Primary Care Collaborative Meeting Minutes

Thursday, May 8, 2025; 10:00 - 12:00 pm

Meeting Attendance

Attended
Josh Benn
Steve Holloway
Cassie Littler
Amanda Massey
Erin McCreary
Dana Pepper
Amy Scanlan
Gretchen Stasica

DOI
Tara Smith
Deb Judy

Absent
Polly Anderson
Britta Fuglevand
Kate Hayes/Jack Teter
Lauren Hughes
Alex Hulst
Patrick Gordon
John Hannigan
Rajendra Kadari
Sonja Madera
Kevin McFatridge

Agenda:

1. Housekeeping & Announcements
2. Federal & State Updates
3. Priorities & tentative schedule for 2025
4. ACOs - Impacts, opportunities, challenges
5. Public Comment

Introductions:

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

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Minutes from the April meeting had recently been posted, but would be approved at the June meeting to give members time to review;

  ACTION ITEM:
  - Meeting minutes for the April meeting will be approved at the June PCPRC meeting.

- **SB25-193 Sunset Primary Care Payment Reform Collaborative** - The legislature passed the bill (SB25-193) to continue the PCPRC for an additional 7 years, which will now go to the Governor for his signature. The Governor has 30 days from the end of session (until June 6, 2025) to sign the bill, veto the bill, or let the bill become law without his signature. The Division anticipates the Governor will sign the legislation.

- **PCPRC membership update** - Tara Smith provided the following membership updates:
  - First, she noted the Division had not had a chance to reach out to current members to discuss the status of their current membership terms, but will be doing so in the next few weeks;
  - Second, she suggested that the group revisit/discuss co-chair roles at the June meeting. One of the members who had been serving as a co-chair (a consumer representative) recently left the Collaborative, so at least one seat is currently open. She briefly reviewed the role of the "chair" or "co-chair" of the PCPRC, as decided on by Collaborative members in the current Standard Operating Procedures; and
  - Third, she informed the group that the Division had extended invitations to 3 new members, and asked the 2 new members who were present to briefly introduce themselves (Note: one new member joined the meeting late, but for clarity in minutes, both responses are included in the Discussion section immediately below):

Dana Pepper
Vice President, Provider Performance and Network Services
Colorado Access

Erin McCreary
Consumer
Colorado Springs

Mannat Singh
Executive Director
Colorado Consumer Health Initiative (CCHI)

Discussion:

- Dana Pepper (DAN-a) expressed her excitement to be part of the PCPRC, and noted she had been in her current role at Colorado Access for around 3 years. She has a background as a clinician- she is a nurse and was previously the Chief Nursing Officer

at Swedish Medical Center, working in the hospital setting, and from there went to the provider side, doing ACO work and early clinically integrated network (CIN) work. From there, she transitioned to the payer setting, working for Aetna, Anthem, and Evelyn Health, but always on the provider side, helping primary care primary care and specialist providers figure out the payer system and how to be successful in it, especially as ACOs and CIN and other kinds of models came along- work that was centered around practice transformation. At Colorado Access, she currently oversees the practice transformation teams, all provider engagement teams, quality behavioral health, and the Children's Health Insurance Program (CHIP). She is also involved in implementing Cover All Coloradans (a new Medicaid program that provides coverage to children and pregnant people, regardless of their immigration status), and the associated network development. Colorado Access does a lot of work around supporting primary care, for the FQHC model and across the entire region in which they operate (in and around the Denver metro area), including rural areas which serve CHIP enrollees. Dana expressed her strong interest in helping primary care providers be successful in today's world, which requires tackling reimbursement challenges, staff shortages, and a variety of other challenges. Colorado Access is very focused on integrated health right now, and how to best facilitate warm hand-offs for members, and where and how they can support integrated health for primary care, to make that process better and easier. They are also working on creating better pathways from primary care to specialists, which is particularly challenging in the Medicaid context.

- Erin McCreary introduced herself to the group, noting that while she has around a decade of experience working in revenue cycle management (the back-end money making area of the healthcare cycle), she is excited to join the PCPRC in the role of health care consumer. She currently works for Colorado Children's Hospital, as a payer relations representative, where she works closely with patient's insurance and mainly with primary care practices that are affiliated with Children's Hospital. She has been joining PCPRC meetings as a member of the public for several months, starting in December as members were working on finalizing the annual recommendations, and thought it was an amazing experience to watch the collaboration that went into the development of the report. She acknowledged that when you work somewhere in the healthcare industry, that is generally the hat you wear in forums like the collaborative, but expressed her excitement in bringing her experience as a patient, and as a mother of children, to help inform the group's work.

- Tara Smith expressed the Division's excitement in welcoming these new members, and their expertise and perspective on primary care. She noted that the Division has also invited Mannat Singh, the Executive Director of the Colorado Consumer Health Initiative (CCHI) to fill the seat vacated by Isabel Cruz, and hopes to welcome her aboard in the near future.

Federal & state updates

The following federal updates were provided:

- **HHS Updates** - HHS recently issued the following announcements/reports:
  - Released "Comprehensive Review of Medical Interventions for Children and Adolescents with Gender Dysphoria" - On May 1, 2025, HHS released a report that provides a "comprehensive review of the evidence and best practices for promoting the health of children and adolescents with gender dysphoria… [that] reveals serious concerns about medical interventions, such as puberty blockers, cross-sex hormones, and surgeries, that attempt to transition children and adolescents away from their sex." This report has been critiqued by medical associations, researchers, advocates for methods, lack of alignment with current guidance, misinformation, decision not to disclose authors;
  - Announced launch of Next-Generation Universal Vaccine Platform for Pandemic-Prone Viruses - HHS also recently announced the "development of the next-generation, universal vaccine platform, Generation Gold Standard, using a beta-propiolactone (BPL)-inactivated, whole-virus platform." The goal of this work is to provide broad-spectrum protection against multiple stains of pandemic-prone viruses (H5N1 avian influenza, coronaviruses). The approach has been questioned by vaccine experts for moving away from more recent science (m-RNA-based vaccines);

- **CMS Rulemaking** - CMS recently issued several new rules containing several provisions that reflect the priorities of the new administration: 1) Inpatient Hospital Whole-Person Care, Proposed Updates to Medicare Payments*; 2) Inpatient Rehabilitation Facility Prospective Payment System; 3) Hospice Wage Index & Payment Rate Update; 4) Inpatient Psychiatric Facility Prospective Payment System & Quality Reporting Updates; and 5) Skilled Nursing Facility Prospective Payment System;
  - While the rules address payment across multiple settings, they share comment elements, such as the inclusion of Requests for Information (RFIs) on ways to streamline regulations and reduce administrative burden, and adjusting quality measures to remove social determinants of health (SDOH) elements and vaccine measurements;
  - In addition, the Inpatient Hospital Whole-Person Care, Proposed Updates to Medicare Payments rule proposes several updates to the Transforming Episode Accountability Model (TEAM), including:
    - Participation – deferment period for new hospitals, timeline for termination;
    - Changes to target pricing and benchmark calculation adjustments; and

    - Quality measure adjustments – add 4th measure, remove health equity & SDOH reporting;

- **Merit-based Incentive Payment System (MIPS)** - CMS announced the suspension of 8 improvement activities for the 2025 performance year, instructing clinicians to select different activities, but not that if any of the suspended improvement activities have already been completed or were in the process of being completed:
    - IA_AHE_5 - MIPS Eligible Clinician Leadership in Clinical Trials or CBPR;
    - IA_AHE_8 - Create and Implement an Anti-Racism Plan;
    - IA_AHE_9 - Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols;
    - IA_AHE_11 - Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients;
    - IA_AHE_12 - Practice Improvements that Engage Community Resources to Address Drivers of Health;
    - IA_PM_6 - Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities (Use of toolset or other resources to close healthcare disparities across communities);
    - IA_ERP_3 - COVID-19 Clinical Data Reporting with or without Clinical Trial;
    - IA_PM_26 - Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B;

- Budget reconciliation – Tara Smith noted that the budget reconciliation process remains underway in Congress;
    - A concurrent budget resolution was passed in April, and House and Senate Committees are now targeting May 9 to have policies completed, with the goal of sending a packed to the President's desk by July 4;
    - In terms of health care, many people are watching what happens in the House Energy & Commerce Committee, which has authority over Medicaid, the Children's Health Insurance Program, and parts of the ACA; the House Energy & Commerce Committee also has shared jurisdiction over large parts of Medicare, but generally defers to Ways & Means on major Medicare changes;
        - House reconciliation instructions directed Committee to find $880 billion dollars in reduced spending, and cuts to Medicaid are anticipated to be the only way the Committee can reach that target;
    - The Congressional Research Services' Reconciliation Process FAQs are available for members interested in learning more about the reconciliation process;

- Attorney General lawsuits - On behalf of Colorado, Attorney General Phil Weiser has joined at least 14 lawsuits against the Trump administration since January, most

recently joining a suit related to the restructuring of HHS (for a complete list, see slide 12, available here);

- Upcoming primary care webinars/events:
  - Standing Committee on Primary Care on May 29-30;
  - CMS Quality Conference rescheduled for July 1-2, 2025;
    - Details in coming weeks;
  - Cornell Health Policy Center – Does Value-Based Payment Work?
    - Expert discussion of state of evidence on Medicare VBP programs;
    - Thursday, May 29 from 2-3 pm MT
  - PCDC Webinar- Primary Care Access and Outcomes in NY State;
    - Data dashboard highlighting need for primary care investment.

Discussion:

- In relation to the recent changes in CMS rules related to quality measures, a member asked about the potential impact such actions might have on Colorado's work to implement aligned APM measures for primary care (promulgated through Insurance Regulation 4-2-96), and whether/how these measures might need to be revisited, now or in the future;
  - Tara Smith put that question back to members, as the PCPRC is one of the entities designated in state statute to participate in annual reviews of the measures; she noted that in developing the measures, multiple stakeholders (including payers and providers), expressed an interest in aligning Colorado's measures with existing (national) reporting requirements; the measure sets in the rules discussed today are specific to those rules, and she noted that she hasn't seen any announcements from CMS related to the Universal Measure Set, which served as an anchor point for Colorado's measures; but moving forward, tracking what is happening at the national level, around both quality measures and core competencies (also included in 4-2-96, and relate, to some degree, to MIPS improvement activities), will be something for the PCPRC and the Division to keep in mind; while Colorado's measures are for state fully-insured plans, under the purview of the DOI, it will be important to recognize where we choose to align with national reporting, and/or where we decide to diverge, as a state, both now and in the future;

- In relation to the budget reconciliation process, a member questioned whether the $880 billion in spending reductions from the House Energy & Commerce Committee were likely to come from Medicaid and CHIP, or if there were other places spending could be cut?

    - Tara Smith noted that Medicaid and CHIP have been identified pretty widely by experts as the programs that will have to be cut in order to reach that magnitude of a target; how they will go about it remains to be seen.

- A meeting participant informed members that Kevin Stansbury, the CEO of Lincoln Health and a new PCPRC member, had been interviewed on "Morning Joe" earlier in the morning regarding his guest commentary in the New York Times about the potentially catastrophic impacts Medicaid cuts would have on his hospital and the community. The member felt the piece was particularly powerful because Kevin calls out that he and his community are conservative (in a state that leans liberal), and speaks directly to the Trump administration about the critical importance of Medicaid.

The state updates at the meeting were primarily related to Colorado's legislative session, which ended on May 7, 2025. Tara Smith was joined by Deb Judy, Deputy Commissioner, to provide an overview of the session (see slides 14-17, available here), and the following bills that are related to the PCPRC's work:

Benefit-related bills:

- **HB25-1309 Protect Access to Gender-Affirming Care** - this was the last bill to be passed by the House this session, and it codifies the gender-affirming care benefits that were added to Colorado's benchmark plan in 2023 into state statute; the bill also includes an amendment that allows the Health Insurance Affordability Enterprise (HIAE) to accept gifts, grants, and donations;

- **SB25-169 Insurance Coverage Preventive Health-Care Services** - this was one of the Division's priority bills, and it will give the Division flexibility to ensure that preventive services continue to be covered with no cost-sharing, regardless of what happens at the federal level; the ACA requires carriers to cover a variety of preventive health services as recommended by the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices (ACIP), three national, expert bodies without cost-sharing, but this could be impacted by a Supreme Court decision, or other actions by the Trump administration (a leaked budget document indicated this coverage could be at risk);

  Discussion:

  - Question: A member asked about the role of the Nurse Physician Advisory Task Force for Colorado Healthcare (NPATCH) in law, and how and why they were the entity selected;

  - Answer: NPATCH is situation within the Division of Professions and Occupations (DPO) at the Department of Regulatory Agencies (DORA), and will act as the entity that will help make preventive services recommendations if USPSTF, HRSA, or ACIP

go away, or existing recommendations are modified or repealed. Some concerns were raised about designating NPATCH, and the Division was open to other suggestions, but ultimately no one came up with a better idea. As it stands, NPATCH will be responsible for making recommendations to the Commissioner, who will then adopt those as rules after a public hearing process. NPATCH meetings are open to the public, and the Division's rulemaking process is also open, and has multiple opportunities for stakeholder input and feedback.

- Follow-up question: This isn't an area where NPATCH has traditionally been engaged- when it comes to vaccines, for pediatrics and adults, do they have a vaccine expert who could speak to vaccines for children and adults, or for Bright Futures for pediatric preventive care?

- Answer: The Division was not aware offhand how NPATCH members are selected, but noted that NPATCH meetings are open to public comment, and that the Division had, at the request of carriers, added language that required NPATCH to consult with national clinical societies, other experts, and/or patient groups, as well as carriers, to provide input on evidence and recommendations during public meetings. The intent is to include all stakeholders and relevant experts at the table, and the Division remains open to other ideas about how to structure the process without creating a large administrative burden.

- Follow-up comment: It is an interesting and novel challenge, in that we don't have this type of infrastructure in the state, because we have always had federal partners doing this work. It is something to keep in mind, in this realm and others, moving forward.

- **SB25-118 Health Insurance Prenatal No Cost Sharing** - this bill requires health benefit plans providing maternity coverage to cover up to prenatal care office visits without cost sharing, consistent with Colorado Option plans;

- **SB25-048 Diabetes Prevention & Obesity Act** - this is a repeat of a bill that was introduced last year, which would have required carriers to provide comprehensive coverage of diabetes and obesity, including coverage of GLP1- medications; the bill was amended, and as passed, it now requires large group plans only to cover treatment of obesity and pre-diabetes, including coverage for a comparable program to the National Diabetes Prevention Program, medical nutrition therapy, intensive behavioral or lifestyle therapy, and metabolic and bariatric surgery; carriers must offer policyholder the option to purchase coverage for FDA-approved anti-obesity medication, including at least 1 FDA-approved GLP-1;

- **SB25-296 Insurance Coverage for Breast Cancer Examinations** - this bill clarifies legislation that was initially passed in 2019 related to coverage of breast cancer screening, and required diagnostic and supplemental screenings;

Reproductive health:

- **SB25-183 Coverage for Pregnancy-Related Services** - this bill makes statutory changes to align with the passage of Amendment 79 last November. Amendment 79 created a right to abortion in state constitution and repealed a state funding ban on abortion;

- **SB25-130 Providing Emergency Medical Services** -this bill requires certain health care facilities (including hospitals, freestanding emergency departments, and community clinics) to provide emergency medical service, including abortion, when a person presents for care.

Prescription drugs:

- **Bills related to Pharmacy Benefit Managers (PBMs):** to bills were passed related to PBMs, but it is uncertain whether they will be signed by the Governor:
    - **HB25-1222 Preserving Access to Rural Independent Pharmacies** - this was one of two bills related to PBMs this year, and it sets a reimbursement rate and a dispensing fee rate for independent rural pharmacies. During the legislative process, there were some concerns about expanding it to chain pharmacies, but that did not happen. As passed, it applies to the ~120 independent rural pharmacies in Colorado;
    - **HB25-1094 Pharmacy Benefit Manager Practices** - this bill allows a PBM to earn income derived from the assessment of a single, flat-dollar service fee for the provision of a drug, which must be transparently expressed in a writing agreement between the PBM and the health benefit plan. The bill prohibits PBMs from earning income that is directly or indirectly based on the price or cost of a prescription drug, or designing a prescription drug formulary to favor certain drugs over therapeutically generic or biosimilar, unless the branded drug or biologic has a lower net acquisition cost and the lower cost is reflected in a lower out-of-pocket expense for consumers. The bill also includes transparency requirements for PBMs.

Discussion:

- With regard to HB25-1094, a member commented that carriers/PBMs remain concerned about the premium impacts associated with HB25-1094. This bill had two main pieces- the first was directed at PBMs, and includes a “delinking” provision that essentially delinks compensation from the price of the drug. From the perspective of

PBMs, this takes away a lot of the downward pressure that is put on manufacturers to reduce the cost of their drugs, and will therefore increase premiums. The second piece of the bill relates to reimbursement to all pharmacies, including chain pharmacies (not just rural independent). The prescribed level of reimbursement in NADAC plus a reasonable and adequate dispensing fee, which is not determined in the bill. During the legislative process, some proponents had suggested a dispensing fee of $12-14 per prescription, which would have an impact on out-of-pocket costs and premiums. As a note to the Division, other states that have implemented similar legislation, which required setting a "reasonable and adequate dispensing fee", have experienced thousands of complaints about what constitutes reasonable and adequate;

- With regard to HB25-1222, the reimbursement rate and dispensing fee is based on Medicaid, which is about $12-14 per prescription. So they are aligned in that component, but HB25-1094 is much broader.

- **Bills related to the 340B drug program:** Two bills were also introduced this session related to the 340B drug programs, which were initially competing, but through the process became complementary. Both bills included provisions related to prohibiting discrimination against 340B entities, and increasing hospital transparency:
    - **SB25-124 Reducing Costs of Health Care for Patients** - this was one of two bills related to the 340B drug program this session, and did NOT pass; at a high level, the bill would have set requirements around how nonprofit hospitals could use 340B net revenue; required hospitals to spend at least 80% of 340B net revenue on direct patient services or capital improvements; established transparency reporting requirements; and prohibited certain third party entities from denying or restricting the acquisition or delivery of a 340B drug to 340B covered entities.
    - **SB25-071 Prohibit Restrictions on 340B Drugs** - this bill similarly prohibits pharmaceutical companies from limiting the acquisition of 340B drugs by a covered pharmacy, and prohibits manufacturers from requiring covered entities to submit health information, claims and utilization, or other specific data that does not relate to a claim submitted to certain federal health care programs. The bill also includes transparency requirements for specified hospital covered entities.

- **SB25-301 Remove Authorization Requirement Adjust Chronic Prescription** - this bill removes prior authorization for chronic drugs, specifically when changes are made to the dose and frequency of chronic maintenance drugs, up to two times a year.

Safety net providers:

- **SB25-290 Stabilization Payments for Safety Net Providers** - this bill was introduced later in the session, as an alternative to an earlier bill that failed to gain traction; at a high level, it creates a new stabilization fund for safety net providers, which would provide funding for federally qualified health centers (FQHCs), community mental health centers and other safety net providers for rural, low-income, or uninsured Coloradans. The fund will be created and seeded with money from the state's unclaimed property trust, starting with $25 million this fiscal year, then $20 million the following year, and $15 million the year after. This bill was supported and backed by the Colorado Hospital Association (CHA), which has agreed to raise an additional $40 million to bolster this fund. Sponsors are anticipating the fund can be leveraged for federal matching dollars, and provide immediate relief to safety net providers;

- **HB25-1288 Support for Federally Qualified Health Centers** - this bill included a "gifts, grants, and donations" clause, with parameters and provisions around gifts that are specifically designated for FQHCs or certain other providers, and the way such money is allocated. The bill also allows FQHCs to set up a subsidiary that could offer services outside of the standard cost report on a fee-for-service (FFS) basis.

  Discussion:
  - A member commented that the bill was trying to create different kinds of payment models that could support FQHCs in providing care to Medicaid members; currently, FQHCs have restrictions around payments/services that fall outside the cost report structure, and this will allow for the establishment of a separate entity that HCPF and RAEs can fund to support services that fall outside of cost reporting;

- **HB25-1162 Eligibility Redetermination for Medicaid Members** - the goal of this bill was to allow Medicaid and RAEs to process members in a more timely manner, and facilitate redeterminations; the Division will follow-up with additional details for members at the June meeting;

Provider-related bills:

- **SB25-083 Limitations on Restrictive Employment Agreements** - this bill makes two important changes to current non-compete laws in Colorado for individuals involved in the practice of medicine, which includes advanced practice registered nursing and the practice of dentistry. First, current law includes an exemption from the general prohibition against "covenants not to compete" (non-compete) that allows for the use of such covenants (non-competes) for individuals whose compensation is equivalent or greater to a threshold amount for highly compensated workers. The bill removes individuals practicing medicine from the exemption, such that non-competes are no longer allowed for individuals engaged in the practice of medicine. Second, current law also includes an exemption from "covenants not to solicit customers" that allows

for the use of such covenants (nonsolicitation) for individuals at or above a certain compensation threshold. The bill removes individuals practicing medicine from the exemption, such that non-competes are no longer allowed for individuals engaged in the practice of medicine;

- **HB25-1176 Behavioral Health Treatment Stigma for Providers** - this bill makes certain changes to the application for a license to practice medicine in Colorado, and to the questionnaire accompanying the form for a license renewal, related to the disclosure of certain health information and conditions. It also clarifies that health care professionals are not required to disclose a physical illness, physical condition, behavioral health disorder, mental health disorder or substance abuse disorder if it no longer impacts their ability to practice in their applicable field.

  Discussion:
  - A meeting participant involved in the passage of SB25-083 and HB25-1176 noted that one of the key purposes of changes to the non-solicitation provisions in SB25-083 was to allow communication between doctors and patients when a doctor is leaving one setting to practice in another. Without this ability, patients are left in the dark, and must do a lot of leg work to figure out where their doctor is going if they want to continue to see that individual (and have continuity of care). In terms of HB25-1176, currently the medical licensing application asks questions about a physician's mental health up to five years into the past, which is not recommended by either the Federation of State Medical Boards or the Larry A. Green Foundation, or others who have come out as advocates for promoting physician well-being and mental health. So the revisions to the questions on the medical licensing application are really about encouraging physicians and other health care providers to seek care, without fear of losing their license. HB25-1176 also addressed a carve out for substance use disorders in current law, by removing a provision that mandated that if a physician had a substance use disorder and was being treated for it through the state's peer health assistance program, they would have to have that stipulation or treatment public on their record. This change will allow physicians seeking confidential treatment, if the peer health assistance program deems they are safe, to be in treatment and continue to practice. They can have stipulations or a pause on their license while they are receiving treatment, but it will now be up to the peer health provider to determine if they are safe, rather than making it a blanket public disclosure.

- **SB25-152 Health-Care Practitioner Identification Requirements** - this bill will require health care practitioners who practice in certain settings to wear identification/name tags during patient encounters, and require advertisements for

health care service to identify the license, certificate, or registration health by the practitioner;

Access-related bills:

- **SB25-017 Measures to Support Early Childhood Health** - this bill as introduced supported the Healthy Steps program within primary care practices and childcare facilities, but it had a large fiscal note attached, so was amended and pared down to put the Healthy Steps program into statute in Colorado.

- **HB25-1274 Healthy Schools for All** - this bill will add a measure to the statewide election in November 2025 to continue funding for the Health Schools Meals for All program, which pays for public schools to offer free breakfast and lunch to K-12 students;

- **HB25-1026 Repeal Copayment for Dept of Corrections Inmate Health Care** - this bill would have eliminated the copayment for inmate-initiated visits for medical, dental, mental health, and eye care, and prohibited the Department of Corrections from assessing a few when the inmate fails to attend or refuses a scheduled health care appointment. The Governor vetoed this bill on May 29, 2025 (veto letter here), and issued an Executive Order (available here) with directions for the Dept of Corrections to reduce barriers to care for legitimate health needs;

Other bills:

- **SB25-045 Health-Care Payment System Analysis** - this is a bill that has been introduced multiple times, but passed this year, which requires the Colorado School of Public Health to analyze draft model legislation for implementing a sing-payer, nonprofit, publicly financed, and privately delivered universal health-care payment system for Colorado. It also creates a statewide health-care analysis collaborative, with specified representatives, to advise the School of Public Health in its analysis. This work will (must) be funded through gifts, grants, and donations.

- **SB25-010 Electronic Communications in Health Care** - This bill allows a notice or other document required by law in an insurance transaction or that is to serve as evidence of health insurance coverage to be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the "Uniform Electronic Transactions Act". Delivery of a notice or document by electronic means is considered the equivalent to and has the same effect as any other delivery method required by law. It also requires health insurance carriers to deliver paper communications to individuals that may not have consistent access to the internet and to any individuals that may elect to receive paper communications upon request

- **SB25-126 Uniform Antitrust Pre-Merger Notification Act** - this bill requires a person filing a pre-merger notification with the federal government (under the "Hart-Scott Rodino Act") which has its principal place of business in the state or directly or indirectly has annual net sales in the state of at least 20% of the filing threshold to contemporaneously file electronic copies of the forms and any additional documentary material with the Colorado Attorney General. The bill gives the AG authority to issue civil entities for individuals that fail to comply.

- **HB25-1088 Costs for Ground Ambulance Services** - this bill is the latest in a conversation around ground ambulance services that started back in 2019, with Colorado's passage of out-of-network billing legislation. That statute, and subsequent rulemaking by the Division, only addressed private ambulance companies, and set the out-of-network reimbursement rate for those entities as 325% of Medicare. This bill incorporates public as well as private ambulances into the out-of-network reimbursement structure, and covers both emergency and non-emergency transport by ambulance service companies. It sets a rate of 325% of Medicare for emergency service, but a local government entity (public ambulance service company) can charge a higher rate if it goes through a process of determining that a higher rate is needed, and submits those rates for public posting on the Division's website. For non-emergency transport services, carriers must reimburse the out-of-network provider at the lesser of the ambulance service's billed charges or 325% of Medicare. The Division was in an "amend" position on this bill, and remains concerned about the premium impacts of the rates required for non-emergent services.

Bills that did NOT pass -

- **HB25-1174 Reimbursement Requirements for Health Insurers** - this bill would have allowed rate setting for the state employee health plan and small group health benefit plans, and required any savings to go to safety net providers and the primary care fund. This bill concept was modeled after a program implemented in Oregon, but received pushback from multiple stakeholders– and efforts were shifted to SB25-290;

- **HB25-1151 Arbitration of Health Insurance Claims** - this bill would have allowed for the batching of claims in out-of-network arbitration disputes, but did not pass;

- **SB25-318 Artificial Intelligence Consumer Protections** - Last session, the legislature passed the "Colorado Artificial Intelligence Act" (SB24-205), one of the first comprehensive AI bills in the nation. The Governor signed the bill, but in doing so expressed concerns about the legislation's impact on innovation and the tech industry in Colorado, and was clear in expectations that lawmakers would advance proposals this session to fix some of the bill's problematic provisions. SB25-318 was released last

in the session, and was an attempt at some of these fixes, but it stalled during debate and was pulled by the sponsor due to a lack of votes;

- **HB25-1297 Health Insurance Affordability Enterprise Update** - this was one of the Division's priority bills, and it would have increased the fee up to 1%, to continue to maintain the existing programs of the Health Insurance Affordability (HIAE) - including reinsurance, additional state subsidies (for increased cost-sharing reductions), and OmniSalud. The bill would have created an additional category of funding that could be used by the HIAE to pay the $1 per member per person that must be paid separately for abortion services, and to potentially cover gender-affirming care (depending on what happens at the federal level). The intent of the bill was to maintain funding for existing programs, but several legislators had concerns about the fee, and the bill ultimately failed. The HIAE board will likely be talking about next steps at their upcoming meeting, which is open to the public.

  Discussion:
  - *Question:* What happens next? What options are available?
  - *Answer:* The HIAE board will ultimately need to figure out the path moving forward from here. The Division is currently at the HIAE budget, where the money is, and what kind of funding is available, but the Board will likely need to make some tough decisions if additional money is not put into the enterprise. An additional variable is whether the enhanced federal subsidies, which are currently set to expire at the end of 2025, will be extended.
  - *Question:* The enhanced subsidies are for on-exchange enrollees, correct? Which are separate from OmniSalud? If so, will the end of subsidies impact OmniSalud, or just the other HIAE programs?
  - *Answer:* You are correct that the enhanced subsidies are for on-exchange enrollees, but the way the HIAE enterprise is set up under the state's 1332, the path of incoming funds and the way it is then distributed to programs (through a "waterfall") intertwines the programs from a dollar perspective.

- Tara Smith asked members if there were any additional bills that members or meeting participants wanted to raise for the group's awareness;
  - A member asked about **SB25-198 Transparency Transactions Medical Care Entities**, and how it might impact the PCPRC's work; it did NOT pass, but is one that may return again next year;
    - Neither the Division nor any meeting participants had an immediate answer, but the DOI will follow-up with additional information at the June meeting;

- A member also highlighted the role of TABOR, and its importance in thinking about both short- and long-term impacts it has on the state budget, and in turn on state policies and programs;
  - Tara Smith noted that the Democrats had introduced a joint resolution in the House (HJR25-1023) which would have retained counsel to file a lawsuit on behalf of the General Assembly to determine the constitutionality of TABOR; the bill make it through the House, but was not introduced in the Senate due to the lack of votes;

Additional state updates, unrelated to the legislative session, included:

- Office of eHealth Information (OeHI) - Colorado Health IT Roadmap
  - OeHI recently released the 2025 Colorado Health IT Roadmap, which provides an update to the state's strategic plans for health technology in Colorado;
  - Goals identified for health technology include:
    1. Enhance community engagement in health IT solutions;
    2. Support secure and appropriate sharing of data; and
    3. Foster responsible innovation;

- Eugene S. Farley, Jr. Health Policy Center - Advancing Primary Care Payment Reform in the Commercial Sector: A Report and State Policy Playbook
  - The Farley Health Policy Center recently released a report and playbook (accessible through the links below), summarizing research examining five states that are advancing primary care APM policy for the commercial sector, with the goal of better supporting the foundation of the health care system:
    - State Policies to Advance Primary Care Payment Reform in the Commercial Sector
    - Advancing Primary Care Payment Reform in the Commercial Sector

Tara Smith closed out the discussion of state and federal updates by noting that while the last two meetings had included rather extended discussions of federal and state activities, moving forward the Division will be streamlining these lists, to ensure PCPRC members have adequate time for discussion. If members or other stakeholders have updates on federal or state activities that they would like to share in-between meetings, they are welcome to send them to Tara Smith for distribution to the group.

ACTION ITEMS:

- The Division will provide follow-up information about **HB25-1162 Eligibility Redetermination for Medicaid Members** and **SB25-198 Transparency Transactions Medical Care Entities;**
- If members have federal or state updates that they would like to share between meetings, please send to Tara Smith (tara.smith@state.co.us) for distribution.

Priorities and Tentative Schedule for 2025

Tara Smith reviewed key themes that were raised during the PCPRC's discussion of 2025 priorities at the May meeting, including:

- Flexibility to respond to changes at federal level;
- Access issues – sources of care, disruptors, direct primary care, Medicaid funding implications;
- Learning from each other and others – tapping into state and national expertise;
- Flow of dollars – deeper dive into payment flows for primary care; and
- In ALL of the above in service of strengthening primary care to reduce costs and improve health outcomes.

She then put forward the following proposed, tentative schedule for 2025 meetings, and asked members for feedback:

APRIL Updates & Priorities	**MAY** Accountable Care Organizations	**JUNE** Patient perspectives on primary care; GUEST SPEAKER - OTHER STATES
JULY SUMMER BREAK	**AUG** Data - sources, gaps; CDPHE presentation; FREE SPACE	**SEPT** * * Review APM Parameters * * Comprehensive Primary Care Discussion
OCT Access - sources of care; Flow of dollars	**NOV** CIVHC Report/ Recommendations	**DEC** Draft Recommendations

* * * DRAFT Proposal * * *

Discussion:

- A member commented that it would be helpful to have a presentation from CDPHE, as part of a larger data discussion, earlier rather than later, as it will likely inform what the Collaborative wants to look at moving forward, and how it wants to proceed with that work;

  - The member representing CDPHE indicated that the August meeting would be a good time, as the Office of Primary Care will likely have some new analyses to share at that time;
  - Tara Smith noted that it might be helpful to try to get another state's perspective on the collection/analysis of data that can help inform strategies to strengthen primary care;

- A member expressed interest in exploring a comprehensive primary care strategy, noting that coordination will be a key element; they asked if any states had advanced such a strategy that has coordinated government agencies and public and private organizations that Colorado could learn from?
  - Tara Smith indicated that she thought other states were having similar conversations about coordinated strategies, and potentially have implemented some components of them, but she was not aware of a state that had solidified or fully implemented such a plan;

- A member asked about the review of APM parameters, and how much time the Collaborative needed to set aside for that discussion. They noted that because it was the first year of implementation, there should probably be a conversation from all parties about what is working, and what's not working, in terms of implementation, and changes that might be needed for the next year. In addition, the Division will need time to reissue rules if changes are needed, and it would be helpful to get a sense of timings, and how much the Collaborative and other stakeholders will need to review, based on rules and statute;
  - Tara Smith briefly reviewed the 4 aligned APM parameters that were implemented through Regulation 4-2-96: patient attribution, risk adjustment, quality measures, and core competencies. The requirements for patient attribution and risk adjustment at this point are primarily focused on transparency, and communications between payers and providers.
    - She agreed this year's review will be an important opportunity for the Division to hear about challenges with implementation, and whether adjustments are needed.
    - In terms of patient attribution and risk adjustment, transparency was seen as an important first step for these two parameters, and the Division anticipates that any adjustments to these two parameters would still be related to that topic. Additional stakeholder discussions will be needed, as will additional data from payers (through 4-2-96 reporting) before additional requirements will be put in place; such requirements are likely outside of the scope of revisions for calendar year 2026.

- In terms of quality measures and core competencies, Regulation 4-2-96 did establish specific standards, and the feedback the Division will be seeking is around the implementation of these standards. The Division anticipates this year's discussion will pick up from the conversation last year, regarding adding elements to the process for reviewing and revising existing standards (e.g., for quality measures, identifying a set of "stretch" measures, or "measures under consideration" for future implementation).
- If stakeholders identify needed changes to any of the aligned parameters, the Division anticipates such changes would likely not be effective until calendar year 2027 (depending on the issue(s) identified). This timeline- identifying changes in September, commencing a rulemaking process that will start in Oct/Nov and conclude in Feb/March of the following year, will give payers and providers the opportunity to prepare for and make any needed changes.

  - The member thanked the Division for this information, and noted that as a payer organization, their internal teams have feedback that would be valuable for all stakeholders on this first year of implementation. The member representing the Colorado Association of Health Plans could also likely collect additional payer feedback on what they are experiencing with their provider partners. And providers will also have a valuable perspective to add to the conversation, and how we move forward with a next iteration;

- A member elevated a question/comment raised about the ability to get data about self-funded employer plans; even those these plans are not regulated by the DOI, given that they play such a large role in terms of payment structures around primary care, is there any opportunity to get at least some input from that perspective, in terms of what they are seeing? Calling out the gap in data, in discussions and reports, is important- but if it is a large gap, is there any way the Collaborative can learn more?
  - Tara Smith recognized the importance of both data and engagement with self-funded employers in Colorado's primary care and APM work, but noted ongoing challenges in making meaningful connections with the segment of the market. She suggested potentially connecting with the Purchaser Business Group on Health, and seeing if they would be willing to make introductions with some of their employer contact in the state. CIVHC is also collecting data from self-funded plans, through voluntary reporting, and that could be another source of potential data, or employer contacts;
  - The member appreciated these suggestions, noting they were increasing hearing about direct primary care (DPC), and employers going directly to DPC and those types of contracts, so it would be valuable for the Collaborative to

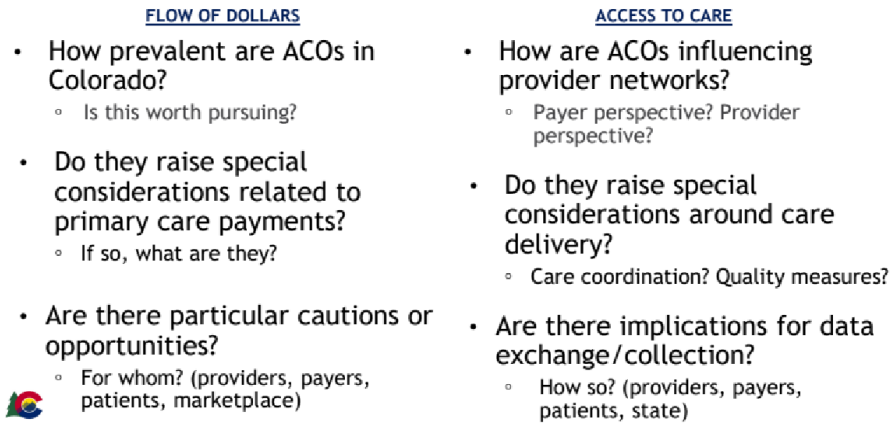
have some insight into that arena, and being aware of what's happening, especially if the group is going to come up with a comprehensive primary care plan;

- A member asked if it would be possible to use July as a month for members to prepare for the APM parameter review? Would it be possible for the Division to circulate materials for the September meeting in July, so members could come prepared and ready to dive deep into the discussions?
    - Tara Smith appreciated this suggestion, and indicated the Division would do its best to have some materials prepared for members (and other stakeholders) to review.

Tara Smith closed out the discussion of priorities and scheduling by encouraging members to spend some time considering the proposed calendar, and sending and changes, refinements, or suggestions to her directly (tara.smith@state.co.us).

ACOs - Impacts, opportunities, and challenges

Tara Smith began a discussion of accountable care organizations (ACOs) and their influence on the primary care landscape in Colorado by providing a brief overview of the definition and history of ACOs (see slides 24-26, available here). She then laid out the beginnings of a sketch of ACOs currently operating in Colorado (see slides 27-29, available here), before presenting the group with the following discussion questions:



Discussion:

- A member who serves as the Chief Medical Officer for a CIN in Colorado that was not on the slides, which serves 170 practice locations and about 1,000 primary care doctors, commented that ACOs are likely very prevalent in Colorado, and have a fairly large impact on how payment flows through to practices on the ground and translates

to care delivery. They noted their system is currently doing a lot of work with practices in their network, and what they call the "in between" spaces, working with both the hospital systems that are their owners and the primary organizations that are part of the network to try to ensure patients are effectively guided through their care journey, and are getting the right care at the right time, by the right person, for the right cost. In terms of affecting the primary care landscape, ACOs play a role;

- A member commented that from the perspective of a Medicaid payer, the ACOs play a huge part in the way they design their payment models; every year they are setting new PMPM rates to incentivize primary care for a variety of things - whether that is access and increasing panels, hitting quality metrics, forming other kinds of partnerships. In some ways the ACO model helps these efforts, because there is a central place to these strategies, flesh them out, get their feedback, and create a model that impacts more providers than they could reach individually. On the downside, it can be challenging when they try to talk about key issues with specific providers, particularly those with a large number of attributed lives, as the provider often refers them back to the ACO administration, or the work of the ACO. The member thought that a balance is needed- as ACO models grow, and everyone becomes more familiar with them and strategies are developed, communications and relationships will improve-but today we are in the "messy middle"- where we have both good things happening, and also some barriers to working directly with provider groups that are really influential for their membership. It could be a great model for funding value-based models and/or PMPM models (pay-for-performance), but we could probably do better if we could always navigate the ACOs, know who to talk to, how to do that in a timely way, and how to pass data back and forth. ACOs have implications for payment, and for data exchange- sometimes we share data appropriately with the ACOs, but it never gets shared at the practice level.

- A member asked if there were any reporting or registration requirements for ACOs, or if Colorado had any sort of database the ACOs currently operating, which could help fill in the state landscape;
    - Tara Smith noted that information about ACO participating in specific payment models is most readily available for CMS Medicare models (e.g., MSSP), but she was not aware of other good sources, or registration or reporting requirement in Colorado;
    - A member noted that the National Association of ACOs (NAACOS) had a directory for each state, which their organization uses to track; most belong to it, but it is not mandatory, so it is not always complete;

- A meeting participant commented on their experience with ACOs, as a practice manager for two organizations on the Western Slope. Their initial experience was for a

small (single) provider practice, and an ACO that was formed on the Western slope. For a very small practice, participation proved to be super onerous- dealing with the reporting requirements, as well as the number of meetings that participants had to attend. At the time, the practice wasn't really working with the other entities in the ACO- it was mainly limited to the hospital in their immediate area. The practice had to sign a contract to be part of the ACO, and never saw any money flowing back (never received any shared savings)- in part, the minimum threshold to participate in this type of ACO was really hard on a small practice. While the practice's numbers were good, they were too small to receive any shared savings, and it was nearly impossible to withdraw from participation. The second experience was with a larger group (9-10 providers) in Gunnison, and were part of a transition from one ACO to another (Medicare ACO models). A part of the ACO included Washington state, and providers in Utah- which made little sense in terms of care delivery. Even with a larger practice, and more staff and providers, participation was still onerous administratively (reporting requirements, meeting attendance), and the practice never saw shared savings. The larger practice also participated in Medicaid initiatives, working with RAEs, and did see shared savings- and also had more support. While there was still some administrative burden, in terms of meeting attendance and other tasks, much of that work was able to be absorbed by the practice administrator, and did not impact as many other staff. The meeting participant was hopeful that the structure of Medicaid's ACC program was based on learnings from other ACOs, and would lead to more success in the future. Overarching lessons, from 15 years of experience with these models include: there is a minimum threshold of work that needs to be dedicated to the ACO; if practices are too small, it is very onerous; across all experiences, there were a lot of attribution issues, both removing people who the practice wasn't seeing, and adding people who were definitely using the practice for their primary care- which is an administrative issue, but ultimately does impact the dollars that are flowing to the practice.

- Tara Smith asked members about the impact of ACOs on provider networks- from a provider perspective, did it offer advantages (or disadvantages) to contracting or inclusion in networks, and from a payer perspective, is it easier to form networks by contracting with a singular ACO entity, vs contracting with multiple independent providers?
    - A meeting participant who served as a practice administrator noted their small practice did not see value, in terms of carrier contracting, based on their participation in ACOs; both Medicare and Medicaid did require the practice to put up notices, to make patients aware the practice was in an ACO, and explaining what that meant;
- A member agreed with many of the points that had been raised regarding the "pain points" of ACOs, particularly for small practices; attribution is often a challenge for

their organization (a CIN), and they recognized that there are some contracting nuances that can be very difficult for a small practice, and make it hard to be successful. Yet they also saw a great opportunity for alignment between some of the state programs, specifically with the RAEs and Medicaid, around quality measures and care delivery/practice transformation. Currently, a lot of duplicative work is happening- at the practice level, at the ACO level, at the system level- so it would be incredibly valuable to figure out who is the best person to lead the team, and then find easy to streamline the work and make sure it is attached to that team leader. The primary care provider is likely best suited for that role, to serve as the "umbrella" person who can be aware of the stuff happening in the background, while ensuring teams can function effectively. ACOs require a lot of data exchange, which adds to administrative burden- and while the goal is to pull that work off a small practice's plate, it is still not an easy lift. Some ACOs do this better for small practices than others, but there are some benefits, around some of the contracting pieces, that small practices should be able to take advantage of and benefit from;

- Another member also agreed with the comments made thus far, and added some historical context around the inception and evolution of ACO models. Many formed around the time of MSSP, to be able to take advantage of those dollars- and in the beginning, they supported the development of models in which primary care served as a hub, and coordination with specialist was included, with some elements of risk- and everyone was seen to be "in it together" to achieve better member outcomes. But in the way it has evolved over time, small practices have been left behind, and many have not seen value. This has happened nationally, not just in Colorado, and was a topic of discussion at the NAACOS conference last week. So issues around small practices are being acknowledged, and the current scrutiny will hopefully lead to future change and improvement;

- Tara Smith noted that the discussion thus far indicated that ACOs do play a significant role in Colorado (and nationally), and had important implications for both payment and care delivery. She asked members about potential next steps, and areas they would like to explore in greater detail- for example, because ACOs are structured differently, would it make sense to try to find out more about specific models, and use that exploration to inform some best practices? Or did members have other ideas about how to best proceed with the conversation;
    - A meeting participant noted that Aledade's model is different than others in that it offers prospective payments- so practices get the money now (up front) to do the work, rather than having to wait 2 years to see if they get any savings from the work they have already done; this is a huge and extremely important shift. In terms of data exchange/collection, they wondered about the impacts of consolidation and the increasing use of AI- AI has been hailed as a way to

potentially reduce some administrative burden, and will certainly have an influence on this work moving forward, and to potential evolution of models;
    - A member agreed, noting that their organization (a CIN) was constantly negotiating with payers around getting or increasing prospective payments as part of their contracts. On a positive note, Medicare has also recognized the importance of prospective payments, and it was a significant topic of conversation at the recent NAACOS meeting- where should those payments go, and what does that look like across different ACO structures (physician group ACOs vs hospital ACOs), as well as small practices. They agreed that data exchange is also a huge issue- a key need/goal is to make it possible for practices to see the patients who are attributed to them but seeking care outside of the office, at various hospitals or other locations. They need to have that visibility to get in front of that kind of care, and prospective payments will help them make some of the infrastructure changes that are needed to streamline and improve care. More investment is also needed in how we make data more available to practices, so they can see patients they are taking care of when they are outside of the office. These are both really important areas to make forward movement.

Public comment:

- No public comments were offered.