DRAFT 1.6.26

Colorado's Primary Care Payment Reform Collaborative

SEVENTH ANNUAL RECOMMENDATIONS REPORT

February 15, 2026

Table of Contents

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:

- Polly Anderson, Vice President of Strategy and Financing, Colorado Community Health Network
- Josh Benn, Director of Employee Benefits Contracts, Colorado Department of Personnel and Administration
- Britta Fuglevand, Payment Reform Implementation Unit Supervisor, Colorado Department of Health Care Policy and Financing
- Patrick Gordon, Chief Executive Officer, Rocky Mountain Health Plans
- John Hannigan, Regional Administrator – CMS Denver (Region 8), Centers for Medicare and Medicaid Services
- Steve Holloway, MPH, Health Access Branch Director, Colorado Department of Public Health and Environment

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- Lauren S. Hughes, MD, MPH, MSc, MHCDS, FAAFP, State Policy Director, Farley Health Policy Center; Associate Professor, Department of Family Medicine, University of Colorado Anschutz Medical Campus
- Alexandra Hulst, PhD, LMFT, Practice Manager, Family Health West
- Rajendra Kadari, MD, MPH, FACP, Chief Executive Officer and Co-Founder, Summit Medical Consultants
- Cassana Littler, MD, FAAP, American Academy of Pediatrics Colorado Chapter
- Amanda Massey, Lead Director, Government Affairs, CVS Health
- Kevin McFatridge, Executive Director, Colorado Association of Health Plans
- Dana Pepper, RN, MPA, Vice President, Provider Performance and Network Services, Colorado Access
- Amy Scanlan, MD, Chief Medical Officer, Trinsic Clinically Integrated Network
- Mannat Singh, MPA, Executive Director, Colorado Consumer Health Initiative
- Kevin Stansbury, Chief Executive Officer, Lincoln Health
- Gretchen Stasica, ASA, MAAA, Executive Director, Actuarial Services, Kaiser Permanente
- Jack Teter, Regional Director of Government Affairs, Planned Parenthood of the Rocky Mountains, Colorado, New Mexico, Southern Nevada, and Wyoming

The recommendations in this report are a product of the Collaborative and should not be construed as recommendations or specific opinions of the Division of Insurance (DOI) or Department of Regulatory Agencies (DORA).

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.[1]

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 (HCPF) 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.

[1] The Pathway to Primary Care Investment is Bolstered by Accountable Care, Milbank Memorial Fund, 12.16.25

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).

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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."[2] 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~~ and extends the Collaborative through September 1, 2032, and adds language to its existing statutory charge to ensure the unique needs of primary care delivery in pediatrics are considered in discussions of alternative payment models.

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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

[2] 2024 Sunset Review Primary Care Payment Reform Collaborative Report, COPRRR

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.

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 federal 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.[3] 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 ACA marketplace provisions in future years, such as bans on automatic reenrollment and new pre-enrollment verifications, will result in additional coverage losses.

Even for those who remain covered under public or private insurance, H.R. 1 includes provisions that impact health care access and affordability. The law immediately (as of July 4, 2025) forbade Medicaid payment to certain "prohibited entities", including Planned Parenthood and other providers offering abortion services, for a one year period.[4] Colorado was able to protect access to the critical primary care and preventive services provided by these entities for over 14,000 Health First Colorado (Colorado Medicaid) members through a joint lawsuit filed with other state Attorneys General,[5] and the passage of Senate Bill 25B-002, which allows the Department of Health Care Policy and Financing (HCPF) to continue to pay Planned Parenthood for services using state funds only.[6] Yet at a time of constricting federal and state resources, access to preventive and reproductive services remains a concern.

For ACA marketplace enrollees, H.R. 1 makes several changes related to Health Savings Accounts (HSAs), which are tax-advantaged saving accounts that can be paired with high-deductible health plans (HDHPs); HDHPs often have lower annual premiums, but require enrollees to pay out-of-pocket for nearly all medical services before the deductible is met. In addition to making bronze and catastrophic plans eligible for HSA contributions, H.R. 1 also allows HSA funds to be used to pay for direct primary care (DPC) services starting on January 1, 2026.[7] While it is difficult to predict the implications of HSA expansions, research has

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[3] Understanding the Impact of H.R. 1 and Federal Changes to Medicaid, HCPF
[4] OBBBA's Medicaid Abortion Provider "Defund": An Overview, National Health Law Program, 8.11.25
[5] Colorado joins lawsuit challenging federal 'defund provisions' targeting Planned Parenthood, Colorado Newsline, 7.29.25
[6] Understanding the Impact of H.R.1 and Federal Changes to Medicaid, HCPF
[7] H.R. 1's health care impacts explained, AAFP 7.23.25

shown racial and income disparities associated with these arrangements- with White, higher-income individuals being more likely to enroll.[8]

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, the number rises to more than 14 million.[9] 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. In 2024, two-thirds (64%) of CHCs in Colorado reported negative operating margins, and 94% instituted cost-cutting measures of some kind.[10] 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,[11] directly impacting rural hospitals and some of the state's most vulnerable populations.

Additional actions by the Trump Administration, related to the health care workforce and the availability of federal health data sets, also have significant impacts for primary care. A Presidential Proclamation issued in September 2025 (PP 10998, Restrictions on Entry of Certain Nonimmigrant Workers) increased the fee for H-1B visa petitions, which allow US employers to hire non-US citizens in certain occupations (including physicians and other health care professionals) from $3,500 to $100,000. A recent analysis of H-1B visas found that physicians practicing through the H-1B visa program in the US were "far more likely than their domestic counterparts to fill critical gaps in health care delivery systems, such as primary care and psychiatry," and that the "prohibitive increase in H-1B application fees will disproportionately affect rural and socioeconomically disadvantaged communities, which already experience the greatest healthcare workforce shortages."[12,13]

The actions taken around H1-B visas, coupled with H.R. 1 provisions that cap federal loans available to medical students, raise serious concerns about the primary care workforce pipeline. Under H.R. 1, medical students will be limited to $50,000 annually, and a total limit of $200,000, in federal loans starting in July 2026, at a time when the median 4-year costs for public and private medical schools are $286,454 and $390,848, respectively.[14] Without financial support, students may decide not to go to medical school, and those who do attend may choose higher-paying specialities over primary care, exacerbating existing provider shortages. The diversity of the future primary care workforce may also suffer, if only the

[8] Expansions to Health Savings Accounts in House Budget Reconciliation: Unpacking the Provisions and Costs to Taxpayers, KFF 5.29.25
[9] How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?, KFF, 8.20.25
[10] Letter to Colorado Congressional Delegation, Colorado Community Health Networks, 9.18.25
[11] Understanding the Impact of H.R.1 and Federal Changes to Medicaid, HCPF
[12] Health Care Professionals Sponsored for H-1B Visas in the US, JAMA 12.9.25
[13] Rural Health Providers Hit by $100K Trump Visa Fee, KFF, 12.12.25
[14] A Prescription for Debt- How Federal Loan Caps Burden Medical Students, JAMA, 11.10.25

wealthiest students are able to afford medical school, which has important downstream implications on patient care and health disparities.[15]

A set of Executive Orders signed in January 2025 related to gender ideology (Executive Order 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government) and diversity, equity, and inclusion (DEI) (EO 14151, Ending Radical And Wasteful Government DEI Programs And Preferencing), led federal agencies to pull multiple federal government websites and datasets offline on January 31, 2025, including national health surveys, indices, and data dashboards used by providers, researchers, and policymakers.[16,17] A series of lawsuits over the ensuing months has led to the partial restoration of data on websites maintained by HHS, NIH, and the CDC,[18,19] but ongoing questions and concerns remain about the current and future integrity of key federal data sources.[20,21] For example, recent changes to a CDC website asserting baseless and false claims that vaccines may cause autism have been widely criticized by scientists, public health experts, and medical professional associations.[22,23]

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.[24] 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.[25] The Colorado DOI estimates premium increases will lead to approximately 75,000 Coloradans losing coverage.[26] 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.[27]

[15] Ibid
[16] A Look at Federal Health DataTaken Offline, KFF, 2.2.25
[17] Trump health info blackout shocks providers, Axios, 2.3.25
[18] Judge: Trump Must Restore Missing Health Websites and Data, Medscape, 7.29.25
[19] HHS Agrees to Settlement Requiring the Restoration of Deleted Health Data and Websites, The HIPAA Journal, 9.10.25
[20] Data manipulation within the US Federal Government, The Lancet, 7.19.25
[21] Trump admin agrees to restore public health webpages, Axios 9.2.25
[22] The CDC revives debunked 'link' between childhood vaccines and autism, National Public Radio, 11.20.25
[23] What To Know About the CDC's Baseless New Guidance on Autism, KFF Health News, 11.21.25
[24] How Much and Why ACA Marketplace premiums are going up in 2026, Peterson-KFF Health Systems Tracker, 8.6.25
[25] Congressional Inaction Leads to An Average Doubling of Health Insurance Costs for 225,000 Hardworking Coloradans, DOI Press Release, 10.27.25
[26] Ibid.
[27] 2025 KFF Marketplace Enrollees Survey, KFF 12.4.25

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).[28] 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 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.[29,30] Primary care serves as a key point of access into the health care system, and through the provision of preventive services, care coordination, and chronic disease prevention, can improve both individual patient and population health.[31] 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.[32,33]

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.

Commented [7]: I think we would be remiss not to note that the growth in Colorado Medicaid costs is still less than commercial insurance and in line with other states. The budget constraints are real, however, I don't want this advisory committee to imply that we think Medicaid spending should be inline with a completely unrelated spending cap. The only way Colorado could achieve a 4.4% Medicaid spending growth is to cut services, covered populations or provider rates, or likely all three.

Acknowledging the challenge is different and okay with me.

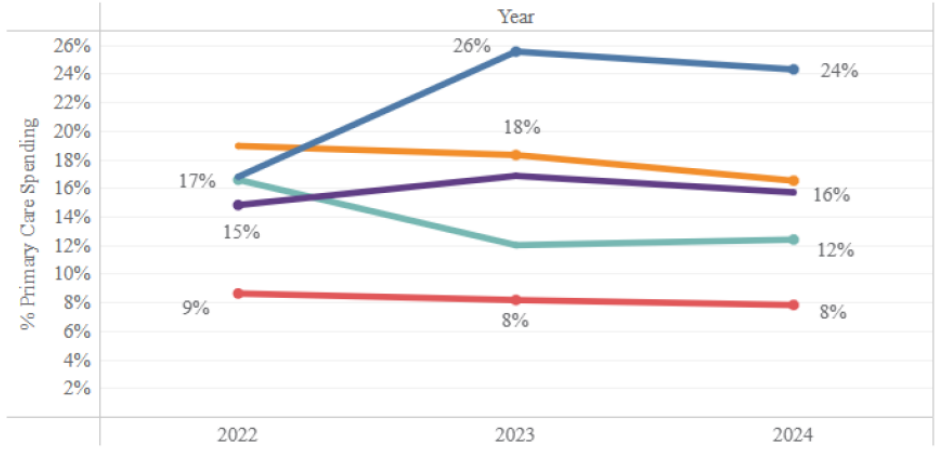
[28] Governor Policy FY 2026-2027 Budget Request Presentation to the Joint Budget Committee, 11.12.25
[29] HHS is Taking Action to Strengthen Primary Care, HHS Issue Brief, 11.7.23
[30] The Health of US Primary Care: 2025 Scorecard Report - The Cost of Neglect, Milbank Memorial Fund, 11.18.25
[31] Increasing Primary Care Access to Improve Population Health, National Governors Association, 4.10.25
[32] Using Primary Care's Potential to Improve Health Outcomes, Purchaser Business Group on Health, 10.4.21
[33] The Nation's Biggest Healthcare Challenge, National Association of Community Health Centers, 3.31.25

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 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



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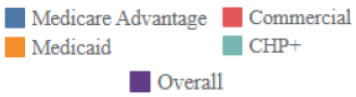

Value-Based Payment Model Spending. In addition to overall primary care spending, CIVHC reports on the percentage of primary care spending that is funneled through APMs, both as a percentage of total medical expenditures and as a percentage of primary care spending. In 2024, value-based APMs (which, 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.[34] 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.[35]

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.[36] 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.

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

Commented [12]: Are we going to acknowledge in this section that APM and prospective payment data from CIVHC does not match provider experience?

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Commented [16]: 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?

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[34] 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.
[35] Primary Care Spending and Alternative Payment Model Use in Colorado, 2021-2023
[36] 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.

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 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 direct 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

Commented [19]: Recommend adding caution that APM category shifts and Expanded Framework recoding meaningfully affect trendability. In addition, prospective payment percentages are significantly influenced by Kaiser Permanente Colorado and Denver Health — systems excluded from Regulation 4-2-72 — and therefore should not be used to infer scalable market norms for commercial carriers.

Commented [20]: Caution that category shifts impact ability to trend included in sentence; discussion of impact of integrated care delivery systems included in "Flow of Payment - Prospective Payment" section below

Commented [21]: Recommend acknowledging that carriers' operational capacity to expand APMs is affected by concurrent regulatory obligations (MHPAEA NQTL compliance, Colorado Option filings, APCD DSG updates, and Transparency in Coverage). These cumulative requirements materially limit readiness to implement new payment models.

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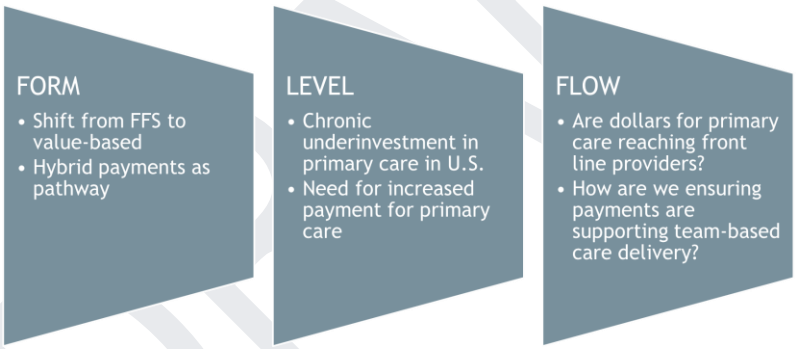
stakeholders. Infrastructure investments include workforce development incentives, system transformation initiatives, quality improvement initiatives, data interoperability (the ability to access, exchange and cooperatively use data in a coordination ways) and broadband access, and other tools needed 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.

Commented [23]: Distinction between rural and safety net providers

Figure 2



Source: Derived from work of Asaf Bitton; see Primary Care Needs a Triple Double: A Call to Action, Milbank Memorial Fund Blog Post, 11.19.25

Form of Payment

Fee-for-service (FFS) payment structures, which reward distinct services, are incompatible with the complex, coordinated, and comprehensive care that is the hallmark of advanced primary care delivery.[37] 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.[38] The Collaborative has

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

consistently stressed the need to move away from FFS payment structures, and strongly advocated for increased investment in primary care to flow primarily 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.

The form or structure of payments is particularly important in reducing provider administrative burden, which has been an underlying tenant of the Collaborative's work and a theme throughout previous reports. A recent Commonwealth Fund survey of international physicians found that two of five primary care providers in the US report feeling "burned out" (defined as being physically or emotionally exhausted, having ongoing symptoms of burnout and frustration in the workplace, or feeling completely 'burned out'), more than nearly every other country, and that more than two in five reported administrative burden as the primary reason.[39] In the US, it has been estimated that primary care physicians would require almost 27 hours in a day to complete all required administrative and clinical tasks, with team-based care reducing this burden to just over 9 hours a day.[40] While APMs can reduce certain burdens associated with coding, billing, prior authorization and other tasks, without intentional structuring and alignment across payers, they can also increase provider workloads through other types of reporting requirements. Both payers and providers require a degree of flexibility to structure APMs to meet the needs of specific populations (e.g., nuanced quality metrics or attribution strategies for pediatric providers), yet these types of adjustments can lead to increased model complexity. The Collaborative continues to work to find a balance between these competing priorities, and advocate approaches that help simplify and streamline provider participation.

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. 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.

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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. Currently, payers are asked to identify payment arrangements that include a prospective component through a specific field in their APM data submissions to CIVHC. The total dollars in the payment model are then

[39] The Causes and Impacts of Burnout Among Primary Care Physicians in 10 Countries, The Commonwealth Fund, 11.20.25
[40] Revisiting the Time Needed to Provide Adult Primary Care, Journal of General Internal Medicine, 7.1.22

"counted" as prospective in overall reporting, even if only some of the money is actually being paid prospectively, which may be contributing to the higher figures. The data reporting instructions that CIVHC provides to carriers also indicate that prospective payments are generally associated with certain model types; while the instructions are meant to be illustrative, it may be that some carriers are interpreting them to mean that if a certain model type is selected, the prospective payment field should also be reported as "yes", when that may not be the case.

The Collaborative also recognizes that the high proportion of prospective payments reported in the APCD may be influenced by a small number of fully integrated systems whose infrastructure is not reflective of the broader commercial market. To account for this, CIVHC reports prospective payment data for all payers, and for all payers excluding the two fully integrated systems (Kaiser Permanente and Denver Health). The difference between the two figures (with integrated systems included and excluded) was smaller this year than in previous reports, at 84.4% of all APM primary care spending and 82.2%, respectively. Although the reasons for this are not clear, the Collaborative will continue to monitor the amount of prospective spending, for all payers and for payers excluding integrated delivery systems.

The Collaborative also acknowledges that variations in primary care spending across different lines of business are structural as well as discretionary. Commercial benefit designs, employer purchaser constraints, and federal rating rules all impact insurance carriers' ability to deploy prospective models at scale, and should not be interpreted as insufficient carrier investment. In addition, many independent and multispecialty practices cannot operationalize prospective payments without significant investment and multi-payer alignment.

RECOMMENDATIONS:

- The Collaborative continues to advocate for prospective payment models that allow for flexibility in care delivery and provide revenue stability for providers.

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.

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

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January 1, 2025.[41] 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.

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 new primary care model. However, under the Trump Administration the Making Care Primary model was ended early (in September of 2025); while Colorado initially had low enrollment in the model, it was nevertheless 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[42] 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

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[41] 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.

[42] 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.

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.

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),[43] 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

[43] 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.

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.[44]

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 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

RECOMMENDATIONS:

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DATA NEEDS:

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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).[45,46] 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

[44] 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.
[45] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[46] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25

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).[47] 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%.[48] 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.[49]

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."[50] Health centers form a central point of access, with rural health clinics (RHCs) providing care for nearly one-third of rural residents, and health centers funded by the federal government caring for 1-in-5 residents.[51] 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.

In an attempt to mitigate the impacts of H.R. 1 on rural communities, the law also created the Rural Health Transformation Program (RHTP), a federal initiative that will allocate $50 billion in federal funds to states over the next five years ($10 billion each year) "to strengthen rural communities across America by improving healthcare access, quality and outcomes by transforming the healthcare delivery system."[52] In December 2025, CMS announced that Colorado will receive just over $200 million for the first period of this grant (December 2025 through September 2027). This award puts Colorado on track to receive more than $1 billion in RHTP funds through federal fiscal year 2030, to support rural health care initiatives that will serve all of the state's 52 rural and frontier counties and Colorado's two federally recognized tribes.[53] The Collaborative is excited about the opportunities associated with the RHTP, and looks forward to partnering with HCPF and other stakeholders as the

[47] Rural Health Transformation Program, Project Narrative, Colorado Department of Health Care Policy and Financing, November 2025
[48] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25
[49] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[50] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25
[51] Closing the Distance in Rural Primary Care: Evidence, Stories, and Solutions, Primary Care Collaborative, November 2025
[52] Rural Health Transformation (RHT) Program, Centers for Medicare & Medicaid Services website, accessed 1.2.26
[53] Colorado Celebrates $200 Million for Rural Health Care, Colorado Department of Health Care Policy and Financing Press Release, 12.29.25

implementation of projects commences, to identify and maximize opportunities to support the rural primary care infrastructure.

[CALL OUT BOX - RHTP in Colorado]

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.[54] 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.

RECOMMENDATIONS:

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

DATA NEEDS:

- Measure primary care spending across payers and across urban and rural geographies.

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 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.

[54] The State of Rural Primary Care in the United States, The Commonwealth Fund, 11.17.25

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Medicaid covers approximately 40% of children in Colorado, and more than 40% of births in the state.[55] 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.

RECOMMENDATIONS:

- The Collaborative recommends that payers consider the unique needs of pediatric practices in the design and implementation of APMs. Specific examples of such needs include:
  - Payments must be structured to support preventive care, a hallmark of pediatric care that is ill-suited for models that geared toward chronic care (such as shared savings);
  - Quality measures such as immunizations may be hard to meet in the face of increased vaccine hesitancy;
  - Pediatric APMs should include age ranges in their design; for example, PMPMs should be higher in the first 3 years of life to support the frequency of visits during this time frame (versus teenagers); and
  - Current risk stratification methods, based on Hierarchical Condition Categories (HCC), are not well suited for pediatric practices.
- The Collaborative encourages all payers, when possible, to align with strategies included in HCPF's ACC 3.0 care delivery model that are designed to support pediatric practices, including:
  - Access Stabilization payments, which support practices in delivering care, and maintaining access for patients, families, and communities; and
  - Integrated behavioral health payments, which include a combination of FFS and PMPM payments.

DATA NEEDS:

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

- 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.

Safety Net Providers

The term "safety net providers" is used generally to describe clinicians, provider organizations, and health systems that disproportionately serve low-income, underinsured, and uninsured patients.[56] Safety-net providers, including community health centers (CHCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), are a foundational component of primary care in the U.S. and Colorado, serving primarily lower-income populations in rural and urban communities (see Colorado Safety Net Providers call out box).

Colorado Safety Net Providers

Community Health Centers, also known as **Federally Qualified Health Centers**: Primary care, including preventive physical, dental, and behavioral health services. Located in medically underserved areas and among medically underserved populations.

Community Mental Health Centers: Outpatient, emergency, day treatment, and partial hospitalization mental health and substance use disorder services for residents of designated geographic service areas.

Community Safety Net Clinics: Free, low-cost, or sliding-fee primary care services for people who have low incomes and/or who do not who do not have insurance. These can include faith-based clinics, facilities staffed by volunteer clinicians, and family medicine residency clinics.

Community-Based Dental Clinics: Oral health services for Coloradans who have low-incomes, and/or do not have insurance.

Critical Access Hospitals: Inpatient, acute, and emergency services in rural hospitals with no more than 25 inpatient beds located 35 miles or more from another hospital, or 15 miles or more in mountainous terrain.

Emergency Departments of Community and Public Hospitals: Emergency medical care regardless of ability to pay or insurance status.

Local Public Health Agencies and Public Nursing Services: Limited primary care services, varying by community. May include health assessments and screenings for children covered by Medicaid, immunizations, family planning, oral health, cancer screenings, and testing for sexually transmitted infections and HIV.

Rural Health Clinics: Primary care services, differing by clinic. Located in non-urban areas

[56] Saving the Health Care Safety New: Progress and Opportunities, Annual Review of Public Health, 2025.

Commented [39]: Definition of safety net: https://pubmed.ncbi.nlm.nih.gov/39392871/

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with documented shortages of health care providers and/or medically underserved populations.

School-Based Health Centers: Primary health care services, including immunizations, well-child checks, sports physicals, chronic care management for conditions such as asthma and diabetes, and acute medical care, in schools with many children who live in households with low incomes. May also include mental and oral health care, substance use disorder services, and violence prevention.

Source: Colorado's Health Care Safety Net: A Primer, Colorado Health Institute, September 2021

In 2024, FQHCs and other community health centers served 32 million patients nationally, including one in six Medicaid beneficiaries.[57] Colorado's 21 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.[58] In 2023, Colorado CHC's provided almost 2,8 million clinical and virtual visits.[59]

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.[60]

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.[61] NACHC further estimates health centers will lose $7.3 billion in revenue over the next 10 years.[62]

RECOMMENDATIONS:

- The Collaborative recommends that payers consider the unique needs of safety net providers in the design and implementation of APMs. Specific examples of such needs include:

[57] For Community Health Centers, A Winding Path to Accountable Care, Health Affairs, December 2025
[58] Colorado Community Health Network Brochure, Colorado Community Health Network 2024
[59] Ibid
[60] For Community Health Centers, A Winding Path to Accountable Care, Health Affairs, December 2025
[61] Community health centers brace for a big hit, Modern Healthcare, 8.15.25
[62] Ibid

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    - CHCs and other safety net providers report substantial administrative burden in dealing with differing quality measures across payers and APMs; quality measures and contracting approaches should be harmonized whenever possible;
    - Patient churn and loss of coverage pose special challenges for safety net providers; if a patient loses coverage and is no longer "attributed" to a clinic, it limits the clinic's access to timely information, and therefore their capacity to effectively manage the patient's care;
    - Community health centers are required by federal law to provide care for uninsured patients, yet any improved care or reduced costs for those patients aren't "counted" under value-based contracts and therefore don't result in shared savings;
- The Collaborative encourages government and payer investment in data infrastructure and staffing that will allow CHCs and other safety net providers in identifying, tracking, and efficiently managing the care of high-risk, high-cost patients.

DATA NEEDS:

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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."[63] The report highlighted that in 2022, primary care spending dropped across all payer types, including commercial payers, Medicare, and Medicaid, to an insurance-wide average of just 4.6% of total medical spending.[64] 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.[65]

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

[64] 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.

[65] Ibid.

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.[66]

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.

[66] State Policies to Advance Primary Care Payment Reform in the Commercial Sector Report, Farley Health Policy Center, April 2025

RECOMMENDATIONS - LEVEL OF PAYMENT:

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DATA NEEDS:

- 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?

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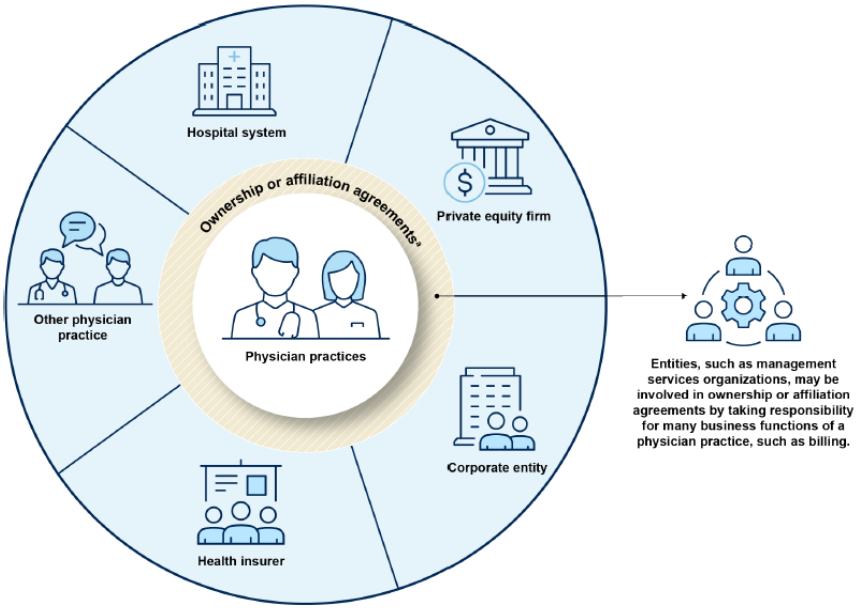
Flow of Payment

In the Sixth Annual Report, the Collaborative highlighted the impact that marketplace dynamics - including increased consolidation, as well as private equity and venture capital investments - have on the quality and cost of health care, and recommended continued monitoring of this landscape and its impact on the primary care infrastructure and workforce. While these forces can be challenging to track, due to a lack of data and transparency around various types of mergers or acquisitions, the Collaborative remains interested in observing and understanding these trends and their implications for primary care.

The complexity of interactions contributing to increased physician consolidation was recently underscored in a U.S. General Accountability Office (GAO) report, Health Care Consolidation-Published Estimates and Effects of Physician Consolidation (GAO Report). As described in the this report, and illustrated in Figure XX, physician consolidation can occur both horizontally, when physician practices merge together, and vertically, when practices are acquired by a range of other entities, including hospital systems, health insurance companies, corporate entities (such as retail or medical supply companies), and private equity firms.

Figure XX - Entities That May Consolidate with Physician Practices



Source: GAO (information); lovemask/stock.adobe.com (icons). | GAO-25-107450

[a]Physician consolidation can occur through acquisitions of physician practices by other entities, as well as affiliation agreements between physician practices and other organizations.

Currently no one data source is available to identify physicians who work in consolidated practice environments versus those who remain independent. Estimates of these numbers vary, based on how researchers define and measure physician affiliations and practice ownership, but recent studies indicate that the number of physicians working in independent, privately-owned practices is continuing to decline. An American Medical Association Physician Practice Benchmark Survey (AMA Survey) found that only 42% of physicians were in private practice in 2024, an 18 percentage point drop (from 60.1%) since 2012, while 47% of physicians reported working in practices that were owned by a hospital, hospital system, or health system (34.5%), or were directly employed (or contracted with) a hospital (12.2%).[67]

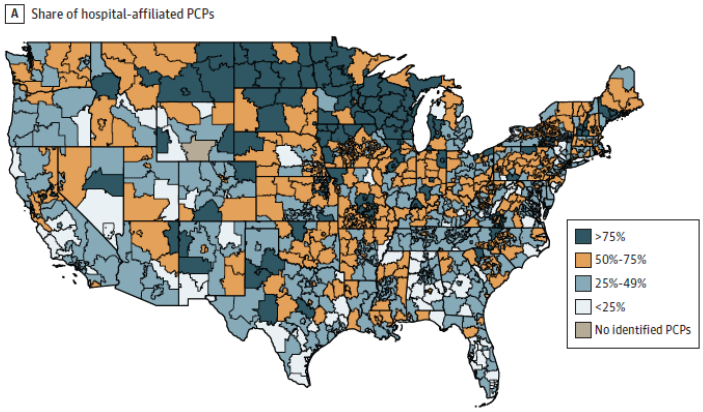
A study by the Physician Advocacy Institute (PAI study) examining hospital and corporate ownership found that 58.5% of physician practices in the US were owned by hospitals or corporate entities (including private equity firms, insurers, and other businesses such as CVS and Amazon) in January 2024, an increase of 9.2% over the last two years; of these, ownership by corporate entities (30.1%) surpassed ownership by hospitals (28.4%).[68] The PAI

[67] Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties, American Medical Association Policy Research Perspective, 2025
[68] Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023, Physicians Advocacy Institute, Prepared by Avalere Health, April 2024

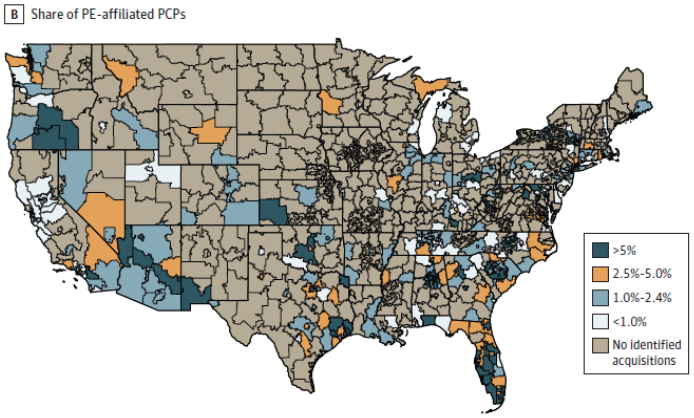
study found that over three-fourths of physicians, or 77.6%, were hospital- or corporate-employed in January 2024.[69]

Primary care physicians and practices in particular have been subject to increased acquisitions by hospitals, private equity forms, and other corporate investors over the last decade. A recent study by researchers from Oregon Health & Science University (OHSU study) found that the share of hospital-affiliated primary care physicians increased from 25.2% in 2009 to 47.8% in 2022, and the number of PE-affiliated primary care physicians increased to 1.5% over this same time frame.[70] The concentration of hospital- and PE-affiliation varied by geography (see Figure XX); generally, states with higher rates of hospital-affiliation showed lower rates of PE-affiliation.

Figure XX - Geographic Variation in Hospital-Affiliated and Private Equity-Affiliated Primary Care Physicians in 2022



[69] Ibid
[70] Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications, JAMA Health Forum, 1.17.25

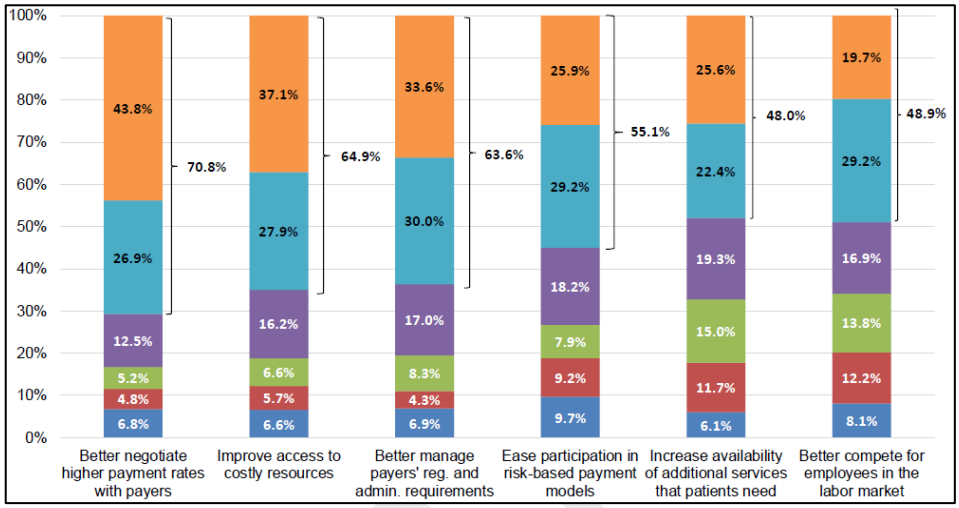


Source: Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications, JAMA Health Forum, 1.17.25

The OHSU study indicates that within primary care, both nationally and in Colorado, vertical integration with health systems is the primary driver of consolidation, with almost one-half of physicians nationally affiliated with hospitals. PE-affiliation is a more recent phenomena, and while increasing, to date it remains concentrated in local and regional markets. These trends have important implications for affordability, as the study also found prices were higher in hospital- and PE-affiliated settings relative to care provided in independent settings.[71] For primary care office visits, negotiated prices were 10.7% higher for hospital-affiliated PCPs, and 7.8% higher for PE-affiliated PCPs, compared to independent physicians. The ability to negotiate higher fees is consistently cited as a reason that primary care physicians may opt for (or are being pushed to) corporate ownership; 70.8% of physicians responding to the AMA Survey cited the need to "better negotiate higher payment rates with payers" as "very important" or "important" in their decision to sell their practice, followed by the need to "improve access to costly resources", and to "better manage payers regulatory and administrative requirements" (see Figure XX).

Figure XX - Reasons Why Private Practices Were Sold

[71] Ibid

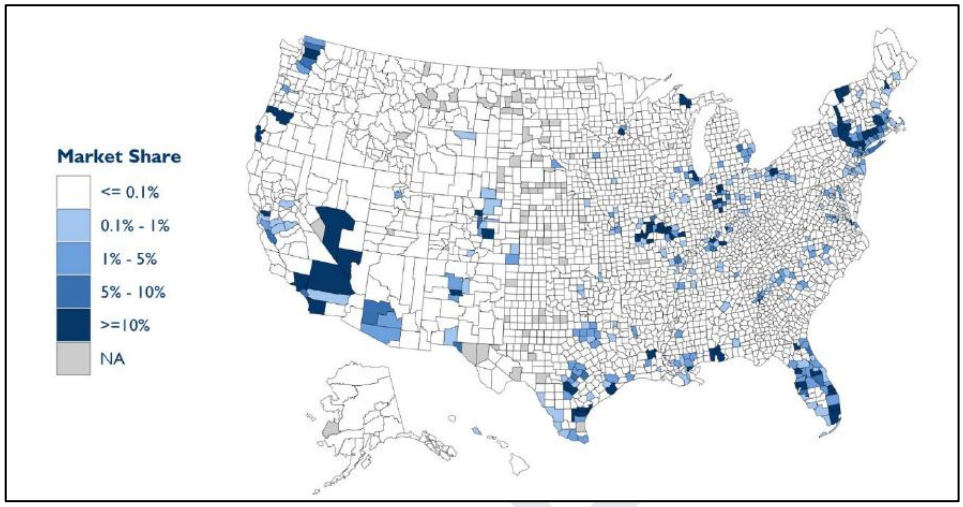


Source: *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties, American Medical Association Policy Research Perspective, 2025*

In addition to hospital and corporate acquisitions, health insurance company ownership of primary care practices has gained increased attention in recent years as a contributing factor to health care consolidation. To date studies in this area have been more limited, but one recent analysis found that the share of the national primary care market operated by insurers increased from 0.78% in 2016 to 4.2% in 2023.[72] Optum, a subsidiary of the UnitedHealth Group, was the primary driver of this growth, increasing its share of the primary care market from 0.55% in 2016 to 2.71% in 2023. In 2023, 15.1% of the US population lived in counties where an insurer controlled more than 10% of the primary care market, and 10.1% lived in counties where Optum alone was above this threshold (see Figure XX).[73] In Colorado in 2023, insurers controlled over 10% of the primary care market in two counties - Boulder and El Paso - with Optum alone controlling 20% of the market in El Paso County.

Figure XX - All Insurer Primary Care Market Share by County, 2023

[72] The changing landscape of primary care: an analysis of payer-primary care integration, Health Affairs Scholar, 6.11.25
[73] Ibid



Source: The changing landscape of primary care: an analysis of payer-primary care integration, Health Affairs Scholar, 6.11.25

The Collaborative highlighted significant concerns about the negative impacts that consolidation, private equity, and the financialization of the health care sector can have on patients, providers, and payers in the Sixth Annual Report, and the issues discussed - including increased health care costs, decreases in care quality, and the extraction of wealth and resources from primary care practices - remain salient concerns. In this year's report, the Collaborative is focusing on developments in the primary care landscape that are not "new" in terms of their appearance, but have particular relevance in the wake of H.R. 1's passage: direct primary care and "soft consolidation" trends that have the potential to help (or harm) provider participation in APMs.

The Collaborative also raises key research questions and data needed in order to understand and track the flow of payments to primary care providers in the context of larger health system dynamics. As noted in the NASEM Report, "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." 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.

Direct Primary Care

Direct primary care (DPC) is a business and care delivery model in which clinicians provide a defined set of primary care services and charge patients a flat monthly or annual "membership" fee for unlimited access to those services. DPC providers do not bill third parties, including commercial health insurance, Medicare, or Medicaid, and instead rely on membership fees from their patients as their primary source of revenue; patients, in turn, are

able to access a range of primary care services without paying anything at the time of care delivery. In some DPC arrangements, patients are able to access additional services, such as imaging, prescription drugs, or lab services, for an additional flat fee, which some DPC providers are able to negotiate reduced prices. While the DPC model is similar to concierge medicine, in that both charge patients a fee to support their operations which allows for allowing for smaller patient panel sizes than in traditional fee-for-service practices, it is distinguished by not accepting insurance, generally charging smaller fees than concierge practices, and their focus on saving money by providing a select set of services (see Figure XX).[74]

Figure XX - Difference between DPC and Concierge Practices

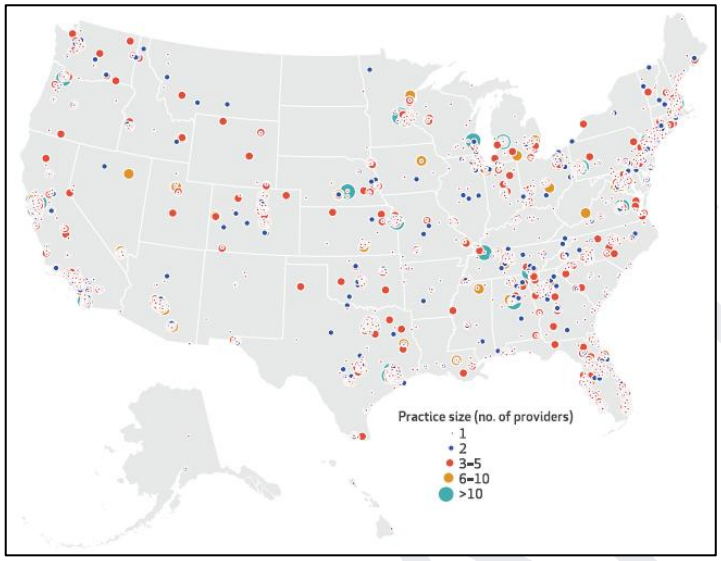
Direct Primary Care	Concierge Medicine
• Generally do not accept insurance or bill any third parties (Medicare, Medicaid, commercial insurance) for services provided • Often rely on monthly fees of less than $100 per month • Patient panel sizes are between 400 and 800 per provider • Focus on providing core services and saving patients money, rather than on offering premium services	• Often accept insurance and bill third parties for office visits and procedures • Charge higher monthly payments than DPC practices in addition to insurance collection • Patient panel sizes are relatively small, between 200 and 300 per provider • Often focus on providing "premium" services (e.g., vascular scans, "executive" lab panels, extended office visits, etc.)

Source: Difference between concierge and direct care, Medical Economics Blog, 2.18.25

While data regarding DPC practices has been challenging to collect, as clinicians engaged in these models intentionally exist outside of billing and other reporting systems, researchers are starting to provide insights into the scope and characteristics of this workforce. One recent study reported the number of total concierge and DPC practices increased by 83.1% between 2018 and 2023, growing from 1,658 to 3,036, and the number of clinicians in such practices similarly increased from 3,935 to 7,021 (a 74.8% increase) during this time frame.[75] The majority of practices were small, with fewer than 5 clinicians, and were located throughout the US, with the greatest concentrations in the Northeast and Southeast (See Figure XX). In Colorado, the number of concierge and DPC practice sites increased from 54 to 105 between 2018 and 2023 a 94.4% increase, and the number of clinicians increased by 100%, from 116 to 232.[76]

Figure XX - Practice Locations of Concierge and Direct Primary Care Practices, 2023

[74] Difference between concierge and direct care, Medical Economics Blog, 2.18.25
[75] Growth in the Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018-23, Health Affairs, December 2025
[76] Ibid, Appendix Exhibit A1



Source: Growth in the Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018-23, Health Affairs, December 2025

During the study period (2019-2023), authors found the types of clinicians in concierge and DPC practices was shifting, with the percentage of physicians (MD/DOs) as a share of all clinicians in such settings decreasing from from 67.3% in 2018 to 59.7% in 2023, as the number of advanced practice clinicians increased from 32.7 percent to 40.3 percent.[77] Of physicians entering a concierge or DPC practice, nearly 30% reported coming from health systems or integrated delivery networks, followed by approximately 25% from independent practice, and just under 20% coming from a corporate owned or affiliated practice. Surprisingly, the study also found that the independent ownership of concierge and DPC practices declined from 84.0% to 59.7%, while practices affiliated with corporate owners (defined as for-profit firms excluding hospitals and health systems) increased from 9.2% (152 practices) to 33.8% (1,027), an evolving trend that the authors note runs counter to "a model that was originally conceived as a means of preserving independent practice."[78]

Commented [49]: Scope of practice - check this

Self-reported data on DPC participation, tracked through DPCFrontier.com, an industry support website, indicates a higher number of DPC practices in Colorado, but is directionally aligned with other research indicating increasing numbers. Using data from this website, a Colorado Health Institute (CHI) study from 2018 estimated that roughly 90 DPC clinics were operating in Colorado as of May 2018, which accounted for roughly 10% of the nation's clinics

[77] Growth in the Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018-23, Health Affairs, December 2025
[78] Ibid

at that time, and served approximately 63,000 patients .[79] The CHI analysis further estimated that 86% of Coloradans (more than 4.6 million people) lived within a 15-minute drive of a DPC clinic. As of December 2025, DPCFrontier.com data indicates the number of DCP practices has increased to roughly 144, accounting for just over 5% of practices across the nation, with the majority (around 80%) located along the Front Range.[80] Assuming a panel size of 700 patients (the number used in the CHI study), this equates to just under 101,000 patients served.

Commented [50]: Pure, hybrid, onsite

H.R. 1 significantly boosts the DPC model by allowing people who participate in DPC to contribute to Health Savings Accounts (HSAs) and to use those tax-free HSA funds for DPC fees, starting January 1, 2026, as long as monthly fees are under $150 (individual) or $300 (family). This removes a major barrier, making DPC more accessible and affordable by combining low-cost primary care with high-deductible plans, potentially improving access to care and lowering overall costs. H.R. 1 also permanently extended the ability to use HSA funds for telehealth, further supporting DPC's virtual care components.

Collaborative members appreciate many of the components that make the DPC model attractive to clinicians - including smaller and regular panel sizes, freedom from the administrative burdens and reporting requirements associated with billing third-party payers, and a pathway for physicians in employment situations to regain autonomy and devote more time to direct patient care. The State of Colorado has offered a DPC option for state employees for the last 10 years, and found it has been an effective tool to increase utilization of some preventive services (e.g. cancer and depression or anxiety screenings). The state has also used DPC practices as a way to increase access in certain areas of the state, recently opening a new DPC clinic site in Salida, and utilizing nurse practitioners in more rural areas. Currently only 20-25% of eligible state employees are using this option, but those who have received care in this setting have generally been very satisfied.

Yet Collaborative members also have several concerns related to DPC. While the DPC model has the capacity to expand access to care, it may do so in a manner that exacerbates inequities. DPC membership fees, while lower than those for concierge medicine, may be unaffordable for some, leading to differential access; also, because DPC only includes primary care services, patients still need insurance to cover other health care costs (including emergency and specialty care), compounding affordability challenges. The quality of care in DPC practices is also hard to evaluate, as clinicians are not subject to quality measure and other reporting requirements, and the lack of regulatory structure for DPC practices means patients are left without the consumer protections associated with traditional insurance. Colorado law explicitly excludes DPC as a form of “insurance”, and therefore from regulation by the Commissioner of Insurance (§ 6-23-102, C.R.S.).

The DPC model may also negatively impact access by exacerbating physician shortages. The smaller panel size of DPC practices, one of the major benefits cited by providers and

[79] Direct Primary Care: A New Way to Deliver Care, Colorado Health Institute, June 2018
[80] DPC Frontier Mapper, available at https://mapper.dpcfrontier.com/, accessed 1.4.26

patients, may also result in fewer available providers; by one estimate, the US would need to "nearly triple the physician workforce just to break even."[81] While concerns have been raised that the DPC business model incentivizes providers to accept healthier patients, in more affluent areas, recent research is showing a more nuanced picture. One 2024 study found that while DPC practices were less likely to be located in high-priority Health Care Professional Shortage Areas (HPSAs), and in HPSAs overall, they were more likely to be located in rural or partially rural HPSA compared to non-DPC primary care physicians.[82] A 2025 study found that while DPC practices were more commonly located in urban and suburban zip codes, family medicine practices were more prevalent in lower-income zip codes, suggesting DPC may be filling care gaps in under-resourced urban areas.[83]

It is currently unclear how H.R. 1's implications for public and private insurance - namely, losses in Medicaid and CHP+ coverage, and premium increases for ACA marketplace coverage, exacerbated by the failure to extend ePTCs, that may result in people dropping coverage - will intersect with the law's expansion of access to DPC. As people lose access to affordable insurance coverage, some may turn to DPC as a bridge, leaving them with "quasi-coverage," which may prove workable for some, but catastrophic for others. It is also unclear how increases in DPC membership might have on larger market dynamics, including the individual risk pool for the ACA. It is anticipated that healthier members enrolled in such coverage will be most likely to drop their coverage, and large numbers of individuals and families migrating to DPC models could exacerbate this trend, leading to a spiral of increasingly sick enrollees in ACA plans, driving premiums even higher.

The Collaborative recommends continued monitoring of the DPC landscape, both nationally and in Colorado, to better understand not only the qualities and characteristics of practices and providers, but the reasons people are turning to DPC coverage. The Collaborative is also interested in exploring strategies for payers to incorporate some of the principles of the DPC models into APMs, which ideally can maintain incentives for access and still drive population health changes.

"Soft Consolidation" Trends and Clinically Integrated Networks (CINs)

In addition to the acquisitions and mergers that are often associated with vertical and horizontal consolidation, other less formal types of provider integration that do not involve changes in ownership (sometimes referred to as "soft consolidation") are also transforming the primary care landscape, both nationally and in Colorado. Entities such as Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), and Independent Physician Associations (IPAs) - all arrangements in which groups of providers voluntarily join together to improve care delivery and reduce costs - have existed for decades, but entered a period of

[81] Is Direct Primary Care the Solution to Our Health Care Crisis? Family Practice Management, 2016
[82] Are Direct Primary Care Practices Located in Health Professional Shortage Areas? Annals of Family Medicine, Nov-Dec 2024
[83] Geospatial and Socioeconomic Analysis of Direct Primary Care Practices in the United States, medRxiv, 9.22.25

rapid growth following the passage of the ACA. As many as 1,800 ACOs are currently operating in the US, with the top 25 serving nearly 15 million patients.[84] Data on the number of CINs are harder to find, as such entites are not monitored by the FTC and do not need to seek FTC approval prior to formation, but a 2015 white paper estimated around 500 CINs were operating in the US.[85,86]

Accountable Care Organization (ACO) - defined by CMS as "a legal entity recognized and authorized under applicable federal or state laws, comprised of eligible groups of providers that work together to manage and coordinate care for a payer specific population."

Clinically Integrated Networks (CIN) - defined by the Federal Trade Commission as a "structured collaboration between physicians and hospitals to develop clinical intiatives designed to improve the quality and efficiency of healthcare services."

Independent Physician Association (IPA) - defined by the American Academy of Family Physicians as "a business entity organized and owned by a network of independent physician practices to reduce over or pursue business ventures such as contracts with employers, ACOs and/or managed care organizations (MCOs)."

The Collaborative is not aware of any publicly available data sources that include the number of ACOs or CINs operating within Colorado, but member experience, combined with national data and trends, indicates such arrangements are likely very prevalent in the state and have significant impact on how primary care payments are flowing to practices on the ground. ACOs and CINs can facilitate the adoption of and administration of APM payments, as they create a central location for payers and providers to develop strategies and obtain feedback around key elements, such as access and panel size or quality metrics, and to implement models that impact more providers than a payer may be able to reach individually. They can also provide an operational and organizing structure for hospitals and other participating providers to to move efficiently navigate the "in between" spaces in a patient's care journey, to ensure individuals and families are getting the right care, at the right time, by the right person.

The presence of integrate provider networks including ACOs and CINs can also pose challenges and barriers to the flow of payments and APM participation. While ACOs or CINs can streamline payer negotiations for participating providers, this centalized structure can serve a barrier for payer communication with specific providers (as they may be referred back to the ACO administrators, or the work of the ACO). This dynamic is particularly acute as relationships are forming between payers and these enetite, and may improve over time as ACO models grow. Participation in ACOs or CINs can also be extremely onerous for small

[84] Top 25 ACOs by patient population, Definitive Healthcare website, accessed 1.5.26
[85] Consolidation by Any Other Name: The Emergence of Clinically Integrated Networks, Rand Corporation Research Report, 2020
[86] Understanding clinically integrated networks, Medical Economics, 2.10.16

practices, that are less likely to have resources available to help meeting reporting requirements or attend required meetings, and may not be able to meet minimum thresholds for participation. In addition, although a small practice may be successful in meeting required metrics, they still may not be large enough to receive shared savings or other incentive payments. Small practices may also struggle with the contracting nuances that are involved in ACO or CIN arrangements.

The Collaborative acknowledges that provider integration arrangements, including ACOs and CINs, are currently a significant component of Colorado's primary care landscape, and should be included in state efforts to increase alignment across payers and providers. Currently duplicative work is happening around administrative and operational functions within APMs - at the practice level, the ACO level, and the system level- and in the absence of an identified "team leader", to help streamline work and assume responsibility, ACOs and CINs are less effective in reducing administrative burdens, particularly for small practices. Prospective payments also play a crucial role in supporting providers in ACOs/CINs, and meaningful conversations are needed between payers and hese organizatinos about where those payments go, and what they look like across different ACO structures (e.g., physician group ACOs vs hospital ACOs), as well as small practices. Data exchange is fundamental to the success of APMs, as practices need to have visibility around where attributed patients are seeking care outside of the office in order to get in front of those needs and effectively manage patient care. Prospective payments and systemic investments are needed to support infrastructure changes that will allow for improved data exchange, both at the practice level and within and across integrated provider systems.

[ADD - Opportunity presented by RHTP, explore possibility of CINs in supporting rural participation in APMs]

[ADD - Collab interested in learning about other state strategies/efforts to better understand the flow of dollars through systems; MA PC report, RI example]

RECOMMENDATIONS - FLOW OF PAYMENTS:

- The Collaborative recommends establishing relationships and/or partnerships with ACO and CIN leaders who design the incentives and value-based payment models for their employed PCPs. Partnering with and influencing these leaders will facilitate greater alignment across payment approaches.

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?

Commented [52]: PLEASE ADD HERE

Commented [51]: Consider ACO and CIN leaders who design the incentive and value based models for their employed PCPs. Either partner or influence with these leaders.

Part 2 - Comprehensive Primary Care Strategy

In its FIrst Annual Report, the Collaborative adopted a working definition of primary care, drawn from work by the the Institute of Medicine:

> Primary care is the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated care encompasses the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care.

Over time, the Collaborative has continued to iterate on this definition, adding important components around person-centered, whole-person and whole-family care, as well as the core role of interdisciplinary teams in advanced primary care delivery. These concepts have been fundamental to the Collaborative's recommendations around primary care reimbursement, payment and care delivery.

The Collaborative remains committed, statutorily and philosophically, to advancing strategies to increase investment in primary care. Yet to truly support and sustain a robust primary care infrastructure that can meet the needs of all Coloradans- and serve a pivotal role in ensuring care remains accessible and affordable- will require systemic investments and cross-sector strategies. Therefore, in addition to the recommendations related to payment offered in Part 1 of this report, the Collaborative is dedicating Part 2 to the discussion of a comprehensive, statewide primary care strategy.

Vision and goals

The Collaborative's vision for a comprehensive primary care strategy in Colorado is grounded in the belief that primary care is a common good, and is instrumental in creating healthy communities. As such, a statewide strategy should be focused on the goal of ensuring all community members - across disparate community settings - have reliable access to high quality, person-centered, team-based care that measurably improves population health and truly advances equity.

A comprehensive strategy should create a clear, shared understanding of the current state of primary care in Colorado and support the collective movement of practices, payers, and purchasers toward advanced primary care. Such a strategy – organized by the Primary Care Payment Reform Collaborative – can be a powerful tool for promoting shared accountability for developing impactful primary care policies across multiple state agencies and other key stakeholders. While such a strategy must emphasize payment, a focus on this alone would not be sufficient to ensure that high-quality primary care is readily available for all Coloradans as a common good. The scope of a comprehensive strategy can be widened to include initiatives to strengthen the interprofessional primary care workforce, reduce administrative burden,

Commented [53]: Recommend clarifying that the State Primary Care Scorecard is intended for transparency, measurement, and alignment—not as a regulatory enforcement mechanism. Use of scorecard metrics for rate review, product approval, or network adequacy would require future legislative direction.

streamline health insurance requirements and practices, and advance other efforts that improve patient access and affordability.

Related to payment, a comprehensive statewide strategy should meaningfully involve all payers and support accountability to multi-payer alignment. Absent multi-payer alignment, incentives to improve care may only cover a small proportion of a practice's patients and not enable significant changes. Multi-payer alignment moves incentives in the right direction across payers, while still recognizing differences across commercial, Medicaid, and Medicare populations.

A comprehensive state-level strategy can establish key goals regarding the status of Colorado's primary care system, as well as metrics to assess progress toward those goals. The strategy should rely on transparent claims-based and other high-quality data and focus on identifying system gaps and aligning efforts where feasible and beneficial.

Example goals include:

- Enhance access to high-quality primary care, including for different populations with specific medical needs, e.g., the growing percentage of older Coloradans who need help navigating frailty and/or dementia.

- Invest sustainably in the state's primary care infrastructure, e.g., information technology, the interprofessional workforce, practice facilitation, so that the system is better equipped to deliver on the promise of high-quality, whole-person, team-based care in diverse settings across the state.

- Design improvements to Colorado's primary care system in partnership with patients and providers who have lived experience and rich perspectives about what changes need to be made.

- Create interoperable data systems with appropriate patient protections in place but that also streamline access for primary care teams so that they can connect to the broader health care system and enable more seamless care across different settings and conditions. Data shared should be clear, accurate, and actionable.

- Improve integration of primary care with behavioral health, social services, and public health to enhance the whole health of individuals and populations.

Measures selected to track implementation of goals should be clinically relevant, important to patients, and not administratively burdensome to primary care practices.

At present, the state's primary care workforce is stressed and navigating profound burnout related to chronic underinvestment, more complex patient care needs, and increasing burdens made worse by our fragmented health care system. As a result, many providers are

choosing to leave traditional primary care roles, reduce their hours, retire early, or leave medicine altogether, leading to substantial challenges for timely access. The current state of primary care also influences the career choices our trainees make, and we are witnessing declining interest in primary care across several professions. A comprehensive, state-level strategy can inform needed changes to strengthen our state's primary care system so that it is a healthier environment for our patients, providers, and practices and more attractive to students in the pipeline.

Potential Partners

The Collaborative includes a diverse set of partners across the state; a comprehensive state strategy would draw on all of these perspectives, and pull in additional stakeholders for input, and consider accountability structures for other agencies and groups. These partners may include:

- State agencies and divisions, including CDPHE, HCPF, Behavioral Health Administration (BHA), Department of Personnel and Administration (DPA)
    - Additional state partners may include the Colorado Department of Education and Colorado Department of Early Childhood, for strategies and metrics related to primary care pediatrics;
- The General Assembly;
- The Governor's Office;
- Professional clinical societies;
- Health professions training programs;
- Primary care non-profit and advocacy organizations;
- Patients and families who depend on and use primary care;
- Primary care providers;
- Payers;
- Health systems, CINs, and ACOs, including the leaders/organizations who influence or design value-based models or provider incentives; and
- HIT/data organizations.

The partners involved in the creation of the state strategy will also serve as key audiences. A successful strategy will identify and inform policy development and implementation across multiple domains, and serve as a mechanism for keeping all stakeholders abreast of and engaged in primary care and keep all stakeholders informed of actions and activities related to primary care. The strategy can also serve as a useful tool for educating new partners and members of the general public, and foster a greater understanding and appreciation of the consequences of shifting public finance and policy change on access to needed health services.

Commented [54]: Providers describe they often don't have enough participation in these models that they have to execute in their workflows. - Not sure what this comment means??

State Primary Care Scorecard

To support the development and execution of a comprehensive primary care strategy, the Collaborative proposes the creation of a state Primary Care Scorecard to measure and track the state of primary care across multiple domains. Such a tool will encourage transparency and accountability, creating a mechanism for promoting alignment where it makes sense to pursue and for evaluating the implementation of primary care legislation and regulation. It will also help identify and draw attention to areas of need and can help guide the most efficient and effective use of resources to address critical gaps by collating data from multiple sources and locations into a single and synthesized resource.

In considering a primary care scorecard for Colorado, the Collaborative has reviewed similar efforts in other states, including Massachusetts, New York, and Virginia. Most existing state scorecards are in the form of dashboards, and include a combination of federal and state data sources with measures related to payment/financing, workforce, access, health outcomes, and equity. Several national organizations have also developed mechanisms for tracking key health care measures that include primary care related data. The Milbank Memorial Fund and The Physicians Foundation, in partnership with the Robert Graham Center and HealthLandscape, developed a Primary Care Scorecard Data Dashboard to measure key primary care indicators identified in NASEM's 2021 Implementing High-Quality Primary Care Report across the nation and in states. Additional national data sources, which compile key primary care measures over time, include The Commonwealth Fund's annual Scorecard on State Health System Performance, the University of Wisconsin Population Health Institutes's County Health Rankings and Roadmaps, and the UnitedHealth Foundation's America's Health Rankings.

The Collaborative puts forth the following recommendations related to the development of a Colorado Primary Care Scorecard, with the acknowledgement that this proposed framework will necessarily involve engagement with an array of stakeholders to inform the specific domains, measures, and data sources that will be required for implementation. The Collaborative is also cognizant of the resources that will be needed for the ongoing maintenance of such a tool, and is interested in exploring partnerships with other state agencies and organizations to assist in this effort. A scorecard is only useful to the degree that it effectively captures relevant metrics and engages and focuses policymakers, consumers, and other stakeholders on what is most important to ensure the viability and sustainability of primary care in Colorado.

Data sources:

A wide range of state and federal data sources can be leveraged to inform the creation of the Colorado Primary Care Scorecard, including:

- State
  - Colorado Health Access Survey (CHAS)
  - CIVHC/APCD

Commented [55]: Consider streamlining the scorecard spreadsheet that Tara and Matt have and potentially sharing it in the report as some common themes of what should be included in a scorecard

Commented [56]: Recommend including readiness metrics — attribution stability, reporting capability, panel continuity, and data infrastructure — to ensure scorecard measures reflect operational feasibility, not aspirational design.

Commented [57]: From Lauren Hughes: These could be listed in a call-out-box in the report

    - Colorado Health Systems Directory

- National/Federal
    - AHRQ's Primary-Care Related Data Resources
    - County Health Rankings and Roadmaps
    - America's Health Rankings

Utilizing existing state and federal data sources lowers the initial burden of gathering and analyzing data to shape the scorecard and allows for comparison with other states. Over time, the state can identify data gaps and create new data sources and systems as needed. Using state-level data is also prudent given concerns about reliable, ongoing access to and availability of federal data given recent decisions and actions by HHS officials. National data sources also evolve (e.g., the County Health Rankings data will only be available through 2026).

Potential Domains:

The Collaborative recognizes the development of domains and metrics included in the scorecard should be jointly determined in partnership with other stakeholders. The following proposed domains are intended to serve as an initial framework and starting point for further conversations. Potential metrics for each domain are suggested in Appendix XX, but would require further discussion and refinement prior to adoption and implementation.

- **Access and utilization** - The Collaborative recommends identifying a set of metrics to track access to and utilization of primary care. Such metrics should leverage state data resources, such as the Colorado Health Access Survey and the Colorado Health Systems Directory when possible, but may also include state metrics that are compiled by national organizations to provide some level of comparability.

- **Financing and payment** - The Collaborative recommends identifying a set of metrics to track financing and payment for primary care. The annual Primary Care and APM Spending reports produced by CIVHC should serve as a backbone for this reporting, but additional metrics may be added to capture different dimensions of spending and/or infrastructure investments that are outside of the scope of that report. Members are curious about the idea of tracking how underinvestment in primary care raises costs elsewhere/ in other ways.

- **Training and workforce** - The Collaborative recommends identifying a set of metrics to track the primary care workforce and training programs i.e. 'pipeline'. The Colorado Health Systems Directory maintained by the Office of Primary Care offers a rich source of data about primary care clinicians in Colorado, and allows for the analysis of clinicians by provider type (family medicine, internal medicine, pediatrics,

etc.), provider profession (MD/DO, Nurse Practitioner, Physicians Assistant), geographic distribution, demographics, and other characteristics.

- **Performance and health outcomes** - The Collaborative recommends identifying a set of metrics to track primary care services' performance and population health outcomes. This could include analysis into how populations' health related social needs are being met in conjunction with primary care, potentially through utilizing the BHASOs' Care Access programs.
- **Practice readiness** - The Collaborative recommends identifying a set of metrics to track provider and practice readiness to help ensure scorecard measures reflect operational feasibility, and not just aspirational design.
- **Equity** - The Collaborative recommends identifying a set of metrics to track inequities in the primary care system and care delivery. This includes analysis across populations with specific medical/ health needs, beyond standard population demographics.

Commented [58]: Add administrative burden here? "Burden/alignment could also ensure that scorecard elements do not duplicate existing reporting or exceed operational capacity."

Commented [59]: Note from a member: important to ensure metrics are sliced and diced by age. But not sure whether this necessary needs to be added/ seemingly fits in anywhere based on how you currently have this laid out.

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

Appendix D: Potential Metrics for a State Primary Care Scorecard

Access and Utilization	Financing and Payment	Training and Workforce
Percentage of adults and children with a usual source of care; Percentage of residents using primary care/primary care use trends; Time between booking and actual appointment for both PCPs and specialists. Care avoided due to cost; Access to a variety of provider types (MD/DOs, NPs, PAs) including behavioral health providers Referral completion rates Available form(s) of access: in person, telehealth, asynchronous Continuity of care with the same primary care provider or practice, Follow-up after emergency department visits Reliability/integrity of Provider Directories	Primary care spending as a share of total health care spending by all payers, commercial health insurance, Medicare, and Medicaid;	Number of providers by provider type Number of Providers Profession (MD/DO, NP, PA, BH professionals, RNs, MAs) Percentage of primary care residents trained in rural areas, MUAs, small independent practices, or community-based settings; Percentage of new physicians entering primary care workforce each year; Provider-to-population ratios by region; including by FTE status or hours seeing patients each week Residency training capacity in primary care; Percentage of Physicians practicing primary care Practice participation in team-based models. Provider age (ex. Number of physicians over 65) Primary Care provider shortages, with supply and demand projections

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		Practice participation in team-based models

Performance and Outcomes	Practice Readiness	Equity
Patient satisfaction Low birth weight Uncontrolled diabetes Substance abuse Avoidable premature mortality Immunizations Preventable hospitalizations Preventive screenings (breast, cervical, colorectal) Ambulatory Care Sensitive Conditions "Adherence to evidence-based preventive care"	Attribution stability Reporting capability Panel continuity Data infrastructure - interoperability and data sharing	