COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

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

Meeting Attendance

Attended
Polly Anderson
Josh Benn
Steve Holloway
Lauren Hughes
Rajendra Kadari
Cassie Littler
Amanda Massey
Amy Scanlan
Gretchen Stasica

Absent
Britta Fuglevand
Kate Hayes/Jack Teter
Alex Hulst
Patrick Gordon
John Hannigan
Sonja Madera
Kevin McFatridge

DOI
Tara Smith
Deb Judy

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Priorities for 2025
4. Public Comment

Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

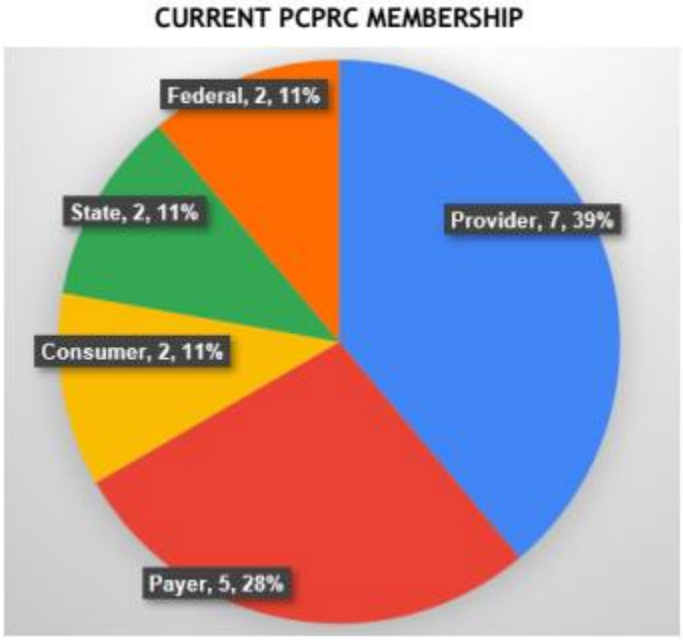
- **Meeting minutes** - Tara Smith requested approval of Dec and Jan meeting minutes;

ACTION ITEM:

- Meeting minutes for December and January were approved and will be posted on the PCPRC website as final.

- **Sixth Annual Recommendations Report** - Tara Smith noted that the 6th Annual Recommendations Report was posted on the Division's Primary Care Payment Reform Collaborative on Feb 14, one day in advance of the statutory deadline (on Feb 15);
    - The report can be accessed directly at HERE.

- **Membership Update** - Tara Smith reviewed the current membership composition of the PCPRC, and noted that the Division is hoping to extend invitations to two new consumer representatives and one new payer representative in the coming weeks:



    - Tara Smith also noted the Division would be reaching out to individual members shortly regarding their current terms, to check in regarding potential extensions and/or the end of their service on the PCPRC.

- **PCPRC Sunset Review Update** - Tara Smith informed members that Senate Bill 25-193, which would extend the PCPRC for an additional seven years (through Sept 2032) has been introduced in the Senate;
    - The bill's sponsors in the Senate are Kyle Mullica and Matt Ball, and in the House are Lori Garcia Sander and Karen McCormick;
    - The bill passed the Senate Health & Human Services by a vote of 8-1; an amendment (L.001) was added to explicitly include pediatric primary care providers as represented members of the PCPRC, and to amend the

Collaborative's statutory charges to that APMs responsive to the needs of pediatric primary care providers are considered;
- The bill will now be heard in Senate appropriations, and on approval would move to the Senate floor for a second and third reading; if passed by the Senate, it will then move to the House, and follow a similar process.

Federal & state updates

The following federal updates were provided:

- **HHS Leadership Announcements** - Key new leadership at the US Department of Health & Human Services has been confirmed, including:
  - Robert F. Kennedy, Jr. as Secretary;
  - Mehmet Oz as Administrator of Centers for Medicare and Medicaid Services (CMS);
  - Abe Sutton, as Director of the Center for Medicare and Medicaid Innovation (CMMI) and Deputy Administrator of CMS;
    - Prior to this role, Sutton co-founded 2 health services companies, which focused on enabling primary care providers (called Honest Health) and nephrology providers (Evergreen Nephrology);
    - Sutton was also part of the first Trump Administration, serving on the National Economic Council and Domestic Economic Councils, where part of his role involved coordinating cross-agency efforts to shift from fee-for-service to value-based payments.

- **HHS Activities** - HHS leadership recently announced a reorganization of the department, called the "Transformation to Make America Healthy Again." The goals of this reorganization include saving money through workforce reductions, and streamlining functions through the consolidation of various divisions. Through taking these actions, HHS will be better able to advance the new priority of ending America's epidemic of chronic illness by focusing on safe, wholesome food, clean water, and the elimination of environmental toxins. Specific changes with implications for primary care include:
  - Creation of a new Administration for Health America (AHA), which combines the Office of the Assistant Secretary for Health, Substance Abuse and Mental Health Services Administration, Agency for Toxic Substances and Disease Registries, and National Institute for Occupational Safety and Health;
  - Creation of the Office of Strategy, which merges the Office of the Assistant Secretary for Planning and Evaluation and the Agency for Healthcare Research and Quality.

- **CMMI Model Portfolio Changes** - CMS also recently announced changes to CMMI's model portfolio, based on the statutory goals of reducing program spending while maintaining or improving care quality. The actions taken around the following six models are estimated to save ~$750,000,000:
    - 4 models identified to end early include:
        - Maryland Total Cost of Care (2019-2026);
        - Primary Care First (2021-2026);
        - End-Stage Renal Disease Treatment Choices (2021-2027; propose termination through rule-making); and
        - Primary Care First (2024-2034);
    - 2 previously announced models that will not be implemented include:
        - Medicare $2 drug list
        - Accelerating Clinical Evidence;
    - While two of the models that are ending have a primary care focus, CMS noted in the announcement that primary care remains foundational to CMMI's strategy, stating specifically that the early termination of PCF and MCP "does not signal a retreat from support of primary care providers, but rather a need to focus on different approaches that are consistent with CMMI's statutory mandate to produce saving."

- **CMS Rulemaking** - CMS recently released the following proposed and final rules:
    - **2025 Marketplace Integrity and Affordability Proposed Rule**
        - This proposed rule includes policy and operational changes related to affordability, benefits, and eligibility, as well as administrative requirements for marketplaces that offer ACA coverage;
        - Additional information about changes included in the proposed rule is available in the following resource prepared by the State Health & Value Strategies: New CMS Proposed Rule: ACA Marketplace Integrity;

Discussion:

- A member asked about how the Marketplace Integrity Proposed Rule might impact Colorado, and specifically the OmniSalud program, which provides coverage for individuals without legal status.
    - Tara Smith explained that the proposed rule would primarily impact ACA health plans that are offered through Connect for Health Colorado, the state's health insurance marketplace. The OmniSalud program is a little different- it is a state program, and individuals enroll through a separate platform, called Colorado Connect. OmniSalud is one of the programs administered by the Health Insurance Affordability Enterprise, in addition to reinsurance, which operates as part of Colorado's 1332 waiver, a federal waiver that a state can receive to operate programs

that meet certain guardrails (e.g., they must provide the same amount of coverage that would be available through the ACA). The Division is certainly anticipating conversations with the new administration about our 1332 waiver, but those discussions would be state specific, and aren't really addressed in the proposed rule.
    - The member appreciated this explanation, noting it was helpful to understand OmniSalud's relationship to the exchange, and how it fit into the 1332 waiver.
    - Tara Smith further clarified that certain elements within the proposed rule, such as those around benefit structure (specifically gender-affirming care) would apply to plans that are sold on Connect for Health Colorado (the marketplace) and Colorado Connects. So there is overlap, but also some areas that will be distinct.

- **Medicare Advantage Payment Rate Announcements for Calendar Year 2026**
    - CMS announced they will finalize a 5.06% in average benchmark payment for MA plans for Calendar Year 2026, slightly more than what the Biden administration had proposed;
    - In addition, CMS will finish a phase-in of risk adjustment model changes, and move forward with the proposal to remove medical education costs from expenditures in growth rate calculations;
- **Contract Year 2025 Medicare Advantage and Part D Final Rule**
    - This final rule contains multiple operational provisions; a summary of changes is available in the CMS Fact Sheet.

- **Budget Reconciliation** - Congress is currently working on a budget reconciliation package, which requires members of the House and Senate to first pass identical versions of a budget resolution;
    - The House passed a budget resolution in February, and the Senate recently passed a version on April 5; the House was to vote to approve the Senate version earlier this week, but the measure was pulled from the floor due to a lack of votes;
    - Those interested in learning more about the budget reconciliation process can access the Congressional Research Services' Reconciliation Process FAQs, available at the following link: https://www.congress.gov/crs-product/R48444

- **Attorney General Lawsuits** - On behalf of Colorado, Attorney General Phil Weiser has joined at least 13 lawsuits against the Trump administration since January, over the following issues (many of which are related to Executive Orders):
    - Federal election changes;
    - HHS grant cuts ($11 billion);

- Department of Education cuts, including staff layoffs;
- K-12 Teacher Preparation grants (providing training in rural school districts);
- Defending the Consumer Protections Bureau;
- Birthright citizenship;
- Gender-affirming care (specifically the Executive Order ending federal spending to hospitals and criminalizing doctors);
- Defunding medical and public health research (capping indirect costs at 15%);
- Federal worker buyout;
- Department of Government Efficiency (DOGE) access to payment systems; and
- Federal funding freeze ($3 trillion in federal assistance).

- **Additional Federal Policy Updates**
  - **Primary Care Enhancement Act** - This legislation was introduced in Congress, with bipartisan support, and would clarify provisions of the Internal Revenue Code to remove barriers for individuals with Health Savings Accounts (HSAs) from using those funds to access Direct Primary Care;
    - Additional information available here;
  - **Medicaid Primary Care Improvement Act** - This legislation was also introduced in Congress, with bipartisan support, and would clarify state Medicaid programs' authority to expand healthcare access through direct primary care;
    - Additional information available here;
  - **CMMI Policy Update** - CMMI recently announced that it will no longer collect data on race, ethnicity, sexual orientation, gender identity, and preferred language. The collection of self-reported disability status is also "pending further review."

- **National Meetings/Conferences** - The following upcoming meetings, webinars, and conferences were highlighted:
  - **Standing Committee on Primary Care** - The National Academy of Medicine Standing Committee on Primary Care held an open meeting on March 6, and a recording of the event is available here;
    - The next open meeting will take place on May 29-30, and will have a hybrid option for in-person or virtual attendance; additional details will be shared when available;

Discussion:

- A member who also serves as a co-chair of the Standing Committee on Primary Care offered some additional information about the recent and upcoming meetings. As a brief refresher, the Standing Committee on Primary Care is situated within the National Academies of Sciences, Engineering and Medicine, and the purpose of the committee is to advise the federal government on a myriad of primary care policy issues. They

primarily do their work through publications and public meetings, and this calendar year the committee is focused on enhancing access to high quality primary care by tackling payment workforce and digital health issues;

- A virtual open meeting was held on March 6, so the recording and all the proceedings will be on the Committee's website. The meeting at the end of May is a hybrid meeting, so it will be in-person in DC, but have an opportunity to join virtually as well;
- The Committee is currently working on the May agenda, but is tentatively planning to include a trio of sessions related to AI digital health technologies in primary care. One panel will potentially focus on Medicaid and access to primary care with a focus on the pediatric population, and may explore the role and implications of Medicare Advantage in primary care. Another panel will likely be a patient consumer panel, which will discuss their interaction(s) with different digital health technologies, the use of AI in the primary care setting, what their take is on this. A third panel may look at pricing out the cost of providing high quality primary care to everyone in the US (what the total price tag might be). When the agenda is available and registration is available, those details will be shared with PCPRC members;
- As an additional update: the Standing Committee released a report at the end of February that provided a series of evidence-based recommendations to the federal government on alternative data sources and methodologies that can be used to evaluate primary care services outside of the current RUC (American Medical Association's Relative Value Scale Update Committee) process. The report can be accessed at the following link: https://nap.nationalacademies.org/catalog/29069/improving-primary-care-valuation-processes-to-inform-the-physician-fee-schedule.

- **Milbank 2025 Primary Care Scorecard** - The Milbank Memorial Fund recently released a Report from the Frontlines of US Primary Care on the Impact of Recent Federal Policy Changes, which was shared as one of the pre-readings for the meeting;
  - A webinar event was hosted on Feb 7, and a recording is available here;
- **PCC Webinar Series** - The national Primary Care Collaborative organization is hosting a webinar series related to primary care;
  - The next webinar, "Why Don't Patients Have More Time with Primary Care?", will be on April 16 at 11 am MT; registration available here;

Discussion:

- A member noted that the PCC would be hosting their annual summit on June 4-5; registration is available at the following link: https://thepcc.org/event/scaling-what-works-for-better-health/

- **CMS Quality Conference** - The annual CMS Quality Conference, originally scheduled to take place March 17-19, has been postponed.

The following state updates were provided:

- **2025 Colorado General Assembly Legislative Session** - The 2025 legislative session kicked off on January 8, and will end on May 7. On day one ~130 bills were introduced. To date, ~ 682 bills have been introduced; of those, 100 have been postponed indefinitely, 88 have been signed by the Governor, and there have been no vetoes.
  - Two bills related to reproductive health (SB25-129 and SB25-183), and two bills related to transgender rights/gender-affirming care (HB25-1309 and HB25-1312) have generated a lot of debate, and continue to work their way through General Assembly;
  - Additional bills that may impact the Collaborative's work include:
    - HB25-1002 Medical Necessity Determination Insurance Coverage- passed;
    - SB25-010 Electronic Communications in Health Care- passed;
    - SB25-017 Measures to Support Early Childhood Health;
    - SB25-048 Diabetes Prevention & Obesity Act;
    - SB25-118 Health Insurance Prenatal Care No Cost Sharing;
    - SB25-126 Uniform Antitrust Pre-Merger Notification Act;
    - SB25-152 Health-Care Practitioner Identification Requirements;
    - HB25-1088 Cost for Ground Ambulance Services;
    - HB25-1162 Eligibility Redetermination for Medicaid Members.

At the end of federal and state updates, Tara Smith asked members for feedback on ways the Division can most effectively convey important updates, and facilitate information sharing and discussion. To date, these presentations have been somewhat static, and a reading of bullet points on issues/topics identified by the Division- member suggestions on how to make these presentations more dynamic, and/or to engage members more directly (in terms of presentations, sharing of resources etc.), are welcome.

Priorities for 2025

Tara Smith provided a brief summary of the pre-reading materials for the meeting, which included articles about the current state of transition in the national landscape and its impact on health care policy and primary care specifically (see slides 17-23, available HERE). She then walked members through discussions of goals, priorities, resource needs/requests, and

overall satisfaction with the Collaborative, using a combination of results from an online survey that was circulated to members prior to the meeting, and interactive Menti comments offered during the meeting.

2025 Goals

The Division received the following responses to the online survey question: "What are your goals for the PCPRC this year?"

This will be my first full year participating, so just getting a sense of the full process

- To further advance primary care investment goals/targets;
- Draw attention to access to care issues (especially in rural);
- Start to lay the regulatory framework for AI in health care;
- Create a comprehensive, statewide primary care strategy (possibly including a state-level scorecard)

Continue to influence how Primary Care is funded and resourced in Colorado

Ensure the PCPRC work continues and makes a difference for primary care in CO

My goals for the PCPRC this year focus on ensuring that primary care payment reforms enhance affordability, maintain access, and promote value-based care without adding unnecessary costs or administrative burdens.

1. **Affordability & Sustainability** - Advocate for payment reforms that improve primary care investment while maintaining affordability for consumers and employers. We support sustainable models that do not drive-up premiums or impose unfunded mandates on health plans.
2. **Alignment & Consistency** - Promote alignment across stakeholders (payers, providers, policymakers) to avoid fragmented or duplicative initiatives. We seek consistency in quality measures, reporting requirements, and payment models to reduce administrative complexity.
3. **Value-Based Innovation** - Encourage reforms that advance value-based care models rather than fee-for-service increases. Our focus is on incentivizing high-quality, patient-centered care rather than simply increasing reimbursement.
4. **Data-Driven Decision-Making** - Support the use of transparent data to assess the impact of primary care investments. We advocate for data-sharing mechanisms that allow for meaningful evaluation of cost, quality, and patient outcomes.
5. **Equitable and Accountable Care** - Ensure that reforms promote equitable access to primary care while holding all stakeholders accountable for cost and quality improvements.

During the meeting, members were asked to respond to the following question in Menti: "As a PCPRC member, my top goal for 2025 is…"

Contribute often!	Share new claims analysis	Moving us toward the creation of a comprehensive PC strategy for the state	Evaluate where patients get primary care across the state

Build new research collaborations	Listen, learn, collaborate so that we can move high quality primary care forward in Colorado	Monitor how funding for primary care changes with overall funding changes in new administration	Focus efforts on growing primary care investment

Discussion:

- Tara Smith asked for further clarification on the comment "share new claims analysis";
    - The member who provided the comment noted that CDPHE (which they represent) is working on new analyses involving claims that will likely be informative to the Collaborative, and may be able to fill in gaps created by the loss of access to some federal data sets. Specifically, the project involves adding social determinants analysis to existing data, in a geospatial sense, that will allow for the analysis of ambulatory care sensitive conditions down to the Census Block group level- it will be similar to hot spotting work done several years ago, but with much larger data and very tied to primary care access;
    - Another member was very interested in this data, and noted that it fit well with their comment, which was to evaluate where patients get primary care across the state, including where it is received and how it is paid for, with an ability to look at the pediatric population;

- In thinking about locations of care, Tara Smith asked members about their knowledge of direct primary care (DPC), and the prevalence of this care delivery model in the state- is this an area of interest for the Collaborative to explore?
    - One member expressed interest in the topic, and noted they have heard it is a direction people are moving in; as a practicing physician, they could appreciate the attractive components of DPC- it is likely that many clinicians at the burnout stage have asked themselves whether it would be worth doing. But I think in some ways, DPC is a threat to the access goals we all have, and can set up personal conflict- the member noted that as a physician, they didn't go into medicine to just take care of some people. It is really hard to give the great kind of care that we would like to give with the limited access we have in some of our practices. The draw is that you can see regular panels, and have income that is more guaranteed- and it is an alternative to some of the employment situations that many docs find themselves in.
    - A member noted via chat that equity is a large concern with DPC; multiple members agreed with this comment;
    - Another member noted that it is hard to understand the scope of DPC in Colorado, because "you don't know what you don't know"; when you don't have codes or claims, it is hard to know where people are getting care. In the

pediatric space, it's less common, because you cannot get care if you have Medicaid. However, in the last two years the use of direct telemedicine care seems to be increasing. Again, it is hard to gauge how much it is being utilized due to the inability to track claims or payments, and what may be driving it.

- A meeting participant noted that DPC had been discussed by the PCPRC a few years ago, and at that time they had encouraged payers to consider how to incorporate some of the principles of the model to work with providers to reduce administrative burden. One of the primary draws of DPC for providers is that it eliminates a lot of the reporting and other administrative tasks. The participant supported the comments of other members, and agreed the lack of data makes it hard to gain insight- but the reason the data sources don't exist is because the providers are freed from the burden of doing that reporting, which is why DPC is so attractive. Colorado has been a leader for DPC across the nation- a lot of those original practices started here, as well as in North Carolina and other spots- and it has really taken off;
- A member added that it's hard to check quality in DPC practice when they are not generating bills (and associated codes). In addition, in some places, such as Portland, it is hard to find a primary care doctor without joining a DPC practice and paying a membership fee each year. It can create a barrier to access, if people have to pay a membership fee in addition to the rest of their costs, and it may create more inequality in benefits;
- A member agreed with the idea of taking some of the payment concepts from DPC and applying them a little more directly; they noted that they work with a couple of systems that are looking at how they compensate primary care and trying to incorporate this idea of some sort of a payment panel, in which payment was associated with the panel versus payment associated with the volume of care. They are trying to think through whether they can pay primary care doctors in a way that is more like DPC to drive some of the population health change that we are all trying to get to, but still maintaining some kind of incentive for access. Ideally you want a system in place that is going to encourage people to see patients when they need to be seen.
- Another member, who administers the state employee health plans, offered comments on the state's experience with primary care. They noted that the state started contracting with primary care about 10 years ago through Palladina, and when the contract was set up the state had around 21-22,000 employees. The contract was set up in a way that all of Paladina's fees were at risk, and if the state didn't see an ROI, they it would be reimbursed- and Paladina actually wound up paying the state back a lot a lot of decapitated fees for the first two or three years. Once the state hit a critical mass, the contract was switched to a flat capitated fee without an ROI, because at that

point the state would have wound up paying them. Over time, we have seen utilization grow and grow; it isn't mandated on the state plan, and about 20-25% of eligible people are using it. That's not as high as the state would like it to be, but the state plan has had very good results with it. For example, when trying to roll out an initiative, such as increasing breast cancer screening or colon cancer screening, or making sure everybody's getting screened on depression or anxiety tests, it has been an effective tool. The state has also used nurse practitioners in more rural areas to expand access there where it makes sense. The member further noted that the initial contract was with Paladina, which was a subset of Davita, but was then sold to or recreated as Everside, which has subsequently been sold to or recreated as Marathon. So, there is a lot of money moving around in this space, but state employees have generally liked it a lot, and the company itself has been very responsive to things that the state has asked them to do.

- Tara Smith asked about the geographic distribution of participation, and whether enrollees were concentrated in Denver, or if there were options in other areas of the state;
- The member noted that Denver has higher participation in terms of raw numbers, but the state does consider access issues when determining whether to add a new clinic; for example, a site was added in Salida, knowing that while the ROI would not be the same, the people in that area weren't able to get the same level of care. So having a good DPC that they could go to would help employee morale, and "level the playing field" in different areas of the state. It is not just a matter of getting the best ROI by stacking clinics on top of each other on the Front Range.

  - A member commented on the impact of potential reductions in Medicaid funding, and a large number of people that may drop off of Medicaid or CHP+ as a result, and whether that might drive an increase in DPC, which could act as sort of a bridge. People may get a DPC membership, as opposed to true health insurance, and end up with quasi-coverage; it would be interesting to look at in the context of overall funding changes.

- Tara Smith next asked members about the Menti comments related to "new research collaboration", and a "comprehensive primary care strategy for the state".
  - The member who offered the comment on research collaboration explained they were thinking about change and availability of things like birth outcome data. For example, the pregnancy risk assessment monitoring system data that's been collected for decades is no longer available on CDC website, and we all know that healthy people start with healthy pregnancies, and we need to be able to evaluate primary care's role in healthy pregnancies, healthy deliveries,

healthy first year of life, healthy moms, etc. Finding ways to collaborate to make sure we have good resolution and good surveillance data on the needs of the state, so that we can assure those with the highest risk pregnancies receive the care and support they need to have healthy babies, will be important.

- A member agreed with this comment, and noted that it would be interesting to know the scope of federal data that Colorado previously had access to, but is no longer available. That might help inform where the Office of Primary Care and other organizations can build up state data to replace what we have lost or will potentially lose. In terms of primary care, that would be very valuable.
- The member from CDPHE provided links in chat to familiarize other members with what is available, and noted the state would certainly continue to maintain Colorado specific data. However, funding for the Pregnancy Risk Assessment Monitoring System (PRAMS) is federal, and funding for those services is not expected to continue going forward. So, for this type of data, we will need to find other ways to support good public health surveillance efforts so we can understand birth outcomes. And this is just one example of an area of concern that we would like to address, through better data. Pregnancy-related care is certainly closely adjacent to primary care, but there are other data sets that are even more explicitly related to primary care.
  - https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring
- A meeting participant asked via chat whether CDPHE was keeping track of clinic closures and hospital service line availability/ceasing of services such as OB/GYN services;
  - The member from CDPHE explained that last session legislation was passed that required birthing centers that intend to close to notify CDPHE, but noted the legislature didn't specify what needed to be done with that information. But CDPHE is supposed to be notified of those changes, and is currently updating their Board of Health rules related to primary care workforce analysis to include new perinatal care analysis, which again is not directly tied to but closely related to primary care. CDPE is very interested in the contribution to the full scope of primary care, or full scope of family medicine physician, including pediatric access for the first year of life in particular. We are drafting assessment work now, and will start to share that among stakeholder communities, to gain feedback and input on what we have done, how we have done it, and ways we can make it better.

- In relation to the comment "comprehensive primary care strategy for the state", the member who added this in Menti noted they were thinking about measures, such as access or workforce, or multiple others that could be used to holistically assess the

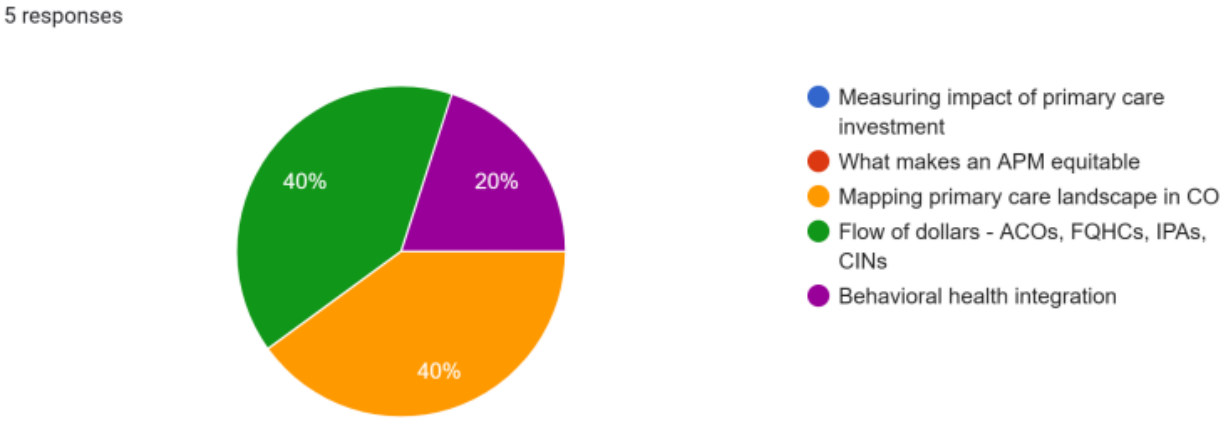
state of primary care. The comment was triggered by research the member is currently doing with colleagues at the Farley Center, examining state level policy levers to advance adoption of primary care APMs, and there are a couple of states in the sample that have something that is a more holistic look at across state agencies. These efforts recognize the different roles of different state actors - on the insurance side, or payment side, or data tracking - but try to create a guiding primary care plan and strategy across state agencies. In the five states that we've studied in this particular project, there isn't a state that has done this, so there isn't necessarily an example we can point to. But several key informants in that work have talked about things like the frustration of working in the commercial sector, and having it be such a small part of the overall picture- which makes it challenging to wrap your hands around and affect access to and the quality of primary care delivered, when you are only operating in "your lane", and it only constitutes a small portion of the market and how people access primary care. The member noted any such undertaking would require a lot of definitions and other ground work, but an ideal mentioned by many in the study was having a statewide comprehensive primary care strategy, in which different agencies, divisions, and departments would be responsible for their component, but that it would be sort of integrated primary care policy across these, these different actors at the state level.

- Multiple members agreed with this comment, and liked this idea. Tara Smith noted that the executive branch in Colorado has a solid foundation of cross-agency collaboration, and Governor Polis has created a state Dashboard with goals that often involve contributions from multiple state agencies. The idea of a strategy also fits in well with the themes of accountability, and new data sources, which members have often discussed.

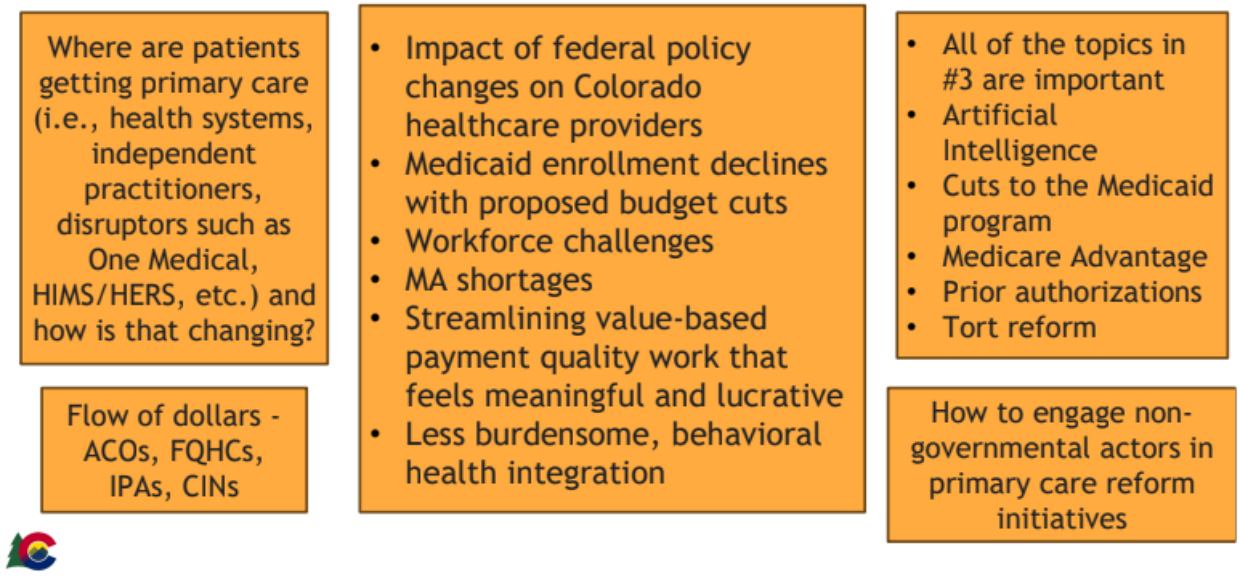
2025 Priorities & Topics

Tara Smith then turned the discussion to specific topics of interest and priorities for 2025. She briefly reviewed priorities identified through the online survey, and led two Menti exercises.

The Division received the following responses to the online survey question: "What issues or topics would you like to see the Collaborative address this year?" (multiple choice question)



The Division received the following responses to the online survey question: "What additional topics are you interested in?"



Discussion:

- In discussing the survey responses, Tara Smith asked the group about interest in looking at issues related to Medicare Advantage (MA);
    - One member commented that while it sounds interesting, it is also a big body of work to take on, particularly at a time when the Collaborative may need/want to preserve flexibility to capture and respond to the damage that's being done to the primary care part of the healthcare system; taking on this brand new area of work might distract us from being able to pivot to being the witness or the monitors of the system;

- Another member agreed with this comment, noting that while there is some "there there" with Medicare Advantage, the Collaborative would need to be very specific about using a primary care lens, and identifying where the group would want to focus, so that it is not subsumed by the many challenges in this space. Based on what the member has heard through their networks, including rural colleagues, issues like narrow networks and referral, and the ability to access needed specialty care, are two pain points from a primary care perspective and are incredibly challenging. There have been reports of people who have received primary care at a particular location for decades, then switched to a Medicare Advantage plan, and are now having to drive a far distance to receive services because their previous provider is no longer in-network. So, there is a primary care angle there, but we would need to be specific in what we want to look at and what we hope to achieve.
- Another member commented that as the Collaborative started to look at where people are getting primary care, issues around Medicare Advantage may come up, as certain groups are owned by plan, etc. In addition, MA plans are doing some clinical work as well, in terms of in-between spaces- so looking at where care is coming from may surface questions around MA plans.
- Tara Smith asked if any of the payer representatives on the call wanted to comment, regarding their book(s) of MA business, but did not receive a response during the meeting.

To look at priorities from a different perspective, Tara Smith asked meeting participants the following questions via Menti.

During the meeting, members were asked to respond to the following question in Menti: "What keeps you up at night when you think about the future of primary care?"

The Administration will fully repeal PWORA exemptions and CHCs won't be able to care for community members without documentation using federal funds. Or at all because they get federal funds.	The implosion of the safety net system	Draconian Medicaid funding cuts	Moral injury to my colleagues
Honestly, I worry that as fewer and fewer policymakers have personal or familial experience with high-	The lack of primary care access, accompanied by the tyranny of the 20 minute visit that leads	Children suffering due to lack of access	The implosion of the rest of primary care, supplanted by poorly connected non-systems (urgent care, virtual

quality primary care, it will become harder to advocate for this very thing.	to the "deskilling" of our primary care workforce.		care, surgicenters, etc) that don't talk to each other (and don't do prevention).
Primary care providers (MD, DO, NP, PA) leaving the clinical field - retiring, non-clinical roles, suicide, different models - and rapid decline of new healers to the system.	Draconia (and thoughtless) Medicaid funding cuts	Access, and a shrinking pool of primary care providers	Precipitated rural health systems collapse

Discussion:

- A member asked what PWORA stood for; the member who made the comment explained that they were referring to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that was signed into law by President Clinton in 1996. It included rules around public charge and the spending of federal dollars on people who are undocumented, and certain programs like Head Start and the community health center program were exempted from at that time.

During the meeting, members were asked to respond to the following question in Menti: "What gives you the most hope when you think about the future of primary care?"

An opportunity to see what is most valuable to move the needle in health of patients and families	The trainees I work with every Friday	Tapping into untapped patient power to speak up for what they need and want and deserve	Advocacy of our youth
Resiliency of youth and innovation of technologies (AI used for benefit!)	Primary care spending saves money. It aligns with the MAHA agenda.	I do think we are at a place where, if thoughtful investment can be made, we can create platforms and connections that will enable better overall care	

2025 Speakers, Initiatives, Research

The Division received the following responses to the online survey question: "Are there speakers, initiatives, research, or articles that you would like to share/hear about at an upcoming meeting?"

National Experts on Value-Based Payment Models	• Dr. Mai Pham (former Chief Innovation officer at CMS) • Dr. Mark McClellan (Duke-Margolis Center for Health Policy) • Health Plan Innovation Leaders
Payer Organizations	• Reps from AHIP on national trends in primary care investment • Executives from CO-based Health plans to discuss successful primary care payment models in practice
Actuarial & Economic Experts on Primary Care Investment	• Experts from Milliman, Wake or RAND • Research on how increased primary care spending impacts total costs of care, premiums, and affordability
State Policy & Implementation Experts	• Officials from states like Oregon, Rhode Island, or Washington that have implemented primary care investment policies and can share lessons learned
Key Research & Reports of Interest:	• Recent Studies on Primary Care Spending & Affordability • How shifting payments to PC impacts overall healthcare costs, premiums • Effectiveness of APMs vs. fee-for-service in improving outcomes
DOI & HCPF Data Insights	• Further discussion on DOI's primary care spending analysis and how it aligns with broader cost containment strategies • Updates on HCPF's Alternative Payment Model efforts
Initiatives of Interest:	• CO-Specific Payment Innovation Pilots: Examples of successful health plan-driven primary care payment initiatives • Case studies on risk-sharing arrangements and care coordination efforts that have improved patient outcomes
Technology & Data-Sharing Initiatives	• How real-time data sharing and interoperability can enhance primary care effectiveness in a value-based model

Discussion:

- In reviewing the suggestions received through the survey, Tara Smith asked members to please be thinking about their own networks, and connections with national figures and/or organizations that might facilitate invitations to the PCPRC;

- A member expressed interest in engaging in some way with participants in the Medicare Transforming Episode Accountability Model (TEAM), which is being implemented in some of the markets here in Colorado. That model explicitly calls out collaboration with primary care, and might offer the PCPRC a way to have a voice at that table, so that we aren't doing work in siloes.

DOI Support, Facilitation

The Division received the following responses to the online survey question: "How can the DOI/PCPRC co-chairs support your active participation/engagement in PCPRC meetings?"

At least 1 week to review materials

Continue with support as is - you are doing great!

I would find it helpful to learn a little more about other participants - each one of us brings a unique perspective, and it would be helpful to learn more about what those perspectives are.

You do a great job of sending the materials ahead of time and providing multiple opportunities for us to contribute!

Ensuring a Balanced Discussion	• Facilitate discussions that allow for diverse perspectives, including the voices of health plans, providers, employers, and consumers. A balanced approach ensures that affordability and sustainability remain central to reform efforts.
Clear Agendas & Advance Materials	• Providing meeting agendas, relevant materials, and discussion topics well in advance allows CAHP to prepare meaningful contributions. Clear objectives for each meeting will help drive productive conversations.
Data Transparency & Collaboration	• Ensuring that shared data and analyses are accessible and reflective of real-world implications for health plans and consumers. Collaborative discussions on data interpretation will help inform practical, sustainable reforms.
Defined Goals & Measurable Outcomes	• Establishing clear priorities for PCPRC and defining how success is measured will help CAHP and other stakeholders align efforts effectively.
Flexible & Efficient Meetings	• Structuring meetings to maximize efficiency—such as targeted workgroups, virtual participation options, or defined time for key stakeholder input—can improve engagement and allow for more substantive discussions.
Recognition of Market Realities	• Acknowledging regulatory and financial constraints that health plans navigate when implementing reforms ensures that recommendations are actionable and sustainable.

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Discussion:

- Tara Smith noted the Division's appreciation of this feedback, and was particularly interested in getting members' ideas about how they can learn more about each other. She mentioned the possibility of hosting another hybrid meeting this year, so that members would have a chance to interact with each other in person, but was also open to ideas on how to do this in a virtual environment (e.g., setting aside 5-10 minutes during each meeting for more personal introductions, etc.).

To get additional perspectives on how to improve PCPRC meetings, **during the meeting**, members were asked to respond to the following question in Menti: "Think of the best meeting you have been to this year- what made it great?"

Opportunity to connect in person + clear discussion questions posed to committee members to spark conversation + opportunity for different committee members to present	Case Bonita and also CIVHC first annual research conference	I have always liked the meetings where half is didactic, and the other half is discussion around how this particular idea might apply to what we are trying to accomplish. And, love the Menti thing!	Connecting on a shared purpose - interaction
Interactive discussion	A community meeting in Gunnison that was engaging and fulfilling- concise agenda, expectations of participants, well run meeting by two moderators	Leaning from national experts	

Aligned APM Parameters Implementation

The Division received the following responses to the online survey question: "What are the best mechanisms to facilitate the PCPRC's review of the aligned APM parameters?"

5 responses

The Division received the following responses to the online survey question: "What are the key considerations for the aligned APM parameters (either individually or in total) in the short-term? Medium-term? Long-term?"

Alignment with other payers; comprehensive data sets

Patient attribution - Patient choice is important but may not be reflective of availability. Example: patient wants to see female doctor or local pediatrician but if those doctors are not available then the patient sees an APP or non-preferred clinician. Claims data would accurately reflect who rendered services to the patient and attribute accordingly.

Patient attribution - Careful consideration and review should be practiced for geographic assignment. What happens with second homeowners? Example: We experienced an issue where claims were being denied for one of our providers as "out of network" as the health plan had a cohort of patients in Gunnison County assigned to providers in Pitkin County which was due to an automated geographic attribution algorithm.

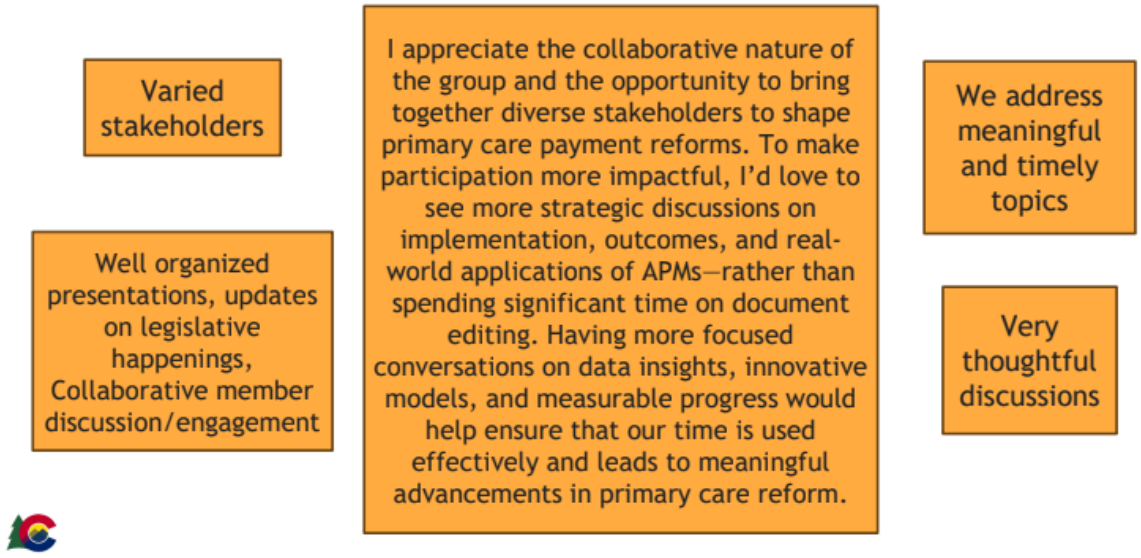
Short-Term (2025-2026)	Feasibility & Market Alignment	• Ensure parameters are practical, avoid unnecessary administrative burdens
	Risk Adjustment & Patient Attribution	• Use transparent, fair methodologies that account for patient complexity
	Quality Measures	• Focus on meaningful, outcome-based metrics aligned with national standards
Medium-Term (2025-2027)	Financial Impact & Sustainability	• Assess effects on cost, premiums, and provider reimbursement
	Provider Readiness	• Support smaller practices in transitioning to value-based care
	Data & Performance Metrics	• Improve transparency and streamline reporting to reduce administrative burdens
Long-Term (Beyond 2027)	ROI & Cost Containment	• Ensure primary care investment leads to affordability and improved outcomes
	Evolving Payment Models	• Explore capitation or alternative structures for long-term sustainability
	Stakeholder Engagement	• Regularly review data and adapt parameters as needed

Discussion:

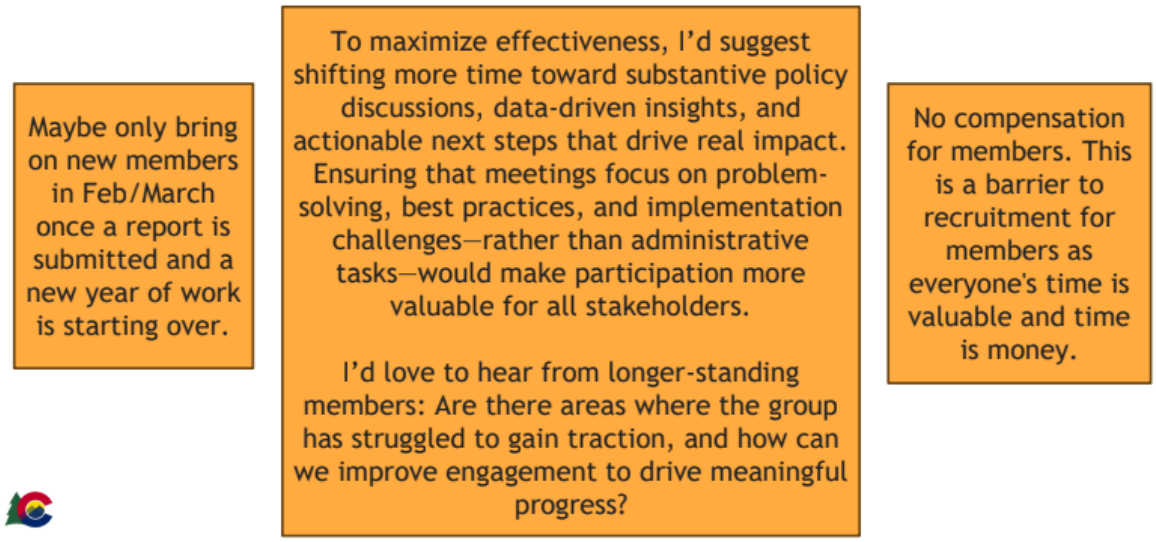
- Tara Smith reviewed the survey responses related to the Collaborative's annual review of the aligned APM parameters. Once again, members expressed a preference to utilize an existing meeting, rather than scheduling an extra session. The Division anticipates the meeting to discuss parameters will again be held in September, but will confirm that date with members and stakeholders before the next PCPRC meeting in May.

Overall Satisfaction with PCPRC

The Division received the following responses to the online survey question: "What do you like best about the Collaborative, and/or think makes it most effective? (What should we ramp up?)"



The Division received the following responses to the online survey question: "What do you like least about the Collaborative and/or think make it less effective? (What should we dial back?)"



The Division received the following responses to the online survey question: "Please share any additional thoughts or ideas you have related to the Collaborative (e.g., operations, meeting structure, annual report, member recruitment, etc.)"

Would like to see greater participation in discussion from payers, including ideas they have for solutions on reducing administrative burden and increasing investment in primary care.

There is so much material to digest, and I wish I had more time to really prepare.

Discussion:

- Tara Smith briefly reviewed the online survey responses, and invited members to send any additional ideas, suggestions, critiques, or concerns to her directly.

Other State Primary Care Initiatives

- In the remaining time of the meeting, Tara Smith briefly reviewed some of the activities other states are engaged in related to primary care, to give members a sense of the current landscape; in addition to states that have either primary care spending reports or some sort of investment or cost/growth target (see slide 46, available HERE), she highlighted 3 states that may be of particular interest to members:
    - **Virginia** - established a Task Force in 2020, with a focus on data platforms, and has since created a Primary Care Scorecard and Dashboard that allowed annual tracking of primary care investment and regional clinician capacity; the PCPRC has expressed interest in developing some sort of state dashboard for Colorado, and Virginia could be a resource/example for guidance (see slide 47, available HERE)
    - **Rhode Island** - Rhode Island has long been a leader in primary care investment efforts, and was the basis for HB19-1233; over the last 15 years, they have updated their primary care investment target and methodology, and taken additional actions around integrated behavioral health strategies, and measure alignment; Rhode Island's experience and expertise on a multitude of topics might be of interest to PCPRC members, particularly if the Collaborative is in a position to start thinking about goals over the next 7 years, if SB25-193 passes (see slide 48, available HERE);
    - California - California currently has one of the most aggressive investment targets (at 15%), and their state-level work has also included initiatives around measure alignment and purchaser engagement; to date, Colorado has not been successful in engaging self-insured employers, and California may have strategies and/or lessons that could inform possible next steps here(see slide 49, available HERE).

Discussion:

- A member noted that they have a colleague in Virginia, Beth Forks, who serves on the Standing Committee on Primary Care; she is the Director for the Virginia Center for Health Innovation, which supports the Primary Care Task Force; they would be willing to reach out to Beth if of interest;
- Tara Smith also noted that Washington and Oregon could easily be added to the list, and she noted that a meeting participant had entered the name Chris Kohler in the chat, who is always a powerful voice and champion for primary care.

Public comment:

- No public comments were offered.