COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, June 12, 2025; 10:00 - 12:00 pm

Meeting Attendance

Attended
Polly Anderson
Josh Benn
Steve Holloway
Lauren Hughes
Alex Hulst
Cassie Littler
Amanda Massey
Erin McCreary
Kevin McFatridge
Dana Pepper
Amy Scanlan
Gretchen Stasica

DOI
Tara Smith
Jill Mullen
Daisy Zoll

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

Guest speakers
Venice Haynes
Raymond Tsai
Allyson Gottsman

Agenda:

1. Patient perspectives on primary care
2. Employer/purchaser engagement
3. Coordination with practice transformation
4. Federal & state updates
5. Housekeeping & announcements
6. Public Comment

Welcome and Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda, goals and desired feedback.

Patient Perspectives on Primary Care

Tara Smith introduced Venice Haynes, the Senior Director of Research and Community Engagement with the United States of Care (USoC), to present recent research to better understand people's perceptions of primary care (see slides 6-27, available here). Highlights from the presentation:

- Background context for USoC's research included findings from the Milbank Memorial Fund's Annual Scorecard in 2022, which found nearly 31% of adults and 12.5% of children lack a usual source of care; USoC wanted to understand why, and find out more about people's primary care priorities, experiences, etc.;

- When the research was conducted in 2024, USoC again did a scan of the landscape; key elements that stood out included: a decline in the availability of primary care physicians, particularly in rural areas; high rates of physician burnout, leading to concerns about recruitment and retention of the current and future workforce; increasing rates of consolidation. While virtual care options have increased access in some instances, that is an entire separate body of research;

- Key takeaways from the survey and focus groups:
    - People are generally satisfied with their primary care and highly prioritize having a regular primary care clinician and receiving primary care services;
    - Young adults, people living in rural communities, and people of color face the biggest barriers to getting the primary care they need- primarily due to cost and access;
    - Satisfaction with primary care increases as age increases due to more established relationships with primary care clinicians and their health care coverage;
    - While insurance coverage ultimately guides the choice of a primary care clinician, the ability of the clinician to listen, communicate effective, and is culturally responsive is most important for adults when receiving primary care- particularly among people of color;

- People have different definitions of primary care, but generally think it includes a wide range of services, including routine physical exams, screening exams, prescription refills, treatment for general health concerns, vaccines/immunizations, and chronic disease management;

- When asked the first word that came to mind in relation to various health care terms, sentiments were mainly negative for health insurance, hospitals, U.S. health care system, and minute clinics, but were relatively neutral for primary care;

- In terms of access, 74% of adults have received primary care services, either in-person or virtually, during the past 2 years; utilization of primary care services increased with age, but was lower among adults of color, and those who were uninsured;

- Most adults reporting seeking primary care services for routine physical exams (67%), prescription refills (63%), vaccines/immunizations (51%), and screening exams (50%); fewer reported seeking care for cold/flu (38%), mental health concerns (27%), or chronic disease management (24%);

- While most adults found it easy to access primary care services (80%), that dropped for adults that identify as Asian, American Indian, Alaska Native, or Pacific Islander (74%0, for members of Gen Z (69%), and uninsured adults (50%);
    - Reasons given for access challenges included: health insurance issues; scheduling and wait times; financial constraints; and provider availability;

- In terms of affordability, 35% of adults said they didn't need to see a doctor if they weren't sick, 26% said they haven't received primary care in the last 2 years because they can't afford it, and 13% said it was because they don't have health insurance;
    - Of the 26% that said they couldn't afford primary care, those in rural areas were more likely to report affordability concerns (32%), compared to those in suburban (24%) or urban (21%) areas;

- Patients reported a range of emotions related to finding a primary care clinician, including stressful, easy, hard, nervous, confusion, uncertainty, drained, nerve-wracking;

- Having a regular primary care physician was more of a priority for older populations (baby boomers) than younger generations; whether a physician was in-network was the main factor cited in choosing a PCP (57%);
    - Other factors that patients prioritized included: clear communication (88%); addressing the root of health problems; timely follow-up on test results and referrals; understanding medical history; understanding what is covered by health insurance; and convenient appointment times;
    - Among adults of color and those living in urban communities, clinicians having a comprehensive understanding of cultural and linguistic differences was also important;

- In terms of satisfaction with primary care, the large majority of adults reported being satisfied with primary care services (92%), with satisfaction increasing as age increases;

    - The top 3 reasons for dissatisfaction with primary care included: provider rushed through an appointment (26%); provider did not spend much time with them (23%); wait time at doctor's office was too long (20%);

- When asked about satisfaction with health insurance coverage for primary care, 61% of adults reported being very satisfied (61%); again, satisfaction with health insurance for primary care increased with age;
    - The top 3 reasons for dissatisfaction with health insurance coverage for primary care included: high out-of-pocket costs; unexpected medical bills; difficulty finding an in-network provider;

- Barriers and potential solutions coming out of the research include:
    - Rural and young people have a clear vision that primary care in the U.S. should be accessible, affordable, and convenient
        - Accessibility is associated with appointment scheduling; shorter wait times; communication with practitioners for questions/concerns; having more options of practitioners; affordability for all; outreach and education;
    - For rural participants, some live over an hour from nearest quality medical center, and people in their community lack transportation to get there and experience long wait times;
    - Young participants expressed particular dissatisfaction with expensive medical bills, even though they were insured, and that their concerns are not being taken seriously;

- In terms of policy solutions, key themes include:
    - People want to see policymakers focusing on reducing costs and increasing access to health care services;
    - Affordability needs to be addressed; young people in particular expressed distrust of health care system, and believe it values "profit over people"
    - Rural patients expressed high agreement on convenience being an important element of access;
    - Affordability was linked to accessibility, along with factors including distance, wait times (both to get an appointment and once they arrive)
    - Younger participants had a broader variety of solutions they wanted to see, but most agreed lowering costs, especially for vision and dental, was an important focus.

Discussion

- A member thanked Venice for the presentation and noted that most clinicians would completely agree that trust is foundational to patient relationships and primary care.

However, clinicians are often held accountable, and measured on, patient satisfaction rather than trust. How can we tell the story of trust, and how that is linked to outcomes? How do we push to measure trust, so that becomes more of a focus than satisfaction? Many clinicians see those as different things, and patient satisfaction doesn't adequately capture the importance and centrality of trust, as was illustrated in the research findings. In their practice, the member noted they lead by asking a patient what they need to be able to trust them, and it doesn't lead to the same answer across the board- "what is it that helps you establish or helps you feel comfortable or feel like you can trust me and I can trust you?" This has come up in some of our community conversations, and even just asking about it often causes people to open up- oh my gosh, you value me enough to even ask me that question in the first place, I think I can trust you, let's have a conversation, right. And after that you can start to unpack satisfaction as it relates to a visit and care received, but most often, people just want to feel seen. And when you ask them questions about what it is that is important to them, that helps them and makes them feel seen. The member questioned whether and how, at a system and policy level, we can push toward the idea that we need to pay attention to trust rather than just paying attention to satisfaction. Patient surveys often include questions like "did your doctor ask you about urinary incontinence), but a better question would be "did your doctor do something to make you trust them".

    - Venice agreed with this comment, noting that it would likely be an uphill battle to change the how and what we ask patients, but is nevertheless an important shift. Having conversations about trust is incredibly important- putting a measurement in place will require re-envisioning how and what we assess in terms of patient experience (not just satisfaction).

- Tara Smith asked Venice about the low percentage of responses that indicated utilizing primary care both for chronic disease management and for behavioral or mental health issues. She noted that many PCPRC members have increasingly seen a high number of patients, in both family practice and pediatrics, presenting and being treated in primary care settings.
    - Venice noted that US of Care was also curious about the response for behavioral health services, as they thought it would be higher, and was interested in doing additional research around chronic disease. She wondered if rephrasing the question, to ask about chronic disease management during a routine physical exam, rather than separating them out, might have led to a different response. She also noted that if the number of people completing the survey didn't have chronic diseases, that might also skew the numbers.

- A meeting participant appreciated the findings and discussion related to Gen Z, but expressed concern about the primary care landscape for pediatrics, particularly as

there potentially be less and less funding for pediatric residency training. He asked if US of Care had any thoughts about how the pediatric landscape might shift, based on some of their research, and where it might go in the future.

- Venice noted that the US of Care has not looked at the pediatric population in depth in the past. A lot of their research starts with young adults (ages 18-21) and asks about how they are transitioning into adulthood and interacting with the health care system as an adult, particularly if they are going to college or rolling off their parent's insurance. So, pediatrics is a great point to consider in the future- it has not been a focus to date but would be an area for rich qualitative research.

Employer/Purchaser Engagement in Primary Care

Tara Smith introduced Raymond Tsai, the Vice President of Advanced Primary Care for the Purchaser Business Group on Health (PBGH), to offer his insights on purchaser goals and needs around primary care, and potential strategies to engage employers in the PCPRC's work. Highlights from the presentation/discussion included:

- PBGH is a nonprofit collaborative of 40 jumbo purchasers of health care, which includes private employers and public agencies that collectively spend about $350 billion to purchase health care services for 21 million Americans and their families
  - PBGH has been coming together as an organization for about 35 years, to advance quality, drive affordability, and foster health equity;
  - As the health care landscape has changed over time, so have PBGH's strategies, but the membership has remained committed to coming together as purchasers of health care that have a fiduciary responsibility towards purchasing health services for their workers and their families or members, or for some of the public purchasers, what can they be doing to be better and to be more responsible fiduciaries, or to just improve the health care system?

- Primary care has been one of the top priorities of PBGH, and Dr. Tsai (a family medicine physician with an interest in clinical informatics) joined over two years ago to help them think through how to "save" primary care;
  - PBGH members came together to develop a definition of advanced primary care, which focuses on whole person care and includes not just medical care, but also social determinants and ancillary services such as integrated behavioral health, nutrition, physical therapy or physical wellness - all of the things we know both prevent and health treat chronic disease.

Discussion

- A meeting participant shared her experience as a practice manager for two independent practices in Colorado for the last 15 years, and the challenges associated with not only providing care for patients, but also being a small employer, and offering insurance to practice employees. She reflected on her struggles as a small employer, in terms of affording health insurance, and wondered how that played out for really large employers, where the costs would be exponentially larger. The previous presentation highlighted the importance of cost and affordability from a patient perspective, but that is also true for small employers- what does that look like for large employers?
    - Dr. Tsai noted that affordability is a huge issue for PBGH, not just for employers, but for employees as well, because employer costs ultimately do affect employees. The cost of health care affects employees in a multi-pronged way, in terms of premiums, copays, and deductibles, but also in terms of wages, because money that could go to wages is instead going to health care. But we know investing in primary care actually lowers costs, and that is what PBGH is trying to advance.
    - Prior to joining PBGH staff, Dr. Tsai noted that he worked for a member company in California, an agricultural producer that wanted to approach care for their employees differently. The company conducted an employee screening in 2014 and found that 50% of their employees had pre-diabetes, and another 12% on top of that had diabetes that was not well controlled. In looking at what they were already paying for health care, and the poor results of that spending (i.e., two-thirds of their workers still had some sort of glucose intolerance), they decided to take a new approach and focused on investing more in primary care, as the right thing to do. By building out a robust type of primary care - which wasn't based off fee-for-service, allowed more time patients, included ancillary services such as nutrition, physical wellness, and integrated behavioral health, and was mindful in making specialist referrals - the company was able to cut pre-diabetes in half (from 50% to 24%). So, when we talk about trying to use primary care to prevent disease and keeping people within primary care as much as we can, we know that it works.
    - Tying that experience back to the question about cost- we didn't build out the primary care system for the company because of costs, we did it because it was the right thing to do. But costs did go down- the total cost of care went down 20% when I left the company two years ago. At a recent meeting, they reported last year's results, and they cut costs by 30% compared to groups that don't have this type of robust primary care. So, when we think about costs overall, with jumbo employers and particularly those that are PBGH members, we know investment in primary care does reduce costs. It might not be immediate, but the investment is very much worth it- we have a lot of companies that are

initially investing in primary care because it is the right thing to do but then are also realizing cost savings on the back end.

- A member, a pediatrician who has worked in rural and urban Colorado, appreciated the comment that prevention is key to lowering costs, and asked if/how PBGH was talking to members about paying for preventive care in pediatrics. Is there a framing for employers that it is important to pay not just for whole person care but for whole family care, and that pediatrics is important to be able to realize cost savings long-term.
    - Dr. Tsai appreciated the question and noted that pediatrics wasn't often raised as an issue by members- but felt they would generally be on board with and supportive of paying for good, comprehensive, preventive care on the pediatric side. He wondered if the member had a specific example or data that show pediatrics is not a priority?
    - The member noted that it is generally very challenging to get paid for certain pediatric services, such as pediatric behavioral health, preventive and screening services (e.g., developmental screening), in a primary care practice. Many of the things we do for pediatric prevention and screening and early intervention are sometimes hard to get covered and to prioritize, so in thinking about employer engagement overall, are there ways we can ensure pediatrics is part of the conversation.
    - Dr. Tsai reflected that many employers, especially in PBGH, think about pediatrics in the same way that they think about adults- in that the primary goal/need is to get rid of fee-for-service payment. Fee-for-service doesn't pay adequately for primary care overall, and so PBGH has been working with members on direct contracting for primary care, so that providers receive almost like a per patient per month (PMPM) type fee over the course of a year, whether you see that patient or not. You are paying for outcomes, rather than the nitty gritty of how you get to those outcomes.
        - In Seattle, PBGH was able to bring 3 employers together - Boeing, eBay, and a member that prefers to stay unnamed outside of membership - to start paying a PMPM fee, a direct primary care model, with the caveat that the companies were upfront in setting the expectation they were paying more because they wanted to pay primary care more, and with that increased payment, they expected additional services, including whole person care (integrated behavioral health, etc.).
    - The member agreed that PMPM payments are important to support primary care but noted that pediatric PMPMs tend to be undervalued in the context of risk stratifications. Pediatric care costs more because we are delivering care, but you don't see the high risk that you are actually saving money on- for example, in pediatrics we get a $3.50 PMP for care coordination, and the

family practices are getting a $4.50 PMPM. In light of that challenge, how can we convey that the work of pediatric primary care prevention is just as important as chronic disease risk stratification and management?
    - Dr. Tsai felt that employers are with you, and generally supportive of pediatric care, but there may be a few steps in between that are diluting what pediatric practices are seeing. Overall, PBGH is aligned with supporting care delivery through PMPM payments, rather than FFS, and we are talking about a PMPM not of $4.50, we are talking about a $100 PMPM which includes everything, including care.

- Another member asked what would be at the top of PBGH's policy wish list, in terms of changes at the state or federal level, and what on that list would be specific to primary care?
    - Dr. Tsai indicated that PBGH is currently very focused on giving employers the ability to pay for primary care through monthly PMPM payments, rather than fee-for-service, and removing barriers to that type of payment structure, for both patients and employers; put another way, PBGH is very in favor of direct primary care, and enabling that type of arrangement;
    - The One Big Beautiful Bill includes provisions related to direct primary care, and PBGH has been working hard to have that language included, even though there are other parts of the bill that we don't like as much- but we are working to include things that will promote primary care;
        - Allowing employers and others to use direct primary care arrangements, and how this interacts with high-deductible health plans (HDHPs) is a specific component that employers are tracking;
        - Overall, our employers do not want primary care to be included as part of the deductible for HDHPs, they would much rather promote the utilization of primary care by allowing such expenses to be exempt.

- Another member asked if PBGH members were interested in or engaging in individual coverage health reimbursement arrangements (ICHRAs), and how that concept supports (or doesn't support) your model of reimbursement (direct primary care)? Do those work together, or is there some potential conflict?
    - Dr. Tsai declined to answer this question, noting that ICHRAs can be controversial among PBGH's members, and that overall, PBGH is more on the side of preserving ERISA insurance.

- Tara Smith noted a high degree of alignment between PBGH's work and that of the PCPRC- both are interested in saving primary care, are focused on improving patient outcomes, have similar definitions of advanced primary care, and want to shift payment away from FFS. How can the PCPRC capitalize on the synergy, and build out a

comprehensive and market-wide strategy as a state? Alignment around provider reimbursement mechanisms is important, but infrastructure investment is also needed, and something that would benefit employers and other payers- and could be framed as a win-win that could bring them to the table. What sort of "on ramps", or engagement strategies, do you think could be helpful?

- Dr. Tsai agreed the dream would certainly be to have all payers - public, private, and purchasers - come together, and that is the work to be done in such a disjointed system. He suggested two strategies: first, aligning on definitions; and second, leveraging purchasers to force the hand of health plans.
  - In terms of definitions, aligning on measures and definitions sends a strong signal to the market- this is where we are moving, and you either join or get out of the way. Employers are very good at disruption, in a positive way- they can present the threat that they are going to move on their own unless people listen. A good example of that is in the Seattle Puget Sound market, where, with the direct contracting of Boeing, eBay and a third purchaser, the health systems and other traditional players in the healthcare space are now taking note, and engaging with PBGH, because now that Boeing and eBay and this third employer have made that first move, it becomes a credible threat that they may lose business if they don't adjust and start implementing advanced primary care delivery models. The more we align on these definitions, and all send these same signals, the more the market will slowly move in that direction.
  - In terms of purchasers forcing the hand of health plans, Dr. Tsai noted California has seen success in this area. For example, the City and County of San Francisco saw what Boeing was doing in Washington State, and went to their third-party administrator (TPA), Blue Shield of California, and said we want this type of advanced primary care for our members. So, the City and County worked with PBGH, and other large public purchasers, to push for this type of care, and force Blue Shield of California into incorporating the model. And the threat of losing that business in turn helps spur the types of infrastructure investments that are needed. To provide integrated care as part of primary care, a practice needs to hire behavioral health staff, which requires upfront costs, and reimbursement that allows it to be sustainable. Those upfront costs can be barriers, but employers can push payers to make it happen. And in the end, the health plans will likely be pleasantly surprised at the results- which is the case with Blue Shield of California- we just don't have permission to release them yet.

- A member appreciated the examples of employers working with health plans to drive innovation in primary care and asked whether PBGH members had any concerns about the potential encroachment of state regulations on ERISA plans. They noted that nationally, and in some other states, they were aware of legislation that tried to apply certain mandates to ERISA and wondered if PBGH members were concerned this would stifle innovation.
    - Dr. Tsai said he was not aware of any instances where this was happening- ERISA plans are regulated by the Department of Labor, and there are preemption laws- and he wasn't aware of any member concerns on this front. If state regulations would come into play for ERISA plans, that would definitely limit employer innovation, as they would have to navigate 50 different sets of results to bring anything to scale nationally, especially for the jumbo national employers. But due to ERISA preemption laws, it isn't something on their minds.

- In closing, Dr. Tsai noted that employers can be strong allies in building support for primary care and have been active with PBGH in working on language to support primary care and direct primary care in the One Big Beautiful Bill. He felt there was a lot of space to work with employers around primary care, and he was happy to continue conversations about how to engage with them, and how they can support, within the confines of their operations.

Coordination with practice transformation

Tara Smith next introduced Allyson Gottsman, with the Practice Innovation Program and the University of Colorado Department of Family Medicine, to provide an update on practice transformation efforts currently underway in the state, and to get PCPRC feedback on the best mechanisms for ongoing coordination and collaboration. Key points from the presentation and discussion included:

- To level-set, Allyson briefly reviewed the practice transformation infrastructure in Colorado, which has resulted from Colorado's tremendous history and culture of collaborating across organizations to do the right thing for patients and providers. Our state has an entity called the Colorado Health Extension System (CHES), which is built around the agricultural extension system paradigm and serves as an educational knowledge dissemination instrument.
    - CHES is a very loosely organized infrastructure of practice transformation organizations operating in the state, which have come together voluntarily to coordinate efforts to support primary care, behavioral health, and in some instances work with specialists.

- Currently, CHES has over 20 members, including clinically integrated networks, Regional Accountable Entities (RAEs), some health plans, Colorado Community Health Network (federally qualified health centers), and rural health centers.
- CHES has aligned around the Bodenheimer Building Blocks as a way to organize practice transformation support services offered by various organizations in Colorado for over a decade. With some notable exceptions, we know most practices benefit from facilitation when transitioning to new care delivery models and payment systems, rather than trying to figure it out on their own;
- In addition to practice transformation organizations, CHES has also brought in the Regional Health Connector network to help primary care practices access community supports that help address health-related social needs.
- CHES is convened by the Practice Innovation Program, but the real power is in collaboration, and the commitment of members that have set competition aside and come together to share best practices and do the right thing.

- Late last year, two federal initiatives were coming together that would have bolstered Colorado's existing practice transformation infrastructure. The first was a funding opportunity put forward by the Agency for Healthcare, Research and Quality (AHRQ), and the second was Making Care Primary (MCP), a Centers for Medicare and Medicaid Innovation model.
  - The AHRQ grant would have allowed CHES to expand its capacity as a multi-stakeholder conveyor and would have provided some actual funding to continue practice transformation.
  - Making Care Primary was an opportunity to engage payers in primary care transformation and would have complemented the AHRQ work- as we know that to achieve system reform, we need both delivery system redesign and compensation and payment reform.

- Both initiatives have been ended by the Trump Administration, which is disappointing, but the goodwill, the infrastructure, the willingness and the culture to collaborate and do the right thing for Coloradans in terms of improving their health and health care is still there. As CHES is considering next steps, we wanted to get the Collaborative's ideas on how we can continue to move forward with both payment reform and practice transformation, to get a better idea of how CHES can best contribute. Two immediate vehicles that could be leveraged include:
  - CHES currently has a contract with HCFP to provide training and support for the Regional Accountable Entities (RAEs) to move ACC 3.0 forward, specifically as it relates to preparing practices to deliver care differently and to succeed in value-based payment. With HCPF's permission, we could potentially expand training opportunities to all of the practice transformation organizations in the state under the CHES umbrella. Making professional development available to

all facilitators who work with practices - in terms of supporting practices to think with a culturally, systemically, and operationally different mindset - would benefit HCFP, commercial payers, and the state. To move toward a $100 PMPM payment, as mentioned by Raymond, would be phenomenal for primary care, but the delivery system has to be ready to take that on, and right now it is not. Expanding HCPF's current work in support of ACC 3.0 more globally would be an opportunity to continue to move transformation efforts forward.

- CHES had put together a multi-stakeholder convening proposal as part of its application to the AHRQ grant fund, and in doing so conducted extensive outreach to state agencies, payers, employers, practice transformation organizations, and public health. All entities expressed a willingness to align, and develop a broader, statewide infrastructure to support primary care, which would allow for economies of scale, and break down silos so we are moving forward in an orchestrated fashion. The AHRQ funding would have allowed CHES to pursue that, with a defined set of deliverables, expectations, reporting, etc. And while the grant is not moving forward, the work still can, and it is still the right thing to do.

- In closing, Allyson asked PCPRC members for their feedback on opportunities they see to leverage existing infrastructure and bring delivery system redesign together with payment reform.
  - Tara Smith noted two immediate considerations for PCPRC members to think about/comment on:
    - The core competencies included as part of the Division's aligned primary care payment parameters (set forth in regulation 4-2-92) are based on ongoing practice transformation work in the state, which has been championed by CHES, and built out under previous demonstration models, in particular the State Innovation Model. So, as we are moving forward, an important question is how we are getting dynamic feedback on that framework, from payers, from PCPRC members, and from providers and practice transformation organizations that are seeing what is happening on the ground. Right now, per statute, the Division will be conducting an annual review- but establishing mechanisms so that it is a dynamic and ongoing conversation, and the Division is getting the key feedback it needs to understand how those competencies may evolve and change, which is going to be important.
    - In terms of the broader multi-stakeholder table, the PCPRC has expressed interest in developing a comprehensive, statewide primary care strategy that would necessarily involve engagement with the entities that CHES included in the AHRQ grant application. If this is still

an interest, how can we be levering and building off that and other existing work in the state?

Discussion

- A member thanked Allyson for all of the Practice Innovation Program's work and echoed the disappointment about the change in federal direction. The member noted transformation support is incredibly important for practices that are in the early stages of adopting new care delivery models and shifting to value-based payments, and that includes a lot of pediatric practices. As we have heard today, investing in primary care is the right thing to do- it's important for patients and their families, and it decreases costs of care. And while providers are on board with it being the right thing, it is really challenging to engage them to do the work when they don't have time protected to come to collaboratives and participate in training. One of the key reasons SIM was helpful was that it paid money to provide time for practices to get technical assistance. The member supported the idea of moving forward with a comprehensive primary care strategy and felt it should be at the front and center of the primary care work we are doing as a state.
    - Allyson appreciated this comment and noted that while many people on the PCPRC meeting didn't need to be convinced of the value of transformation, the Practice Innovation Program does have data from a recent program that provided transformation support using the Bodenheimer Building Blocks and showed significant savings for Medicaid, both initially and over a two-year period. To the degree that data helps build the case- and it would be great to see the employer data that Raymond referenced- we can show we are on solid ground.

- A meeting participant, who ran two independent practices in Western Colorado, echoed the previous comment about the importance of financial and technical support for practices to be successful in care delivery and payment reform. Money is important to keep doors open, but it also takes time to train staff, and having facilitation (guidance, resources) is also very helpful and important. These challenges are even more acute in rural areas- and are compounded by payer reporting requirements and trying to manage multiple systems of reimbursement (FFS, different payment models for different payers). These pressures often lead practices to join larger systems, which have that infrastructure. So, the question of what to do next, and how we can continue to move care delivery and payment reform forward, without funding for practice, is a tough one. The model and system have to change- the demands of managing multiple payment models are burning providers out, and additional requirements such as prior authorization are adding moral injury- we are seeing providers leave the field or not wanting to enter it. We need systems change- and in that process, facilitation and assistance for practices is crucial.

- A PCPRC member seconded the previous comments, noting that the current system is broken, and systemic change is one half of the battle- but having a way to connect people working on the same thing, so you can spread knowledge and practice very quickly, is also necessary to advance and maintain change. It can sometimes seem overwhelming, in the face of systemic challenges.

In wrapping up the speaker/presentation section of the agenda, Tara Smith put forward some discussion questions, related to presentations and data in general, for members to reflect on for future conversations.

In regard to the US of Care presentation on patient perceptions of primary care:

- What surprised you about the data?
- Interest in continued monitoring in Colorado? If so, how?
    - Colorado Health Access Survey
- How does the patient perspective fit into the development of a comprehensive primary care strategy?
    - Who/how do we need to engage stakeholders?
- How does the patient perspective factor into the tools we have around payment/care delivery?
    - Aligned payment parameters

In regard to the removal of federal data sets:

- What datasets, if any, do you currently access?
    - Behavioral Risk Factor Surveillance System (BRFSS)
    - Youth Risk Behavior Survey (YBRS)
    - CDC AtlasPlus – surveillance data for HIV, viral hepatitis, STD, TB
    - Area Health Resource Files
    - Social Vulnerability Index
    - Environmental Justice Index
- What are you most concerned about?
    - Immediate impacts?
    - Long-term?

Federal & state updates

The following federal updates were provided:

- **Vaccine Updates** - HHS Secretary Kennedy recently removed all sitting members of the CDC's Advisory Committee on Immunization Practices (ACIP), under the justification of "prioritizing the restoration of public trust above any specific pro- or anti-vaccine agenda."
    - HHS' press release noted that the 17 ACIP members who were removed were all nominated by the Biden administration, with 13 of the nominations happening in the last year. This meant the Trump Administration would not be able to install a majority of members until 2028.
    - Secretary Kennedy has named 8 new members, and the previously planned ACIP meeting in late Jun (6/26-6/27) is still scheduled to occur.

Discussion:

- Tara Smith mentioned the Colorado law that was passed which gave the Division authority to adopt rules related to preventive services coverage if the USPSTF, ACIP, or HRSA guidelines are repealed, modified, or otherwise no longer in effect. The adopted rules may require compliance with the federal guidance in effect as of January 2025, or with recommendations of the Nurse-Physician Advisory Task Force for Colorado Health Care (NPATCH). A member asked about the NPATCH process, and when those meetings were being held- Tara did not immediately know but said she could update the group at a future meeting. Another member commented that the NAPTCH process would not start until there was a ruling in the court case challenging the USPSTF, which was slated sometime in July. Tara Smith said she would do some follow-up research, and report back to the group.

- **CMS Oversight Announcements** - CMS recently issued two letters announcing increased oversight of the activities:
    - Oversight Initiative on Hospitals Performing Experimental Sex Trait Modification Procedures - A letter was sent to select hospitals on May 28 outlining urgent concerns with quality standards adherence and profits related to pediatric sex trait modification procedures.
    - Increasing Oversight on States Illegally Using Federal Funding for Health Care for Illegal Immigrants - A letter was sent to states on May 27 announcing the ramp up of financial oversight "across the board" to identify and stop improper spending.

- **Healthcare Price Transparency** - The U.S. Departments of Labor, HHS, and Treasury released a Request for Information (RFI) on how to improve prescription drug price transparency. The Departments also issued updated guidance for health plans and issuers to eliminate meaningless or duplicative data, and to make cost information easier for consumers to understand and use. New guidance was also issued requiring

hospitals to post actual prices of items and services, not estimates (in conjunction, CMS issued an RFI on how to boost hospital compliance and enforcement).

- **CMMI Model Updates** -CMMI has issued the following announcements regarding existing models:
  - Kidney Care First (KCF) - model will be ending one year early, on 12/31/25;
  - Comprehensive Kidney Care Contracting (CKCC) - model will be extended by one year; changes to the model include reducing quarterly capitation payments, and eliminating bonuses for successful transplants;
  - REACH ACO - changes will be made to the REACH model, including narrowing risk corridors in the global risk option, and increasing the quality withhold.

- **Budget reconciliation** – the following updates were provided on the ongoing budget reconciliation process:
  - On May 22, the House passed a reconciliation bill, which is now with the Senate; the Senate is now reviewing, and may propose changes;
  - The entire bill will also be reviewed under the Congressional Budget Act guardrails (including the Byrd rule) in the Senate;
  - Current estimates indicate approximately 16 million people may lose coverage due to a combination of the expiration of enhanced premium tax credits (4.2 million people), Marketplace and Medicaid proposed in the reconciliation package (10.9 million people), and the proposed Marketplace Integrity rule (900,000 people);
    - The projected rise in the uninsured rate, to 12.4% by 2023, would be the largest and fastest in US history, and would erase almost three-quarters of the decline in the uninsured rate since the ACA's main coverage provisions took effect at the start of 2014.

- Attorney General lawsuits - Since January 2025, Colorado Attorney General Phil Weiser has joined at least 20 lawsuits against the Trump administration (for an updated list, see slide 42, available **here**);

- Upcoming primary care webinars/events:
  - CMS Quality Conference - July 1-2, 2025;
    - Register (in-person or virtual) here;
  - NASEM Standing Committee on Primary Care
    - Recording of May 29-30 open meeting available here.

The following state updates were provided:

- Final legislative session updates

- Final veto count = 11; in addition to the bills discussed at the May PCPRC meeting, the Governor vetoed the following bills:
  - HB25-1088 Costs for Ground Ambulance Services
  - HB25-1026 Repeal Copayment for Dept of Corrections Inmate Health Care
  - HB25-1220 Regulation of Medical Nutrition Therapy
- The Governor also issued signing statements on bills related to health insurance benefits, expressing concerns about premium impacts.

- Dept of Health Care Policy and Financing (HCPF) updates
  - Accountable Care Collaborative Phase 3 launches on July 1, 2025
  - HCPF is hosting a series of Integrated Care Sustainability Policy webinars
    - Policy training sessions will be held on June 20
    - Additional information available here.

- Division of Insurance (DOI) updates
  - DOI recently issued a press release warning about the projected impacts of federal actions (and inactions) on the health care marketplace in Colorado, including:
    - The end of enhanced premium tax credits and provisions in the reconciliation bill are estimated to be at least to as many as 110,000 Coloradans losing health insurance access;
    - In addition, the state will lose an estimated $100 million in federal "pass through" money, which funds affordability programs (reinsurance, state premium assistance, and OmniSalud)
    - Due to reductions in the reinsurance program, health insurance premiums in 2026 are estimated to increase by 7% along the Front Range, and as much as 16% in rural Colorado;
    - If Congress fails to extend the tax credits alright, net premiums could increase on average by 104% for Coloradans that receive them.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith requests approval of April and May meeting minutes;

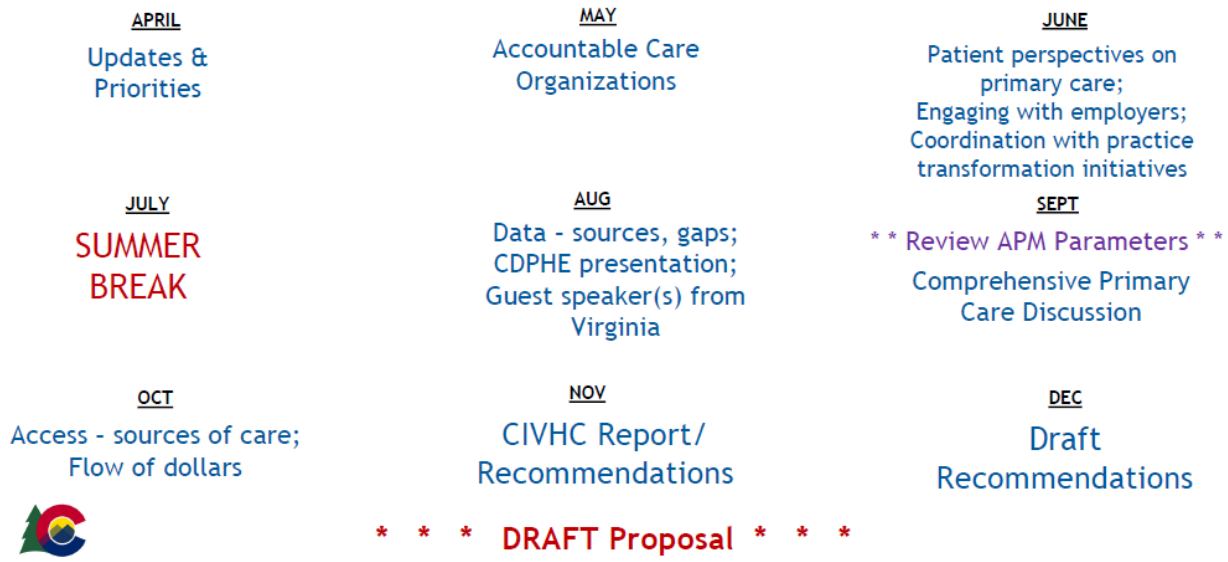
  ACTION ITEM:
  - Meeting minutes for April and May were approved and will be posted on the PCPRC website as final.

- **PCPRC membership update** - Tara Smith provided the following membership updates:

- The Division has reached out to members regarding their current terms, to determine interest in continuing/extending or winding down/ending their service; members are asked to respond to the Division (by contacting Tara Smith at tara.smith@state.co.us or 720-701-0081) by the end of June;
- The role of the "chair" or "co-chair" of the PCPRC, as currently defined in the PCPRC's Standard Operating Procedures, was briefly reviewed; members were invited to put forth nominations for the chair or co-chair role, which will be presented at the July meeting.

ACTION ITEMS:

- Members should reach out to Tara Smith by the end of June regarding their terms on the PCPRC;
- Members should send nominations for PCPRC Chair or Co-Chair position to Tara Smith.



Public comment:

- No public comments were offered.