Primary Care Payment Reform Collaborative Meeting

November 13, 2025

Agenda

- Primary Care & APM Spending Report
- Housekeeping & Announcements
- Federal & State Updates
- Annual Report Recommendations
- Public comment

Meeting Goals & Requested Feedback

GOALS

- Review key findings from primary care & APM spending report
- Finalize topics for annual recommendations report
- Identify key issues for follow-up research, discussion

FEEDBACK

- Questions/comments on this year's spending report
- What are the key topics (and subtopics) for the annual recommendations report?
  - Targeted research needs for December meeting

* * Incorporate equity into discussion and recommendations * *

2025 Primary Care Spending Report

November 13, 2025

CIVHC
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Background

- Primary Care Spending Report satisfies statute:
  - CRS 25.5-1-204(3)(c)(II) - Report includes the percentage of medical expenses allocated to primary care, the share of payments that are made through nationally recognized alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.

Report Content

- Analysis of primary care and Alternative Payment Model (APM) spending as a percentage of total medical spending for:
  - 2022, 2023, and 2024
  - Commercial, Medicaid, CHP+, and Medicare Advantage (excludes Medicare FFS)
- Does not include pharmacy or dental spending
- Two separate sources of information for report:
  - Carrier-submitted APM files (18 payers submitted APM files)
  - Claims from the CO APCD

Report Content

- This year, payers submitted their data using the Expanded Non-Claims Payment Framework to better align the CO APCD APM layout with the Common Data Layout for Non Claims Payments (CDL-NCP).
- Followed data collection and validation process established in 2021:
  - Qualitative field collection to ensure accurate APM categorization
  - Ensured carriers appropriately categorized FFS payments under larger APMs (i.e. pay for performance)
  - Attestation by C-suite payer representative
- Inclusion of payer vs. member portion of spend, prospective payment spending, and reporting of PMPM spending

Report Content

#	Non-claims-based Payment Categories and Subcategories	Corresponding HCP-LAN Category
A	Population Health and Infrastructure Payments	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	Performance Payments	
B1	Pay-for-reporting payment	2B
B2	Pay-for-performance payments	2C
C	Shared Savings Payments and Recoupments	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N
D	Capitation and Full Risk Payments	
D1	Primary Care Capitation	4A, 4N
D2	Professional Capitation	4A, 4N
D3	Facility Capitation	4A, 4N
D4	Behavioral Health Capitation	4A, 4N
D5	Global Capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	Other Non-Claims Payments	
X	Fee for Service	
X9	Fee for Service	01
Z	Member Count	

8

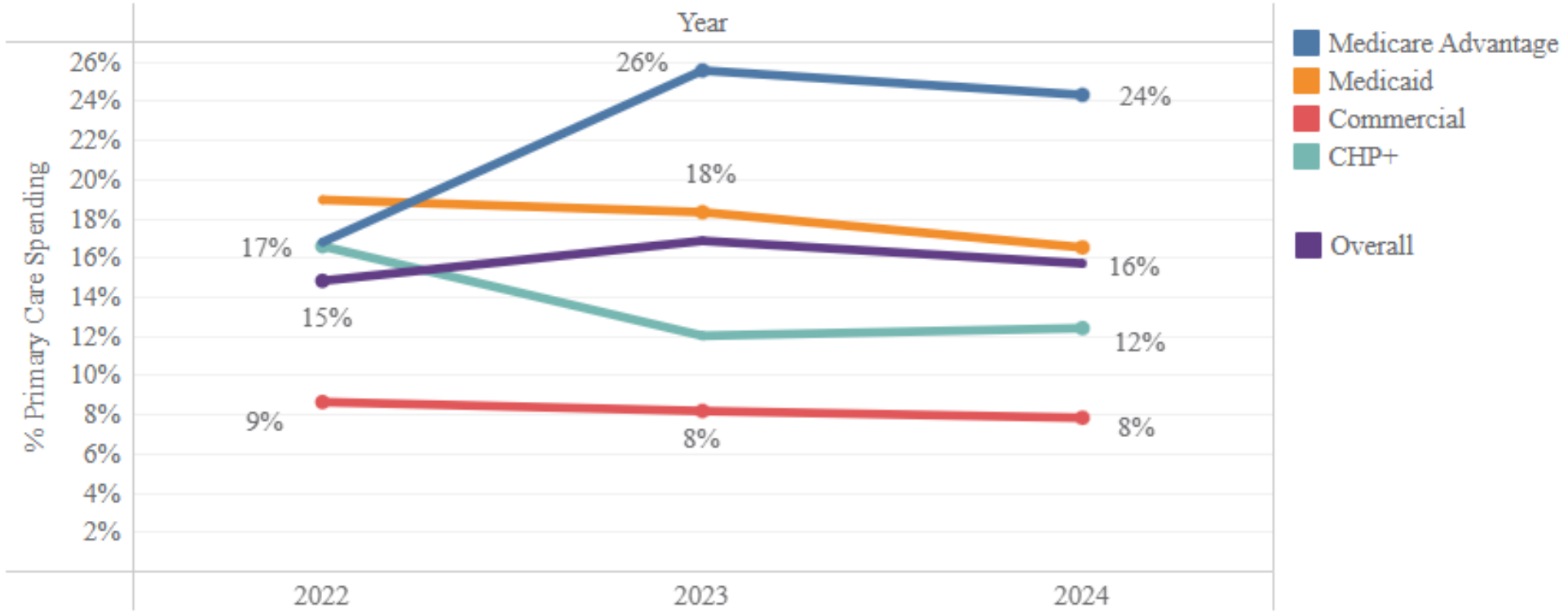
Report Content

- An APM contract file is collected to describe the contract between carriers and providers and its HCP LAN category. Carriers provide details on:

Category	Options
Mode of Payment	Claims, Non-Claims, or Both
Type of Services Paid	Specific medical services, Non-medical services, Comprehensive medical services
Timing of Payments	Prospective with retrospective reconciliation, Prospective without reconciliation, Retrospective
Population-based Payment	Yes/No
Provider Risk	Upside, Downside, Both, N/A
Quality Measurement	Yes/No
Target Spending	Yes/No

Primary Care Spending as a Percentage of Total Medical Spending by Line of Business: 2022-2024

Figure 1: Percent of Primary Care Spending by Payer Over Time, 2022-2024



Primary Care Spending as a Percentage of Total Medical Spending: 2024

Figure 2: Share of Primary Care Spending, 2024.

Payments for primary care account for **15.7%** of total medical spending in 2024.

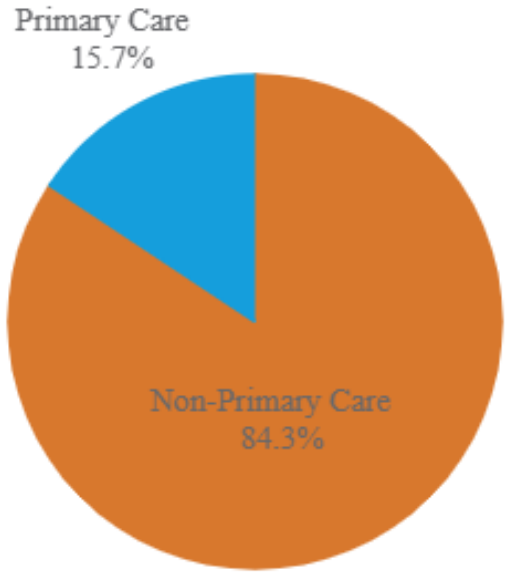
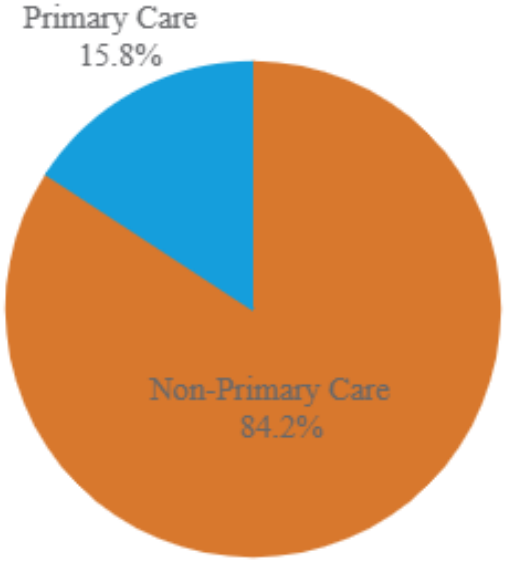


Figure 3: Share of Primary Care Spending, excluding Kaiser Permanente and Denver Health, 2024.

Payments for primary care account for **15.8%** of total medical spending, excluding Kaiser Permanente and Denver Health, in 2024.



Notes:
(1) Total Medical Spending does not include dental and pharmacy spending
(2) Kaiser Permanente and Denver Health are not currently subject to the required targets for primary care investment established through Colorado Regulation 4-2-72 due to their unique integrated payer-provider systems.

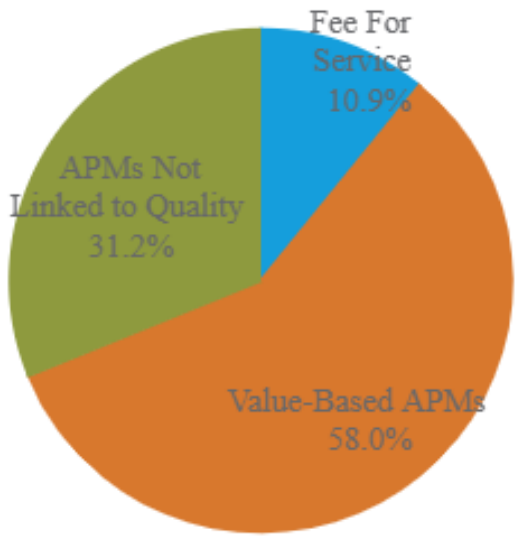
Alternative Payment Models (APM) as a Percentage of Primary Care Spending: 2024

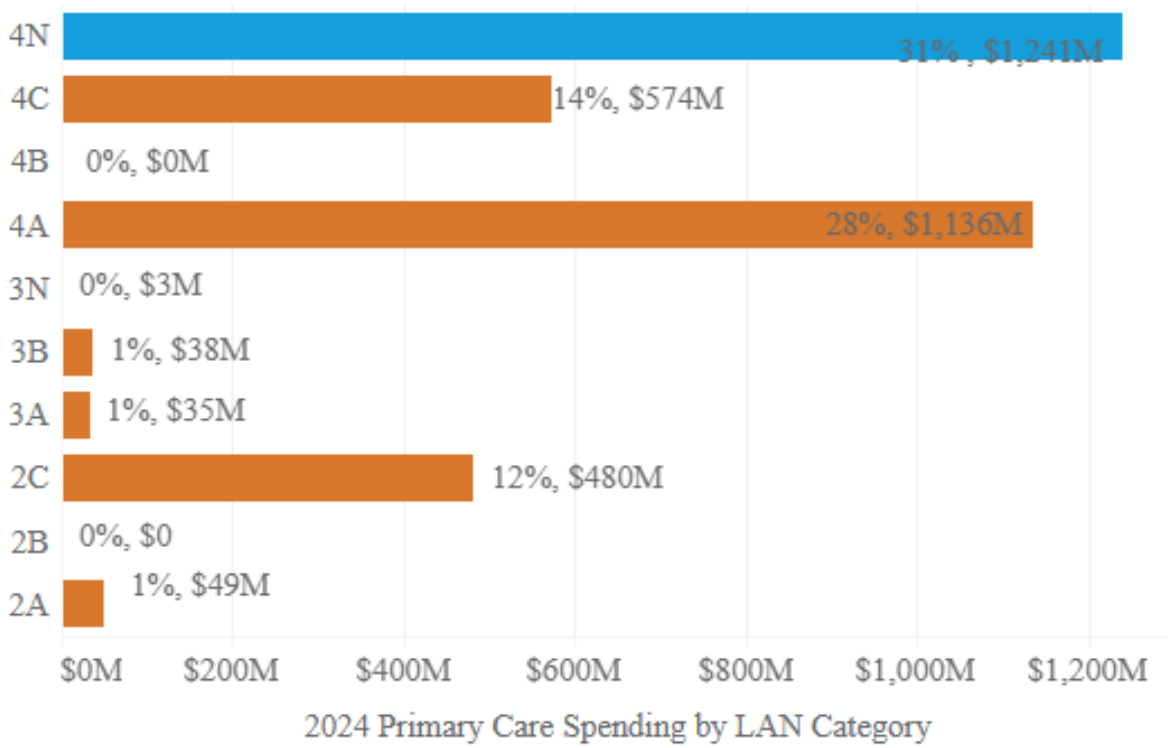
Figures 4: Share of Primary Care Spending by APM Category, 2024.

Payments under value-based alternative payment models account for

58.0%

of total **primary care spending** in 2024.





Note: Value-Based APMs include LAN Category 2, 3, and 4 payments, with the exception of 3N and 4N (payments with no link to quality)

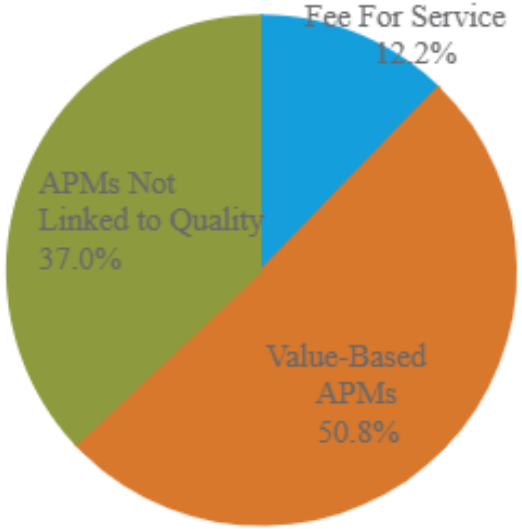
APM as a Percentage of Primary Care Spending, excluding Kaiser and Denver Health: 2024

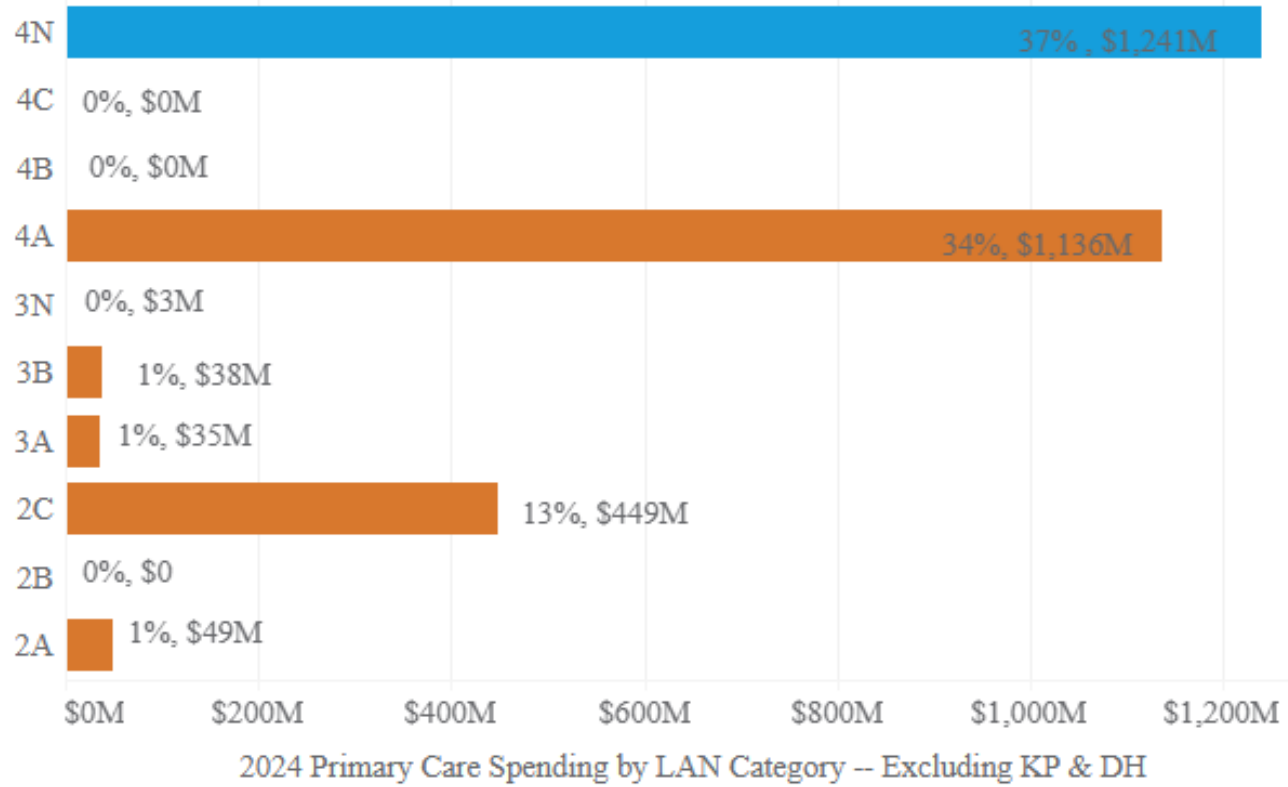
Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser Permanente (KP) and Denver Health (DH), 2024.

Payments under value-based alternative payment models account for

50.8%

of total **primary care spending**, excluding Kaiser Permanente and Denver Health, in 2024.





Note: Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

APM Spending as a Percentage of All Medical Spending: 2024

Figure 6: Share of Total Medical Spending by APM Category, 2024.

Payments under value-based alternative payment models account for

33.5%

of **total medical spending** in 2024.

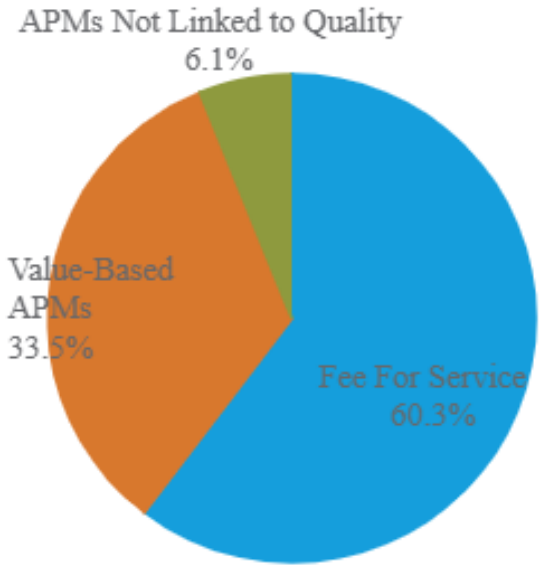
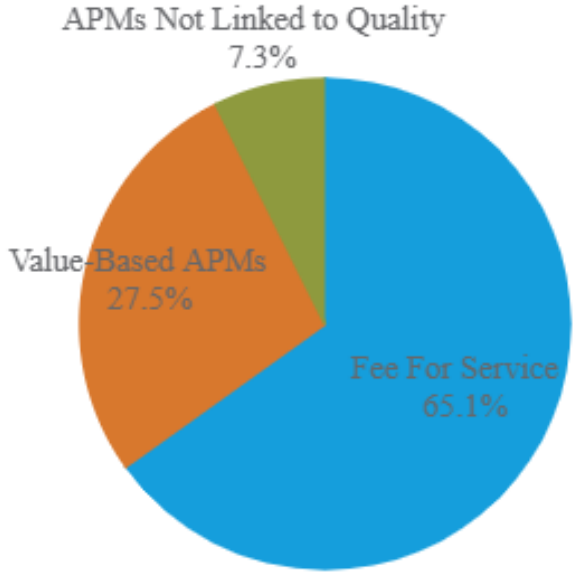


Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser Permanente and Denver Health, 2024.

Payments under value-based alternative payment models account for

27.5%

of **total medical spending**, excluding Kaiser Permanente and Denver Health, in 2024.



Notes:
The denominator (total medical spending) does not include pharmacy expenditures.
Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

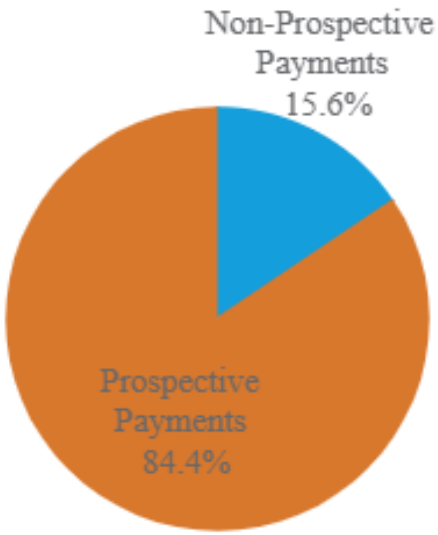
Prospective Payments as a Percentage of Primary Care Spending: 2024

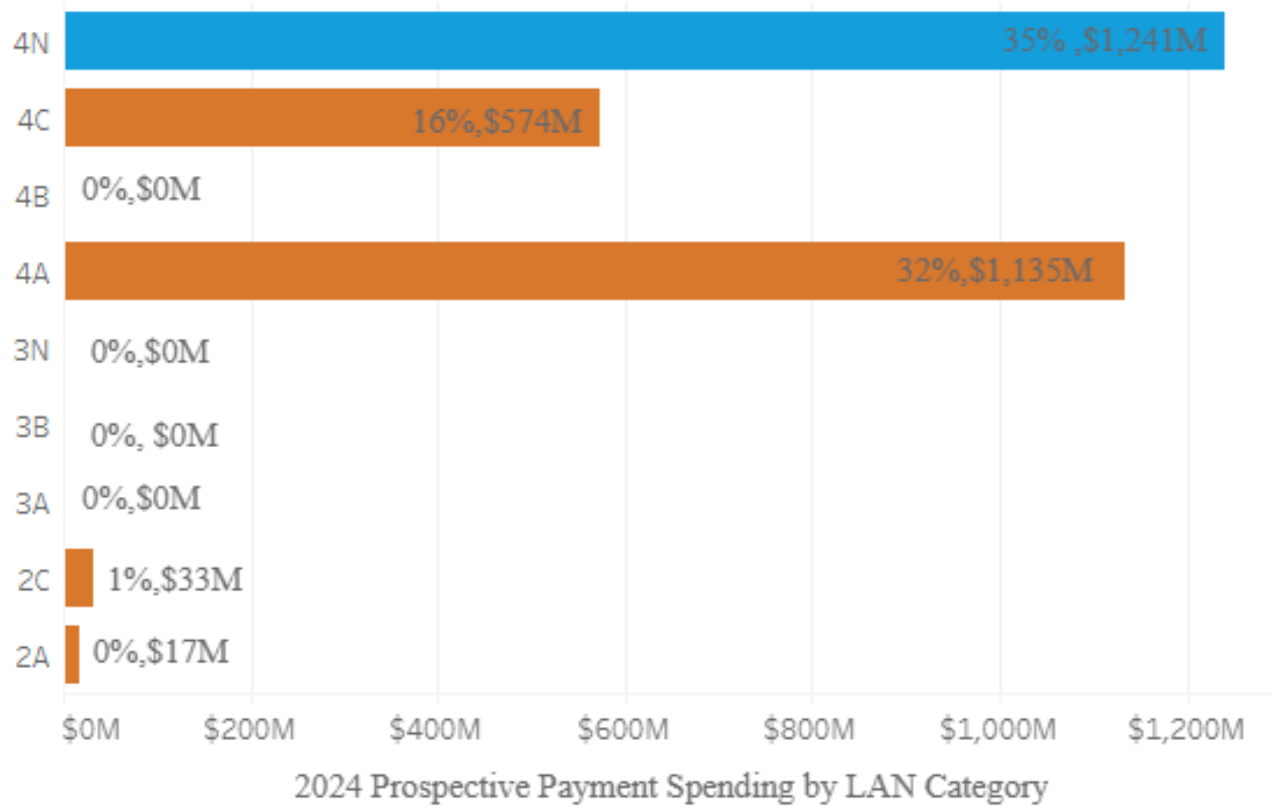
Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2024.

Prospective payments under alternative payment models account for

84.4%

of total **primary care spending** in 2024.





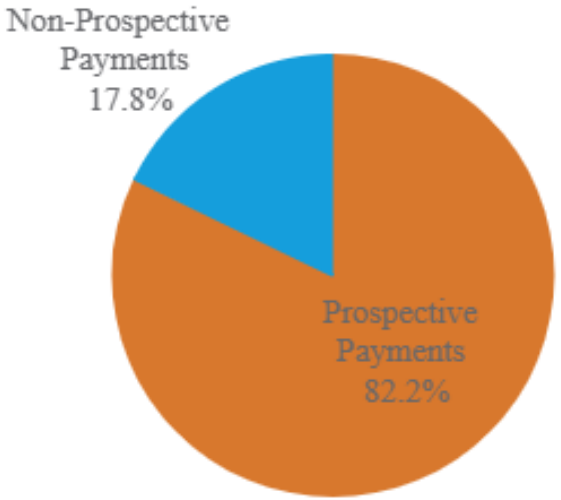
Prospective Payments as a Percentage of Primary Care Spending excluding Kaiser and Denver Health: 2024

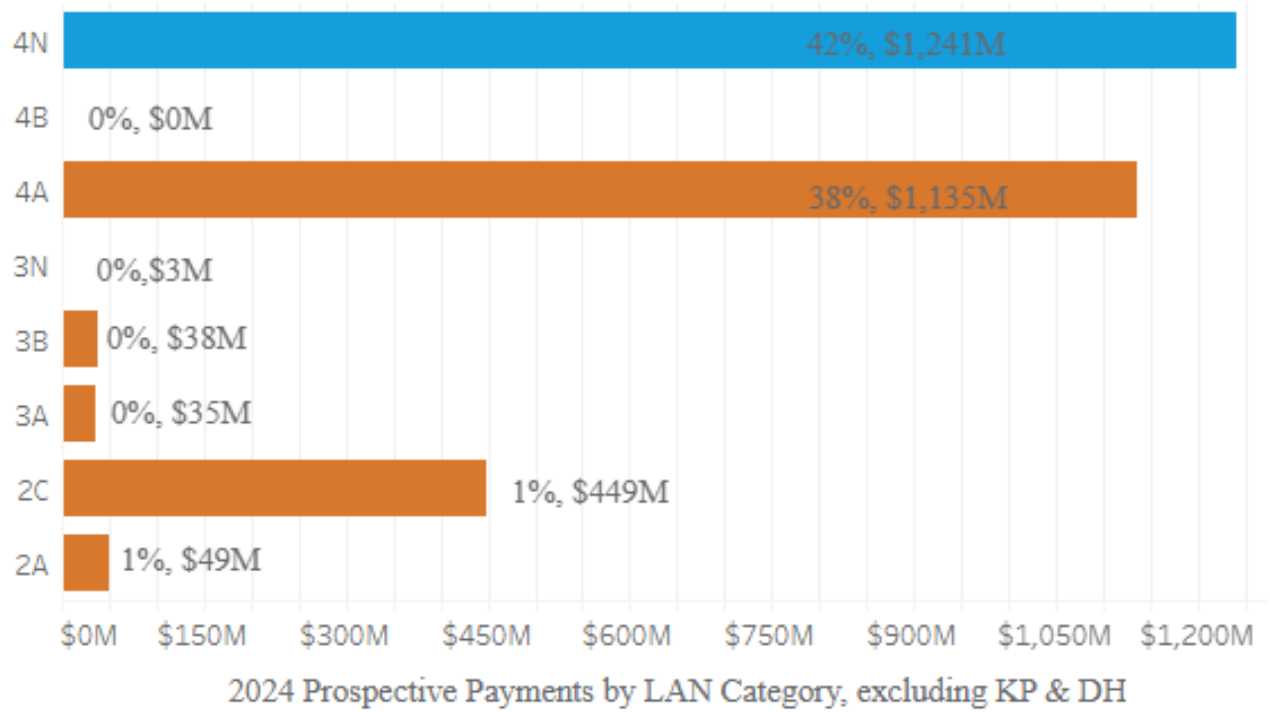
Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser Permanente (KP) and Denver Health (DH), 2024.

Prospective payments under alternative payment models account for

82.2%

of total **primary care spending**, excluding Kaiser Permanente and Denver Health, in 2024.





Prospective Payments as a Percentage of Total Medical Spending: 2024

Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2024.

Prospective payments under alternative payment models account for

47.6%

of **total medical spending** in 2024.

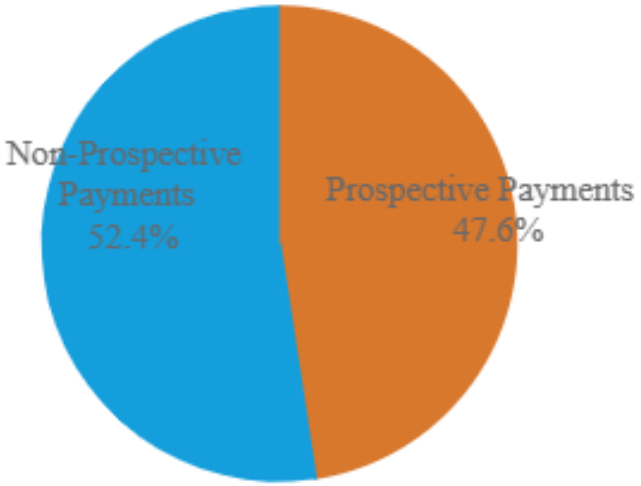
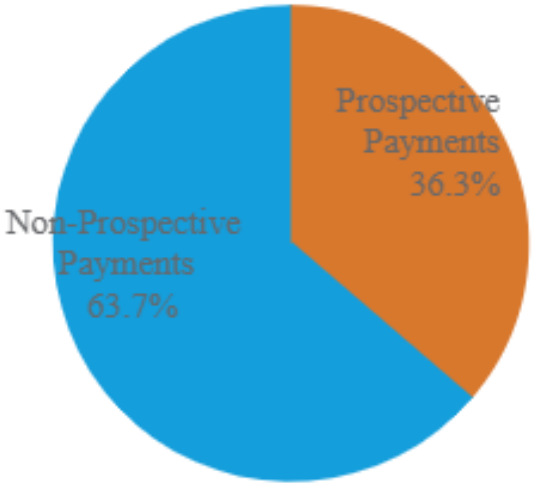


Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser Permanente and Denver Health, 2024.

Prospective payments under alternative payment models account for

36.3%

of **total medical spending**, excluding Kaiser Permanente and Denver Health, in 2024.



Limitations

- Resource constraint from payers presented challenges with submission logic and validation feedbacks
- Multiple entities/teams reviewing data at different times on the payer's side caused timeline issues
- Complexities of APMs data collection
  - New APM categories
  - Need to continue year-round outreach with payers around APM categories criteria and PMPM calculations
- Challenges in validating APM data with CO APCD data
- Primary care definition's reliance on provider taxonomies
  - No clear methodology to identify portion of capitated payments designated for primary care
  - Primary care designation varies by payer
  - Continue investigation on primary care designation comparisons with payers with large differentials
- Medicaid
  - Payers only reported payments they made directly to providers, this avoids duplicating payments going from HCPF to RAE/MCO organizations

Next Steps

- Continue working with payer representatives to ensure accurate reporting
  - Use various payer forums to talk about APM data collection and criteria used to identify APM categories
  - Continue improving data collection process by clarifying instructions on data fields and contract supplement
- Investigate and add/remove as needed new primary care codes
  - Behavioral health, L&D
- Plan for incorporating Capitation File data into the annual reporting

Questions?

Housekeeping & Announcements

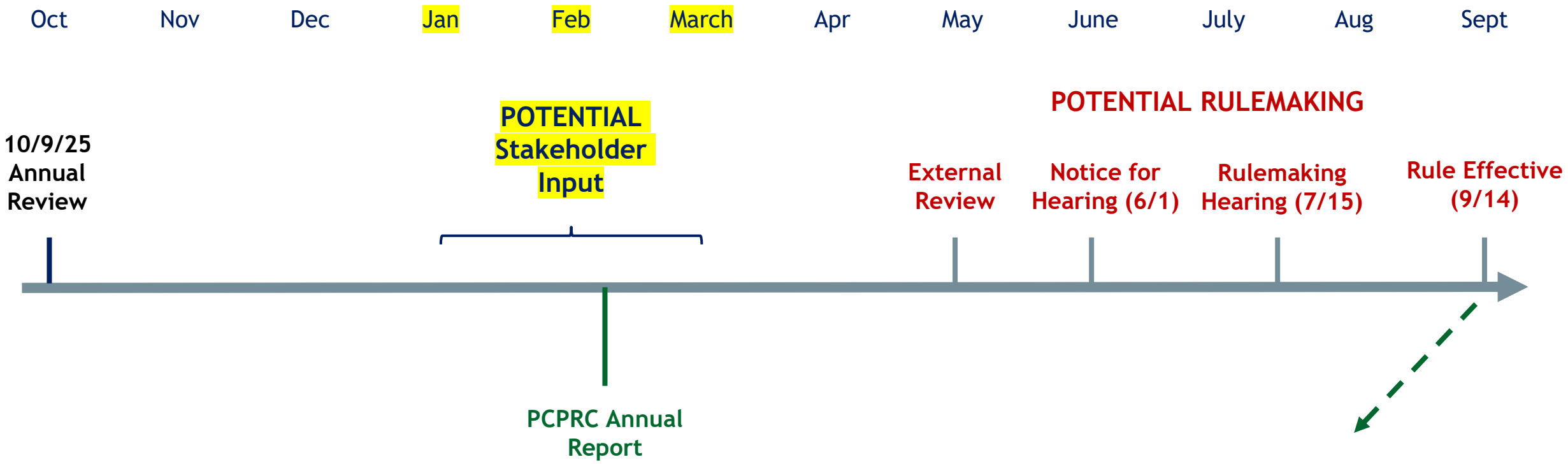
Housekeeping & Announcements

- Meeting minutes – Approval of Sept and Oct meeting minutes
- Attendance and feedback at upcoming meetings
  - Dec 11 – pre & post meeting review
  - Jan 8 - pre & post meeting review
  - Feb 12 - pre & post meeting review
- Proxies allowed for meetings and voting

Follow-up from Aligned APM Parameters Review

- Key themes
  - Transparency requirements for risk adjustment and patient attribution methodologies are important and helpful, but challenges remain
    - Diagnosis codes would be a helpful addition to risk adjustment model descriptions
    - A metric to measure improvement in attribution would be helpful/is needed
  - Integrated behavioral health and pediatrics are important components of core competencies framework
  - Measures that include clinical data are more challenging for carriers to collect; alignment with national standards simplifies administrative complexity; identify mechanism for updating set based on changes to measure specifications
- Topics for future discussion
  - Quality measures: create “pipeline” for future measure updates (e.g., on deck, developmental, monitoring)
  - Core competencies: potential alignment with Advanced Primary Care Management (APCM) Services codes

POTENTIAL Timeline



Depending on nature of new requirements, in place either 1/1/**26** or 1/1/**27**

Federal & State Updates

Federal Updates

- End of government shutdown
  - Continuing resolution passed House and signed by President last night
    - Funds government at current levels through Jan 2026
    - Separate spending bills cover agriculture (USDA, SNAP), veterans, military construction, and legislative agencies through end of Sept 2026
    - Reverses layoffs of federal workers, ensures retroactive pay for those furloughed
    - Does **NOT** include extension of enhanced premium tax credits
- Rural Health Transformation Program
  - All 50 states submitted applications for 5-year, $50B fund
    - Of $10B allocated annually, ½ split evenly, ½ based on state proposal
    - Factors considered: “rurality”, situation of hospitals serving disproportionate number of low-income patients with special needs, “any other factors”
  - CMS will announce awardees by 12/31/25 (funds start 10/1/26)

Federal Updates

- Prescription Drugs
  - Pharma companies striking deals with White House to provide certain drugs at reduced most favored nation (MFN) prices
    - Pfizer, AstraZeneca, EMD Serono (fertility therapies through TrumpRx)
    - Eli Lilly, Novo Nordisk (GLP-1)
  - CMMI announced new GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model
    - Five-year, voluntary model for drug manufacturers and states
    - Goal: to ensure fair and reasonable drug prices for Medicaid through CMS-led negotiations with drug manufactures
    - Participating manufacturers will enter negotiated agreements with CMS to set pricing on covered outpatient drugs
    - Pricing to state Medicaid programs will be calculated based on select international pricing data, effectuated through supplemental rebates
    - RFA released, model will launch in Jan 2026

Federal Updates

- HHS – CY 2026 Physician Fee Schedule Final Rule
  - Behavioral health integration payment for advanced primary care
    - 3 new G-codes billed as add-on services when APCM base code reported by same practitioner in same month
    - Meant to be comparable to existing Collaborative Care Model (CCM) and behavioral health integration codes
    - No changes to cost sharing requirements for APCM codes
  - "Efficiency adjustment" – rebalance payments
    - Adjustment to work relative value units (RVUs) and corresponding intraservice portion of physician time for non-time-based services
    - Calculated using Medicare Economic Index, 5-year look-back period
    - Final adjustment for CY 2026 = -2.5%
  - Practice expense (PE) reimbursement – shift resources from facility to independent, community-based practices
    - Reduce amount of indirect PE allocated per work RVU to 50% of amount allocated for non-facility services (maternity services exempt)

Federal Updates

- HHS – CY 2026 Physician Fee Schedule Final Rule - Continued
  - Improvements to Medicare Diabetes Prevention Program
    - Multiple changes to increase uptake and participation
  - Telehealth
    - Simplified process to add services by removing distinction between provisional and permanent services and limiting review (reducing 5-step process to 3 steps)
    - Added 5 new services to Medicare Telehealth Services List
    - Removed frequency limits for subsequent inpatient & nursing facility visits, critical care consults
    - Allows real-time A/V communications to meet “direct supervision” requirements
  - Ambulatory Specialty Model (ASM)
    - New 5-year, mandatory model; will launch January 2027
    - Targets heart failure and low back pain care
    - Holds specialists accountable for quality, cost, care coordination and EHR use
    - Payment adjustment begin in 2029, ranging from -9/+9% (up to -12%/+12% by 2033)

Federal Updates

- HHS – CY 2026 Physician Fee Schedule Final Rule - Continued
  - Medicare Shared Savings Program (MSSP)
    - Finalized changes projected to reduce Medicare spending by $20M through 2035 and encourage broader participation
    - Reduced time ACO can participate in one-sided model of BASIC track (5 years, not 7)
    - Increased flexibility around minimum beneficiaries (<5,000 allowed in BY 1 and 2)
    - Removed health equity adjustment
    - Updated APM Performance Pathway Plus quality measure set to align with other programs
  - Merit-Based Incentive Payment Program (MIPS)
    - Finalized policies to stabilize program, support goal of fully transitioning to MIPS Value Pathways
    - Added 6 new MIPS Value Pathways
    - Maintained 75-point performance threshold to avoid penalties and receive positive payment adjustment through 2028 performance period

Federal Updates

- Primary Care Collaborative - New Report
  - Closing the Distance in Rural Primary Care: Evidence, Stories and Solutions
  - Webinar on 11/12 – available online in coming days

- NAM Standing Committee on Primary Care – November Meeting
  - 11/20/25, 11-2 pm MT
  - Register HERE

State Updates

- SNAP benefits restarting
  - Joint Budget Committee voted in late Oct to approve $10M to support food banks starting 11/1, extend WIC funding through end of Nov
  - With end of shutdown, state moving to deliver 100% of payments, starting as early as today
- Governor's Proposed FY 26-27 Budget
  - Total expenditures of $50.7B ($18.6B General Fund); budget reserve of 13%
  - Hold Medicaid growth to 5.6% in FY 26-27
    - Specific program expenditure reductions outlined in updated Executive Order
    - HCPF Budget Reductions Fact Sheet – Oct 31, 2025
- Rural Hospital Transformation Program Application
  - HCPF Colorado Rural Health Transformation Program website
  - Colorado application: Project Summary, Narrative, Budget

State Updates

- Colorado RHTP Application
  - Goal 1: Make Rural America Health Again
    - Initiative 1: Transforming Rural care: Hospitals and Chronic Disease Prevention
    - Initiative 2: Build Data and Evaluation Infrastructure for Chronic Disease Programs: Diabetes, Cardiovascular Disease, Hypertension, and Obesity
  - Goal 2: Sustainable Access
    - Initiative 3: Build and Connect Colorado's Rural Health Networks
    - Initiative 4: Strengthen Rural Care Delivery Systems
    - Initiative 5: Sustain Rural Hospital Operations and Regulatory Readiness
  - Goal 3: Workforce Development
    - Initiative 6: Strengthen and Expand the Rural Health Workforce
    - Initiative 7: Expand Clinical Capacity to Perform Preventative Care
    - Initiative 8: Strengthening State and Local Health Care Coordination
  - Goal 4: Innovative Care
    - Initiative 9: Design and Pilot Rural Value-based Care Model(s)
  - Goal 5: Tech Innovation
    - Initiative 10: Expand Rural Telehealth & Technology Integration

State Updates

- Initiative 5: Sustain Rural Hospital Operations and Regulatory Readiness
  - Enable hospitals to procure technical assistance and targeted operational support to help rural hospitals realign or sustain essential service lines (such as primary care, emergency, maternal and child health, behavioral health)
  - Enhance administrative and compliance capacity, including regulatory readiness for value-based care participation
- Initiative 6: Strengthen and Expand the Rural Health Workforce
  - Strengthen rural health workforce by expanding access to credentialing and continuing education opportunities for health professionals and other health workers serving in HPSAs
  - Funding will be used to attract, train, and retain local essential providers (physicians, nurses, pharmacists, behavioral health clinicians, Health Worker, technicians, and others) who are critical to improving chronic disease prevention and management
- Initiative 7: Expanding Clinical Capacity to Perform Preventive Care
  - Expand clinical workforce capacity to deliver preventive services and procedures in rural and frontier communities
  - By equipping rural clinicians with advanced procedural skills, Colorado will help local rural providers meet preventive screening needs in their regions

State Updates

- Initiative 9: Design and Pilot Rural Value-Based Care Model(s)
  - Research, design, pilot, and ultimately scale value-based care model(s) tailored for rural providers and hospitals
  - Assess feasibility of shared savings, bundled payments, and other approaches that reward prevention, care coordination, and improved health outcomes
  - HCPF will collaborate with rural health clinics, hospitals, and RAEs to implement scalable, value-based frameworks that are aligned with Colorado's ACO and Clinically Integrated Networks (CINs)
  - Measurable outcomes:
    - Number of new APMs or value-based care models launched
    - Number of facilities in ACO-like collaborative networks
    - Number of facilities engaged in quality improvement under the Hospital Transformation Program
    - Number of new rural payment arrangements or shared savings programs

Report Recommendation Topics

State levers to advance alternative payment models for primary care

Stephanie Gold, MD; Lauren S. Hughes, MD, MPH, MSc, MHCDS; Kyle Leggott, MD; Sarah Hemeida, MD, MPH; Lakshmi Karra, MD, MS; Apoorva Ram, MD; De'Janae' Guillory-Williams, MPH

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UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Project Overview

Scope of work

This project examined state policy levers to better understand how they:

1. Advance the adoption of primary care APMs in the commercial sector
2. Support multi-payer alignment (within the commercial sector *and* across sectors)
3. Ensure monitoring and enforcement

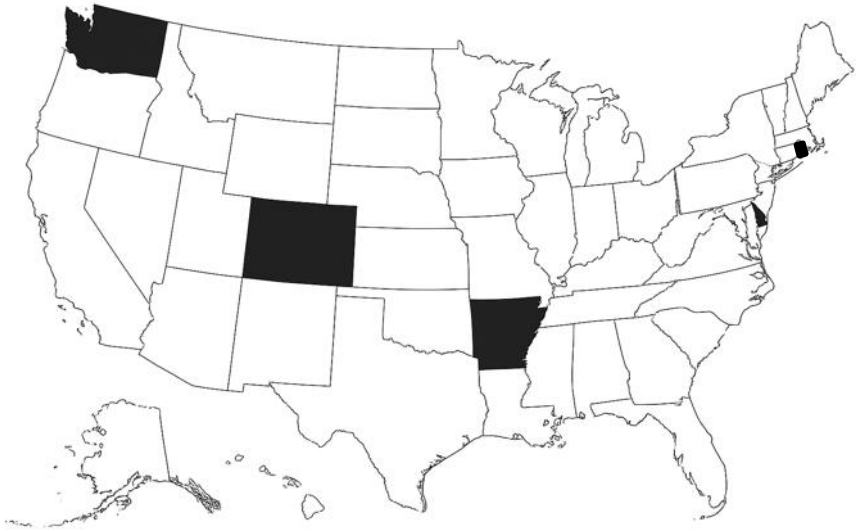
We interviewed 50 stakeholders across 5 states

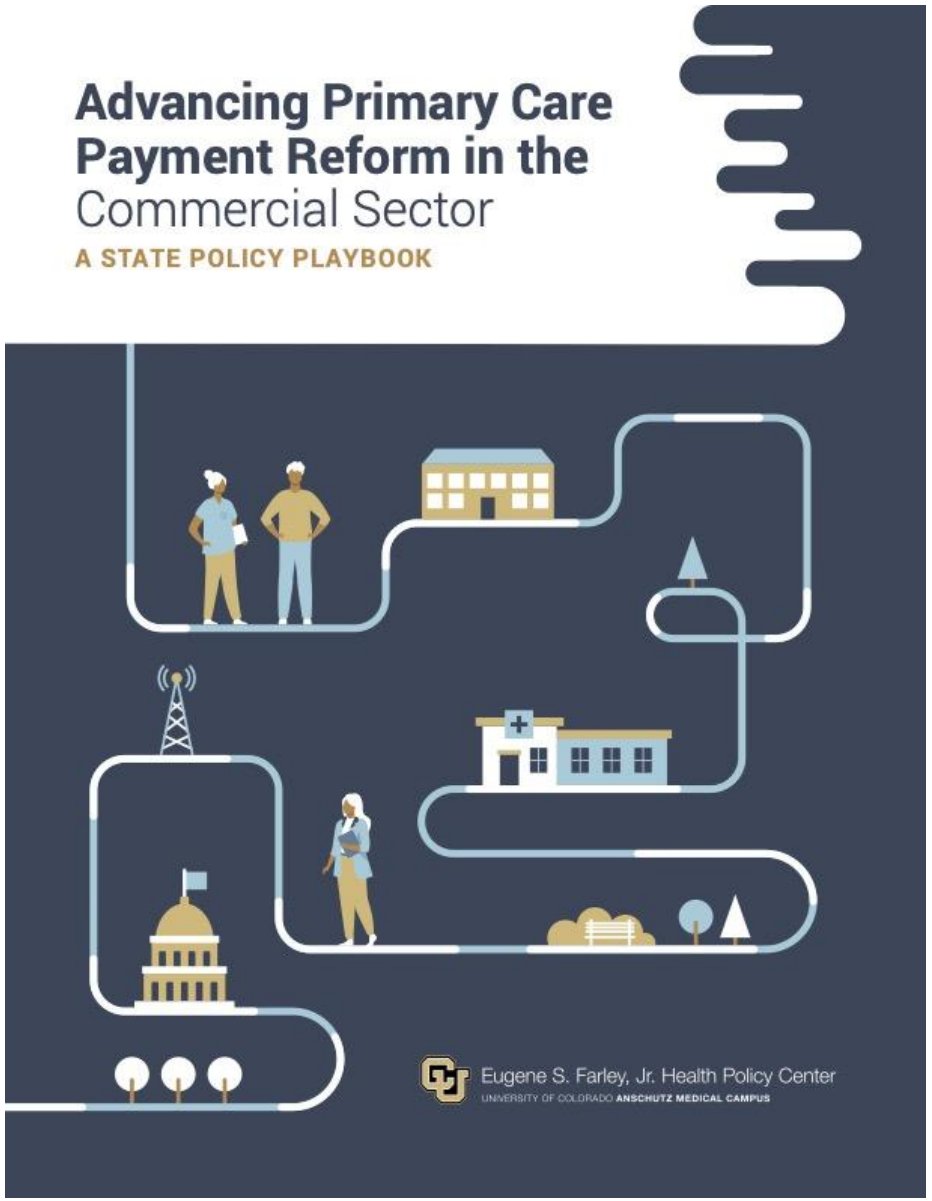
Types of interviewees

- Payers
- State insurance regulators
- Medicaid
- Providers
- Consumers/patients
- Health systems
- Leaders from other primary care / healthcare organizations
- Purchasers/business
- Aggregators/Clinically Integrated Networks (CINs)
- Legislators
- Managers of All Payer Claims Databases

By the numbers

- 47 interviews (7-13 per state)
- 50 interviewees




Advancing Primary Care
Payment Reform in the
Commercial Sector
A STATE POLICY PLAYBOOK
Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS


State Policies to
Advance Primary Care
Payment Reform in the
Commercial Sector
APRIL 2025
Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

For state policies advancing primary care APMs to be successful…

1. the APMs must provide a meaningful amount of payment delivered through non-fee-for-service mechanisms, including prospective payment;
2. investment in primary care must be increased;
3. there must be multi-payer alignment both within the commercial sector and across all sectors of payers.

Overview of playbook steps

Type of Policy	Step	Description
Voluntary	1	Build your base. Find (or be) a champion.
	2	Develop your vision for aligned primary care APM policy and situate this in a broader state primary care strategy.
	3	Hold voluntary stakeholder convenings prior to drafting legislation, developing regulation, or participating in federal demonstrations.
	4	Take advantage of federal demonstration opportunities when available.
Legislative	5	Advance legislation that expands regulatory authority to develop affordability standards for primary care, drive multi-payer alignment, and create an infrastructure for continued improvement.
Regulatory	6	Set requirements for APM design in regulation that balance standardization and flexibility.
	7	Scale and support APM adoption through regulatory targets, data monitoring requirements, and enforcement mechanisms.
Implementation	8	Maintain regular communication in enforcement and implementation.

Key Lessons from Other States and Opportunities for CO

Step 7.C. Ensure payment intended for primary care ultimately benefits the primary care practice.

Why it's important

There is a potential risk that incentive structures in APMs and additional investments intended for primary care paid to a health system or intermediary organization may not make it to the level of the practice.

State example

- The Rhode Island Affordability Standards require insurers to provide a PMPM to primary care practices meeting criteria as patient-centered medical homes.
- Carriers may make the PMPM payments to an ACO only if there is a contractual obligation to use the funds to finance care management services at the primary care practice.

Colorado opportunity

- Recommend that shared savings arrangements and PMPMs to an ACO or system have contractual obligations for payments intended for primary care to be used at the practice level.

Step 5.E. Require alignment across all payers under state jurisdiction (all plans subject to state insurance regulation, Medicaid, and state employee health plans) [+ employers to the greatest extent possible.]

Why it's important

- State-regulated commercial plans comprise a minority of insured individuals.
- Incentives or investments that only apply to a small proportion of a practice's patients are not enough to enable significant changes in care delivery.
- Primary care practices also face increased administrative burden from needing to comply with different requirements across payers.

State example

- The AR Health Care Payment Improvement Initiative (AHCPII) includes Medicaid, the state employee health plan, the largest commercial insurers, and one of the largest self-funded employers.
    - Legislation expanding Medicaid through a private option requires that all plans on the exchange participate in the AHCPII.
- In Washington, state agencies partnered with PBGH to help convene employers interested in championing primary care.

Colorado opportunity

- Greater alignment with Medicaid ACC III:
    - Require medical home PMPM based on competencies
    - Include extra PMPM for BHI
- Aligned contractual obligations for the state employee health plan
- MOU or other agreement with self-funded employers around alignment
- ** Alignment with Medicare 2026 fee schedule APCM codes

Step 2. Develop your vision for aligned primary care APM policy and situate this in a broader state primary care strategy.

Why it's important

- Advancing and aligning primary care APMs in the commercial sector is a necessary component of a broader state strategy, but not sufficient on its own to address the current primary care crisis.
- Additional solutions are needed related to workforce supports, decreasing administrative burden, and having aligned payment approaches across all state payers and purchasers (as on the prior slide).

State example

- The Rhode Island Affordability Standards require health insurers to reduce prior authorization requests by 20% and prioritize services ordered by primary care.

Colorado opportunity

- Recommend target decrease in prior authorizations to decrease administrative burden, building on the work of HB24-1149.
- **Recommend creation of a state scorecard/ dashboard for tracking (including on payment and workforce)

Step 6.D. Establish requirements to support behavioral health integration.[to a greater extent]

Why it's important

Integrated behavioral health services, including for mental health and substance use disorders, contribute to improved outcomes in advanced primary care models but lack sustainable funding.

State example

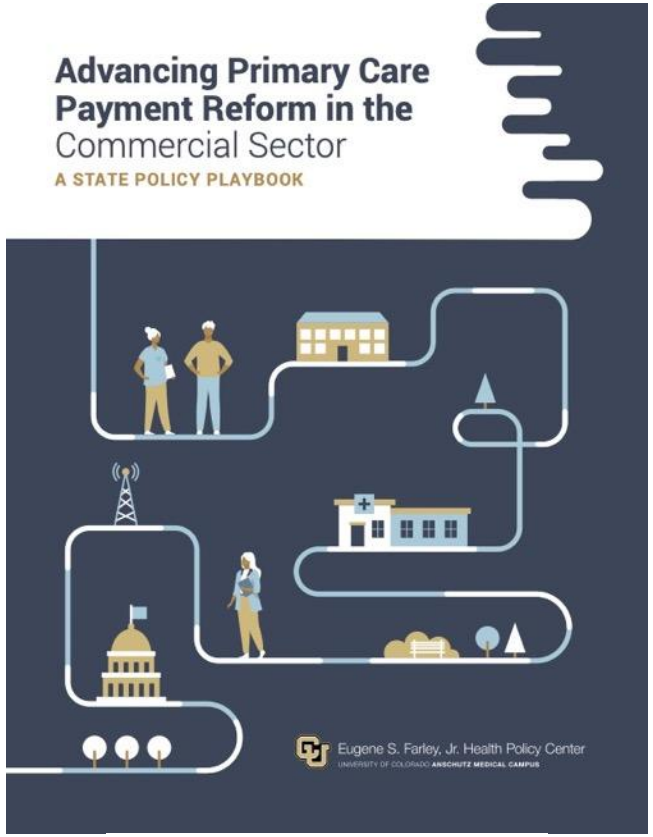
- The Rhode Island Affordability Standards:
  - include behavioral health integration as part of their practice transformation expectations,
  - prohibit same day co-payments for integrated services,
  - open up additional codes for integrated care, and
  - require adopting policies for behavioral health screenings that are no more restrictive than for other preventive services.

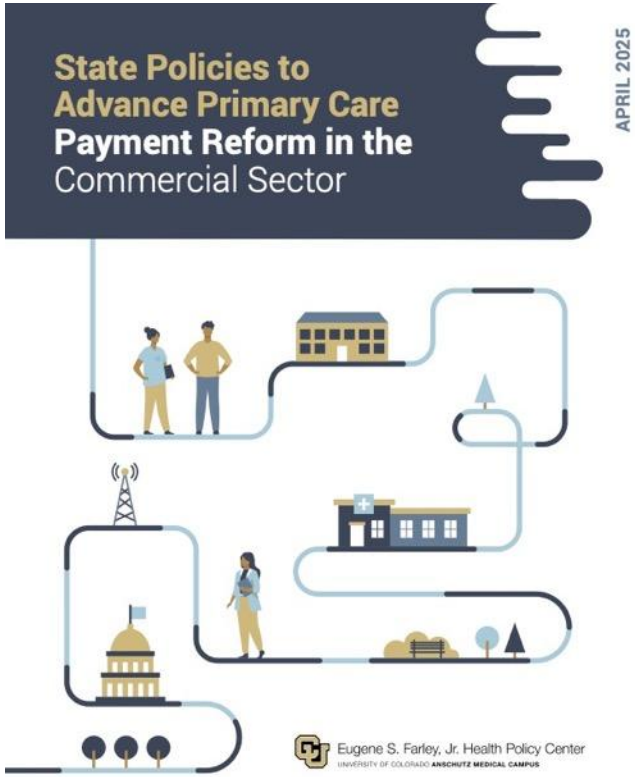
Colorado opportunity

- Recommend alignment with Medicaid ACC III by requiring:
  - PMPM for integrated practices
  - Opening up codes for behavioral health integration (CoCM, HBAI)
- **Recommend alignment with Medicare CY26 fee schedule add-on codes to APCM

For state policies advancing primary care APMs to be successful…

1. the APMs must provide a meaningful amount of payment delivered through non-fee-for-service mechanisms, including prospective payment;
2. investment in primary care must be increased;
3. there must be multi-payer alignment both within the commercial sector and across all sectors of payers.


Advancing Primary Care
Payment Reform in the
Commercial Sector
A STATE POLICY PLAYBOOK
Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS


APRIL 2025
State Policies to
Advance Primary Care
Payment Reform in the
Commercial Sector
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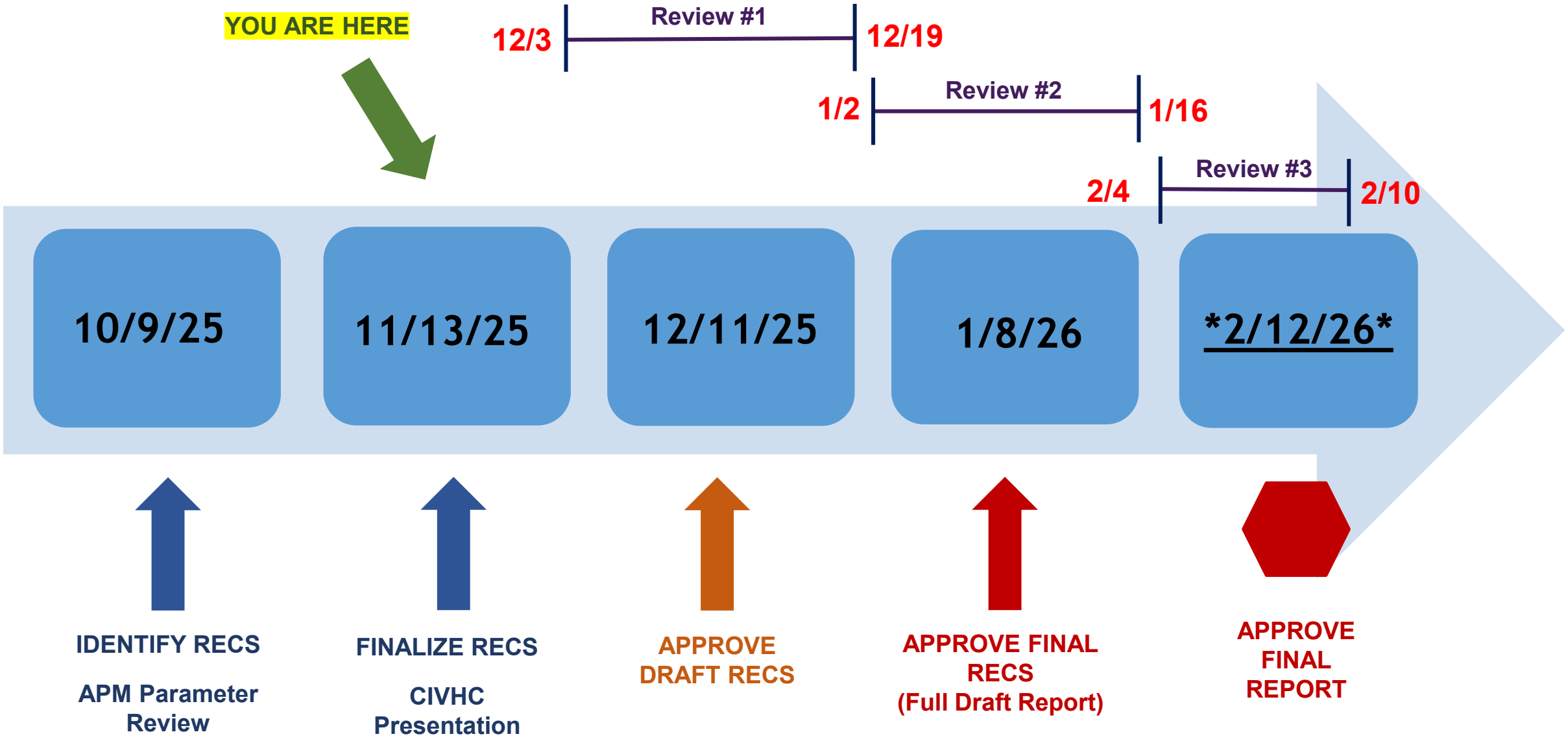
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

THANK YOU!

Eugene S. Farley, Jr. Health Policy Center

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Recommendations Report



Organizational Structure

Executive Summary	• Summary and recommendations
PCPRC Background	• Statutory charge • Operations (report process/voting, membership)
Introduction	• Key themes
Recommendations	• Recommendation 1, 2, 3…
Conclusions	• Summation • Next steps

Potential Intro/Framing

- First 5 years
  - Brief review of reasons PCPRC was created, key achievements to date
- In 2025, legislature reaffirmed state's commitment to primary care
  - Sunset review extended PCPRC for 7 years
  - At time of passage, federal changes under discussion, but clear picture had not emerged
- With passage of H.R. 1, entering new landscape
  - Implications for Medicaid, community health centers, rural providers, ACA marketplace
  - Impending budget cuts/tightened resources have heightened focus on access and affordability
  - Primary care lies at nexus of those twin goals
    - Access to primary care – improved outcomes, reduced disparities, ability to lower costs
    - Affordability – keeping people healthy reduces costs; one of the most cost-effective areas for investment
- For primary care to be part of solution, it needs to survive
  - Payment strategies to support/sustain primary care in increasingly complex market dynamics
  - Development of a comprehensive primary care strategy, to ensure visibility and accountability in building and sustaining a strong primary care infrastructure in CO

Potential Report Topics

PART 1:
Payment

- Recommendation 1:
- Recommendation 2:
- Recommendation 3:

PART 2:
Comprehensive primary care strategy

- Goals/objectives:
- Partners:
- Potential Domains:

Payment Priorities

- North star goal:
  - Strengthening Colorado's primary care infrastructure and care delivery system through increased investment and the adoption of value-based payment models, also known as alternative payment models (APMs), that drive value, not volume, and improve health outcomes
- Additional considerations/priorities?

Payment Landscape

- Systems
  - Accountable Care Organizations (ACOs)
  - Clinically integrated networks (CINs)
  - Independent Physician Associations (IPAs)
- Disruptors
  - Direct Primary Care
  - One Medical
  - HIMS/HERS
- Consolidation
  - Private equity
  - Vertical and horizontal mergers
  - Insurer-owned

Payment Issues/Themes

FORM

- Shift from FFS to value-based
- Hybrid payments as pathway

LEVEL

- Chronic underinvestment in primary care in U.S.
- Need for increased payment for primary care

FLOW

- Are dollars for primary care reaching front line providers?
- How are we ensuring payments are supporting team-based care delivery?

Previous Recommendations – Form

FIRST ANNUAL REPORT

- Investing in infrastructure and through alternative payment models (APMs)
  - Increased investment should be offered primarily through infrastructure investment and APMs that offer prospective funding and incentives that improve quality

THIRD ANNUAL REPORT

- Guiding increased investment in primary care
  - Investments should be offered primarily through value-based payments and infrastructure investments, include prospective funding and incentives for improving quality, improve accessibility and affordability
- Integrating behavioral health care within the primary care setting
  - A variety of effective models for the integration and coordination of behavioral health and primary care should be encouraged and supported through APMs and other strategies

FIFTH ANNUAL REPORT

- Payment for behavioral health integration
  - Behavioral health should be intentionally supported as a key component of increased investment in primary care

Form of Payment – Additional Dimensions

- Alignment
  - Medicare APCM
  - HCPF ACC 3.0, Integrated Behavioral Health
- Employer engagement
- Rural providers
- Safety net providers

Previous Recommendations – Level

FIRST ANNUAL REPORT

- Primary care investment target
  - All commercial payers should be required to increase percentage of total medical expenditures (excluding pharmacy) allocated to primary care by one percentage point annually (for 2 years)

Level of Payment – Questions & Data Needs

- What is current level of system stability/instability- how much breathing room do PCPs have?
- How much is administrative burden adding to cost of running a practice?

Previous Recommendations – Flow

FIRST ANNUAL REPORT

- Investing in advanced primary care models
  - Increased investment should support adoption of models that build core competencies for whole person care

FIFTH ANNUAL REPORT

- Workforce for behavioral health integration
  - Payers should support and incentivize clinician and non-clinician providers working as part of the care delivery team to holistically address whole-person and whole-family health needs
- Health-related social needs screening
  - Payers should support and incentivize clinical and non-clinician providers working on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services
- Medication-assisted treatment
  - Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment services through adequate payment that reflects the additional time and training needed to address complex patient needs

Flow of Payment - Questions & Data Needs

- Where are patients getting primary care? What is driving them?
- How many providers in CO are independent vs “system”?
- How much money in systems actually gets to primary care?

Additional Topics – Call Outs

- Practices that are thriving
- Other state strategies
- And - ? ? ?

Comprehensive Primary Care Strategy

- What – North star goal
- Why - Intended goals/uses?
- Who - Partners?
- Proposed Framework – Chart, Scorecard, Both ?

Comprehensive Primary Care Strategy

- North star goal:
  - Measure, track state of primary care, impact of increased investment & alignment efforts
  - Ongoing cross-agency, multi-stakeholder collaboration
  - Aligning/coordinating [payment, workforce, access, data] to strengthen PC as system's front door and improve [cost, quality, and equity]
  - Defining primary care as a common good – where are the gaps in community, and how do we structure payment systems to support those gaps in a better way
    - Designing payment structures, expectations, data requirements thoughtfully to support current and future workforce – where are the gaps in

Comprehensive Primary Care Strategy

- Intended goals/uses:
  - Improve collaboration, coordination
  - Increase visibility, accountability
  - And/or - ? ? ?

Potential Partners – AHRQ Grant

STATE

- HCPF
- DOI
- CDPHE
- BHA
- ➢ Early childhood - ?

HIT/DATA

- Office of eHealth Innovation (OeHI)
- Contexture
- CO Community Managed Care Network (CCMCN)
- ➢ CIVHC

PROVIDERS

- CO Academy of Family Physicians
- CO Medical Society (CMS)
- CO Academy of Pediatrics
- Colorado Hospital Association
- Valley Wide Health
- CO Community Health Network

PAYERS

- Rocky Mountain Health Plans
- Denver Health
- Colorado Access
- Purchaser Business Group on Health (PBGH)

OTHER

- Trailhead Institute
- CO Rural Health Center
- CO Health Areas Education Center
- CO Cooperative Extension
- Pediatric Mental Health Institute
- ➢ Consumers

State Primary Care Scorecards

NEW YORK

- **Goal(s):**
  - Report on current state of primary care in New York State to support policy, programmatic and budgetary decision-making, serve as a baseline for future measurement
- **Domains:**
  - Workforce
  - Access
  - Performance
  - Health Outcomes

VIRGINIA

- **Goal(s):**
  - Provide an annual tracking tool to monitor the health and well-being of primary care in Virginia through an interactive exploration of data
- **Domains:**
  - Spend
  - Workforce
  - Use
  - Outcomes

MASSACHUSETTS

- **Goal(s):**
  - Inform targeted policy solutions & investments, and to monitor the impact of such reforms. Provides a fact base to Primary Care Access, Delivery, and Payment Task Force
- **Domains:**
  - Finance
  - Access
  - Care
  - Capacity
  - Equity

Workforce Metrics

NEW YORK

- Primary Care Providers per 100k
- Pediatricians per 100k
- Geriatricians per 100k
- OB/GYN Providers per 100k
- Behavioral Health Providers per 100k
- Primary Care Providers Physicians over 60
- Primary Care Providers Accepting Medicaid

VIRGINIA

- Primary Care Provider Workforce
- Primary Care Provider Shortages
- Workforce Practicing Primary Care
- Primary Care Workforce Supply and Demand Projections
- Primary Care Physicians in Areas Above the Median Social Deprivation Index (SDI)

MASSACHUSETTS

- % of PCPs
- % of PCPs Aged 65 or Older
- % of PCPs Leaving Primary Care
- PCPs per Population
- PCP Assistants per Population
- Primary Care Nurse Practitioners
- Percentage of Massachusetts Medical School Graduates Entering Primary Care
- Primary Care Physician Salary

Access Metrics

NEW YORK

- Avoided Care Due to Cost
- Usual Source of Care
- Preventable Hospitalization Rate
- Pediatric Preventable Hospitalization Rate
- Preventable Emergency Department Visits

VIRGINIA

- Percentage of Residents Using Primary Care*
- Primary Care Use Trend
- Range of Primary Care Use by Payer
- Access to Behavioral Health Providers

MASSACHUSETTS

- Difficulty Obtaining Necessary Healthcare
- Primary Care Access (Adult & child, Commercial & MassHealth)
- Residents Who Have a Primary Care Provider
- Usual Source of Care
- Usual Source of Care by Setting Type
- Preventative Care Visit
- FQHC Patients Served

Outcome Metrics

NEW YORK

- Avoidable Premature Mortality
- Low Birthweight
- Maternal Mortality
- Uncontrolled diabetes

VIRGINIA

- Quality of Life*
- Life Expectancy
- Preventable Hospitalizations
- Diabetes Prevalence
- Multiple Chronic Conditions

MASSACHUSETTS

- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Well-Child Visits in First 30 Months of Life: 0 – 15 mos.
- Childhood Immunization Status (Combo 10)
- Adult Influenza Vaccinations
- Patient-Provider Communication (Adult & child, Commercial & Mass Health)
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)
- Behavioral Health Screening (Adult, Commercial & MassHealth)

New York State Primary Care Scorecard

WORKFORCE

- Primary Care Providers per 100k
- Pediatricians per 100k
- Geriatricians per 100k
- OB/GYN Providers per 100k
- Behavioral Health Providers per 100k
- Primary Care Providers Physicians over 60
- Primary Care Providers Accepting Medicaid

ACCESS

- Avoided Care Due to Cost
- Usual Source of Care
- Preventable Hospitalization Rate
- Pediatric Preventable Hospitalization Rate
- Preventable Emergency Department Visits

PERFORMANCE

- Adequate Prenatal Care
- Core Preventative Services, Adults 65+
- Early Childhood Vaccinations
- Hypertension Control

HEALTH OUTCOMES

- Avoidable Premature Mortality
- Low Birthweight
- Maternal Mortality
- Uncontrolled diabetes

Virginia Primary Care Scorecard

SPEND

- Primary Care as a Percentage of Total Healthcare Spend
- Primary Care Spend Per Insured Person Per Month
- Primary Care as a Percentage of Total Healthcare Spend Trend
- Primary Care Spend Per Insured Person Per Month Trend
- Range of Primary Care Spend by Payer

WORKFORCE

- Primary Care Provider Workforce
- Primary Care Provider Shortages
- Workforce Practicing Primary Care
- Primary Care Workforce Supply and Demand Projections
- Primary Care Physicians in Areas Above the Median Social Deprivation Index (SDI)

USE

- Percentage of Residents Using Primary Care*
- Primary Care Use Trend
- Range of Primary Care Use by Payer
- Access to Behavioral Health Providers

OUTCOMES

- Quality of Life*
- Life Expectancy
- Preventable Hospitalizations
- Diabetes Prevalence
- Multiple Chronic Conditions

Massachusetts Primary Care Dashboard

FINANCE

- Primary Care Spending
- Managed Member Months Under an APM

EQUITY

- Difficulty Obtaining Necessary Healthcare by Race/Ethnicity
- Usual Source of Care by Race/Ethnicity
- Residents Who Have a Primary Care Provider by Race/Ethnicity
- Avoidable Emergency Department (ED) Use by Race/Ethnicity

ACCESS

- Difficulty Obtaining Necessary Healthcare
- Primary Care Access (Adult & child, Commercial & MassHealth)
- Residents Who Have a Primary Care Provider
- Usual Source of Care
- Usual Source of Care by Setting Type
- Preventative Care Visit
- FQHC Patients Served

CAPACITY

- % of PCPs
- % of PCPs Aged 65 or Older
- % of PCPs Leaving Primary Care
- PCPs per Population
- PCP Assistants per Population
- Primary Care Nurse Practitioners
- Percentage of Massachusetts Medical School Graduates Entering Primary Care
- Primary Care Physician Salary

CARE

- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Well-Child Visits in First 30 Months of Life: 0 – 15 mos.
- Childhood Immunization Status (Combo 10)
- Adult Influenza Vaccinations
- Patient-Provider Communication (Adult & child, Commercial & Mass Health)
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)
- Behavioral Health Screening (Adult, Commercial & MassHealth)

Potential CO Dashboard Metrics & Data Sources

WORKFORCE/CAPACITY

- Number, geographic, and age distribution of PCPs
- Number, geographic, and age distribution of other clinicians (NPs, PAs)
- ➢ Health systems directory

ACCESS

- Avoided Care Due to Cost
- Usual Source of Care
- Preventable ED Visits
- ➢ Colorado Health Access Survey

PERFORMANCE

- Core Preventative Services, Adults 65+
- Early Childhood Vaccinations
- ➢ BRFSS
- ➢ CDPHE -?

HEALTH OUTCOMES

- Avoidable Premature Mortality
- Preventable hospitalizations
- Diabetes prevalence
- ➢ Public sources - ?

FINANCE/SPEND

- Primary care as percentage of total spend
- Primary care spend PMPM
- ➢ PC/AMP Annual Report

CARE

- Cancer screenings
- Adult influenza
- ➢ BRFSS

EQUITY

- Health disparities data
- ➢ Colorado Health Access Survey

Primary Care Scorecard – Discussion Questions

- Interest in developing a primary care scorecard?
- Next steps:
  - Outreach
  - Research on data sources
  - Other - ? ? ?

Draft Schedule

APRIL

Updates & Priorities

MAY

Accountable Care Organizations

JUNE

Patient perspectives on primary care;
Engaging with employers;
Coordination with practice transformation initiatives

JULY

SUMMER BREAK

AUG

Data – sources, gaps;
CDPHE presentation;
Guest speaker(s) from VA, WA

SEPT

Comprehensive Primary Care Discussion

OCT

APM Parameter Review
Payment, Comprehensive PC Strate

NOV

CIVHC Report/ Report Recommendations

DEC

Draft Recommendations

*** * * DRAFT Proposal * * ***

Public Comment

Thank you!!