COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative Meeting Minutes
Thursday, March 14, 2024; 10:00 - 12:00 pm
Virtual meeting

Meeting Attendance

Attended
Polly Anderson
Brandon Arnold
Isabel Cruz
Steve Holloway
Lauren Hughes
Cassie Littler
Amanda Massey
Lisa Rothgery
Amy Scanlan

Absent
Josh Benn
Patrick Gordon
John Hannigan
Rajendra Kadari
Anne Ladd
Kate Hayes for Jack Teter
Patricia Valverde
Pete Walsh

DOI
Tara Smith
Deb Judy

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Planning for 2024
4. Public comment

Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda.

Housekeeping & Announcements:

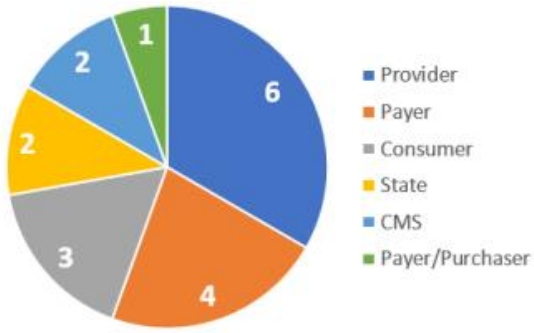
The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith noted a delay in getting the Feb meeting minutes posted online and will be approved at the April meeting.

ACTION ITEM:

- Meeting minutes from the Feb meeting will be posted and approved at the April PCPRC meeting.

- **Membership update** - Tara Smith provided a brief update on the current status of PCPRC membership. Since its creation in 2019, PCPRC membership has ranged from 16-21 members; over the last year, membership has held relatively steady at 18 members. However, two members (a payer representative and a payer/purchaser member) have recently resigned due to changes in their own roles. Current representation, across the membership categories established by HB19-1233, is as follows:



Tara Smith noted that opportunities currently exist for new members in all membership categories. In adding new members, she reiterated the Collaborative's (and the Division's) commitment to increasing the diversity of the group's membership across multiple dimensions, including geography and race/ethnicity. Tara indicated that the Division would be engaging in more active recruitment over the coming weeks and months, and asked members if it would be helpful for the Division to recirculate a one-page/flier related to the PCPRC that they could share through their networks. Members agreed a one-payer would be a helpful recruitment tool.

ACTION ITEM:

- Tara Smith will recirculate a draft one-pager about the PCPRC for members to review prior to the April meeting, and any revisions/edits can be discussed and finalized at the April meeting.

- **Fifth Annual Recommendations Report - DEBRIEF** - Tara Smith congratulated members on the posting of the Fifth Annual Recommendations Report, which is available on the PCPRC website. The final vote, which was taken through email, was approval of the report in its entirety by 12 members. Tara asked members for

feedback on the timeline/process for the production of this year's report, what could be improved moving forward.

Discussion:

- A member commented that they thought the listening sessions were an interesting idea, but noted they were not able to attend any of them due to their schedule. They questioned if other members were able to participate, and whether they were valuable- to the DOI, CHI, and to other members.
    - Tara commented that from the Division's perspective, they did provide important opportunities to touch base with members that were able to attend- and either get feedback on outstanding issues from the larger meeting discussions, or to workshop new content. She did note that generally only 2-3 members joined, for relatively short periods, during each of the scheduled times, and suggested that rather than hosting a few large time blocks, it might be more effective to set up multiple short sessions.
    - Several members agreed that it would work better to host shorter sessions more frequently (both live and via chat); one noted that they felt intimidated by the 2-hour blocks and were hesitant to hop in and out because they did not want to disrupt the conversation.

- Another member commented that in terms of opportunities for feedback, they felt this year's process struck a good balance (not too many, not too few, but just right); regarding the workload and time commitment, the member noted they were also not able to attend any of the listening sessions, and agreed that shorter sessions more frequently would likely work better in the future; they further expressed appreciation for the contractor support, and the value that CHI brought in keeping the process on track and on schedule, as well as their expertise with graphics and copy editing; finally, in terms of reviewing report drafts, having clear guidance on the sections that needed close review and the timeline for providing feedback was also very helpful;
    - Tara expressed appreciation for the feedback, particularly around CHI- and flagged a lesson learned this year was the need to think about graphics early in the process, so there is adequate time for design and production;
- A member commented that most parts of the process went well; while it was helpful for staff to integrate feedback into the drafts, at times having comments that were "anonymous" proved challenging, and required the group the try to "work smith" in real time, without certainty that the full intent of the comment was being captured; the member suggested it might facilitate the process in the future if comments were attributed to individuals, to make it easier to request any needed clarifications and/or ask follow-up questions;

- Members agreed that the process would be easier if comments were attributed and agreed that for the purposes of the report drafts and working sessions during meetings, a member's name would be listed in association with their comment unless the member requests otherwise.

Federal & state updates

The following federal updates were provided:

- **Making Care Primary (MCP)**- Colorado is one of 8 states selected to pilot CMMI's Making Care Primary model, which is designed to improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health and health-related social needs (HRSNs). The 10.5-year model will launch on July 1, 2024- to date, the following activities have taken place:
  - The application window for provider participants closed in Dec 2023; CMMI subsequently provided all applicants that met eligibility criteria with a breakout of their Medicare attribution and estimated payments/revenue under MCP, so each provider or practice could make an informed decision about joining the model;
  - CMS is currently in the process of obtaining signed participation agreements from providers and practices that want to enroll in the model; once this process is complete, Colorado will have a better idea of what provider participation looks like across the state;
  - Providers will enroll into one of three tracks available through MCP (which can be thought of most simply as beginner, intermediate, and advanced), which will increasingly shift them away from fee-for-service (FFS) to prospective, population-based payments;
    - As practices move across and within the tracks, they will have access to national and state-based support;
    - At the state level, CMMI is looking to leverage existing efforts and infrastructure (for practice transformation, data sharing, etc.), and has engaged with DOI/HCPF in ongoing conversations to identify and make connections with state-based resources;
  - While much of CMMI's attention to date has been focused on provider recruitment and enrollment, CMMI has also been engaging with commercial payers in ongoing conversations about participation in MCP;
  - Interested payer partners were encouraged to submit a Letter of Intent to participate in the model by Feb 2024- in Colorado, the following 3 payers submitted an LOI:
    - Anthem BCBS (Elevance);

    - Cigna;
    - Denver Health;
  - The focus of payer-partnerships in MCP is on directional alignment, or alignment across certain key model components, with the goals of reducing administrative burden for providers (and payers), and supporting the shift from FFS to prospective, population-based payments;
    - In signing the LOI, commercial payers have indicated a willingness to align with CMMI around the following model components:
      - Performance measurement & reporting;
      - Aligned payment approach;
      - Timely and consistent data sharing; and
      - Learning supports and technical assistance;
  - CMMI will continue to engage with any interested payers over the coming weeks and months; payers that wish to participate in the model will need to submit a plan to CMMI in Aug 2024, describing how their primary care APM(s) align with MPC, and ultimately will be asked to sign a non-binding Memorandum of Understanding during the 2025 calendar year;
    - A new resource, MCP Payment Attribution Methodologies, has recently been posted on CMMI's MCP website, and contains detailed information about the model's payment approach and methodologies.

- **State Transformation Collaborative (STC)** - Colorado is one of four states (in addition to Arkansas, California, California, and North Carolina) participating in STC, an initiative of the Health Care Payment and Learning Action Network (LAN) that launched in Dec 2021. The goals of the STC are: 1) explore shared goals and approaches across state initiatives to identify opportunities for cross-state alignment and build a foundation for national alignment; and 2) foster and test approaches to multi-payer alignment that have potential for regional or national application. Activities to date have included:
  - The first year of the initiative was primarily focused on learning about the various multi-payer alignment efforts that were occurring in each of the selected states, to identify commonalities and differences; in Colorado, the introduction and passage of House Bill 22-1325 was a key effort that was shared with the LAN and other state participants;
  - In December 2022, the Duke Margolis Center for Health Policy put forward a framework of Foundational Elements of Alignment (publication: "A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care", pg. 7) that included 5 key "pillars": 1) performance measurement and reporting; 2) measures and initiatives related to health equity; 3) aligned key payment model components; 4) timely and consistent

data sharing; and 5) technical assistance. This framework was adopted by the STC as a mechanism to structure discussions around individual and cross-state alignment efforts and opportunities;
    - In July 2023, the LAN published the "Multi-Payer Alignment Blueprint," which compiled successful multi-payer alignment initiatives from the various STC states, along with national efforts and contributions from the LAN. The document is intended to provide real world examples that other states can adapt and incorporate into their own multi-payer alignment strategies.
    - As a group, the STC states continue to have regular convenings, where ideas and strategies around each of the 5 pillars are shared and explored. Each participating state also continues to receive technical assistance and support from the LAN.
        - In Colorado, this support was used to facilitate stakeholder engagement around the development of the aligned primary care APM parameters established through HB22-1325, and led to the Division's promulgation of Regulation 4-2-96.
        - Moving forward, the Division is working with the LAN team to explore processes and mechanisms for implementing the aligned quality measure sets established through HB22-1325.

- **President Biden 2025 Budget** - The proposed 2025 budget release by President Biden has identified closing gaps in access to primary care as one of the administration's priorities. Specific provisions and funding proposals, which at this time are still proposed (and must be approved through the budget process) include:
    - Creating a pathway to double federal investment in community health center programs;
    - Expanding health center street medicine services to ensure people experiencing homelessness have access to primary care; and
    - Expanding coverage and investing in behavioral health services.

- **New CMMI model - Innovation in Behavioral Health (IBH)** - CMMI recently released a new "Innovation in Behavioral Health (IBH)" model, which is focused on improving the quality of care and health outcomes for people moderate to severe behavioral health conditions, including mental health conditions and/or substance use disorders. The model will use a value-based payment approach to enable community-based behavioral health practices to integrate behavioral health care with physical health needs and health-related social needs. The Division and other state partners are currently learning more about the model, and how it might fit with other work Colorado is pursuing in this space.

The following state updates were provided:

- **2024 legislative session** - Tara Smith provided a brief update on the current legislative session, and highlighted the following bills, which could have potential relevance to the Collaborative's work:
    - HB24-1005 - Health Insurers Contract with Qualified Providers
    - SB24-093 - Continuity of care
    - SB24-080 - Transparency in Coverage
    - Benefit related
        - Obesity & diabetes; infertility; substance use disorders; biomarker testing
    - HB24-1040 - Gender-affirming health care study
    - SB24-059 – Children's Behavioral Health Statewide System of Care

  Discussion:
  - A meeting participant offered a comment/question on HB24-1005, noting their organization had been engaged in discussions about how to potentially develop certain pieces from the initial bill concept that might be less problematic and have fewer unintended consequences. The participant highlighted in particular conversations around potentially setting the floor for reimbursement rates for providers in value-based contracts, as well as discussion about creating a different set of contract options that commercial payers can provide independent practices. In addition, there seems to be interest in continuing to define independent primary care. The participant asked if Collaborative or the DOI has been engaged in conversations with the bill sponsors around any of those concepts, and if the Collaborative might pick up any of that work in the future.
        - Tara Smith noted that the Division does not have a position on the bill but has been involved in discussions with the bill sponsor. She invited other Collaborative members to offer comments from their perspective, but noted that overall, the PCPRC tracks legislation that may have an impact on primary care or their work but has stopped short of weighing in as a group on particular pieces of legislation, as many members are engaged in the legislative process representing their own organizational interests.

- 1325 Implementation - In December 2023, the Insurance Commissioner adopted Regulation 4-2-96, which established aligned parameters for primary care APMs in four

areas: 1) risk adjustment; 2) patient attribution; 3) core competencies; and 4) quality measures. The regulation includes reporting requirements for carriers in all four areas, and the Division is currently working on guidance and reporting templates for carriers to submit annual information. A draft copy of this guidance should be available by the end of the month.

- HCPF Initiatives - Several of HCPF's current and ongoing activities related to primary care and behavioral health were highlighted, including:
    - Expanding Health Related Social Needs Services in Colorado
        - Stakeholder kickoff on March 11
    - HB22-1302 implementation
        - Grant program, legislative report
    - Accountable Care Collaborative (ACC) Phase III
        - Draft contract released; for updates on ACC Phase III or to provide feedback on draft contract, visit https://hcpf.colorado.gov/accphase3
    - Value-based program design
        - APM 2
        - Payment Alternatives for Colorado Kids (PACK)

- PCPRC Sunset Review - HB19-1233, which formed the PCPRC, included a "sunset clause", which set a date of September 1, 2025, for the Collaborative to terminate unless the legislature passes new legislation to continue (i.e., the "sun sets" on the PCPRC if it is not reauthorized). When such clauses are included in legislation, it falls within the purview of the Colorado Office of Policy, Research & Regulatory Reform (COPRR) to conduct a sunset review of the entity or function - in this instance the PCPRC - and produce a report of its findings and recommendations prior to the agencies' sunset. Tara Smith introduced Jennifer Lockwood, a Policy Analyst with COPRR, to provide an overview of what this process will look like over the coming months.

PCPRC Sunset Review - Jennifer Lockwood, Policy Analyst, COPRR

Jennifer provided the following overview of sunset review process:

- The General Assembly set a sunset date for the PCPRC for 2025, and that automatically begins a sunset review through COPRR a year prior to that date;

- A sunset review process includes 3 basic phases:
    - Research phase - attempting to identify any issues, make sure have an opportunity to vet any issues that do arise; to do this, COPRR talks to industry and professional associations, stakeholders, staff, look at current state law and federal statutes, programs and statutes in other states (if applicable), and

experts in the field; goal is to identity any issues by May of this year, so there is time to thoroughly vet;
    - Writing phase - In June, will start drafting a report that will contain: a summary of the current law, a description of the program, and any recommendations that COPRR may make to the General Assembly (may be statutory or administrative in nature); the report will be published on October 15- it will be posted on the COPRR website, and any stakeholders who participated in the process will receive a copy by email;
    - Legislative phase - once the report is published, a bill will be drafted that will contain the statutory recommendation in the report; a committee hearing will be scheduled sometime near the beginning of the legislative session in 2025; COPRR attends the initial introductory hearing to present the report and answer any questions from committee members; public testimony is typically taken at that time as well; after that initial hearing, the bill draft will move through the legislative process just like any other bill during the 2025 legislative session;

- Additionally, the Colorado General G has established a set of statutory criteria for COPRR to use through the sunset review process; examples of these criteria include:
    - Criteria #1: A determination regarding whether regulation or program administration by the agency is necessary to protect the public health, safety, or welfare;
    - Criteria #3: If the program is necessary, whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with public interest;
    - The remaining criteria dovetail off of those first two criteria;

- Stakeholder input is an important part of a successful sunset review process; Jennifer will be reaching out to individual members of the Collaborative to see if interested in participating in the process or in sharing feedback; if interested in participating, don't need to wait for COPRR to reach out- Tara can connect members to Jennifer if they reach out.

Questions/Discussion:

- A meeting participant encouraged engaging stakeholders who worked on the enabling legislation through the outreach process, as they can provide a valuable perspective;

- A member asked how often the sunset review process resulted in a recommendation for the entity under review to continue (i.e., to repeal the repeal language in the initial legislation; if stakeholders strongly support the continuation of the PCPRC, is

that recommendation put forth in the report, or are there other mechanisms to put that position forward/provide that feedback?

- Jennifer response that the continuation of the entity is part of what is considered during the sunset review process; the statutory criteria are applied through the research conducted and stakeholder feedback received to develop the report recommendations; one of the primary recommendation included in the report will be whether to continue or to sunset the entity- can also make a recommendation to continue the entity with modifications; the report can also include statutory or administrative recommendations, based on research and feedback;
- Once the report is released it will contain a recommendation whether to continue or to sunset, or continue with modifications; each report is specific to an entity, and the recommendation is based on what is uncovered during the review process;

- Another member asked about the next steps in the process- if the report recommendation is to sunset the PCPRC, would that potentially prompt other bills to continue the work of investing in primary care?
  - Jennifer noted that the stakeholder feedback received during the review process is certainly considered in developing the recommendations in the report; one of the elements that is considered relates to public health, safety, and welfare- so one of the considerations will be if the Collaborative, which is created in statute, no longer exists, is that detrimental to public health and welfare;
  - Once the report is published, the bill will be drafted that essentially mirrors the report recommendations; once the bill is introduced in a committee of reference, it will move through the legislative process like any other bill; it can be amended during that process, as it works its way through the General Assembly;

- A member asked how the sunset review affected the annual recommendations report for next year, as the report timeline and the sunset date are not currently aligned;
  - Jennifer noted that COPRR will be looking at the 5 prior fiscal years of the program, and demonstrating trends or other data points to illustrate a picture of the program; anything that would be happening in the current year likely wouldn't be included in the report;
  - Tara Smith noted that in terms of the Collaborative's annual recommendations report, the group will need to think through how that will play out; after the COPRR report is released in Oct, the PCPRC will have more information about the potential future path of the Collaborative and the work, and it is something

that will need to be monitored as the 2025 session starts and progresses, to see what makes sense after the Feb 2025 report is complete.

Goals and Priorities for 2024

Tara Smith started a discussion of potential PCPRC goals and priorities for 2024. To frame this conversation, she reminded members of actions that Collaborative has taken since its creation, reviewing the group's statutory charges (see slide 24, available here), as highlighted at the February meeting. She then asked members for ideas about what they would like to see the PCPRC accomplish in 2024 (and beyond), and how group members would like to contribute. Members were asked to either comment directly or provide feedback through a Menti presentation.

Discussion of potential topics:

- A member who entered "Examination of what networks in the state are contributing to improved outcomes and how further investment could improve outcomes and reduce costs" offered the following additional comment:
    - The member is most familiar with the FQHC network and the work that is done through the ACO collaborative (CCMCN), but there are probably other ACOs and provider networks in the state (e.g. SHI-E, etc.)- what is in place right now, what kind of success are they experiencing, should there be more of them, what could we do to better invest in them if they are getting good outcomes?

- A member who entered "Impact of practice consolidations: hospital or VC "investment" of PC" offered the following additional comment:
    - One of the issues is in terms of how we are calculating the primary care spend; as more and more of primary care is part of larger organizations, it becomes harder and harder to figure out how much is being invested in primary care; it clouds our ability to see what is invested in primary care; for example, as part of large multi-specialty group, there are a lot of us doing primary care in that context, and it is difficult to sort out what resources we have and what outcomes are we are making when part of a larger entity;
    - Recent articles have highlighted that venture capital historically goes where the money is, strips the value out, and leaves the remnants behind; is that happening, and if so, how do we sound the alarm about it; OR are they going to be the investors who invest in primary care and allow it to thrive;
    - A member noted that the FQs just had a meeting with Medicaid and others, and HCPF mentioned they were looking into the impact of vertical integration; once published, it can be a valuable resource for this group to examine;

    - A member commented via chat that private equity and venture capital were included in multiple comments, and mean different things; in conversations, the PCPRC will need to be clear when and how the terms are being used.

- Another member noted that OHSU was doing a comprehensive study of different definitions of primary care spend; collectively across all states and jurisdictions they have identified over 60 different definitions- once available, will share with the PCPRC;

- A member commented via chat that "What the spend on primary care is may not be what is actually invested in primary care- that is an interesting point."
    - Several members liked this comment via chat, with one noting "that is a great point- for example, the uninsured are not included in CIVHC data."

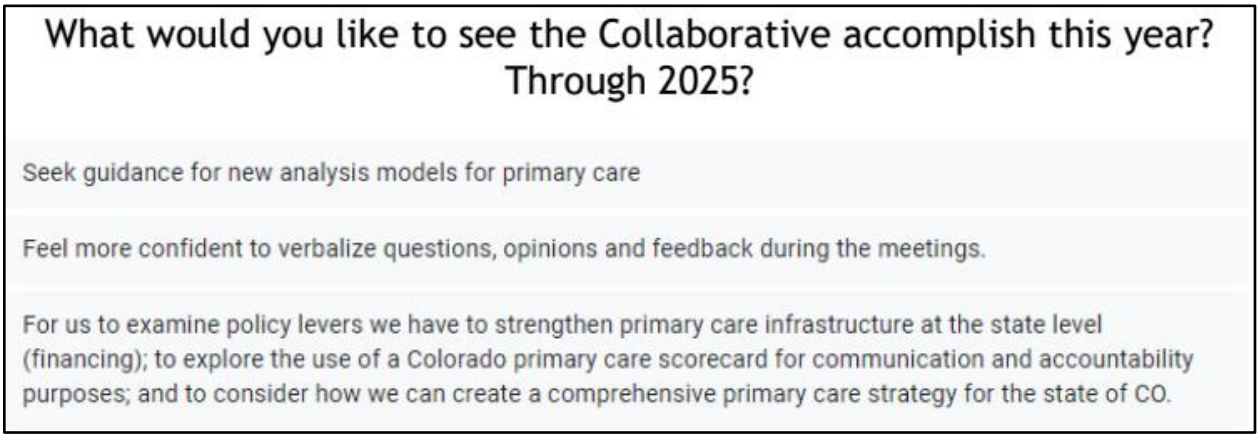
- A comment "Measure outcomes of initiatives" was entered into Menti; Tara asked for clarification around this comment, and how members were interested in engaging/reengaging in this topic;
    - The member who offered the comment noted that we don't have a lot of information about outcomes on health-related social needs, and it is hard to measure, but it is something that affects all of our patients; it was discussed in the last recommendations report, and is a hard and big topic, but interested if group is interested in doing a deeper dive in this area;

- Another member entered "Hearing from practices that are thriving under current payment arrangements"; the Practice Innovation Center at UCDFM was mentioned as a potential resource to tap in this area;

- Additional responses entered into Menti included:
    - Barriers to the adoption of APMs;
    - More recommendations on primary care investment - it's the only palace in health care where increased spending results in lower total costs;
    - Advance to the next step of defining and diving into equity in APMs;
    - I would like us to consider the development of a CO Primary care scorecard that we can use for comms/accountability purposes;
    - I would like us to consider how to move toward an intentional, thoughtful strategy/role/office that coordinates comprehensive PC policy at the state level;
    - I recommend we dive into state-level policy levers that help us better FINANCE primary care infrastructure versus payment for high-quality primary care services;
    - Examination of where current VBP models fall on the LAN-Framework and recs for where payers can invest to move along the framework;

- Barriers to APM adoption;
- Deeper dive on HRSNs and how to collaborate effectively with community partners and how financing and payers can support these collaborations;
- Impact of externalities: refugees, Medicaid unwinding, VC investments on access to primary care;
- Really would love to focus on primary care investment with specific recs of how to increase for MK and other payers;
- Impact of private equity on primary care providers;
- Improve payment equity for primary care vs specialists;
- Reducing administrative burdens, which includes reporting requirements;
- Set aside time.

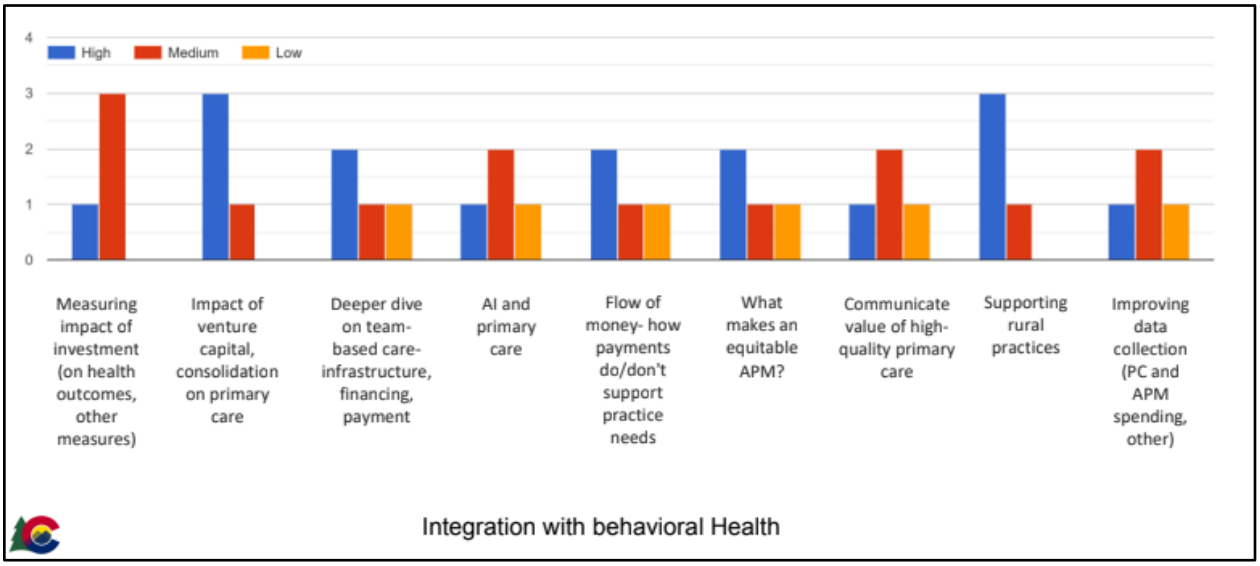
Tara Smith then briefly reviewed member responses to a survey that was circulated prior to the meeting to help identify 2024 priorities and asked for additional feedback.



Additional comments:

- A member commented that they appreciated meeting materials being circulated in advance, and that it was helpful to know the questions that were going to be discussed prior to the meeting;
    - Multiple members agreed with this comment via chat.

Potential topics:



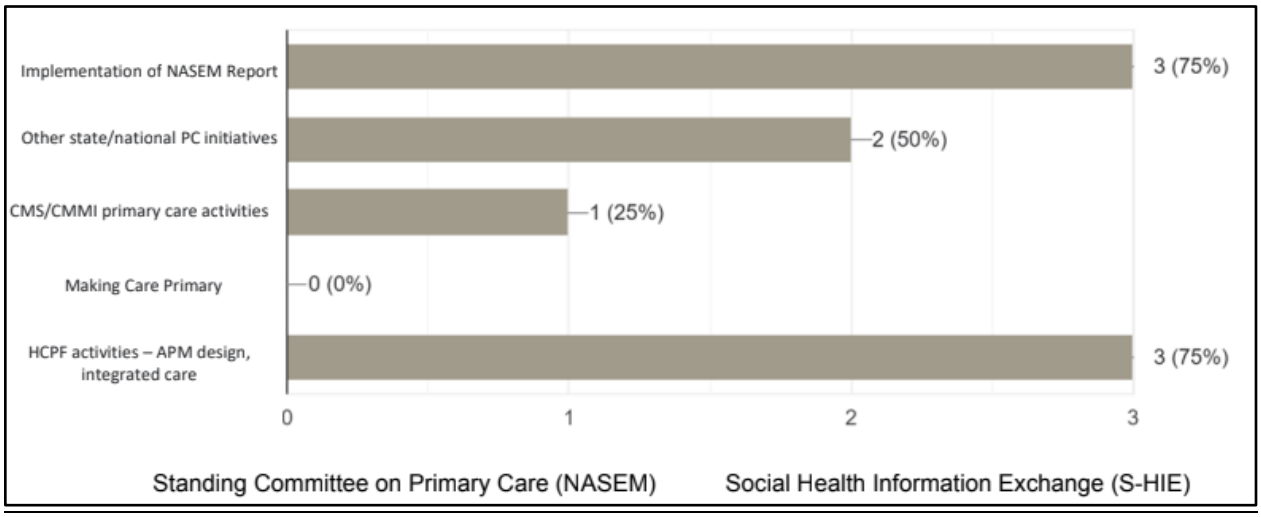
Additional comments:

- Tara Smith noted that many of the comments that were entered in the Menti reflected survey feedback; areas of high interest identified through the survey included:
    - Support rural practices;
    - Impact of venture capital, consolidation on primary care;
    - Deeper dive on team-based care, infrastructure, financing, payment;
    - What makes an equitable APM?

- In terms of supporting rural practices, Tara asked whether members saw a correlation between supporting rural practices and the impact of market trends like consolidation and vertical integration on independent practices- are those similar themes, or should they be considered separately?
    - A member commented that while they were certainly related, the Collaborative should be intentional in lumping where lumping makes sense, and splitting where splitting is needed;

- Members also agreed with revisiting the question of what makes an equitable APM, and building out the framework or "step-by-step" approach outlined in the PCPRC's Second Annual Recommendations Report;

Reports & resources

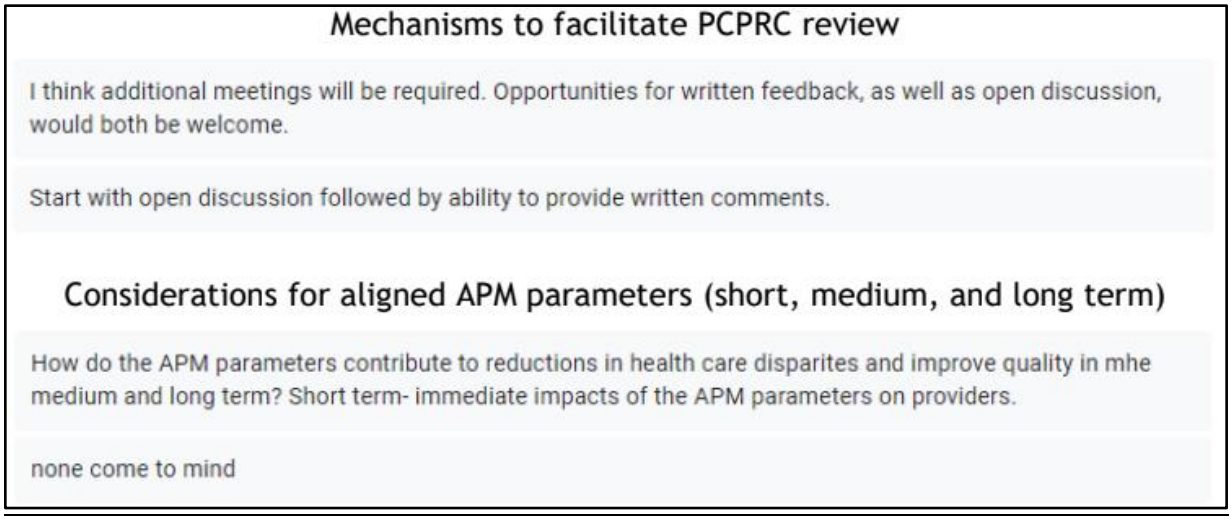


Additional comments:

- Members indicated various levels of interest in learning more about/engaging with a various resources and reports; comments entered in chat during the meeting included:
    - Support for staying informed of implementation efforts related to the NASEM primary care report;
    - Support for learning from other state/national initiatives; a specific recommendation was made to connect with the Virginia Center for Health Innovation (lead by Beth Bortz, who also staffs the Governor's Task Force on Primary Care);
    - A member noted that they can provide an update on where FQHCs landed on joining Making Care Primary next month;
    - A member noted that the PACK meetings would be kicking off in mid-May, and they could keep the group apprised of developments.
    - A member noted that the U.S. Congressional Primary Care Caucus has just been reconstituted; it includes four co-chairs from across the aisle; the Bipartisan Policy Center has been active in ensuring that not just the individuals invited to participate in the caucus, but Congress more broadly have access to high-quality information and education about primary care;
        - The Caucus has been pretty quiescent since around 2015, but there is currently a big push to reconstitute and make it more active;
        - Another federal movement on primary care that the Collaborative can be aware of and tracking;
        - A member questioned if Yadira Caraveo was involved;

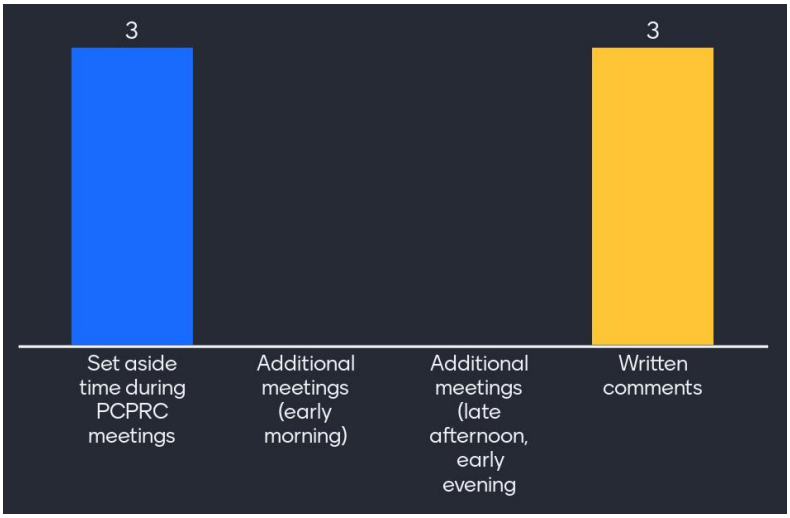
- Another member mentioned connecting with Judy Steinberg, who just left her position at HHS as a senior advisor on the HHS primary care report;
  - HHS is currently working on identifying a new Director for the Strengthening Primary Health Care initiative;

Annual review of aligned APM parameters:



Additional discussion:

- Tara Smith noted that HB22-1325 requires annual review of the aligned primary care APMS developed by the DOI, and asked members about their preferred method for engaging in this work. Comments entered in Menti favored using time during PCPRC meetings and having opportunities to provide written feedback.
  - A member indicated in chat their preference was to set aside time during meetings and provide written comments; several members agreed.



Additional discussion:

- A member noted that it was important to be cognizant of the fact that implementation efforts are currently underway, so cautioned against trying to make changes before implementation even underway;

Other thoughts, ideas, and aspirations:

I am so impressed by the organization, efficiency and quality of the work. I feel honored ot be part of the collaborative.
looking forward to the conversation

Additional discussion:

- A meeting participant expressed appreciation for the Collaborative as an important and welcoming/comfortable forum to discuss challenging issues in a respectful and productive manner; they expressed hope that the conversation will continue, either in the Collaborative, or in a different forum (depending on the outcome of the sunset review);

- A member made a request that the Division help ensure that the PCPRC stays mindful of and within the bounds of the group's statutory charge; for newer members, that were not part of the cohort that were actively engaged in developing and passing HB19-1233, it is helpful to have flags and reminders of the purpose, so that the group stays in its lane and is successful in meeting its goals;
    - Several members agreed with this comment via chat;

- A member from CDPHE noted that the Primary Care Office should have some new data to share with the Collaborative soon related to claims analysis; in addition to the workforce needs assessment, CDPHE has also been looking at how people interact with primary care access spatially, on-the-ground (how people are traveling for care, what asset needs are at the street and community levels);
    - CHDPE is also becoming really interested in the intersection between pregnancy, labor and delivery care and primary care; it is hard not to notice the changes in access for pregnant people for care nationwide, which is affecting CO as well; inasmuch as primary care engages in full-scope primary care, it is an essential feature of healthy pregnancies and healthy deliveries, and is a topic we want to explore more deeply;
    - CHDPE remains interested in behavioral health access, and the capacity that is delivered through the PC system; have had difficulties assessing the proportional contribution of primary care is to overall behavioral health

capacity in the state; are close to having a better understanding of that based on some claims work;

- A final area of overlapping interest is the potential impacts of private equity on primary care; the work of the Collaborative has probably never been more important, given the policy and economic forces around health care delivery, what it costs, who we prioritize for access, how we train, whether primary care practice is healthy for our clinicians let alone healthy for the people they serve; there is a lot happening on a scale bigger than us right now that is going to make these problems hard, and the hope is that we will be ahead of the curve and able to make good recommendations to resist some of those negative forces.

Public comment:

- No public comments were offered.

Next steps:

- The Division will work with co-chairs to put together a mechanism for prioritizing topics for discussion and developing a working schedule for upcoming meetings.