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Colorado's Primary Care Payment Reform Collaborative

SEVENTH ANNUAL RECOMMENDATIONS REPORT

February 15, 2026

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Acknowledgements

Special thanks to the members of the Primary Care Payment Reform Collaborative who devoted many hours to developing the findings and recommendations presented in this report:

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Executive Summary

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

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Colorado's Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative was established by House Bill 19-1233 (HB19-1233). It works to develop recommendations and strategies for payment system reforms to reduce health care costs by increasing the use of primary care. Colorado has been an early leader in primary care payment reform among states. When the Collaborative was established in 2019, Colorado was one of only a handful of states engaged in strategies to increase investment in primary care. Now, more than 20 states are focusing on primary care, through a range of activities including measuring and reporting on primary care, setting spending targets, and establishing primary care task forces.

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The Collaborative is tasked with the following:

- **Recommend** a definition of primary care to the Insurance Commissioner.
- **Advise** in the development of broad-based affordability standards and targets for commercial payer investment in primary care.
- **Coordinate** with the Colorado All Payer Claims Database to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado's Medicaid program), and Child Health Plan Plus (CHP+).
- **Partner** with the Department of Health Care Policy and Financing to align primary care quality models with the Collaborative's recommendations through the Accountable Care Collaborative and other alternative payment models.

- **Report** on current health insurer practices and methods of reimbursement that direct greater resources and investment toward health care innovation and care improvement in primary care.
- **Identify** barriers to the adoption of alternative payment models by health insurers and providers and develop recommendations to address these barriers.
- **Develop** recommendations to increase the use of alternative payment models that are not fee-for-service in order to:
    - Increase investment in advanced primary care models;
    - Align primary care reimbursement models across payers; and
    - Direct investment toward higher-value primary care services with the aim of reducing health disparities.
- **Consider** how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care.
- **Develop** and share best practices and technical assistance with health insurers and consumers.

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

The Collaborative reached the findings and recommendations in this report through a process of iterative discussion. The Collaborative held 10 meetings in 2025. All Collaborative meetings are open to the public, with meeting times and locations posted in advance on the Collaborative's website. Time for public comments is reserved during each meeting. Past meeting materials and reports are also available on the website.

DOI selects members of the Collaborative through an open application process. Each serves a one-year term with the opportunity for reappointment, for a maximum of three years (the Collaborative's Standard Operating Procedures and Rules of Order are linked in Appendix A.) Collaborative members represent a diversity of perspectives, including:

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

Introduction and Key Context

Over the last six years, the Collaborative has worked with steadfast resolve to strengthen the primary care system in Colorado. This seventh annual recommendation report, like its predecessors, builds on recommendations from previous years, but also marks a unique moment - both in the history of the Collaborative, and in the health care landscape in Colorado and the United States.

The Collaborative was initially scheduled to sunset on September 1, 2025. In 2024, The Colorado Office of Policy, Research & Regulatory Reform (COPRRR) conducted a sunset review of the Collaborative's activities to date, and found "the Collaborative addresses a range of complex issues and is unique in its ability to bring together a wide variety of stakeholders to address increasing demands on Colorado's primary care network." COPRRR's final report, released on October 15, 2024, recommended that "[g]iven the dynamic nature of ever-evolving alternative payment models and the advisory committee functions performed by the Collaborative, the General Assembly should continue the Collaborative for seven years, until 2032."[1] This recommendation was accepted by state legislators, giving rise to Senate Bill 25-193 (SB25-193), which was passed and signed into law on June 3, 2025. SB25-193 extends the Collaborative through September 1, 2032, and adds language to their existing statutory charge to ensure the unique needs of primary care delivery in pediatrics are considered in discussions of alternative payment models.

This reaffirmation of the Collaborative's work, and the foundational role of primary care in highly functioning health care systems, could not come at a more crucial time. Many of the challenges currently facing primary care - including chronic, decades-long underinvestment; increased administrative burden leading to clinician burnout; an aging and shrinking workforce; the inability of fee-for-service payments to support/sustain advanced primary care delivery - are not new, and will continue to be important priorities for the Collaborative. Yet recent events at the national and state level stand to not only exacerbate and amplify these fissures, but create new and significant threats to the accessibility and affordability of health care.

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H.R. 1, signed into law on July 4, 2025, is fundamentally reshaping the health care landscape in the U.S. Over the next 2-8 years, the law will impose new Medicaid eligibility and coverage provisions, including mandatory work requirements, bi-annual eligibility redeterminations, and cost-sharing for certain members, which are projected to impact hundreds of thousands of Coloradans.[2] The law's elimination of eligibility for certain legal immigrant groups will result in coverage losses for both Medicaid and Medicare enrollees, and restrict premium tax credits available to those enrolled in coverage through Affordable Care Act (ACA) marketplaces. The enactment of H.R. 1's marketplace provisions in future years, such as bans

[1] 2024 Sunset Review Primary Care Payment Reform Collaborative Report, COPRRR
[2] Understanding the Impact of H.R. 1 and Federal Changes to Medicaid, HCPF

on automatic reenrollment and new pre-enrollment verifications, will result in additional coverage losses.

Overall, the Congressional Budget Office estimates H.R. 1 will increase the number of uninsured people in the U.S. by 10 million by 2034; when combined with the expiration of the enhanced premium tax credits, that number rises to more than 14 million.[3] While devastating to impacted individuals and families, these coverage losses will also lead to increased uncompensated care costs, putting critical strain on community health centers, rural hospitals, and other safety net providers. This financial distress will be further compounded by reductions to the state's provider fee, which is used by Colorado Medicaid to provide supplemental payments to hospitals to help cover uncompensated care costs. By fiscal year 2032, Colorado stands to lose $900 million to $2.5 billion annually,[4] directly impacting rural hospitals and some of the state's most vulnerable populations.

These changes in the federal landscape are occurring in the midst of increasing health care affordability challenges in Colorado. Rising health care costs, inflation (both medical and general), workforce shortages, provider consolidation, and increasing drug costs are impacting both private and public insurers.[5] In the private market, these trends, coupled with the Congressional failure to extend enhanced premium tax credits, resulted in an average 101% increase in premiums in 2026 for the approximately 225,000 Coloradans enrolled in Colorado's individual marketplace.[6] The Colorado DOI estimates premium increases will lead to approximately 75,000 Coloradans losing coverage.[7] A poll conducted by KFF in December 2025 found that one in four Americans would consider going without health insurance if their premiums double in 2026.[8]

Over the last decade, the state Medicaid program's General Fund costs have increased by an average of 8.8% a year, more than double the approximate 4.4% tax revenue growth cap allowed by the Colorado Taxpayer Bill of Rights (TABOR).[9] Colorado's need to reduce Medicaid spending to achieve a constitutionally mandated balanced budget is now being exacerbated by reductions in federal funding (and increased administrative burdens) associated with H.R.1.

At a time of shrinking state and federal resources, as insurers and providers are simultaneously experiencing higher costs, higher utilization, and higher need patients, the question of how to support the continued viability of primary care has taken on increased

[3] How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?, KFF, 8.20.25
[4] Understanding the Impact of H.R.1 and Federal Changes to Medicaid, HCPF
[5] How Much and Why ACA Marketplace premiums are going up in 2026, Peterson-KFF Health Systems Tracker, 8.6.25
[6] Congressional Inaction Leads to An Average Doubling of Health Insurance Costs for 225,000 Hardworking Coloradans, DOI Press Release, 10.27.25
[7] Ibid.
[8] 2025 KFF Marketplace Enrollees Survey, KFF 12.4.25
[9] Governor Policy FY 2026-2027 Budget Request Presentation to the Joint Budget Committee, 11.12.25

urgency. Primary care lies at the nexus of health care access and affordability. Research shows that health systems with a strong primary care foundation provide better access to health care, improved health outcomes, enhanced life expectancy, more equity, and lower health care costs.[10,11] Primary care serves as a key point of access into the health care system, and through the provisions of preventive services, care coordination, and chronic disease prevention, can improve both individual patient and population health.[12] Primary care is also the most cost-effective place for health care investment, with evidence pointing to savings of $13 for every $1 invested, and fewer hospitalizations for patients with complex, high-cost conditions.[13,14]

In the face of strong headwinds, the Collaborative reasserts its commitment to its north star goal of increasing investment in primary care to improve patient outcomes, increase health equity, and reduce health care costs. The recommendations in this report are divided into two parts. Part One addresses key issues related to payment, and strategies that are needed to support primary care in the face of reduced resources and increasingly complex market dynamics and disruptions. In Part Two, the Collaborative proposes a framework for the development of a statewide comprehensive primary care strategy, in line with the statutory goal set forth in HB19-1233: "the state of Colorado will achieve more affordable care and better outcomes by consistently measuring and sustaining a system-wide investment in primary care." Such a framework, which connects [payment, workforce, . . .] will create visibility and accountability in building and sustaining a strong primary care infrastructure in Colorado, and ensure primary care remains a central component of state strategies to address access and affordability challenges.

Update on Primary Care and Alternative Payment Model Spending

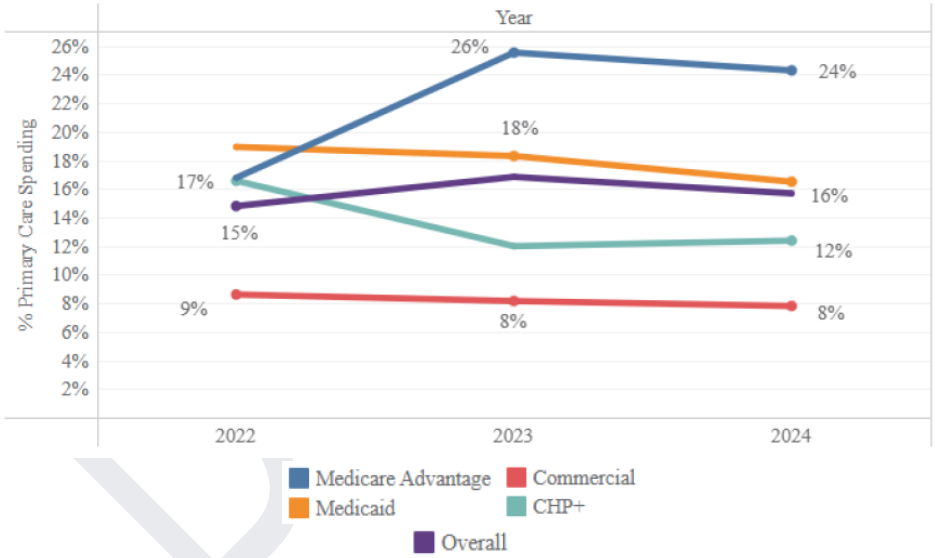
To understand spending on primary care in Colorado and track changes in investment over time, the Collaborative has received annual reports on primary care spending and APM use in Colorado from the Center for Improving Value in Health Care (CIVHC). In November 2025, CIVHC presented the most recent findings of spending based on data from the Colorado All Payer Claims Database (APCD) for calendar years 2022-2024. The Primary Care and Alternative Payment Model Use in Colorado, 2022-2024 report includes an analysis of data reported by commercial, Medicaid, and Medicare Advantage payers. Importantly, the primary care spending data does not include data from self-funded employer plans. Self-funded plans, in

[10] HHS is Taking Action to Strengthen Primary Care, HHS Issue Brief, 11.7.23
[11] The Health of US Primary Care: 2025 Scorecard Report - The Cost of Neglect, Milbank Memorial Fund, 11.18.25
[12] Increasing Primary Care Access to Improve Population Health, National Governors Association, 4.10.25
[13] Using Primary Care's Potential to Improve Health Outcomes, Purchaser Business Group on Health, 10.4.21
[14] The Nation's Biggest Healthcare Challenge, National Association of Community Health Centers, 3.31.25

which employers pay for their employee health claims directly, are estimated to comprise around 50% of what most Coloradans think of as the "insurance market" (coverage that is not obtained through a public source such as Medicaid, Medicare, or the Veterans Administration). These plans are not subject to state regulation and therefore are not required to report data to CIVHC.

Total Primary Care Spending. Key findings from CIVHC data show that primary care spending across all reporting payer types has increased from 14.8% in 2022 to 15.7% in 2024. This is down from a 16.8% peak in 2023. Most payer types reported modest changes in primary care spending between 2023 and 2024 (see Figure 1). Medicare Advantage and Medicaid each reported a two percentage point decrease from 2023 to 2024, from 26% to 24% (Medicare Advantage) and 18% to 16% (Medicaid) respectively, while commercial spending remained steady at approximately 8%. The Child Health Plan Plus (CHP+) reported a slight increase, to 12%, but remains below the 17% reported in 2022.

Figure 1



Value-Based Payment Model Spending. In addition to overall primary care spending, CIVHC reports on the percentage of primary care spending that is funneled through APMs, both as a percentage of total medical expenditures and as a percentage of primary care spending. In 2024, value-based APMs (which, for the purposes of this report, exclude risk-based payments and capitated payments not linked to quality) accounted for 27.5% of total medical spending

and 50.8% of total primary care spending across all reported payer types.[15] This represents a slight decrease from 2023, when payers reported 28.7% of total medical spending and 54.1% of primary care spending flowed through value-based APMs.[16]

Prospective Payments. The Collaborative has consistently recognized the importance of prospective payments to support primary care providers' adoption and delivery of high-quality, advanced primary care. Prospective payments allow greater flexibility to providers to deliver care responsive to their patients' needs. Across all reported payer types in 2024, 47.6% of all medical spending made through APMs was paid on a prospective basis.[17] This figure has decreased slightly since CIVHC began collecting this data in 2021 (from nearly 56% in 2021). Of total primary care spending made through APMs in 2024, 82.2% was paid through APMs, a figure that has remained relatively stable (between 83-84%) over the last three years.

Commented [4]: While this data point is helpful on its own, do we try and add any sort of national comparison here? To suggest where we're at, why this hasn't been changing much, or at least not increasing?

Improving Data Quality. Tracking of primary care and value-based payment model spending is essential for understanding payer investments in primary care. Data from the Colorado APCD provides valuable insights, but certain data challenges remain. Changes in payers' data and accounting systems, and in the individuals or teams responsible for data submissions to CIVHC, make it difficult to compile spending data consistently year-over-year. The complexities and nuances of value-based payment arrangements can also make it difficult to capture and appropriately categorize spending.

This year CIVHC also implemented a new method of categorizing payments for APM submissions. Rather than the Health Care Payment and Learning Action Network (HCP-LAN) categories, payers used the Expanded Non-Claims Payment Framework (or Expanded Framework) to better align the CO APCD APM layout with the Common Data Layout for Non-claim payments (CDL-NCP) to submit data. Many payers reported this change caused them to revisit their previous APMs classifications, and in some instances to make adjustments to more accurately represent the payment mechanisms involved. While such modifications overall serve to improve data quality and integrity, they make it difficult to directly trend investment levels within and across categories over time.

Future Priorities. CIVHC currently does not collect data in a way that allows primary care and APM spending to be broken out by age group; therefore, it is not possible to determine the amount of current spending on children or aging adults. Understanding the flow of resources to patient populations by age group continues to be a priority for the Collaborative and an area of focus for future improvement in data collection. Additional data on the number of self-insured lives and the impact this current gap in reporting has on observed primary care spend continues to be of interest. The Collaborative looks forward to continuing

[15] Certain payers are excluded from the primary care investment requirements of Colorado Regulation 4-2-72, including Kaiser Permanente Colorado and Denver Health, and the figures reported here.
[16] Primary Care Spending and Alternative Payment Model Use in Colorado, 2021-2023
[17] Certain payers are excluded from the primary care investment requirements of Colorado Regulation 4-2-72, including Kaiser Permanente Colorado and Denver Health, and the figures reported here.

work with CIVHC, CDPHE, and other partners to improve and augment primary care spending and other areas of data collection to ensure the data is as timely and actionable as possible.

In its Sixth Annual Report, the Collaborative also expressed an interest in gaining a better understanding of where people in Colorado are receiving primary care, and the impact that market disruptors (such as Amazon One, hims & hers, and others) are having in this space. The recommendations in this year's report highlight a series of specific data questions and needs - related to sources of care, the structure of health care systems that influence the flow of dollars, and other marketplace dynamics - all of which will help not only to contextualize observed changes in primary care spending by commercial, Medicaid, and Medicare Advantage payers, but to gain insight into the impact (or lack thereof) of such spending for those on the front lines of practice.

Recommendations

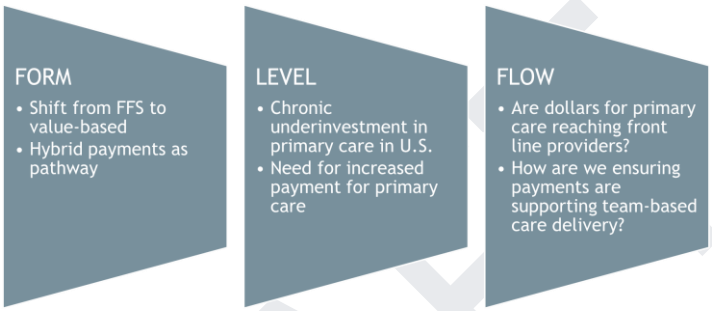
Part 1 - Payment

In their First Annual Report, the Collaborative laid the groundwork for payment strategies that best support advanced primary care delivery by recommending that increased investments in primary care should: 1) be offered primarily through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality; and 2) support providers' adoption of advanced primary care models that build core competencies for whole person care. The Collaborative has built on these core tenants in subsequent reports, offering a series of recommendations related to multi-payer alignment, behavioral health integration, support of care delivery teams, and other key topics. (See Appendix B for a complete list of previous report recommendations). In addition, the Collaborative has distinguished between two important and interrelated dimensions of payment that are needed to support primary care (see recommendations in Third and Fifth Annual Reports). The first involves payments to providers and care teams for care delivery; the second involves investments in the primary care infrastructure, financed through joint, systemic efforts that may include governments, payers, and other stakeholders. Infrastructure investments include workforce development incentives, system transformation initiatives, quality improvement initiatives, interoperable data and broadband access, and other tools needed to deliver high-quality, whole-person and whole-family care.

In this seventh annual report, the Collaborative affirms its north star goal to strengthen Colorado's primary care infrastructure and care delivery system through increased investment and the adoption of APMs that drive value, not volume, and improve health outcomes. Recognizing the impact of shifting market dynamics on primary care practices - including increased consolidation (initially addressed in the Sixth Annual Report) and other market disruptors - the Collaborative's recommendations in this report hone in on three facets of payments: their form, level, and flow (as depicted in Figure 2). The Collaborative also

elevates recommendations related to three groups that face unique challenges with value-based payments: rural providers, pediatric providers and practices, and safety net providers.

Figure 2



Form of Payment

Fee-for-service (FFS) payment structures, which reward distinct services, are incompatible with the complex, complex, and comprehensive care that is the hallmark of advanced primary care delivery.[18] In the 2021 Implementing High-Quality Primary Care Report, the National Academies of Sciences, Engineering, and Medicine (NASEM) identified the need for payment mechanisms that "pay for primary care teams to care for people, not doctors to deliver services" as one of five critical implementation objectives.[19] The Collaborative has consistently stressed the need to move away from FFS advocating for increased investment in primary care to flow through APMs. The recommendations included below offer insights into how these payments can best be structured, to meet the realities of today's health care landscape, and the unique needs of providers that are most threatened by impending resource cuts.

Prospective Payments to Support Care Delivery

The Collaborative continues to support the delivery of comprehensive, whole person and whole family care that improves patient outcomes, payments to primary care teams must be adequate, flexible, and prospective, so that providers and practices can make decisions to best meet the needs of their patients and local communities, in terms of care coordination, education, virtual care, and other services that are needed outside of discrete visits.

[18] The Health of US Primary Care: 2025 Scorecard Report - The Cost of Neglect, Milbank Memorial Fund, 3.18.25
[19] Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, National Academies of Sciences, Engineering, and Medicine, 2021.

Prospective payments and upfront investments are also crucial in allowing practices to build the competencies needed to deliver such care and succeed in value-based payments.

The Collaborative appreciates the annual data provided by CIVHC regarding prospective payments, but notes that the high percentage of payments flowing through primary care APMs seems incongruent with practice experiences on the ground. Collaborative members are also aware that some major health systems are either considering or have made the decision to move away from accepting prospective payments.

Commented [5]: Why? What might this mean/implications for payment more generally?

[What else?]

DATA NEEDS:

- The Collaborative will work with CIVHC to better understand data that carriers are reporting as prospective spending, and potentially explore different methodologies for collecting and analyzing this data.

RECOMMENDATIONS:

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Payer Alignment

Since its inception, the Collaborative has stressed the need for alignment across the various APMs used by payers to support primary care. As noted in the Second Annual Report, providers and practices need common goals and expectations across payers to transform care delivery, and alignment across payers "improves efficiency, increases the potential for change and reduces administrative burden." Based on feedback from the Collaborative and other stakeholders, the DOI implemented a series of aligned parameters for primary care APMs used by commercial payers through Colorado Insurance Regulation 4-2-96 which went into effect on January 1, 2025.[20] In this first year of implementation, it is still too early to tell how the aligned parameters are impacting APM adoption and participation, or whether they are meeting intended goals to increase transparency, reduce administrative burden, and improve health care quality and outcomes. The DOI hosted an annual review of the aligned APM parameters on October 9, 2025, to obtain stakeholder feedback. The Collaborative offered verbal feedback during the meeting; additional written comments are included in Appendix C.

Commented [6]: Is this something you want to include in the report?

While the DOI's regulation applies to commercial payers, the Collaborative recognizes the importance of market-wide alignment, including Medicare and Medicaid. At the time of last year's report, Colorado was one of eight states participating in Making Care Primary, a Center for Medicare and Medicaid Innovation (CMMI) model to enhance access to and quality of primary care services, which provided a key opportunity to include Medicare in the state's

[20] Regulation 4-2-96 applies to fully-insured private health insurance companies marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans in Colorado. Certain provisions do not apply to companies offering managed care plans in which services are primarily offered through one medical group contracted with a nonprofit health maintenance organization.

new primary care model. However, under the Trump Administration the Making Care Primary model was ended early (in September of 2025), a disappointing loss. Yet the Collaborative remains interested in exploring additional avenues for alignment with both Medicare and Medicaid, as well as self-funded employers. Current and future opportunities are highlighted below.

Medicare Advance Primary Care Management (APCM) and Integrated Behavioral Health Codes

In 2025, CMS added Advanced Primary Care Management (APCM) services to Medicare's Physician Fee Schedule, which are a set of codes designed to pay for the resources involved in advanced primary codes. APCM codes are tiered into three levels based on patient complexity[21] and bundle existing care management and communication technology-based service into a single payment that can be billed monthly, relieving providers of the burden of time-based billing requirements for individual services. In the Calendar Year 2026 Physician Fee Schedule Final Rule, CMS finalized the addition of three new behavioral health G-codes (comparable to existing Collaborative Care Model and general behavioral health integration codes) that can be billed as add-on services when the APCM base code is reported by the same practitioner in the same month.

The Collaborative acknowledges the implementation of APCM and the new integrated behavioral health add-on codes, as well as other actions taken in the CY 2026 PFS Final Rule to "rebalance" payments between primary care (time-based) and specialist (largely procedure, non-time-based) services, as an important step towards increased, hybrid payments. With the cancellation of the Making Care Primary model, and in the absence of primary care focused model coming from CMMI, the APCM and behavioral health integration add-on codes offer a potential framework for payer alignment, if adopted by commercial payers and Medicaid.

While the Collaborative is interested in exploring such an opportunity, several key issues will need to be examined:

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

[21] The three APCM codes are based on a patient's medical social complexity and include: Level 1 (G0556): one chronic condition; Level 2 (G0557): two or more chronic conditions; Level 3 (G0558): two or more chronic conditions.

Health First Colorado (Medicaid) Accountable Care Collaborative Phase III

Also in 2025, Colorado's Medicaid program, Health First Colorado, launched a new phase of the Accountable Care Collaborative, the state's primary care delivery system. Known as ACC Phase III, this updated care delivery model was designed to align with the primary care APM parameters set forth in Regulation 4-2-96, but also contains policy and payment provisions designed to address historical barriers to APM participation, and sustained integrated care delivery, that are of interest to Collaborative members.

The first involves payment structures designed to support populations and geographies that have not been able to participate in value-based payment in the past, due to small population size or other factors. Under ACC Phase III, HCPF will provide an Access Stabilization Payment, in the form of a per member payment, to qualifying providers to support the delivery of new services or expand the number of Medicaid members that are served. Providers who are eligible for such payments include: pediatric Primary Care Medical Providers (PCMPs),[22] where more than 80% of members served are 0-18 years old; rural PCMPs that operate in counties classified as rural or counties with 'Extreme Access Considerations'; and small PCMPs, which include independent PCMPs who are operating with 1-5 providers.

In conjunction with the ACC, in 2025 HCPF also implemented an Integrated Care Sustainability Policy to increase access to integrated care services by building a sustainable reimbursement model for primary care providers who are incorporating behavioral health services into their practices. This policy allows PCMPS to bill Health Behavior Assessment and Intervention (HBAI) codes and Collaborative Care Model (CoCM) and receive FFS reimbursement, and requires the Regional Accountable Entities (RAEs) responsible for administering Medicaid's physical and behavioral health benefits to make an integrated care PMPM payment available to Highly Integrated PCMPs.[23]

Unfortunately, due to shortfalls in Colorado's state budget, HCPF has had to walk back a 1.6% provider increase that was in effect on July 1, 2025, which has impacts for providers across the state. Access Stabilization Payments have also been delayed by six months, and planned quality and behavioral health payments have been reduced for the current fiscal year.

The Collaborative nevertheless applauds the innovative payment structures included in ACC Phase III, and is interested in exploring opportunities to expand such approaches more broadly across payers. Such conversations were started during the development of the Integrated Care Sustainability Policy, when HCPF, in partnership with the DOI, reached out to commercial payers to identify potential areas of alignment around the use of codes, PMPM

[22] A PCMP is a primary care provider that is contracted with a Regional Accountable Entity to manage the health care needs of Health First Colorado members. PCMPs must be licensed to practice in Colorado and have an MD, DO, or NP provider license. They must also be licensed in a specialty such as pediatrics, family medicine, internal medicine, obstetrics and gynecology, or geriatrics.

[23] HCPF contractually requires the Regional Accountable Entities (RAEs) responsible for providing care on a regional basis to make the payments to qualifying providers; criteria for Highly Integrated PCMPs are available on HCPF's Integrated Care Sustainability Policy website.

payments, and other design features. Revisiting these discussions, while simultaneously learning lessons and best practices as ACC Phase III is fully implemented, will help ensure solutions to chronic challenges to APM participation - related to practice size, location, and ownership, and payment for behavioral health integration - are implemented on a market-wide scale, maximizing their success and sustainability.

Self-funded employers

[What else?]

DATA NEEDS:

RECOMMENDATIONS:

Rural Providers

Rural providers and communities face unique challenges related to health care access and affordability. Rural areas have 15% fewer primary care clinicians on a population basis than urban and suburban areas, and the current supply of primary care physicians in rural areas is expected to meet only 68% of demand (compared to 74% nationally).[24,25] Geographic distances also pose challenges, which is particularly true for Colorado's approximately 800,000 rural residents (one in 10 people), as mountain roads and inclement weather can make roads impassable. In rural areas transportation options are more limited; only 8% of rural older adults use public transit, and 6% have access to rideshare services (compared to 36% of residents in urban areas).[26] While telehealth offers an opportunity for increased access, obstacles such as limited access to broadband and high-speed internet, and inadequate reimbursement are still barriers; in 2023, only one in five rural residents received primary care via telehealth, compared to the national average of 29%.[27] As a result, rural residents suffer from higher rates of chronic conditions, poorer behavioral health, greater risk of opioid overdoses, and higher mortality than their urban counterparts.[28]

In addition, in the U.S. nearly half of residents in rural areas are uninsured or are covered by public payers; as highlighted in a recent Commonwealth Fund issue brief, "[t]his limited payer mix, coupled with relatively low reimbursement rates and high provision of uncompensated care compared to nonrural areas, poses challenges to the financial stability of rural primary care."[29] Health centers form a central point of access, with rural health centers (RHCs) providing care for nearly one-third of rural residents, and health centers funded by the

[24] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[25] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25
[26] Rural Health Transformation Program, Project Narrative, Colorado Department of Health Care Policy and Financing, November 2025
[27] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25
[28] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[29] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25

federal government caring for 1-in-5 residents.[30] Due to the large role that Medicaid plays in funding health care in rural areas, these communities and providers are likely to be hardest hit by the impending Medicaid cuts imposed by H.R.1. Additional reductions due to state budget issues will only compound the financial strain of rural providers, including community health centers and rural hospitals.

While many components of value-based payments, including upfront infrastructure investments and enhanced reimbursement, could benefit rural providers, in recent years there has been growing recognition that APMs often fail to account for the realities of rural primary care practices. Many are designed for high-service volume areas, and don't work well in rural areas with few patients, fewer specialists, and higher operating costs.[31] But this does not have to be case; as highlighted in the recent Closing the Distance in Primary Care: Evidence, Stories, and Solutions, rural providers are organizations are pursuing a number of innovative strategies to provide high-quality, advanced primary care, including participating in a variety of Accountable Care Organizations (ACOs). CMMI's Pennsylvania Rural Health Model showed some promising results, and the ACO REACH model includes features designed to support the participation of rural providers.

The Collaborative . . . [WHAT GOES HERE]

- Measure primary care spending across payers and across urban and rural geographies, and avoid reductions in Medicaid reimbursement to the greatest extent possible;
- Support RHC, FQHC, and other rural participation in APMs and ACOs;
- Explore the development/formation of CINs in rural areas;
- Advocate for funding for rural primary care workforce education and training.

Commented [7]: These are suggestions from the PCC report on rural primary care- which resonate the most? How should they be built out"

DATA NEEDS:

RECOMMENDATIONS:

Pediatric Providers

The Collaborative has consistently elevated the special considerations and unique needs of pediatric providers related to value-based payments for primary care. Issues related to risk adjustment were highlighted in the Second and Fourth Annual Reports, including the recognition that current risk adjustment models are often developed using standard standard populations that include adults and children that do not translate well to pediatric-only populations, and fail to account for social risks, which are particularly important to predicting

[30] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[31] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25

near-term risk for pediatric populations. Additional considerations around patient attribution, which can be hampered by delays in attributing newborns in pediatric settings, as well as quality measures, and the need for the development and research of additional pediatric measures, were also raised in the Fourth Annual Report. In the Fifth Annual Report, the Collaborative highlighted some of the challenges prospective payments and shared savings models pose for pediatrics practices, due to fluctuations in patient populations.

Medicaid covers approximately 40% of children in Colorado, and more than 40% of births in the state.[32] This makes pediatric providers, and their patients and families, particularly vulnerable to the Medicaid cuts included in H.R.1. As noted by the President of the American Academy of Pediatrics, ""Medicaid is the backbone of how the U.S. health system works for children –from pediatric practices in small, rural towns to children's hospitals in our largest cities. Cutting Medicaid means hospitals and health systems will have fewer resources to support health care for all pediatric patients –including those with private insurance. The result is children in every community will have less access to health care when they need it." Additional provisions in H.R.1 - including work requirements, increased frequency of eligibility requirements, the reduction of retroactive coverage to 60 days, and in particular the end of HCPF's implementation of continuous eligibility for children ages 0-3, are expected to increase churn and reduce coverage. Other actions by the Trump Administration to prohibit evidence-based gender-affirming care for youth and revise vaccine schedules are also impacting pediatricians' ability to deliver high quality, evidence-based, and needed care.

The Collaborative . . . [WHAT GOES HERE]

- Payers should consider the unique needs of pediatric practices in design/implementation of APMs;
    - Quality measures focused on immunizations may be hard to meet in face of increased vaccine hesitancy;
- Payments like Access Stabilization Payments for Medicaid are important in supporting practices in delivering care, and maintaining access for patients, families, and communities;
- Changes in Medicare policies to support primary care are a positive step, but primarily benefit adult practices

Commented [8]: These are points from previous discussions- what needs editing/revision, and what is missing?

DATA NEEDS:

- Work with CIVHC to create mechanisms that allow primary care & APM spending data to be stratified by age, to understand the amount of payments that are focused on children and adolescents.

RECOMMENDATIONS:

[32] Report to the Community, Fiscal Year 2023-2024, Colorado Department of Health Care Policy and Financing

Safety Net Providers

Safety-net providers, including community health centers (CHCs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), are a foundational component of primary care in the U.S., serving primarily lower-income populations in rural and urban communities. In 2024, FQHCs and other community health centers served 32 million patients nationally, including one in six Medicaid beneficiaries.[33] Colorado's 20 CHCs provide a health care home for over 857,00 Coloradans (one in seven people in the state), including 23% of Medicaid enrollees and 21% of Child Health Plan Plus (CHP+) enrollees.[34] In 2023, Colorado CHC's provided almost 2,8 million clinical and virtual visits.[35]

Safety net providers often operate on very slim margins, and experience significant strain in the Medicaid "unwinding" following the COVID-19 pandemic. Nationally, an estimated 25 million people lost coverage due to the "unwind" (or the reinstitution of eligibility requirements, which had been frozen during the pandemic) as of August 2024, which contributed to community health centers reporting average net financial margins of -2.4% in 2024.[36]

Similar to pediatric providers, safety net providers also see a large percentage of Medicaid patients, and are equally vulnerable to H.R.1's impending funding cuts. The National Association of Community Health Centers (NACHC) has estimated the implementation of the law will increase uncompensated care costs by nearly $7 billion, and will cause 1,800 care sites to close, resulting in 34,000 lost jobs.[37] NACHC further estimates health centers will lose $7.3 billion in revenue over the next 10 years.[38]

Additional statistics related to value-based payment:

Paying for Value and Health Equity in Community Health Centers

- About 40% of CHCs participate in some form of VBP, although VBP accounts for less than 5% of CHC revenues.
- Community health centers (CHCs) face substantial obstacles to participation in value-based payment models; such rarely measure and reward efforts toward population health equity, a central CHC goal and outcome.

Challenges and solutions:

- Community health centers have limited access to capital to invest in the needed data infrastructure and staffing to identify, track, and efficiently manage the care of high-risk, high-cost patients;

[33] For Community Health Centers, A Winding Path to Accountable Care, Health Affairs, December 2025
[34] Colorado Community Health Network Brochure, Colorado Community Health Network 2024
[35] Ibid
[36] For Community Health Centers, A Winding Path to Accountable Care, Health Affairs, December 2025
[37] Community health centers brace for a big hit, Modern Healthcare, 8.15.25
[38] Ibid

- Community health centers report substantial administrative burden in dealing with differing quality measures across payers and value-based purchasing programs;
- When patients lose coverage, they no longer are "attributed" to the centers as enrollees under the contract—a change that also limits clinics' access to timely information about those patients. Without that information, it becomes a lot more difficult to manage their care as effectively;
- Even though community health centers are still required by federal law to provide care for uninsured patients, those patients' potentially improved care or reduced costs are not counted toward the value-based contract and thus won't yield shared savings;
- CHCs would benefit from harmonizing quality measures and developing standardized contracting approaches across value-based models and payers.;
- It would also be helpful for government and payers invest in data analytics and adequate staffing to better manage high cost patients

[What else?]

~~Continued Challenges~~

- ~~Employer engagement~~
- ~~Administrative burden - can't add requirements without taking something off the plate~~

DATA NEEDS:

RECOMMENDATIONS:

Commented [9]: Depending on the discussion at the December meeting, each "sub-section" under "Payment Flows" could include a call out box with Data Needs and Recommendations; alternatively, they could be summarized at the end of the Flow section;

Level of Payment

The 2021 NASEM Implementing High-Quality Primary Care Report, in addition to making a series of recommendations for the advancement of primary care in the U.S., also called for the measurement and tracking of progress in five key areas: financing, workforce/access, training, technology, and research. Since 2023, the Milbank Memorial Fund, in partnership with The Physician's Foundation and the Robert Graham Center, has produced an "Annual Scorecard Report" examining various dimensions of primary care payment. As noted in the 2025 report, "the last two years of tracking primary care spend in the Scorecard have demonstrated not only historically low levels of investment, but also ongoing low investment in primary care regardless of payer type."[39] The report highlighted that in 2022, primary care spending dropped across all payer types, including commercial payers, Medicare, and

[39] The Health of US Primary Care: 2025 Scorecard Report - The Cost of Neglect, Milbank Memorial Fund, 11.18.25

Medicaid, to an insurance-wide average of just 4.6% of total medical spending.[40] It further cited data from a 2023 Commonwealth Fund survey of primary care physicians which found that less than half reported receiving any revenue through value-based payment models.[41]

Colorado is extremely fortunate to have an APCD, and remains among a handful of states that has the capacity to collect and analyze both claims and non-claims-based spending in its annual reporting of primary care spending. Colorado's reporting methodology is based on the Collaborative's broad definition of primary care and is therefore higher than national data reported in the Milbank Scorecard (which uses a narrow definition, confined to fewer primary care provider types), but nevertheless shows disturbing similarities with certain trends showing reduced spending across multiple lines of business.

Collaborative is concerned about the decreases in primary care spending reported across all lines of business from 2023 to 2024, and in particular, decreases in commercial payers and Medicaid. While CHP+ reported a slight increase from 2023-2024, the decline from 17% in 2022 to 12% in 2024 is troubling.

While variances in data reporting from year-to-year, as highlighted in the "Updates on Primary Care and APM Spending" section of this report, impact the Collaborative's ability to assess detailed trends over time, some observations can nevertheless be made. Since 2021, primary care spending for commercial payers has hovered near 8% of total medical spending; when integrated care delivery systems (not subject to the primary care investment target set through Regulation 4-2-72) are excluded, that number falls to approximately 5%. Without an increased, sustained investment in primary care systemwide, Colorado will not be able to achieve the desired impacts of improved care delivery and patient outcomes.

The Collaborative is interested in exploring lessons and best practices from other states that have set primary care investment targets, such as those set forth in the State Policies to Advance Primary Care Payment Reform in the Commercial Sector Report by the Farley Health Policy Center. One opportunity highlighted in this report involves the framework that is used to collect and categorize non-claims based spending. While the Health Care Payment and Learning Action Network (HCPLAN) framework has been widely used both nationally and in Colorado, by Colorado to categorize APM spending, certain features make it challenging to discern the amount of FFS versus non-claims based dollars that may be included in a payer contract; for example, if a contract includes both FFS and non-claims based components, the total dollars in the contract are all counted as non-claims based spending. The Expanded Non-Claims Payment Framework, which CIVHC adopted this year for data collection, allows for increased specificity in reporting.[42]

[40] Ibid. The 2025 Milbank Scorecard calculated primary care spending using Medical Expenditure Panel Survey (MEPS) data, and a narrow definition of primary care spending that included primary care physicians only.
[41] Ibid.
[42] State Policies to Advance Primary Care Payment Reform in the Commercial Sector Report, Farley Health Policy Center, April 2025

The Collaborative has also had long-standing interest (first raised in the Second Annual Report) in ensuring that primary care spending is reaching primary care providers on the front lines. In the face of increasingly consolidated systems, understanding if and how dollars intended to support primary care delivery are reaching their intended target - providers and care teams - is increasingly important, and is discussed in the following "Flow of Payment" section of this report.

DATA NEEDS:
To better understand the level of payment that is needed to adequately and sustainably support advanced primary care, the Collaborative is interested in data that will help assess the following issues/questions:

- What is the current level of system stability/instability-how much breathing room do PCPs have?
- How much is administrative burden adding to the cost of running a practice?

RECOMMENDATIONS:

Flow of Payment

How primary care payments flow through organizations to reach and influence primary care delivery, and whether they are aligned with overall intent, remains a critical issue (NASEM)

Understanding these trends is important not just in terms of understanding the flow of payments, but in gaining insight into how and why people are choosing these points of access.

Systems
◦ Accountable Care Organizations (ACOs)
◦ Clinically integrated networks (CINs)
◦ Independent Physician Associations (IPAs)

Disruptors
◦ Direct Primary Care - boosted by H.R.1
◦ One Medical
◦ HIMS/HERS

Consolidation
◦ Private equity
◦ Vertical and horizontal mergers
◦ Insurer-owned

DATA NEEDS:

- Where are patients getting primary care? What is driving them?
- How many providers in CO are independent vs “system”?
- How much money in systems actually gets to primary care?

RECOMMENDATIONS:

Part 2 - Comprehensive Primary Care Strategy

Recommendation 1: Vision and goals

Recommendation 2: Potential Partners

Recommendation 3: State Primary Care Scorecard

Conclusion and Future Work

Appendices

Appendix A: Standard Operating Procedures

Appendix B: Previous Report Recommendations

Appendix C: Comments on Colorado's Aligned Primary Care APM Parameters