# Primary Care Payment Reform Collaborative Meeting

December 11, 2025

# Agenda

- Housekeeping & Announcements
- Federal & State Updates
- Annual Report Recommendations
- Public comment

# Meeting Goals & Requested Feedback

## GOALS

- Identify remaining issues & formal recommendations related to payment
- Develop approach and content related to comprehensive primary care strategy

## FEEDBACK

- What needs to be added or subtracted from payment section?
  - Targeted research needs
- What should be included in the comprehensive primary care strategy section?
  - Targeted research needs

* * Incorporate equity into discussion and recommendations * *

# PC Strategy & Scorecard Survey – PART 1

- Which of the following “north star” goals resonate with you?
  - Measure, track state of primary care, impact of increased investment & alignment efforts
  - Promote ongoing cross-agency, multi-stakeholder collaboration
  - Aligning/coordinating [payment, workforce, access, data] to strengthen primary care as the health care system's front door and improve [cost, quality, and equity]
  - A primary care strategy should define/establish primary care as a common good, and be used to identify gaps in a community, and information on how payments can be structure to fill those gaps
- Please describe your vision for a comprehensive primary care strategy (free-form)
- How would/should a comprehensive primary care strategy be used? Who would it be designed to benefit?
- What partners need to be engaged in the development and/or implementation of such a strategy?

# PC Strategy & Scorecard Survey – PART 2

- Do you think this year's report should include a recommendation that Colorado develop and implement a Primary Care Scorecard? (Y/N/Unsure)
- Which aspects or "domains" of primary care are most appropriate to include in a scorecard?
  - Payment/spend
  - Workforce/capacity
  - Access/Use
  - Performance/Outcomes
  - Equity

| Workforce | Access/Use | Performance/Outcomes |
|---|---|---|
| Number of Providers by Provider Type | Usual Source of Care | Low Birthweight |
| Number of Providers by Profession | Percentage of Residents Using Primary Care | Uncontrolled Diabetes |
| Provider Age | Primary Care Use Trend | Avoidable Premature Mortality |
| Primary Care Provider Shortages | Access to Behavioral Health Providers | Preventable Hospitalizations |
| Percentage of Physicians Practicing PC | Avoided Care Due to Cost | Preventive Screenings (e.g., cancer) |
| PC Workforce Supply and Demand Projections | | |


# Housekeeping & Announcements

# Housekeeping & Announcements

- Meeting minutes – Approval of Nov meeting minutes
- Attendance and feedback at upcoming meetings
  - Proxies allowed for meetings and voting
  - Upcoming review periods for report drafts:
    - Today through Dec 19
    - Jan 2 – Jan 16 (meeting on Jan 8)
    - Feb 4 – Feb 10 (meeting on Feb 12)
- Updating Standard Operating Procedures & Rules of Order
  - Division will work with co-chairs on initial edits
  - Share via email for approval in January
- Meeting schedule for 2026


# Federal & State Updates

# Federal Updates

- Senate vote on health proposals (enhanced Premium Tax Credits)
  - Democrat plan – extend enhanced Premium Tax Credits for 3 years
  - Republican plan – Cassidy & Crapo (one of multiple)
    - HHS payments to Health Savings Accounts (HSAs) for 2 years for enrollees under 700% FLP who choose high-deductible bronze or catastrophic plans (18-49 = $1000; 50-64 = $1500)
    - Changes in 2027: restore federal funding of cost-sharing reductions (CSRs), expand eligibility for catastrophic plans to all individuals
    - Limit ACA funds for abortion, prohibit Medicaid funds for gender transition services
- Vaccines
  - CDC website revisions – modified language that "vaccines do not cause autism"
  - ACIP meeting Dec 4-5 – Hepatitis B vaccine (HBV)
    - "Individual-based decision making" for parents deciding "when or if" to give HBV to children born to mothers who test negative; if birth dose not given, initial dose should be "administered no earlier than 2 months of age"
    - Parents should consult with healthcare providers to decide whether post-vaccination serology test should be offered when weighing need for subsequent doses

# Federal Updates

- CY 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Final Rule
  - Increases hospital OPPS rates by net 2.6% in CY 2026
  - Finalized phase-out of inpatient-only list over next 3 years; removes 285 procedures from IOP list and adds 560 procedures to ASC list
  - Maintained original 340B recoupment policy; 0.5% annual reduction (instead of proposed 2%) for non-drug items and services 1/1/26
  - “Unpackage” and reduce reimbursements for skin substitutes (“incident-to supplies”)
  - Continue to provide temporary separate payments to certain non-opioid pain relief (5 drugs and 13 medical devices
- CY 2026 Home Health Prospective Payment System Final Rule
  - Payment rates will decrease in aggregate by an estimated 1.3%
  - Removing quality measures related to up-to-date COVIC-19 vaccine and SDOH (living situation, food, utilities)
  - New and revised provider enrollment provisions to reduce fraud, waste, and abuse

# Federal Updates

- CY 2027 Medicare Advantage (MA) and Part D Proposed Rule
  - Changes to Star Ratings system
    - Removal of Health Equity Index
    - Continuation of existing reward factor (scheduled to end with 2027 ratings)
    - Proposing to remove 12 measures
  - Proposing to eliminate requirements relating to health equity and requirement for MA plans to send mid-year notices about unused supplemental benefits
  - Includes 2 Requests for Information (RFIs):
    - How to refine risk adjustment and align quality incentives
    - How to incorporate “tools and policies that improve overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connection, purpose, and fulfillment” and tools to “achieve optimal nutrition and improve preventive care”

# Federal Updates

- ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model - CMMI
  - Voluntary model to test outcome-aligned payment approach for Original Medicare enrollees; anticipated launch on 1/1/27
  - Payments support use of digital technologies and novel technology-supported care approaches
  - Focused on common conditions such as high blood pressure, diabetes, chronic musculoskeletal pain, depression
  - FDA will select 40 devised not yet cleared to receive special agency discretion to participate
- TEMPO (Technology-Enabled Meaningful Patient Outcomes) Pilot - FDA
  - Pilot program will select about 10 devices for each condition category laid out by CMMI in ACCESS model
  - 4 categories: early cardio-kidney-metabolic; cardio-kidney-metabolic; musculoskeletal; behavioral health

# Federal Updates

- Primary Care Collaborative – Webinar on 12/18 at 11 am MT
  - Strategies to Improve Health by Bolstering Primary Care
  - Release of Primary Care Investment Guide, developed by Harvard Medical School Center for Primary Care
  - Guide details how advance primary care services leads to better patient outcomes, stakeholder interview insights, and examples from 5 states
  - Register HERE

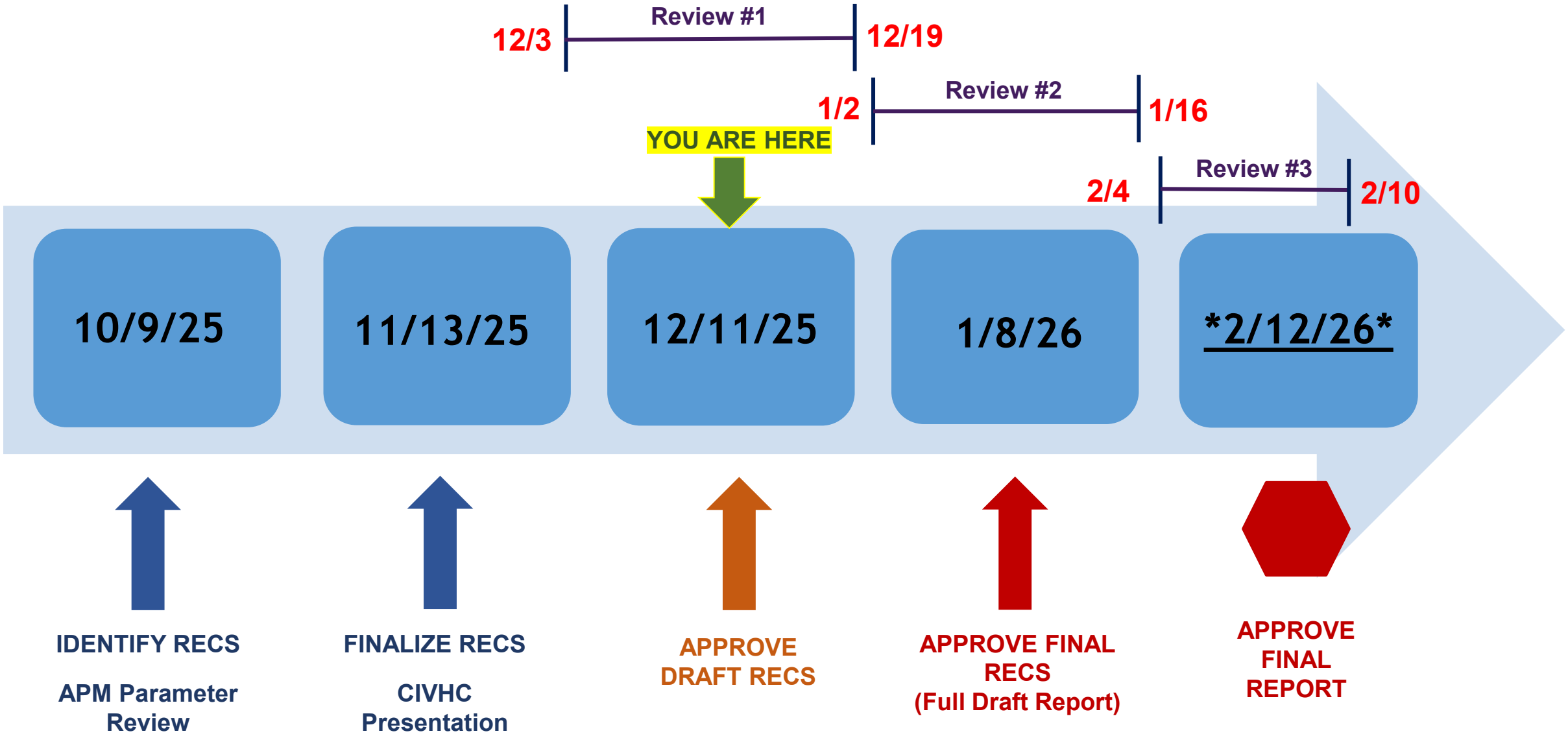
- Primary Care Collaborative – Administrative Burden Survey
  - Survey to support development of recommendations on how policymakers and industry leaders can best alleviate administrative burden associated with APMs
  - Available HERE

# State Updates

- Rural Hospital Transformation Program
  - HCPF webinar on 12/5; recording available HERE, slide deck available HERE
  - CMS will announce awardees by 12/31/25 (funds start 10/1/26)
  - Medicaid Innovation, Sustainability, and Opportunities Webinar
    - Thurs 12/18 from 4-5:30 pm; register HERE
- Open enrollment – now through Jan 15
  - As of 12/4, Connect for Health reporting 5% fewer enrollments than last year (slightly over 210,000 since Nov 1)
  - Colorado Premium Assistance available for households between 100-400% FPL
- 2026 Legislative Session
  - Starts on Jan 14, 2026
  - Proposed bill requiring large employers to help fund Medicaid, SNAP


# Report Recommendation Topics

# Recommendations Report



# Organizational Structure

| | |
|---|---|
| Executive Summary | • Summary and recommendations |
| PCPRC Background | • Statutory charge<br>• Operations (report process/voting, membership) |
| Introduction | • Key themes |
| Part 1 & Part 2 | • Discussion of key issues<br>• Data needs & recommendations |
| Conclusions | • Summation<br>• 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

# 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?

# CIVHC APM Data Submission Manual – April 2025

## B(iv). Prospective Payment Flag

Prospective payments refer to any payments made to providers in advance of services rendered. Typically, these are based on predetermined payment amounts for services.
If a provider contract arrangement includes any prospective payments, then the Prospective Payment Flag (AM008) should be populated with 'Y', even when retrospective reconciliation is part of the contract. Population-based payment arrangements (A4, B4, C4, D4, E4, F4) likely include prospective payments, though other payment arrangement types in in other categories might also be considered prospective. If the provider contract does not include any prospective payments, then the flag should be submitted as 'N'. Please direct any specific questions to CIVHC.

**Payments are prospective or retrospective (AC009):** Populate this field with the value that best answers the question, 'when are providers reimbursed for services under this contract?' Payments that are not for medical services will most likely be submitted as N/A. Arrangements built on a fee-for-service architecture, categories A, B and C will most likely be submitted as RT (retrospective). Category D capitated payments will most likely be either PR (prospective with retrospective reconciliation) or PN (prospective without retrospective reconciliation). Expenditures associated with arrangements described as including prospective payments should be submitted with a Prospective Payment Flag (AM008) = Y in the APM file.

# CIVHC APM Data Submission Manual – April 2025

## APM File

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|---|---|---|---|---|---|
| AM008 | Prospective Payment Flag | char | 1 | Y = Payment to provider for services was made prospectively; populate field with 'Y' even when retrospective reconciliation is part of contract<br>N = Payment to provider for services was not made prospectively | R |

## APM Data Submission - APM Contract (AC) File and Dictionary

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|---|---|---|---|---|---|
| AC009 | Payments are prospective or retrospective | char | N/A – Excel file | PR = Prospective with retrospective reconciliation<br>PN = Prospective with no retrospective reconciliation<br>RT = Retrospective<br>N/A = Not Applicable | R |

# CIVHC APM Data Submission Manual – April 2025

## Appendix F.1: Expanded Non-claim Payment Framework Category Definitions

| # | Non-claims-based Payment Categories and Subcategories | Draft Definition |
|---|---|---|
| A | **Population Health and Infrastructure Payments** | **Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.** |
| A1 | Care management/care coordination/population health/medication reconciliation | Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health. |
| A2 | Primary care and behavioral health integration | Prospective, non-claims payments paid to healthcare providers or organizations to fund the integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavioral change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims. |
| A3 | Social care integration | Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims. |
| A4 | Practice transformation payments | Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics. |

# 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

# Comprehensive Primary Care Strategy

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

# 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!!