COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, September 18, 2025; 10:00 - 12:00 pm

Meeting Attendance

Attended
Polly Anderson
Josh Benn
Britta Fuglevand
Steve Holloway
Lauren Hughes
Rajendra Kadari
Cassie Littler
Amanda Massey
Kevin McFatridge
Amy Scanlan
Mannat Singh
Gretchen Stasica

Absent
Alex Hulst
Dana Pepper
Erin McCreary
John Hannigan
Kate Hayes/Jack Teter
Patrick Gordon
Sonja Madera

DOI
Tara Smith
Debra Judy
Matt Voss

Agenda:

1. Welcome & Introductions
2. Housekeeping & Announcements
3. Strategies, Stakeholders and Data
4. Federal & State Updates
5. Impact of Changes in Federal & State Landscape
6. Public Comment

Introductions

Tara Smith welcomed participants and briefly outlined the meeting agenda, goals and desired feedback. Key goals for the meeting revolved around reflecting on past presentations & discussions, using that to identify priorities for the upcoming report, and then covering a deep dive into how recent federal and state activities have impacted membership organizations

Housekeeping & Announcements

The following housekeeping issues were addressed:

- **Meeting minutes:** Tara Smith requested approval of June and August meeting minutes. The June and August meeting minutes were approved without revisions.

  ACTION ITEM: Meeting minutes for June and August will be posted as final on the PCPRC website.

- **Election of PCPRC Co-Chairs:** The Division received two nominations for co-chair positions: Rajendra Kadari and Cassie Littler. PCPRC members elected to use an informal voting process, and Rajendra and Cassie were approved by unanimous consensus.

- **APM Parameter Review:** The Division's annual review of the aligned APM parameters set forth in Regulation 4-2-96 will take place from 10-11 am MT at the regularly scheduled PCPRC meeting on October 9, 2025. The Division's HB22-1325 - Primary Care Alternative Payment Models website has been updated to reflect this meeting date, and the Division will be posting comment forms for stakeholders interested in providing written feedback prior to the meeting.

  As this is the first year of implementation of the parameters, the Division is interested in hearing stakeholder experiences to date, and in particular: 1) what has changed (if anything) due the existence of the parameters; 2) have these changes been positive or negative; 3) what changes are suggested to existing requirements, and/or are any new requirements needed; and 4) any additional feedback. The comment forms will be available as google forms, and as pdfs. Stakeholders are also welcome to send any direct feedback, outside of the comment form, to Tara Smith (tara.smith@state.co.us).

- **Introduction/welcome**: Tara Smith welcomed Matt Voss from the Division of Insurance, who will be assisting with all matters related to the Collaborative. Members can expect to see future communications coming from Matt. Tara Smith also welcomed Mannat Singh, the Executive Director of the Colorado Consumer Health Initiative, as a new member to the Collaborative. Mannat has taken the place of Isabel Cruz, a former PCPRC member representing CCHI.

Strategies, Stakeholders and Data: Laying the Groundwork for Annual Report

Tara Smith briefly reviewed the PCPRC's meeting schedule to date, including the topics addressed at each meeting. She also highlighted that only four meetings remain in 2025, and it is time for PCPRC members to start identifying potential recommendations for the annual report, which must be published by Feb 15, 2026. This year the Division will not have funding

to retain the Colorado Health Institute, which has helped with both drafting and the production of the report. Without this assistance, the Division and PCPRC members will need to shoulder this work, which will take additional time and effort from everyone. The Division has therefore set aside time during today's meeting to start conversations around potential topics, so work can start in October.

To introduce the annual report to newer members, and to refresh the memory of longer-term members, Tara Smith briefly reviewed the PCPRC's statutory charges, pursuant to § 10-16-150, C.R.S., and the Collaboratives goals and objections, as set forth in the legislative declaration of House Bill 19-1233 (see slides 9-10, available here). She then briefly reviewed the recommendations included in previous reports (see slides 11-17, available here). Finally, she reviewed the 2025 goals and priorities that Collaborative members expressed earlier this year (see slides 18-22, available here), as well as the topics addressed by guest speakers in recent meetings (see slide 23, available here).

As a starting point for discussion, Tara Smith presented the following potential topics for the upcoming report, based on PCPRC discussions to date:

- Payment
  - Flow of dollars (landscape)
  - Market "disruptors"
  - Medicare Physician Fee Schedule
  - Aligned APM parameters
- Data
  - Assets
  - Gaps
  - Uses
- Comprehensive primary care strategy
  - Measure, track state of primary care, impact of increased investments and alignment efforts
  - Ongoing, cross-agency, multi-stakeholder collaborative
- Changes in federal landscape – challenges and opportunities for primary care
- Other - ? ? ?

Discussion:

To facilitate group discussion, the Division used a Menti poll- member responses are included below:

- ***MENTI Q1: What were your key take-aways from presentations? (what excited, depressed, inspired you; was most pilferable)***

Responses included:

- Lots of good ideas, but the money is tied up in old ideas that are difficult to dislodge;
- Employer support of primer care was enviable: score cards are very helpful. Transformation support for primary care is essential;
- PGBH's work in self-funded space and how to involve other payers not regulated by DOI in a similar fashion;
- The real need for streamlined measures and the difficulties in getting there;
- Excited- hearing from other states, ideas around DPC; Depressed- OBBBA; Inspired- good energy, discussion, ideas; Pilferable- collaboration;
- Continued misalignment of payment structures (depressing);
- Other state's ideas and how to collaborate;
- The idea of treating primary care as a public good;
- Engaging all the stakeholders is key.

Additional Discussion:

- A member expressed agreement with the comment that scorecards are a helpful tool in ensuring alignment across primary care initiatives and promoting accountability and awareness across stakeholders.

➢ ***MENTI Q2: What is your level of interest in developing recommendations (content) on the following topics (rated on a scale of 1-5)***

Responses included:

- Payment = 4.2
- Data = 4.0
- Comprehensive PC strategy = 4.2
- Federal landscape = 3.2
- Something else = 1.4

Additional Discussion:

- A member commented that the federal landscape is going to impact everything in the health care system, including primary care, access to health insurance, and it will be an important piece in how we talk about recommendations moving forward, as it will be the reality we will be facing in the coming and future years;
- A meeting participant expressed continued concern about the impact of private equity and practice consolidation, both by private equity and hospital systems, and what that is going to mean for primary care- primary care is at risk of losing its place as a driver in the health care system and becoming the "tail that gets wagged."

- ***MENTI Q3: What are the key issues to discuss in a "payment" section (flow of dollars/landscape, market disruptors, federal policy, etc.)***

Responses included:

- Funds are short all around and there's a lot of change- provide a north star on payment policies to continue to guide the work.

Additional Discussion:

- A member agreed with the concern raised about private equity, and felt a payment section of the report might be a good place to address how consolidation is affected by the payment. A lot of consolidation is being driven by smaller practices' ability to survive in the current payment environment;
- Another member raised concerns about the push to reduce the facility fees that hospitals charge from primary care practices, or whatever practices that they have. Once that happens, there will be a lot of turmoil and chaos in the primary care sector- that, in addition to private equity, will be large disruptors. If there is an existential crisis in the grand scheme of things, it may limit our ability to advocate for things.

- ***MENTI Q4: In mapping the primary care landscape, what are your top research questions?***

Responses included:

- What % of PCP are independent?
- Health care workforce availability (not just physicians);
- Are there primary care practices that are thriving under APM arrangements?
- How much money in systems actually gets to primary care?
- Who gets the money that we label as primary care spend?
- Where are patients getting primary care?
- The landscape is changing so rapidly, the data lag needs to be considered;
- How does money flow through organizations to primary care?
- Stability of the system- how much breathing room do primary care providers have?
- Loss of autonomy for physicians/providers under consolidated systems;
- What role is cost of administrative burden adding to the cost of running a practice?
- What drives patients to particular primary care practices?
- In the employer supported PCP, can we get their ROI to justify a much bigger spend in primary care?
- Parents.

Additional discussion:

- A member posed a larger research question: what are the barriers to reorganizing the payment system to better support primary care? One example would be the graduate medical education (GME) system, which is oriented around specialty and hospital care-

but what are the other big barriers towards the ultimate goal of increasing primary care spending and focusing resources on primary care.

- Another member commented (via chat) that an important question is "Where are patients getting primary care? (DPC, hospital-owned, corporate-owned, private practice, FQHCs, etc.).

➢ ***MENTI Q5: How would you define a comprehensive primary care strategy? Goals/benefits?***

Responses included:

- What is our north star for primary care in the state, and pathways of how to get there with specific recommendations for policy makers and advocates;
- One that aligns payment, workforce, access, data, and accountability to strengthen PC as the system's front door and improve cost, quality, and equity;
- Whole person/ whole family, social determinants of health (SDOH), prospective payment, support decisions made by primary care to keep patient healthy- remove barriers (PARs, copays, etc.);
- Alignment across payment systems is helpful operationally but need to be extremely thoughtful about how that looks in different communities;
- 1. Defining primary care as a common good that all patients should have access to. 2. Designing payment structures, outcomes, expectations, data requirements thoughtfully so as not to crush the workforce.

Additional discussion:

- Regarding the comment about being thoughtful about how alignment looks in different communities, a member explained that for practices on the ground, it is helpful to have similar metrics across payers- but at the same time, the population in one community might have different needs (e.g., rural vs urban). Is there a way payers can be more flexible to align with what a community needs, as opposed to a community needing to align with payer needs.
    - A member asked about how "community needs" could be defined or determined in that context. They noted that payers often struggle to collect that data from the community- people often aren't willing to share with payers, and there seems to be a natural tension. In trying to align, how would those needs be defined and/or reported?
    - The member noted they didn't have an answer to that question, but offered the example of a community such as Durango, where vaccine hesitancy has greatly increased, which makes it challenging, if not impossible, to meet metrics in that realm. It is a request, which is hard, for payers to be more flexible, and meet the needs of practices in those areas, rather than asking providers to be flexible in aligning to payer needs.

- A member provided additional context around the response of defining primary care as a "common good"- noting they were envisioning a concept similar to a certificate of need for hospitals. We have a statewide thought about "where are the gaps in the community," and how do we structure payment systems to support those gaps in a better way. Really incent that we have community-wide primary care that everyone has access to- as a common good, like fire and police, as part of the community.
    - Multiple members expressed agreement with this comment via chat (as well as for certificate of need requirements for hospitals).

MENTI Q6: Who are key stakeholders to engage in comprehensive strategy?

Responses included:

- Employers;
- Employers; healthcare IT vendors;
- Community partners to address SDOH.

MENTI Q7: What is your level of interest in developing a PC scorecard?

Responses (ranked on a scale of High, Moderate, Low Not all) included:

- Ranked first = High
- Ranked second = Moderate
- Ranked third = Not at all
- Ranked fourth = Low

Additional discussion:

- Multiple members noted in chat that their interest in the scorecard included learning more about what other states are doing in this realm.

Federal & State Updates

The following federal updates were provided:

- **H.R. 1** – Tara Smith briefly reviewed the key provisions related to private insurance and the ACA marketplace, noting that the only update from the previous PCPRC meeting is that no action had been taken by Congress to extend the enhance premium tax credits, which are set to expire on Dec 31, 2025; she then reviewed the key provisions related to Medicaid, noting that the only update from the previous meeting was that the injunction in the lawsuit challenging provisions that prohibited funding for Planned Parenthood had been lifted, allowing the ban to take effect; in terms of the impact to Colorado:
    - More than 225,000 people currently rely on and build their budgets around EPTCs to afford their health insurance; if the subsidies are allowed to expire at

the end of the year, Coloradans will have thousands more in monthly expenses or be forced off their health care- this will look like a family of four that makes $128,600 dealing with premium increases of $13,000 to $25,000 on average next year;
    - Due to the passage of Senate Bill 25B-002 during the recent Special Session in Colorado, HCPF can continue to pay Planned Parenthood using state, not federal dollars;

- **Continuing Resolution** - Without action, the federal government will shut down starting on October 1, 2025; House Republicans have introduced a bill that would provide a 7-week "clean" extension of current funding levels for federal programs; Democrats introduced a bill last night that would extend the enhanced premium tax credits and reverse H.R. 1's cuts to the Medicaid program; neither bill is likely to pass, and negotiations are continuing;

- **Vaccines** – HHS Secretary Kennedy recently announced 5 new ACIP members, and ACIP is meeting today and tomorrow (Sept 18-19); expected topics include the COVID-19 vaccine, the MMRV vaccine, and the Hep B vaccine;

- **CMS Rulemaking** – Tara Smith briefly reviewed key provisions the 2026 Proposed Physician Fee schedule, which may be relevant to the Collaborative's work:
    - CMS is proposing optional add-on codes to the Advanced Primary Care Management (APCM) services to facilitate behavioral health integration or Collaborative Care Model services; the proposed rule would allow 3 new G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month;
    - The proposed rule would also create separate conversion factors for qualifying APM participants (QPs) and non-QPs;
    - The proposed rule would also introduce an efficiency adjustment, to adjust for procedures and services that may take less time to perform than when they were added to the PFS; the methodology for determining the time a procedure/service takes, used in calculating RVUs would also be changed- CMS is proposing to shift away from survey data to a Medicare Economic Index (MEI) productivity adjustment percentage to calculate.

The following state updates were provided:

- **Colorado Special Session** – Tara Smith briefly reviewed the bills that were introduced and passed during the recently convened Special Session to address the state budget crisis (see slide 30 available here). Key health related bills included:
    - SB25B-002 State-Only Funding for Certain Services - On and after July 1, 2025, requires HCPF to use only state funds to reimburse entities that provide covered services and that are prohibited from receiving reimbursement from

CMS; exception: an entity is not eligible to receive state-only funds from HCPF if eligible for reimbursement from CMS at the time the services are provided;
    - SB25B-005 Adds language to the Nov 2025 ballot measure, related to $95 million to support the Health School Meals for All Program, to allow funds to also be used to support SNAP (after costs of administering Healthy School Meals Program are covered);
    - HB25B-1006 – Contains a number of policy and funding mechanisms related to the Health Insurance Affordability Enterprise (HIAE) program, including but not limited to an additional one-time $100 million ($50 million towards reinsurance, and $50 million toward OmniSalud), and increased flexibility around the design of the OmniSalud program; as a result of HB25B-1006:
        - Reinsurance impact will be 20% premium reduction (as opposed to projected 12% prior to bill's passage;
        - State subsidies, in the form of a premium wrap, will keep over 20,000 Coloradans covered; and
        - OmniSalud slots will be increased from a projected 2,500 to ~6,700;

- **COVID-19 Vaccines**: In the wake recent federal actions creating uncertainty around COVID-19 vaccines, the Colorado Department of Public Health and Environment (CDPHE) recently issued Public Health Order 21-01: Access to COVID-19 Vaccines, and an accompanying Standing Order by CDPHE's Chief Medical Office, to ensure Coloradans of all ages have access to the vaccine. The Division recently adopted Emergency Regulation 25-E-04, requiring insurance companies to cover the vaccines with no cost-sharing, and encouraging self-funded plans to follow the same policy;

- **HCPF resources**: For up-to-date information on HCPF's actions in light of federal and state changes, the following resources are available:
    - Understanding the Impact of H.R.1 and Federal Changes to Medicaid;
    - Rural Health Transformation Program Fact Sheet.

Impact of Changes in Federal & State Landscape

Tara Smith noted that over the last several meetings, the Division has been providing a variety of federal and state updates, in an effort to keep PCPCR members informed about important developments, but the group has not had a chance to discuss and reflect on the impacts of these events. She welcomed several PCPRC members to report on the implications and repercussions of the changing landscape, from their perspectives.

Impact on Federally Qualified Health Centers (FQHCs)

- Times are challenging right now, and it at times feels like death by a thousand cuts;

- Health centers are heavily reliant on federal funding, although less so than they used to be historically, because federal funding has been flat over the last 10 years;
    - Around 25 years ago, federal funding was 25% of health center's budgets, and is now down to around 10%;
    - This makes health centers even more reliant on Medicaid, commercial insurance, copays, grants, etc., which is difficult in this environment;
- Even though the portion of the budget reliant on federal funds has decreased, largely due to growth that the federal government doesn't support, health centers are still heavily reliant on the federal government for direction, and have to follow a lot of federal rules;
    - The general environment around Executive Orders and Federal Register notices, even though the ultimate impact has not yet resulted in a change in practice at health centers yet, is still chilling, disheartening, and scary for health center staff and patients;
- For example, PWORA was a Clinton-era initiative, with a broad goal of limiting federal public benefits to those who are only lawfully present; the Federal Register notice by the Trump administration is now seeking to make two changes:
    - First, to broaden the applicability to populations beyond those lacking documentation, to certain legal immigrants who don't have permanent status; and
    - Second, they are trying to change the interpretation of a 30-year-old exemption in PWORA that has traditionally applied to long-standing programs like the health center program, Head Start, the mental health center program, Title 10, would no longer be exempt;
    - Colorado is one of 20 states that joined a lawsuit (filed by state Attorneys General), and an injunction is currently in place which is preventing the changes from happening here; in the court's ruling last week, they reiterated that the health center program, Head Start, and a few others should continue their exemption, which could apply more broadly to states that are not party to the lawsuit, but the litigation is ongoing, and could take months or years, and it could go to a Supreme Court that is not friendly to such types of exemptions;

- Executive Orders regarding diversity, equity and inclusion (DEI) and gender affirming care for children have resulted in modest changes in practice (which are not modest to impacted populations)- but those orders have had intended impact- stigmatizing that type of work and making it more difficult for providers to continue it; the Trump administration is conflating the important need to not have civil rights violations with having DEI programs, which are not the same thing, and are not illegal; ultimately it has generated fear and confusion;

    - Health centers are waiting on guidance from federal funders, but are also working with legal counsel to review their policies and procedures and spending a lot of money on that to mitigate potential risks. There are stories from across the country about having the word "equity" on a website resulting in the delay of a grant; even health centers who have removed DEI language are having to provide additional justification for an approved project, which can delay payment;

- While federal funding is a smaller portion of health center budgets, it goes almost exclusively to salaries, so delays in funds can make it challenging for centers to make payroll when they are in tenuous positions;

- The uncertainty around vaccines will impact all primary care providers, but health center patients are particularly reliant on vaccines for children. It additionally raises questions around the way health centers get their malpractice coverage- it currently comes through the federal government and a promise to defend, rather than having to purchase malpractice coverage. If a health center were to prescribe something that wasn't on the VFC or another approved schedule, and something happened, would there be appropriate malpractice coverage;

- Finally, the Medicaid unwind did significant damage to health center finances that persist today- in 2024, two-thirds of health centers had negative operating margins, and the remaining one-third were also not great. Health centers anticipate that work requirements, despite best efforts, will further damage the "payer mix" side of health centers, where they will continue to care for people as they are losing their Medicaid coverage.

Discussion

- A PCPRC member echoed many of the sentiments expressed, noting that many pediatric providers also currently feel like they are being confronted with "death by a thousand cuts."

State of Pediatrics

- Medicaid is a backbone of pediatrics in the U.S., but cuts to hospitals and health systems will have fewer resources overall for all pediatric patients, including those on private insurance;

- Cuts to Medicaid disproportionately impact kids- over half a million kids in Colorado are on Medicaid, and over 100,000 more are on CHP+;
    - These are kids in communities who are either on Medicaid, or have been on Medicaid, or who churn on and off;

- If the enhanced premium tax credits aren't extended and health insurance prices increase dramatically, many kids will lose coverage, and end up on Medicaid;

- The impacts of policy changes on pediatrics are far-ranging, and include:
  - Erosion of equitable vaccines access and infrastructure;
    - ACIP is currently meeting, and changes to vaccine and immunization schedules have complex and confusing implications, and results in decreased vaccine uptake and confusion for parents;
  - Decreased access, due to the halting of continuous eligibility implementation for children ages 0-3;
    - The Medicaid unwind demonstrated the negative impact on kids, families, and providers, that happens when kids lose coverage;
    - Reduction of $5.6 million in General Fund will have a big impact on kids in Colorado- see kids every day that think they have Medicaid and have lost coverage, and therefore can't access needed care/treatment;
  - Increased frequency of eligibility requirements and work requirements will lead to more churn and decreased coverage;
  - Reduction of retroactive coverage to 60 days (from 90 days)- this is a large issue, as people often don't realize they are falling off;
  - Restricting certain immigrant eligibility for Medicaid and CHP;
    - While nothing has changed yet for Cover All Coloradans, right now ~16,000 kids are enrolled, and has been life changing;
  - Expiration of the enhanced premium tax credits;
  - Attacks on evidence-based gender-affirming care for youth;
    - On top of negative impacts on this population, it also results in moral injury to providers, as well as fears about going to jail;
  - Increasing prior authorization requirements that delay services;
    - May result in barriers and delays in care for long-term home health services, nurse assessor program for home health therapy for kids;

- Vaccine access is also under threat;
  - ACIP overhaul and federal instability have led to inconsistent vaccine guidance, resulting in decreased access and lower vaccination rates;
  - FDA restrictions on COVID-19 vaccines are extremely confusing, and pediatricians have real concerns about what to do for kids who have a long-term condition and need one; this is exacerbated by high levels of distrust and misinformation in the current environment;

- Complexity of vaccine access for children; multiple layers/components include:

- FDA authorization of COVID-19 vaccines for children – FDA made changes to Pfizer vaccine, so currently only Moderna authorized for 6+ months, but unclear what that means, because of the role of immunization schedules;
- Evidence-based immunization schedules
  - ACIP is looking at the immunization schedule today (CDC will ultimately approve or adopt ACIP recommendations)
  - AAP put out an evidence-based schedule in August
  - As a provider, which schedule do you look at when a patient comes in the door? Also, what insurance do they have? This complexity and confusion may lead to practices not having vaccines available;
- School entry requirements (recommended by Board of Health within CDPHE) are currently being considered;
- Private insurance and VFC payment & coverage of immunizations and administration and counseling codes;
  - VFC – must relate back to ACIP schedule; practice gets the vaccine product itself from the state (CDPHE), then charge an administration and counseling code;
  - CHP+ - must relate back to ACIP schedule; practice buys the vaccine (pays and charges for it);
  - Private insurance regulated by DOI – with recent legislation, can now be determined by DORA NPATCH if changes are made to existing federal bodies that set preventive services coverage (including ACIP);
  - Self-funded insurance plans not regulated by the DOI – unclear;
- Availability of vaccines to organizations is under threat with changes in supply; for example, some practices have reported challenges getting Moderna COVID-19 vaccine;

- Impacts of funding changes include:
  - Provider payment rate cuts strain pediatric practices;
  - Postponement of ACC 3.0 Access Stabilization funds limits operational support, particularly for rural and pediatric practices;
    - This was the only way pediatric practices could get paid in an APM, as shared savings don't really work for pediatrics;
    - PACC and ACC 3.0 had done a great job of carving out this funding, which has now been delayed and decreased;
  - Provider stabilization funding in Colorado for safety nets and interplay of Cover All Coloradans;
    - If Cover All Coloradans is changed in future, resulting in decreased enrollment, will pediatric providers be able to access provider stabilization funding?

- Core metrics tied to performance pay, including vaccination rates, which are declining due to disinformation by HHS/CDC
- Reduction in State Directed Payments limiting investment in pediatrics;
- Underfunded public health and early intervention programs that leave children without critical support;
- Shrinking investments in social drivers of health programs like SNAP;

- Overall: pediatrics is on a knife edge: financial stress + policy instability + moral distress = potential practice closures

Impacts on Medicaid

- HCPF has a lot of materials available describing impacts, which are available as references (remarks during this meeting not comprehensive, and focused primarily on topics related to the Collaborative's work);

- Medicaid is experiencing 3 main areas of impact:
  - Reduction in state revenue- reduction in incoming revenue due to changes in the tax code, addressed by Special Session;
  - Reduction in Medicaid-specific revenue- hasn't happened yet, but will shortly, so large need to spend time and energy on eventually;
  - Additional restrictions on member eligibility;

- Key priorities related to primary care include:
  - Restrictions in eligibility – HCPF has been told that CMS will not approve Colorado's 1115 waiver for continuous coverage for the 0-3 population
  - Work requirements - work requirements starting on 12/31/26 will create more churn for members, with additional paperwork, making the application process more difficult; HCPF is currently working to develop a process, but verification of requirements is challenging;
  - Additionally, new 6-month verification requirements for the expansion population and reductions to retroactive coverage will also result in increased churn;
    - Retroactive coverage will be limited to 30 days for adults, 60 days for children (instead of 90 days)– this impacts the entire system, including hospitals, providers, patients, the state;
    - Challenging for people of Colorado and HCPF staff, who believe in Medicaid and work hard to ensure those eligible receive coverage;

- In terms of funding and reduction in revenue to the state, immediate high-level impacts include:
  - The disallowance of continuous coverage will result in "savings", since it won't be allowed, and HCPF has been allowed to roll that back into savings;

  - HCPF did have to walk back the 1.6% provider rate increase that was in effect on 7/1/25, which impacts providers across the state;
  - Access Stabilization payments, intended to support small, rural, and pediatric providers, are being delayed by 6 months;
    - Providers will be receiving those payments in 6 months- so you can look at it as a delay (you will be getting the payment in 6 months), or as just not getting paid for 6 months;
  - HCPF has also had to reduce quality incentive payments through the ACC and the Behavioral Health incentive payment program; both reductions are in place for this fiscal year;

- Longer-term impacts, which will be coming down the road, include:
  - Provider fee reductions (called CHASE payments in Colorado) – will be reduced by 0.5% incrementally each year, which equates to $180 million total per year; by the end of required scheduled reductions, losses are estimated to be $900 million (total cap);
  - State directed payments will be capped at Medicare rates, rather than the "across insurer" benchmark rates, which will have significant impacts;
    - HCPF did submit 2- HCPF did get 2 state directed payment preprints before the deadline, which should allow state to avoid the major reductions, but is still waiting to hear from CMS;
    - A PCPRC member, who is also a member of the CHASE board, indicated that there is some discussion about whether one of the preprints was submitted in time; assumption was that if submitted prior to the passage of H.R. 1, but guidance that came out a couple of days ago, and through other channels have heard that deadline was actually May for it not to be set to the Medicare rate; CHASE board is still looking for creative solutions, but is not totally confident that one of the preprints will make it through;

- Starting in 2028, the expansion population will also start to see cost-sharing, which will be another barrier to member access;

- Overall, HCPF's north star is continuing member coverage to the greatest extent that we can; mitigate losses in coverage as much as possible; ensuring all eligible individuals receive coverage;
  - Trying to ensure the least amount of impact on providers and members;
  - Have already faced cuts, and legislature and JBC are going to have tough decisions to make in the next legislative session;

- Changes are happening very quickly, and HCPF is committed to ongoing communication of the information, when they have it;

  - Like others, feeling like the ground is shifting beneath us, and don't have all the answers about what will happen in the future or how HCPF will be able to respond; also, like others, trying to do more with less resources
  - Also, a reminder that HCPF does not get to set the budget, and doesn't get to choose what is funded and what is not; that is the job of the legislature and the JBC, and stakeholders with ideas should reach out to legislators;

- HCPF is also working on the Rural Hospital Transformation Fund, and information is available on their website;

- A member asked via chat what member cost sharing would look like, noting they had heard $35/visit, and also asked what population would be impacted (all beneficiaries, age specific, other determinants);
  - A member responded that cost sharing would apply to expansion adults (100-135% FPL), and noted that primary care, mental health, substance use disorder, and FQHC services are exempt. They provided a link to the following resource: https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/;
  - HCPF confirmed that cost-sharing is specific to the expansion population, and that the state will have some say in what that will look like but doesn't have any additional information at this point- they will start working on it prior to the 2028 implementation date.

- Specific Medicaid resources include:
  - HCPF website with impacts of the Federal funding changes: https://hcpf.colorado.gov/impact
  - Special Session Reduction Fact Sheet: https://hcpf.colorado.gov/sites/hcpf/files/FY%2025-26%20HCPF%20Budget%20Reduction%20Items%20Fact%20Sheet%20-%20Sept%202025.pdf
  - Rural Health Transformation Fact Sheet: : https://hcpf.colorado.gov/sites/hcpf/files/Fact%20Sheet%20-%20%20Rural%20Health%20Transformation%209-5-25.pdf
  - H.R. 1 HCPF Presentation: https://hcpf.colorado.gov/sites/hcpf/files/HR%201%20Presentation%20for%20Legislative%20Leadership%207.30.pdf

Discussion

- A member (consumer representative) noted their organization is part of a Protect Our Care campaign and coalition in Colorado that is pushing for federal action on things like the expiration of enhanced premium tax credits, and trying to push for requesting an extension for the work requirements and other policies; this group is in the midst of

advocacy-related work (less on the technical financing end), but is looking to develop county and district level facts sheets about the impact of federal changes- so as the PCPCR collects specific information about FQHC, pediatrics and other provider impacts, it would be helpful to share;
    - CIVHC has also been engaged to determine what level of data they can pull in terms of utilization and cost, and what those losses might be- if that information is helpful for the work of this group, it could be shared;

- A member recognized that the focus of the PCPRC is to advance primary care and make proactive changes in the healthcare landscape in Colorado, but one potential role of this group over time could be to do some chronicling of the losses that happen over the coming years;
    - As we talk about the things to investigate in this year's report, it might be worth having a page that talks about the erosion of health care, so that it is being catalogued (e.g., coverage losses, etc.);
    - Multiple members agreed with this comment.

- A member reflected that in some ways the current environment harkens back to COVID-19, which was a time of massive, sudden change, and it felt like the ground was shifting beneath us; a difference that in COVID-19, the events were being imposed by an external force (the virus), whereas now, they are the result of policymakers at the federal level; while the work was hard during COVID, there was a sense that we were all working together toward a common goal, and that is lacking in some spaces right now; the member expressed appreciation for the PCPRC, as a group that does have that common spirit and sense of purpose;
    - Multiple members agreed with this comment.

ACTION ITEM:

- All stakeholders are welcome and encouraged to provide written feedback on the aligned APM parameters for primary care prior to the annual review meeting on October 9, 2025. The Division will be posting comment forms on the HB22-1325 - Primary Care Alternative Payment Models website.
- PCPRC members can also send additional ideas for topics/issues they would like to see addressed in the upcoming annual recommendations report to Tara Smith (tara.smith@state.co.us).

Public comment

- Lauren Hughes invited everyone (and please share the invite!) to the next public, virtual meeting of the Standing Committee on Primary Care on 9/25:

https://www.nationalacademies.org/event/44495_09-2025_standing-committee-on-primary-care-september-open-meeting

- Alison Noon introduced herself in the chat, from the Colorado Attorney General's office with a focus on health care fraud and policy initiative, and thanked members for their work, saying how interesting it was to join today.