COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, August 14, 2025; 10:00 - 12:00 pm

Meeting Attendance

Attended
Josh Benn
Steve Holloway
Rajendra Kadari
Cassie Littler
Amanda Massey
Erin McCreary
Kevin McFatridge
Dana Pepper
Amy Scanlan
Mannat Singh

DOI
Tara Smith
Jill Mullen
Matt Voss

Absent
Polly Anderson
Britta Fuglevand
Kate Hayes/Jack Teter
Lauren Hughes
Alex Hulst
Patrick Gordon
John Hannigan
Sonja Madera
Gretchen Stasica

Guest speakers
Laryn Walker
Judy Zerzan

Agenda:

1. Welcome & introductions
2. Virginia Primary Care Task Force
3. Washington State Primary Care Transformation
4. Colorado Health Systems Directory
5. Federal & State Announcements
6. Housekeeping & Announcements
7. Public Comment

Welcome & Introductions:

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

Virginia Primary Care Task Force

Tara Smith introduced Lauryn Walker, the Chief Strategy Office at the Virginia Center for Health Innovation (VCHI), to discuss Virginia's initiatives related to primary care (see slides 5-16, available here). Highlights from the presentation:

- The Virginia Task Force on Primary Care is a public-private partnership model, run by the Virginia Center for Health Innovation (VCHI), a nonprofit, working on behalf of the state, but not for the state;
    - The Task Force on Primary Care was established in 2020, and currently has 31 members; member terms are renewed annually, with some who have been with the task force since the beginning vs others who joined just recently; the group focuses on having representation from different groups, and is chaired & cochaired by 1 payer and 1 clinician;
    - The Task Force meets quarterly, and sets up committees as they are needed; the first committee established was the data & analytics committee, but now that it's been established, the task force is used to vet the materials it puts out, and to vote on consensus recommendations;

- Key focus areas of the Task Force on Primary Care include:
    - Clinician retention: AMA Joy in Healthcare; AI & tech learning collaborative; integrated care learning collaborative;
    - Payment policy: enhanced Medicaid rates, integrated behavioral health alternative payment pilot, primary care spend target;
    - Research: primary care investment report, primary care scorecard, surveys on payments and burnout, Launch Research Consortium: meant to inform and monitor the big picture, holistically for the state rather than at one payer; and
    - Clinical care: AI & technology learning collaborative, integrated care toolkit, person-centered primary care measure, PPE distribution during pandemic, immunization panel data pilot;
        - The AI learning collaborative was created to help identify key pieces of literature, consolidate information into useful buckets, and match people who are using AI to think about how to best use AI, for each particular solution- where they felt like they were getting the most value;

- The responsibilities of the Virginia Task Force on Primary Care fall into 6 broad categories, which are applicable to other state task forces or entities focused on primary care (see Milbank brief Defining the State Role in Primary Care Reform):
    - Define the current state of primary care: using data analytics, definitions, and research (i.e., the primary care scorecard and reports on spend);

- Build a coalition: using a public-private partnership model, to bring in payers, clinicians, etc.;
- Identify policy options: landscape review and stakeholder input (Ie Tool based on HHS issue brief): "what exists out there", a menu;
- Establish consensus priorities: leverage the power of consensus in a coalition: i.e. primary care spend threshold;
- Identify a policy champion: define ownership (executive v legislative, federal vs state), use data to identify impacted populations; and
- Provide an accountability structure: monitor execution of recommendations and related policies (i.e. legislative/ budget trackers), with both public and private resources;

- Early VA Task Force on Primary Care activities were focused on building trust and gaining momentum, and it was important to name early wins; key accomplishments in the early phases of the work included:
  - Distributing PPE and antigen tests during the COVID pandemic, to build trust;
  - Increase Medicaid payment rates by 10% - the payment piece is hardest part to get momentum on, so broke that up into smaller parts, starting with a Medicaid increase;
  - Established a consensus definition of primary care, to get movement and buy-in;
  - Published baseline spending reports and a scorecard; and
  - Conducted surveys and RFIs on clinician burnout and payment models;

- Current initiatives & pilots include:
  - Immutrack - this pilot was designed to provide panel-level vaccination data to practices, but has been paused due to a loss of CDC funding;
  - Person-Centered Primary Care Measure - In partnership with VCU and the American Board of Family Medicine, VA is evaluating the person-centered primary care measure with over 1,000 clinicians;
    - A PCPRC member noted in chat that most payers are not using the PCPCM measure in their network;
  - Joy in Healthcare - this initiative is testing well-being for clinicians, and systemic ways of making joy part of the practice of primary care;
  - Primary Pathways - this is a multi-payer initiative to expand and support pediatric practices in integrating behavioral health into their daily practice; it provides infrastructure investments and hybrid payments, and creates a tiered approach to integrating care (all practices have now achieved the highest tier); the pilot is a partnership with 2 Medicaid MCOs and 33 practices, and include 17,000 children enrolled in Medicaid;

- Current Committees & Partnerships include:
    - Current committees include:
        - Establishing learning collaborative for AI & Technology and Integrated Care;
        - Continue research on primary care spend and cost growth targets;
        - Begin collecting and analyzing non-claims-based payments - Virginia doesn't currently have data on non-claims-based payments, and is currently working with the legislature to try to start collecting;
        - Mating Primary Care Innovation Hub as a centralized source of primary care news, legislative actions, and data inventory
        - Established consensus recommendations for policy recommendations and SFY 2026 workplan;
    - Virginia is also establishing a research consortium, using grant funding from the Robert Wood Johnson Foundation and start-up funds from the Governor and Virginia General Assembly; they have executed a contract to access health data from EPIC to better understand what is really happening in a primary care visit.

- Reports authored by the VA Primary Care Task Force include:
    - An annual report on primary care investment, which does not include non-claims-based information, but shows trends over time, and looks at Medicaid and commercial payers, to show what is happening in terms of spending;
    - A primary care scorecard, which is updated annually; this scorecard has typically focused on spend, workforce, primary care use, and outcome; this year a section on patient experience has been pulled, due to a lack of federal data sources, but the Task Force is re-looking at data to include a measure next year;
    - Other resources and tools, such as a Medicare and Medicaid cost comparison tool.

- VA Primary Care Task Force Recommendations for State Fiscal Year 2026 include:
    - Medicaid rate should be paid at parity with Medicare rates for primary care services;
    - Require health plans to submit non-claims-based payments to VA Health Information using the NAHDO format and incorporate data into APCD; and
    - Require Dept of Medical Assistance Services to pursue federal match for research and Task Force funding to: 1) conduct a marketplace assessment of primary care; 2) review structure alternatives for percentage-based primary care spend targets; 3) conduct review of cost growth targets alongside primary care spend targets; and 4) identify additional payment models that could be deployed in Virginia.

- Virginia is hosting a Primary Care Summit on October 8, 2025, from 8:30-5 pm in Richmond for all interested stakeholders, to examine challenges in primary care and collaborate on actionable strategies.

Discussion

- A meeting participant asked via chat about the impact OBBBA might have on any of Virginia's planned/existing work, such as pilot projects;
    - Lauryn noted the VCHI is actively thinking about what federal funds will still be available, and how they can be leveraged; the state is also considering how to administer the federal match dollars they do receive, and/or may pursue, as well as questions around how to use partnerships with MCOs for a pilot they have right now, what enhanced benefits they're thinking about, scaling pilots to what is feasible; overall, it is a matter of reckoning with the uncertainty to make sure not to grow too fast;

- A meeting participant asked for additional information about the behavioral health pilot for kids, and how outcomes were being measured;
    - The pilot is called the Primary PAC Phase Pilot, and it has started working with 2 of the 5 Medicaid MCOs, one national and one regional, to represent the challenges of multi-payer alignment;
    - A pediatric model across continuum of integrated care, with 3-tiered approach:
        - 1st tier is for small independent practices who haven't done behavioral health screeners, just about requirements to set up the data infrastructure: buy a license, integrate into HR, connect to state HIE;
        - 2nd tier is a care-management approach to follow up on referrals, build partnerships with community behavioral health providers;
        - 3rd tier is having integrated behavioral health provider employed by practice;
    - A broad set of pediatric practices are provided with upfront seed money, with per member per month fee-for-service on top of that, for every member differing by tier;
    - For payment purposes, practices send documentation each quarter to demonstrate how they are meeting the tier requirements, but money is tied only to whether they are meeting those requirement- it is not tied to performance measures or patient outcomes; an evaluation is being conducted right now looking at patient outcomes, but it is not tied to money- it is just gathering information on whether the pilot is working, if it should be continued, and if so how it could be scaled;

- Tara Smith asked if VCHI and/or other organizations had ideas or strategies for conducting a landscape assessment of primary care in Virginia;

- Lauryn noted that Virginia Commonwealth University has started such a project, looking at claims data to assess how it looks in systems vs in independent practices; who might be in a health system; they are also starting to talk to researchers who have been in private equity space, to understand what types of entities are out there; looking at survey approach done by Massachusetts;
- Even in pilots, they are finding that practices are merging, and it is all happening very quickly; it shows the importance of looking at the pediatric space; with fewer health systems, who are more independent or IPA, to try and think through what these arrangements really look like. It also shows the importance of combining powers, both with outside partners and how collaboratives in other states can work together.

Washington State Primary Care Transformation

Tara Smith next introduced Judy Zeran, the Chief Medical Officer at the Washington State Health Care Authority for the last 7 years (prior to that was in Colorado), to discuss various Washington State initiatives related to primary care (see slides XX-XX, available **here**). Highlights from the presentation:

- The Washington State Health Care Authority is the state's largest health care purchaser, for about 3 million residents, mostly through Medicaid but also covering public employees and school employees; it is also the single state authority for behavioral health;

- Washington's 'Primary Care Transformation Initiative' has been in place for a while, and includes the following components:
  - What: to strengthen primary care through aligned payment methodologies, increased investment, and care delivery transformation;
  - How: in collaboration with Washington health care providers, employers, health insurance purchasers, subject-matter experts, and other partners;
  - Goal: to achieve the quadruple aim of enhancing patient experience, improving population health, reducing costs, and improving the work life of providers;

- Washington began the current primary care trajectory by convening payers, providers and patients to come up with a Washington Primary Care Transformation Model, which looked a lot like the Making Care Primary model developed by CMMI; Washington was another state that had been selected to participate in MCP, and was excited to Medicare fee-for-service join the payer table- renamed the PC Transformation Model to the PC Transformation Initiative to reflect action;

    - Now that MCP is not moving forward, that momentum is lost, but the work is still ongoing;
    - One of the biggest impacts of MCP is the loss of funds that were going to practices; without that support, it will be challenging to move forward;

- The WA PC Transformation Initiative includes roles/components across multiple actors and entities:
    - Employers and Purchasers - align contractual expectations for carriers or directly contracted providers; Washington was able to bring employers together, and they did say they wanted primary care;
    - State - administer the Primary Care Practice Recognition Program, and align HCA programs under the PC Transformation Initiative;
    - Insurance Carriers and other payers - align plan offerings (what they do for quality measures, types of payments, practice supports, etc.); design and implement advanced provider payment models;
    - The activities of these 3 groups (employers/purchasers, state, insurance carriers/others payers) all funnel into collaboration domains: performance and quality expectations, infrastructure supports and financing, practice supports, and payment model transformation;
    - Practices to participate in provider recognition program, participate in payment models, progress through practice accountabilities;
    - Practice Accountabilities: what we want primary care practices to advance on: level 1 is anyone that comes in, level 2 is in middle, and level 3 is advanced primary care
    - Turning into transformation goals, which include: 1) better outcomes for patients; 2) improved costs over time; 3) improved experience for patients and providers;

- The Primary Care Transformation Model is similar to Making Care Primary in structure, and includes 3 tiers:
    - Level 1: fee-for-service, upfront infrastructure investment, quality incentives;
    - Level 2: transitional APMs moving toward prospective payment: watching as they are trying to avoid risk; a little less infrastructure investment but more quality incentives;
    - Level 3: prospective payments, with some even larger quality incentives;

- Discussions around the WA Primary Care Transformation Initiative date back to 2019-2020, see slide XX here for a complete timeline;

- WA HCA is using a multi-pronged strategy to advance primary care work that includes:

  - Aligning payment model and quality measures across payers, designed to reduce provider burden, which is accomplished through a Multi-Payer Collaborative and purchaser support;
  - Establish clear criteria for provider readiness and identify areas where support is needed, which is provided through a Primary Care Practice Recognition Program; and
  - Increasing investment in primary care, which is accomplished by measuring, publishing, and incentivizing an increase in primary care expenditures;

- Primary Care Practice Recognition Program - this is a voluntary program (which borrows from work done by Oregon);
  - HCA partnered with payers and providers to define characteristics of high-quality primary care practices, across 3 tiers or levels of recognition;
  - A pilot program was conducted in Seattle with 10 practices; practices received a practice facilitator, and all were able to move up at least one level (some went up 2), making progress within a reasonable amount of time (1-1.5 years);

- Aligned primary care measure set - HCA developed an aligned measure set, similar to what California and Massachusetts have done;
  - WA borrowed from MA's implementation guide, adopting a core set and alternative measures - the measures focus on achieving outcomes together (across payers), and cover kids and adults, acute chronic disease and behavioral health;

- In terms of primary care expenditures, WA passed legislation in 2022 (SB5589), which established a goal of spending 12% of total health care expenditures on primary care;
  - A committee was formed to establish a technical definition of primary care, including both claims and non-claims-based services;
    - Define primary care by the person delivering the care and the place of rendering; so, a relatively narrow definition;
    - Currently waiting to get reporting under the new definition- previous measurements showed between 4-6%;
  - Committee and a cost board in WA also came up with 2 policy recommendations for the goal of how much primary care expenditures should increase per year-
    - Increase Medicaid reimbursement rates for primary care to no less than 100% of Medicare;
    - Increase PCE ratio by minimum 1%, up to 2%
  - Neither recommendation was adopted by the legislature this past year, and likely will not be this year;

  - A bill was passed that will require the DOI, starting next year, to measure any increases in primary care spending as part of annual rate review process;

- WA has a voluntary Multi-Payer Collaborative with 10 participating health plans, including the HCA and CMS;
  - The MCP is focused on collaboration and alignment; in 2024, participating payers signed a Memorandum of Understanding in a ceremony at the Capitol, pledging their commitment to alternative payment policies and to aligning with Making Care Primary;
  - Participating payers have also engaged with providers through learning cohorts, which have allowed for payer/provider conversations around pain points (e.g., payers had questions about why practices weren't using data, providers were able to explain that the data wasn't good); it has been helpful to bring people together in targeted ways for discussions;
  - MPC has also supported the Primary Care Practice Recognition Program;

- WA has also had challenges engaging purchasers, but was able to lean on PBGH and a local group, the Washington Health Alliance, that includes purchasers and payers; also reached out to organizations that already had a relationship with HCA, including King County, SEIU 775 (caregivers, CNAs), and the Washington Health Exchange;
  - Have intermittently engaged larger companies like Amazon, Microsoft and Boeing; this group also did an MOU with purchasers, and have been working with PBGH to get others back to the table, but it is a slow-moving process;

- Challenges and areas of opportunity in Washington State:
  - State budget deficit - even before federal changes WA was facing a $16 billion budget deficit that needs to be addressed this year; this was the reason that increased reimbursements for primary care didn't happen this year;
  - Policy shifts are also happening at federal and state level; WA has a new Governor, and HCA has a new agency director, so will need to see what course new leadership charts;
  - Still working to improve measurement- non-claims-based data won't be included in the figures released this year, but the newly created definition will now provide direction for a baseline;

- WA is continuing to move forward, and things on the future horizon include:
  - Creating a provider forum to match the MPC and purchaser groups;
  - Primary Care Practice Recognition Program was launched this year, and update has so far been slow- implemented in about 20 practices;

    - Leaning in on the plans encouraging contracting, but one challenge has been addressing the why - the budget is tight, so it is a harder sell for practices in terms of what will really change;

- Health Care Payment and Learning Action Network Update - Dr. Zerzan is one of four co-chairs for the HCPLAN, which has been around a long time as part of CMMI; after a period of relative inactivity, the LAN has relaunched with a new strategy
    - The first Executive Forum meeting was last week, and review 4 focus areas:
        - Tech-enabled health care - an area of interest for Trump Administration;
        - Evidence-based prevention - how to scale primary, secondary, tertiary prevention, what sort of initiatives have to happen, with lifestyle changes;
        - Patient empowerment - tools for how to motivate patients to be engaged in their health care, and make good, informed decisions
        - Choice and competition - opportunities and barriers to participation in alternative payment models
    - Tech-enabled health care workgroup has already started convening, the other 3 will be rolled out this fall;
    - The "A" is for action in HCPLAN but has been less so the past 3 years; the new refresh focused on doing things quickly, and what sort of steps to take to start to move the needle in these areas.

Discussion

- A meeting participant asked whether the "evidence-based prevention" work group will focus on immunizations, noting that CMMI's website touches on vaccines as "great primary prevention";
    - Dr. Zerzan wasn't sure how much immunizations will be part of the evidence-based prevention work stream;

- A member asked about the number of primary care providers in Washington who are independent, rather than salaried, or the % of them;
    - Dr. Zerzan didn't know the exact number, but noted it has gotten smaller in the last year, with the loss of 7 or 8 practices;
    - The member reflected a similar experience in Colorado, and expressed concern at the implications this trend has for the way APMs can be structured, and the challenges it presents for data sharing
    - Dr. Zerzan agreed, but did say it was an area where plans were willing to invest- they see the value of independents, and making sure more aren't getting sucked into larger systems; the Collaborative in Washington has been talking a lot lately about how to help independent practices hang on;

        - She also noted that Southern CA is doing interesting work to focus a data platform on independent primary care practices, a project that PBGH is involved with and launched a few months ago (and is similar to what Colorado tried to do during the Comprehensive Primary Care model) (PBBH involved) (similar to what CO tried to do during CPC);
    - The member also expressed concerns with Boeing and Amazon's evolution to employer models, and taking payers out of the equation where they can;
        - Dr. Zerzan agreed, noting Boeing and Amazon are still on that path, and Seattle is one of the markets in which they are active. In the midst of a lot of conversations about the employer purchaser model, including a recent speech by Linda Brady (a Boeing executive) highlighting the need for primary care, HCA is trying not to get off-track in its work, which is focused on moving everyone forward, not just those few who may already be there. Companies are also interested in what HCA is doing- they need and want more primary care and can't buy direct primary care if it's not there. So, we have similar goals at the end of the day but are going about it differently. It has been very intentional not to break people off from this effort.

- Tara Smith asked about the Provider Recognition Program, and the process of developing and implementing the framework. She noted Colorado has also created aligned measures and core competencies, but are in the initial stages of implementation, and are working to establish processes for reviewing and updating the standards. She wondered if WA had any experiences or best practices in this area.
    - Dr. Zerzan indicated that clinicians were involved in the development of the recognition framework over a year and a half process; with recent stressors, HCA does not have plans to adopt it yet. She noted Washington had borrowed from Oregon, which has now expanded their program to 7 levels, and has kept advancing, with additional steps for everyone. She did not immediately know how Oregon had changed or updated their model over time- but Washington is currently incorporating some of Oregon's steps into their 3 levels. It is a balance- HCA doesn't want to move the finish line on everyone but still believes there is room for improvement in the 10 competencies.
    - Tara Smith appreciated this information and noted that it was heartening to hear that action was going to be coming out of the LAN in the future.

Colorado Health Systems Directory

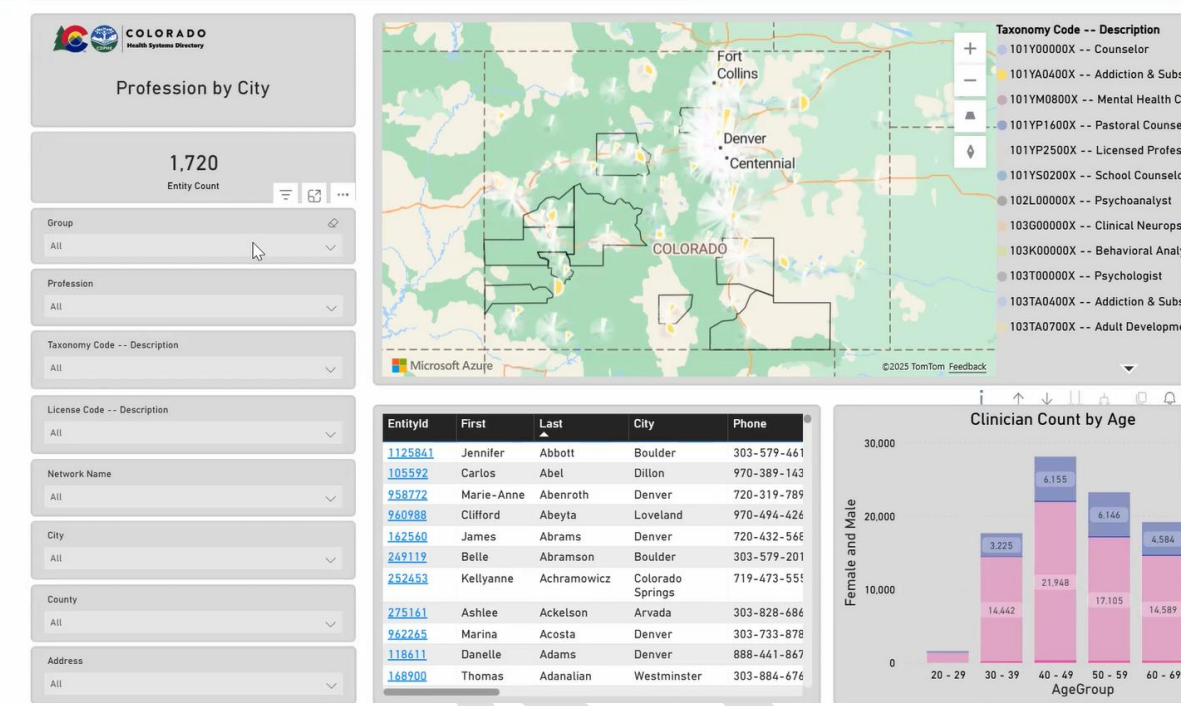
Tara Smith next introduced PCPRC member Steve Holloway, the Primary Care Director of the Health Access Branch at the Colorado Department of Public Health and Environment, to

present data from the Health Systems Directory. Key points from the presentation and discussion included:

- The Health Access Branch in CDPHE is charged with performing workforce analysis, with a heavy emphasis on primary care;
    - Conduct work related to health-related shortage areas (HRSA) at the federal level;
    - Have built a large dataset and a range of tools to provide analysis at state level, which is relevant to policy makers who are thinking at much higher scales than just practice-level policy; a relationship between what happens at higher level policy and what takes place that the practice;

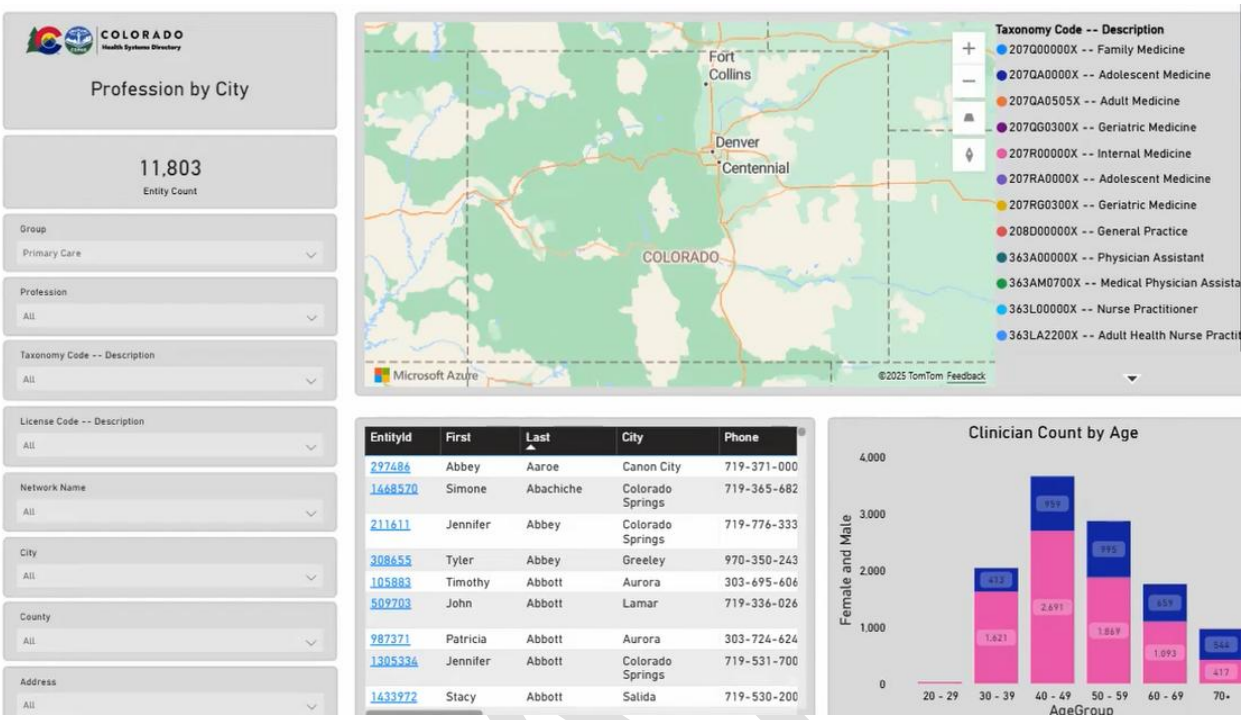
- Colorado Health Systems Directory (CHSD) is a project CDPHE has been working on for 10 years;
    - After a decade have built a powerful tool for the core use cases of the Office of Primary Care, but also has applications across state government and with external partners;
    - The Directory has also generated a lot of national interest, from some of the PEW charitable trusts, Wellbeing Trust, Academy Health, and Milbank;

- The CHSD allows for the construction of visualizations, based on 40 million rows of data, associated with payer (data source is DOI), locations of care (from multiple data sources including the Secretary of State and National Provider Identifiers), and individual clinicians;
    - There are currently around 240,000 clinicians in Colorado with some sort of a license;
    - 30 million rows of data are aggregated over about 7 years for a composite record for health activities going on in the state;
    - Visualizations will be available within a few months- today's demonstration is in beta mode;



- Clinicians are identified by National Provider Identifiers (NPI), a system which is supported by NPES, and includes over 1,200 individual provider taxonomy types, which have a broad range of specializations and sub-specializations;

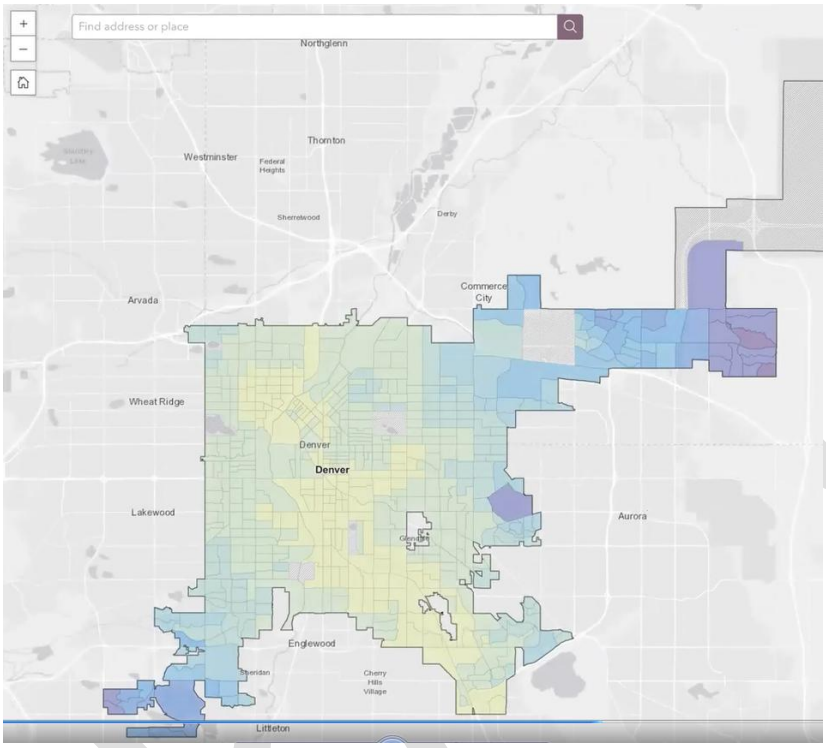
- If a user wants to visualize a provider type, such as primary care, they can select that as a "Group" type and see various characteristics/distributions;
    - In addition to a list of the entities, graphics also show taxonomy types, geographic distribution, age and gender distribution, etc.;
        - Looking at primary care taxonomies: adolescent medicine intentionally listed twice, with internal division between physicians and PAs;
        - Can see that for primary care, for clinicians still in practice over the age of 70, the majority are male, but as you go younger, the workforce is becoming more female;
        - Intuition holds that rural clinicians are older than our urban clinicians- this analysis confirms that;



- The entity count shows the number of licensed clinicians in the state- currently there are just under 12,000 licensed clinicians in Colorado with a primary care taxonomy;
    - In the final version of the visualizations, in each municipality in the state where there is a current practicing clinician, a pie chart will render on top that is a split of all the taxonomies located in that community;
    - The pie chart is interactive, so you can see which clinicians are in primary care, what their taxonomies are, what their age distribution is, and the specific contact information for each;

- The CHSD is also being used for the newest iteration of an analysis of state health professional shortage areas (sHPSAs); federal health professional shortage areas, which are used as a primary declaration of need for workforce investment by the federal government; the landscape for that type of investment is changing dramatically right as we speak;
    - Effort to create a state analysis was both an attempt to have a counterpoint to federal methodologies that are over 40 years old, and to but also to apply certain analytic techniques that reveal much greater resolution on the access to care needs in Colorado;
    - These data and map presentations will soon be available on CDPHE's website for anyone to use; have available for dental health, behavioral health and prenatal care;

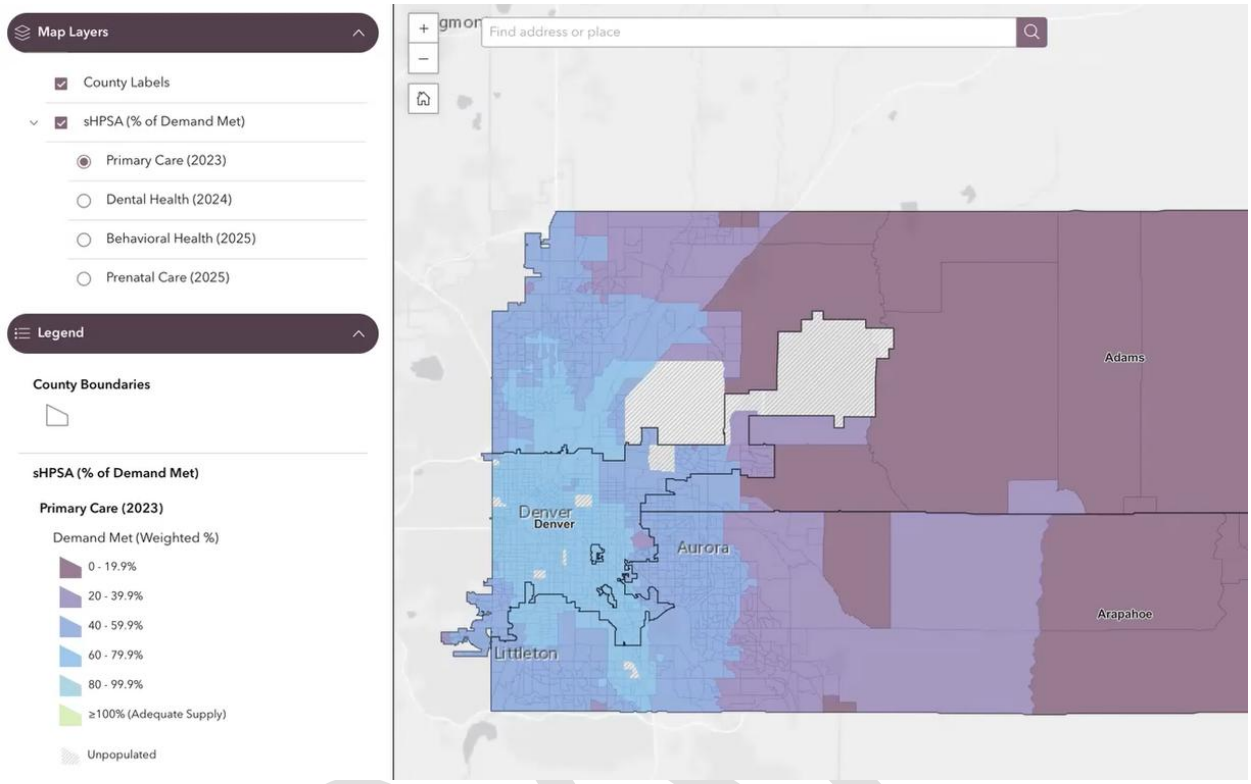
- State is broken up into 4,100 census block groups, which are individually analyzed for access to care; run a supply and demand model down to the community;
- Using Denver as an example, it allows analysis at the neighborhood level;



- Legend contains 10 color-coded, which are 10 groups where we have analyzed supply and demand for primary health services
  - Demand is estimated at 2.54 visits per person per year (data pulled from Medical Expenditure Panel Survey); further stratify according to age and sex (knowing demand for care increases as we age, and women of child-bearing age need more care);
  - Supply side conducted through Health System Directory- estimates made based on 40 million rows of data; recently added additional analysis from the APCD; also use data collected through individual clinician surveys (Office of Primary Care sends 2-page survey every 2 years, share with other state partners to reduce the number of asks on physicians);
- Green means the access is the best or highest (pairing of supply and demand is closest together), and purple means the worst or lowest;
  - Access is often closely associated with the affluence of a neighborhood, but also the geographical grouping of medical care services;

        - Map shows SE half of city where most affluent residents live, transportation is good, and there are many medical office buildings in that corridor;
        - In SW corner, near Sheridan and Ft Logan, or in far NE of city, access tends to decline;
    - Can add adjacent counties to get an idea of what happens on the margins of the city; by adding in Aurora, see a reduction in access as move farther east;
        - Deciles are essential in understanding the allocation of resources; if we were to invest in more access by building services, and have two potential sites where that investment might be made, can apply this analysis, quickly down to the address level, to help determine which community should receive a priority;
    - Another feature of map- can click on a census block group and get additional data relevant to local planning (i.e., local safety net clinic, an insurer can look at network sufficiency)
        - Can see shortage designation information, and a social deprivation index (added based on World Health Organization work, which the Robert Graham Center did additional refinement for use in the U.S.);
            - The social deprivation index is an Index of key social determinants that are correlated with primary care access;
            - Selected social deprivation index because it has greater specificity for analyzing relative access to care for primary health services than the social vulnerability index (larger, more comprehensive index);
    - Currently have 2023 data, hoping to have 2025 data posted within the next month; may see changes, as 2023 may include data influenced by COVID;

- Also organized the data in a slightly different way that may be simpler to understand for a lay audience - a percentage demand met model;
    - Excluded all census block groups that have met or exceeded the primary care supply; divided the remainder into 5 groups, and represented them as a percentage of total demand met;
    - A five-step model instead of a 10-step model, excluding those areas that are currently empty; gives reasonable information to quickly communicate which areas of our communities are most in need of primary care investment;



- The Office of Primary Care has another group of analyses that look at primary care claims data and demonstrates service areas based on claims volume; an analysis of over 2 billion claims- can potentially be shared at a future meeting;

Discussion

- Multiple members expressed appreciation for the presentation, and enthusiasm for seeing future analyses. One member asked if the maps were publicly available;
    - Steve noted the first map is not planned for the public web, but it is sharable with anyone with a public interest use case.
    - The second map is now available at: https://cdphe.colorado.gov/prevention-and-wellness/health-access/health-workforce-planning-and-assessment/health-professional

Before moving into a discussion of federal and state updates, Tara Smith asked members for any thoughts or general reactions to today's grouping of presentations and seeing where members wanted to go in terms of next steps, thinking forward to report recommendations. She noted that earlier this year, the group had expressed interest in developing a comprehensive statewide primary care strategy. In looking at the Collaborative's work to date, and in the group's statutory charge, it has primarily been focused in the payment lane, looking at increased investment through value-based payments. and investment lane. Looking

at the Virginia model, it is more comprehensive - incorporating workforce, access/utilization, research - and includes a couple of bodies of work: first related to data, measurement, and the creation of dashboard; and second related to relationship building- who needs to be at the table, what are strategies for outreach to different actors in the state. If members were still interested in pursuing a strategy, and the multiple components that would be involved, the Division will likely need to start outreach in the near future.

Discussion

- A member expressed appreciation for the presentations and felt the level of detail and the quality of the speakers was excellent. They noted that data continues to be an area of focus and a priority- both in the presentations today, and in thinking overall about what we need to be successful in our work- and would be an important topic for future discussions. Colorado is lucky to have data like the Colorado Health Systems Directory, but we also have gaps, and we have areas where more analyses or at least a discussion about how we are collecting and analyzing data would be useful. We continue to have data, and hear "we have data", but the analysis and use is lacking. Doing a deeper dive and following up on some of the data issues/themes from the speakers today.
    - Tara Smith asked if members were interested in focusing on Colorado data, or national data (such as the sources used by other states for scorecards), or both- and what would be some of the uses that members had in mind?
    - A member noted some of their interests were around benchmarking, how we are making comparisons, and what we think about some of the national databases, and how they are used- having a more uniform approach to that helps us advocate and understand what is possible.

Federal & state updates

The following federal updates were provided:

- **H.R. 1 - "One Big Beautiful Bill" Act (OBBBA)** - H.R. 1 was signed into law by President Trump and includes provisions that represent the largest cuts to the health care safety net in modern history, and "the biggest rollback in federal support for health care coverage ever". The law has major implications both nationwide and for the state of Colorado, which are summarized on the following slides (available here):
    - Overall - see slide 20;
    - ACA marketplace provisions - see slides 21-23;
    - Medicaid provisions - see slides 24-27;
    - Other provisions - see slide 28;

- **HHS Actions** - Additional actions taken by HHS include:

- **Personal Responsibility & Work Opportunity Reconciliation Act of 1996 (PWORA)** - HHS formally rescinded a 1998 interpretation of PWORA that "improperly extended certain public benefits to illegal aliens"; the new interpretation adds a number of programs to a revised list of "federal public benefits programs" that are now reserved exclusively for American citizens, including Head Start, federally funded health centers, mental health and substance use disorder treatment programs and block grants, Title X family planning programs (and 9 others); Democratic Attorneys General from 20 states and the District of Columbia have filed a suit to stop the new interpretation, and HHS has agreed to stay enforcement and application through September 10, 2025.
- **US Preventive Services Task Force** - HHS Secretary Kennedy has announced that he is "reviewing" firing current members of the USPSTF. Over 100 organizations have opposed this action and are urging lawmakers to ensure the task force's integrity.
- **Vaccines** - HHS has cancelled 22 research projects, including $500 million in grants supporting the development of mRNA vaccines. In addition, multiple medical groups have been barred from working on the CDC's panel of vaccine advisers.
- **Ending 1115 waivers for continuous eligibility** - A letter was sent to Medicaid Directors on July 17 announcing CMS does not anticipate approving new or extending existing 1115 demonstration authority for expanded continuous eligibility.
- **Health information technology** - Recent actions by CMS related to health information technology include:
  - CMS recently announced a "Make Health Tech Great Again" partnership with private sector companies including Amazon, Apple, Google, OpenAI, and Anthropic; the initiative will focus on promoting the CMS interoperability framework and improving data sharing between patients and providers;
  - Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator (ONC) released the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefits and Electronic Prior Authorization Final Rule (HTI-4); the rule enables the use of certified EHRs to submit prior authorizations, select drugs consistent with a patient's insurance coverage, and exchange electronic prescription information with pharmacies and insurance plans.

- **Federal rules** - CMS recently released several payment rules, one proposed, and two final:

  - **Proposed CY 2026 Physician Fee Schedule Rule** - the proposed CY 2026 Physician Fee Schedule rule contains several provisions related to primary care, including:
    - Optional add-on codes for Advanced Primary Care Management (APCM) services to facilitate behavioral health integration or Collaborative Care Model services;
    - Separate conversion factors for qualifying APM participants and non-qualifying participants; and
    - Updating the process for efficiency adjustments, shifting away from AMA survey data to a methodology based on the Medicare Economic Index (MEI) productivity adjustment percentage;
  - **Final payment rules** - HHS released three final payment rules for Inpatient Rehab Facilities, Inpatient Psychiatric Facilities, and Hospices; all three rules include payment rate increases (2.6%, 2.5%, and 2.6% respectively, and remove certain quality measures and social determinant of health data elements.

- **CMMI and HCP LAN** - CMMI has announced three new models:
  - **Ambulatory Specialty Model (ASM)** - ASM is a proposed mandatory model focused on specialty care for people with heart failure and low back pain; the goal of the model is to improve upstream chronic condition management and coordination between primary care providers and specialists;
  - **Wasteful and Inappropriate Service Reduction Model (WISeR)** - this model will test whether enhanced technologies, including AI, can expedite prior authorization processes for items and services deemed vulnerable to fraud, waste, abuse, or inappropriate use;
  - **Cell and Gene Therapy Access Model (CGT)** - this model presents a new approach to treating sickle cell diseases in Medicaid beneficiaries and will take place in 33 states and the District of Columbia.
  - The Health Care Payment and Learning Action Network (HCPLAN) has also announced a strategy update, focusing on four new initiatives: 1) health care choice and competition; 2) patient empowerment; 3) preventive care; and 4) technology-enabled health. HCPLAN also announced it will discontinue its APM measurement effort and will explore alternative pathways to advance the availability and reduce the cost of key data needed to improve care.

- **Attorney General lawsuits** - Since January 2025, Colorado Attorney General Phil Weiser has joined at least 33 lawsuits against the Trump administration (for an updated list, see slide 33, available here).

The following state updates were provided:

- **Special Session to address state budget** - Governor Polis has issued a call for a special session to address the state budget crisis created by the passage of H.R.1. The session will start on August 21, 2025, and per the Governor's call (in Executive Order D 2025 009), will be limited to the following four areas:
    - **Fiscal** - tax-related policies to address revenue shortfalls and insufficiencies;
    - **Health care** - policies to address federal actions to end Medicaid funding of Planned Parenthood clinic, and to find potential solutions to fund Health Insurance Affordability (HIAE) programs to address premium increases and coverage losses;
    - **Food security** - policies to address the Healthy School Meals for all Program and SNAP funding; and
    - **Artificial intelligence** - policies to address the fiscal and implementation challenges raised by SB25-205.

- **Health insurance premium increases for Plan Year 2026** - On June 10, the Division of Insurance issued a press release warning about the projected impacts of federal actions (and inactions) on the health care marketplace in Colorado, including the failure to extend the enhance premium tax credits (ePTC), which are set to expire on December 31, 2025; on July 16, the DOI issued a second press release, announcing that carriers are requesting a statewide average 28% increase in premiums for plan year 2026; the impacts and implications of this projected increase are detailed on slides 25-40, available here.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith announced that June meeting minutes will be posted shortly and approved at the September PCPRC meeting.

- **PCPRC Co-Chair update** - Tara Smith announced that the Division received two nominations for PCPRC Co-Chairs: Cassie Littler and Raj Kadari. Members will vote on their appointments at the September meeting.

- **Schedule update** - Tara Smith briefly reviewed the upcoming schedule for Collaborative meetings and noted that the annual review of APM parameters is currently scheduled to take place at the September meeting. She noted that members might want to instead use the September meeting to discuss federal and state events in greater depth, and to have time for discussion of the content of presentations at the June and August meetings. The Division will make a decision on the agenda in the next few weeks and announce the date for the parameter review with enough time for stakeholders to be notified.

APRIL Updates & Priorities	**MAY** Accountable Care Organizations	**JUNE** Patient perspectives on primary care; Engaging with employers; Coordination with practice transformation initiatives
JULY SUMMER BREAK	**AUG** Data - sources, gaps; CDPHE presentation; Guest speaker(s) from Virginia	**SEPT** * * Review APM Parameters * * Comprehensive Primary Care Discussion
OCT Access - sources of care; Flow of dollars	**NOV** CIVHC Report/ Recommendations	**DEC** Draft Recommendations

* * * DRAFT Proposal * * *

- **New member update** - Tara Smith briefly welcomed Mannat Singh as a new member to the Collaborative. Mannat is the Executive Director of the Colorado Consumer Health Initiative and will be filling the consumer representative seat vacated by Isabel Cruz. Welcome Manatt!!

Public comment:

- No public comments were offered.