospective payment;
  - Investments in primary care must be increased; and

    - There must be multi-payer alignment both within the commercial sector and across all sectors of payers;

- State Playbook includes a list of steps, including voluntary or legislative or regulatory or implementation steps, many of which are fully in place or in progress in Colorado, but does include specificity and examples from other states that provide lessons or could inform future efforts in Colorado;

- Slides X-X (available HERE) highlight specific sections/steps from the report that may be of interest to PCPRC members; each slide lists the step/action, why it is important, a specific state example, and what the opportunity might be for Colorado;

- Ensure payment intended from primary care ultimately benefits the primary care practice (Step 7.C. from report)
    - Report authors heard anecdotal that incentive structures and/or additional investments from APMs that are meant for primary care and paid to health system or an intermediary are not always making it to the practice level;
    - State example(s): Rhode Island's accountability standards around per member per month (PMPM) payments to Accountable Care Organizations (ACOs)
        - RI requires insurers to provide a PMPM to primary care practices meeting criteria as patient-centered medical homes;
        - Further specify that those PMPM/ shared savings payments can be paid to an ACO only if there's a contractual obligation to use the funds to finance care management services at the primary care practices
    - CO opportunity: PCPRC could recommend that shared savings arrangement and PMPMs to an ACO or system have contractual obligations for payments intended for primary care to be used at the practice level;

- Require alignment across all payers under state jurisdiction (all plans subject to DOI regulation, Medicaid, and state employee health plans) (plus employers to the greatest extent possible) (Step 5.E. from report)
    - Report authors found that incentives or investments that only apply to a small proportion of a practice's patients are not enough to enable significant changes in care delivery, and practices face higher administrative burden from needing to comply with different requirements across payers;
    - State example(s):
        - Arkansas's Health Care Payment Improvement Initiative (AHCPII) includes Medicaid, state employee health plan, and largest commercial insurers, and one of the largest self-funded employers (Walmart): stakeholders said everyone got on board as they're going to touch everyone at the same time, very valuable for the program that interacts

with all types of patients; Arkansas also uniquely adopted legislation to expand Medicaid through a private option that requires that all plans on the exchange participate in the AHCPII;
        - In Washington State, state agencies partnered with PBGH to help convene employers interested in championing primary care;
    - CO opportunity: PCPRC could recommend:
        - Greater alignment with ACC 3.0, including require a medical home PMPM based on core competencies, and/or include an extra PMPM for behavioral health integration:
        - Aligned contractual obligations for the state employee health plan;
        - A Memorandum of Understanding (MOU) or other agreement with self-funded employers around alignment;
        - Not mentioned in report- but another opportunity might be alignment with Medicare 2026 fee schedule APCM codes;

- Develop your vision for aligned primary care APM policy and situate this in a broader state primary care strategy (Step 2 from report);
    - APM alignment is not enough on its own; additional solutions are needed related to workforce supports, decreasing administrative burden, and having aligned payment approaches across all state payers and purchasers (as on the prior slide);
    - State example(s): Rhode Island affordability standards included a piece related to reducing administrative burden through prior auth requests, requiring insurers to do so by 20% and to prioritize services ordered by primary care
    - CO opportunities:
        - Building on HB24-1149, recommend a targeted decrease in prior authorizations to decrease admin burden;
        - Not mentioned in report - but another opportunity might be creating a state scorecard or dashboard to track how PC is doing more broadly, including on payment and workforce;

- Establish requirements to support behavioral health integration (to a greater extent) (Step 6.D. in report);
    - Integrated behavioral health services, including mental health and substance use disorders, contribute to improved outcomes in advanced primary care models but lack sufficient and sustainable funding
    - State example: Rhode Island Affordability Standards:
        - Include behavioral health integration as part of their practice transformation expectations;
        - Prohibit same day co-payments for integrated services;
        - Open up additional codes for integrated care; and

        - Require adopting policies for behavioral health screenings that are no more restrictive than for other preventative services;
    - CO opportunity:
        - Recommend alignment with Medicaid ACC II by requiring PMPM for integrated practices and opening up codes for behavioral health integration (CoCM, HBAI);
        - Not in report, but recommend alignment with Medicare CY 26 fee schedule add-on codes to APCM for behavioral health;

- While the slides today focused on discrete issues of relevance to recent Collaborative discussions, some additional key findings from the report:
    - A top finding was that APMs must provide a meaningful amount of payment delivered through non-FF mechanisms, including prospective payment;
    - Investment in primary care must be increased; and
    - There must be multi-payer alignment both within the commercial sector and across all sectors of payers.

***Discussion***

- During the presentation, a meeting participant commented via chat that Colorado Medicaid has opened the CoCM codes -but unlike commercial carriers and Medicare require the Care Management component to be a licensed and credentialled individual, which is a major barrier to adoption, especially in rural areas;
    - A PCPRC member added that they thought additional clarification of the behavioral health manager requirements would be forthcoming;
- A meeting participant asked if the report authors looked at all at the challenges of implementing APMs to support primary care for children;
    - Stephanie noted that it was raised during conversations, mostly around the need for additional considerations, and some of the challenges; she wasn't sure that there were specific state strategies related to pediatric APMs, but she and Lauren could review and circle back with any insights.



## Housekeeping & Announcements

The following housekeeping issues were addressed:

- **Meeting minutes:** Tara Smith requested approval of the September and October meeting minutes. The September and October meeting minutes were approved without revisions.

  ACTION ITEM: Meeting minutes for September and October will be posted as final on the PCPRC website.

- **Meeting attendance:** Tara Smith briefly reviewed the upcoming meeting schedule, noting that attendance will be particularly important as the group works to develop 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).

- **Aligned APM parameter review follow-up:** Tara Smith reviewed key themes coming out of the aligned APM parameter review the October PCPRC meeting (see slide 23, available HERE), and noted the Division will likely host stakeholder meetings early next year (January-March) to discuss potential updates to the following parameters:
    - Quality measures: create "pipeline" for future measure updates (e.g., on deck, developmental, monitoring); and
    - Core competencies: potential alignment with Advanced Primary Care Management (APCM) Services codes.

## Federal & State Updates

Tara asked about the helpfulness of doing federal & state updates. Federal updates were provided on the following topics:



- **End of government shutdown** - On Wednesday night (11/12), Congress passed a Continuing Resolution (CR) which was signed by the President, bringing the shutdown to and end;
    - CR funds most of the federal government through January 2026, but includes separate bills to cover certain agriculture (USDA, SNAP), veterans and military construction, and legislative agencies through the end of September 2026;
        - This means SNAP payments will restart, and will not be subject to another possible shutdown next January;
    - Reverses federal worker layoffs, ensures retroactive pay for those furloughed;
    - Does NOT include an extension of enhanced premium tax credits;

- **Rural Health Transformation Program (RHTP)** - All 50 states submitted applications for the RHTP, a 5-year, $50 billion program created through H.R. 1;
    - $10 billion will be allocated annually- of that, one half will be split evenly between states that submitted an application, and one-half will be competitively awarded to states based on their application;
    - CMS will have discretion in state awards for the competitive funds, but announced factors include the "rurality" of a state, and the situation of hospitals serving disproportionate number low-income patients with special need, and "any other factors";

- CMS will announce awardees by 12/31/25, and funds will start on 10/1/26;

- **Prescription drugs** - Recently several pharmaceutical companies have announced deals with the White House to provide certain prescription drugs at reduced most favored nation (MFN) prices;
  - Companies have included Pfizer, AstraZeneca, EMD Serono (fertility therapies through TrumpRx), as well as Eli Lilly, Novo Nordisk (GLP-1);
  - CMMI also recently announced a new GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model, aimed at reducing drug prices for Medicaid;
    - Five-year, voluntary model for drug manufacturers and states;
    - Goal: to ensure fair and reasonable drug prices for Medicaid through CMS-led negotiations with drug manufactures;
    - Participating manufacturers will enter negotiated agreements with CMS to set pricing on covered outpatient drugs;
    - Pricing to state Medicaid programs will be calculated based on select international pricing data, effectuated through supplemental rebates;
    - An RFA has been released, and the model will launch in January 2026;

- **CY 2026 Physician Fee Schedule Final Rule** - The CY 2026 includes multiple provisions related to primary care, including:
  - **Behavioral health integration payment for advanced primary care:** three new G-codes can now be billed as add-on services by a practitioner when a base Advanced Primary Care Management (APCM) code is reported by the same practitioner in the same month;
    - The new codes are meant to be comparable to existing Collaborative Care Model (CCM) and behavioral health integration codes;
    - The final rule did not make any changes to cost-sharing requirements for APCM codes;
  - **Efficiency adjustment:** an efficiency adjustment will be made to relative value units (RVUs) and the corresponding intraservice portion of physician time for non-time-based services;
    - This adjustment will not be appliances to time-based codes, including E/M services, care management services, and behavioral health services;
    - CMS will use Medicare Economic Index (MEI) productivity adjustment percentage, calculated by CMS Office of the Actuary (OACT) each year, to calculate, with a look-back period of 5 years;
    - Final CY2026 efficiency adjustment = -2.5%;
  - **Practice expense reimbursement:** the methodology for calculating indirect practice expense payments is being revised to reduce the portion of Practice

Expense RVUs allocated based on Work RVUs to half the amount allocated to non-facility Practice Expense RVUs beginning in CY 2026;
    - With this change, physicians and other practitioners will see reduction in their indirect practice expense payments if they furnish services in facility settings where overhead costs — such as rent, staffing, and supplies — are already covered by hospital or health system;
- **Medicare Diabetes Prevention Program:** Multiple changes are being made to the DPP program to increase uptake and participation, including;
    - CMS will be testing asynchronous online delivery from 2026 to 2029;
    - New definitions and flexibilities have been added to support virtual participation;
    - Better alignment with CDC standards;
    - CMS is also allowing weight documentation from medical records, expanding acceptable self-reporting locations and introducing a new HCPCS code (G9871) with an $18 payment rate for online sessions;
- **Telehealth:** CMS is making several changes to streamline and simplify the process for adding services to the Medicare Telehealth Services List by:
    - Removing the distinction between provisional and permanent services and limiting review (reducing 5-step process to 3 steps);
    - Adding 5 new services to Medicare Telehealth Services List;
    - Removing frequency limits for subsequent inpatient & nursing facility visits, critical care consults; and
    - Allowing real-time A/V communications to meet "direct supervision" requirements;
- **Ambulatory Specialty Model (ASM):** ASM is a new 5-year, mandatory model that aims to improve prevention and upstream management of chronic disease, leading to reductions in avoidable hospitalizations and unnecessary procedures;
    - Targets heart failure and low back pain care, and holds specialists accountable for quality, cost, care coordination and EHR use;
    - Model will launch in January 2027, and payment adjustment will start in 2029, ranging from -9/+9% (up to -12%/+12% by 2033);
    - Test tools designed to improve collaboration, such as a Collaborative Care Arrangement in which providers have clearly defined roles, responsibilities and expectations for data sharing, co-management of patient care and referral processes with primary care providers;
        - Both specialists and primary care providers will: 1) contribute to screening for health-related social needs; and2) jointly prepare plans for patient transitions between care settings, such as an outpatient treatment facility and home;

- **Medicare Shared Savings Program (MSSP):** Changes to the MSSP program include:
  - Finalized changes projected to reduce Medicare spending by $20M through 2035 and encourage broader participation;
  - Reduced the time an ACO can participate in one-sided model of BASIC track (5 years, not 7);
  - Increased flexibility around minimum beneficiaries (<5,000 allowed in BY 1 and 2);
  - Removed the health equity adjustment; and
  - Updated APM Performance Pathway Plus quality measure set to align with other programs;
- **Merit-Based Incentive Payment Program (MIPS):** Changes made to the MIPS program include:
  - Finalized policies to stabilize program, support goal of fully transitioning to MIPS Value Pathways;
  - Added 6 new MIPS Value Pathways; and
  - Maintained 75-point performance threshold to avoid penalties and receive positive payment adjustment through 2028 performance period.

- **Primary Care Collaborative Report on Rural Primary Care** - The Primary Care Collaborative, a national organization, released a new 2025 Evidence Report, Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, which includes a literature review, a description of federal legislative trends affecting rural primary care, a quantitative analysis of primary care trends (comprehensiveness, primary care spending, and primary care workforce) and five case studies that describe current rural practice models. PCC hosted a webinar on 11/12/15 (recording available HERE), and Lauren Hughes, a PCPRC member, was one of the panelists.



- **NASEM Standing Committee on Primary Care** - The NASEM Standing Committee on Primary Care will be hosting its fourth and final public meeting of 2025 on 11/20/25 from 11-2 pm MT (registration available HERE). PCPRC member Lauren Hughes serves as one of the co-chairs of the Committee.

  ***Comments on both events by Lauren Hughes:***

  - The report was released yesterday, and key findings and policy recommendations are available at the bottom of the overview available HERE;
    - Many of these crosswalks with some of the Collaborative's conversations in the past, around measuring primary care spending, and establishing benchmarks and targets;
    - Given current political environment, two policy recommendations stand out:

        - As heading into Medicaid reductions over the next several years, states should refrain if at all possible from reducing primary care reimbursement rates;
        - Relative to RHTP, report calls for centering of comprehensive whole-person primary care at the foundation of this program
    - Lauren was on a policy reactor panel during yesterday's webinar, which included Alina Czekai as a panelist, the Director of the RHTP within CMS; she received clearance from CMS to participate,
        - While she couldn't go into great detail (as applications were just submitted), from her early scan and review and what she is hearing from reviewers on her team, she noted that supporting and enriching rural PC is a pretty consistent theme across applications and she was pleased to see that;
    - A third policy recommendation that particularly resonated with Lauren was around value-based models in the rural space, and ensuring such models are "rural friendly" and take into consideration the unique challenges of engaging in value-based payment in the rural context.

- The NASEM Standing Committee on Primary Care is hosting its fourth and final public meeting next Thursday, on Nov 20; the 21-member Committee advises the federal government on a wide range of primary care policy issues- the focus areas this year have been payment, workforce, and digital health;
    - The agenda for next week is available HERE; the first panel is focused on pediatric primary care payment valuation and access; the second panel will dive into evidence-based prevention across the lifespan in primary care settings (from pediatrics to geriatrics);
        - The prevention panel was created in response to a request from CMMI;
    - All recordings and materials will be posted on the Standing Committee on Primary Care's website.



The following state updates were provided:

- **SNAP benefits restarting** - With the end of the shutdown, SNAP benefits should be restarting; in the interim Colorado had taken steps to approve funding ($10M) for food stamps, and to extend WIC funding through the end of November;

- **Governor's Proposed FY 26-27 Budget** - The Governor has announced his proposed budget for FY 26-27, which includes total expenditures of $50.7B ($18.6B General Fund), and a budget reserve of 13%;
    - HCPF is a major budget item, and the proposed budget will hold Medicaid growth to 5.6%;

  - Specific program expenditure reductions needed to meet this target are outlined in an updated Executive Order;
  - A HCPF Budget Reductions Fact Sheet - 10/31/25 includes additional information;

- **Rural Hospital Transformation Program Application** - Colorado's full application is available on HCPF's Colorado Rural Health Transformation Program website;
  - Highlights from the application related to primary care are summarized on slides 33-35 (available HERE);
  - A PCPRC member representing HCPF commented via chat that questions can be directed to hcpf_rhtp@state.co.us.

## Annual Recommendation Report Topics

Tara Smith briefly reviewed the timeline for completing the annual recommendations report, and the general report structure. She then outlined a potential introduction/framework for this year's report, as well as an organizational structure (see slides 53-55, available HERE). She then helped facilitate a discussion of payment related issues members wanted to address (see slides 56-63, available HERE).

***Discussion:***

- In terms of the proposed intro/framing, a member agreed with the general direction, and felt it was a good way to meet the current moment, and the right way to start;
  - A member agreed, noting that it was difficult to see a decline in primary care spending the CIVHC data, and felt it would be important to acknowledge that, even if we can't exactly pinpoint the reasons why; but it is something we should try to address in the report;
  - A member (payer representative) did not have objections to the general framework; to the point about the CIVHC data, from a payer perspective they didn't have any immediate insights into why that went down; in terms of looking at the general environment, the impacts of H.R. 1 are certainly significant, but in thinking about access and affordability it is also important to look at the additional pressures on premiums - inflation, costs of services - and all of the issues that are contributing to a difficult environment in insurance and health care;
  - A member agreed with previous comments, and noted that part of the framing involves resources being more constrained in general; as we are seeing higher utilization, higher need patients- as things are getting more expensive, we are getting less resourcing; that is the picture across the state in pretty much every area of health care- so then how do we continue to support the viability of primary care in that context;

    - The answer- can we just pay more? We don't know- and there are some tough questions that we will need to address;

- In terms of report structure, this year's report might be different, and split into two "parts", each with a section of recommendations; Tara Smith asked members for feedback on this approach;
    - Members generally agreed with this approach;

- Focusing in on payment priorities, Tara Smith presented the group with a summary of the "north star" goal around payment that had been expressed in previous reports (see slide 56, available HERE); noting that the statement was drawn in part from the PCPRC's statutory charge, and therefore not open to wholesale changes, she asked members if there were any additional considerations/priorities that members would want to incorporate into the goal in this year's report;
    - A member commented that two additional areas of focus to highlight this year in relation to the north star goal, and particularly in relation to value-based payments, are: what is needed or unique for rural value-based care, and what is needed or unique for pediatric value-based care; these two areas are key sub-sets of this goal;
        - Another member agreed with these two additions;
    - Another member noted that due to the upcoming changes to eligibility to Medicaid, whether it is important to focus on populations that we are concerned will lose access to insurance, and what that looks like; what is the impact to community health centers, safety net providers, etc.;
        - Multiple members agreed with including this as an additional sub-set to the north star goal;

- In terms of the payment landscape, Tara Smith noted that last year's report included an initial discussion of consolidation, and its impact on primary care; this year the PCPRC has raised additional considerations in this space, in terms of the different types of system, and disruptors (see slide 57, available HERE). She asked members about their level of interest in including an expanded discussion of the landscape in this year's report, but viewed more through the lens of how this landscape is impacting/influencing the payments that are flowing to primary care.

- In tandem with this framing, Tara Smith circled back on a potential "Form, Level, Flow" concept (coined by Asaf Bitton), as a way to discuss payment in this year's report (see slide 58, available HERE). She noted that previous reports had focused primarily on the form and level of payment, and this year could dedicate more space to the flow of payments. She asked members for comments/feedback on this approach.

- A member commented that this approach really resonated with them, and captures and builds nicely upon the Collaborative's past work; it also highlights the challenging issues of what is needed to move from volume to value, addressing the chronic underinvestment, and getting the dollars to the front lines of practice;
- Another member commented that they liked the "flow" component of the framework, and felt it was something the Collaborative hadn't talked as much about; they did note the lack of data available in this space, which the Collaborative may only be able to highlight (rather than solve), but felt just because it may be hard to address, it is still really important;
- A member (HCPF representative) commented that a consistent theme they have heard from their stakeholders, across all Medicaid's payment models, is a concern about administrative burden; how much work is required to demonstrate that you are doing the "thing" to get the value-based payment- how much time is being spent on administrative tasks rather than improving the clinical care or experience of care; that trade-off is coming up repeatedly in stakeholder discussions;
  - A member underscored this comment, noting that Clinically Integrated Networks (CIN) has become a strong interest among rural hospitals and rural primary care, as a way to have a structure to support participation in value-based care; theoretically, one advantage of a CIN is to ease administrative burden so you can focus more on population outcomes; a discussion of CINs as a potential entry into value-based payments in rural areas;
  - Another member agreed with this comment, but noted that some of the payments that go an ACO may be used to provide some of the infrastructure around administrative burden; you can look at that as dollars not flowing to the practice, but you can also look at it as dollars being put somewhere to relieve the administrative burden from being on the practice itself;
  - A member noted that this was a fair point, but noted in those instances there should be transparency around dollars that are designated for infrastructure, to show how they being used for the benefit of practices;

- In terms of the form of payment, Tara Smith briefly reviewed some of the Collaborative's past recommendations related to the form/type of payment that best supports primary care; many of these statements have emphasized the need for value-based payments and prospective payments, which are inclusive of integrated behavioral health; she asked members if there were any additions or new elements (more or less granular) that they would like to elevate in this year's report;

    - A member (HCPF representative) noted that another theme they have consistently heard from stakeholders is that payers can't keep adding requirements (e.g., it can't be prospective payments but you need to bill for everything you have already done); the concerns have been less about the form of payment, and more around "you have to take something off the plate" or it is not worthwhile for a practice to participate;

- Additional dimensions related to the form of payment include things like payer alignment, employer engagement, rural providers and safety net providers; Tara Smith asked members which dimensions are most important to address in this year's report;
    - A member noted that a previous comment about using APCM as a potential lever for alignment across state and federal levels, now that Making Care Primary is gone really resonated; in a similar thought process, this (APCM) is an important step, rooted in the Physician Fee Schedule, and so speaking to APCM in some shape or form in the report is important, and would make the report timely and in tune with what is happening at the federal level;
    - Another member spoke to the behavioral health integration piece and noted that HCPF/Medicaid had done a lot of great work in that area; it would be would be nice to align something that was so thoughtfully done in the pediatric space with commercial payers, because there are so many practices that are maybe 10% Medicaid and can't stand up a program without having support from other payers;
        - Tara Smith noted that prior to developing the integrated behavioral benefit, HCPF and the DOI had conversations with commercial payers to inform a legislative report, and perhaps these conversations could be revisited;
    - A member (payer representative) noted that their organization is not involved in Medicaid ACC 3.0 and can't speak to that program, but they have prioritized integrated behavioral health; in terms of the policies that were proposed earlier on that, they noted they would need to check in with their team to see if those policies have been effective, and how we have experienced those in other states;
    - A member agreed it would be helpful to hear what commercial payers are doing in the integrated behavioral health space, and if there is opportunity for alignment;
        - A member (HCPF representative) added context around the conversations that HCPF and the DOI had with several commercial payers about payment approaches for behavioral health, to develop the legislative report and recommendation, and got some preliminary feedback at that time about what other payers would and would not be

able to implement; HCPF would certainly welcome further conversations on this front;

- Tara Smith noted that there wasn't enough time remaining in the meeting to talk about a comprehensive primary care strategy, but encouraged members to look at slides 65-77 (available HERE), to get a sense of how this section of the report could potentially be structured;
    - A member commented that they were not opposed to moving in this direction, but given the new reporting around the aligned payment parameters, and the need to still examine/understand how that plays into all of this strategically, they questioned whether a comprehensive strategy was premature (putting the cart before the horse). They also questioned how to the aligned payment parameters funnel into this strategy, and whether the Collaborative needed more information on how those worked in this first year of implementation;
    - Tara Smith noted that was a question for the group, as to what the strategy would actually entail, but commented from her perspective, the work the PCPRC has done around payment, including the aligned parameters, would be one piece- but a strategy would include other important components needed for a robust primary care system, such as workforce, and access. She noted the strategy could potentially fit in with the Collaborative's charge around the primary care infrastructure more broadly- as members have noted in the past, even if we are paying primary care adequately, not everything is in the control of providers, and there are still systemic supports that are needed to support and sustain advanced primary care delivery. So, a comprehensive strategy could be a mechanism to identify the infrastructure components we need to be tracking and monitoring- payment will likely be an important piece of that- but the strategy will look at how payment is matching up with workforce, and is matching up with access, etc.
    - The member clarified that the goal for the report this year would be to identify the building blocks of a strategy, but not a full strategy;
    - Tara Smith noted that was likely correct- with only two meetings left before the report, the development of a full strategy was probably not possible- but PCPRC members could put forth a vision, and outlines of a strategy;
    - Members generally agreed dedicating part of this year's report to a discussion of a comprehensive primary care strategy, and Tara Smith noted the Division would send out materials to members prior to the December meeting to workshop ideas and get feedback prior to the meeting;

- Briefly returning to payment, Tara Smith left members with two parting questions:
    - What would members like to say about the level of payment? Tara Smith noted this was an area where Collaborative members might have some data needs,

and reminded members of questions raised in previous conversations that might be relevant in this space, including: what is the current level of stability/instability- how much breathing room do PCPs have?; and, how much is administrative burden adding to the cost of running a practice? She asked members to consider what they might want to discuss regarding the level of payment prior to the next meeting;

- What would members like to say about the flow of payments? Tara Smith reviewed some of the Collaborative's past recommendations about flow, noting they focused on funds flowing to support certain activities and/or members of the care team. In thinking about the flow of dollars through systems, Tara noted that data needs are also likely to be an issue, and pointed to some of the Collaborative's questions in this space: how much money in systems actually gets to primary care?; how many providers are independent vs system-affiliated?; and, where are patients getting primary care, and what is driving them? She asked members to consider what they might want to discuss regarding the level of payment prior to the next meeting.

## Public comment

- No public comments were offered.