



Primary Care Payment Reform Collaborative Meeting

August 8, 2024



Agenda

- Housekeeping & announcements
- Federal & state updates
- AI in Primary Care - Discussion
- Colorado Market Dynamics
- Public comment



Meeting Goals & Requested Feedback

GOALS

- Discuss implications of AI for primary care
 - Reactions to July presentations
 - Issues/topics of interest or concern
- Discuss systems & market trends in Colorado, and influence on flow of primary care dollars
- Identify next steps, follow-up tasks, and/or needed resources

FEEDBACK

- What are the most pressing issues/topics related to AI and primary care?
- What are priorities for future discussion and/or recommendations related to AI?
- Is there interest/need to incorporate market or system-level dynamics into primary care investment recommendations?



*** * Incorporate equity into discussion and recommendations * ***

Draft Schedule

APRIL

Equity in APMs

MAY

Impact of venture capital, private equity, consolidation, integration on PC

JUNE

SUMMER
BREAK

Flow of primary care dollars within/outside of “systems” (e.g., ACOs, FQHCs, IDS); rural, independent providers

AI IN
PRIMARY
CARE

JULY

Current state of PC investment (CO, other states, national)

PC
Investment

AUG

Investment strategies- payment (APMS), infrastructure, team-based care, care coordination (HRSN)

SEPT

* * Review APM Parameters * *

CIVHC
preview?

Measurement, scorecard, communications

OCT

Identify recommendations

NOV

CIVHC Report/
Recommendations

DEC

Draft Recommendations



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



Housekeeping & Announcements



Housekeeping & Announcements

- Meeting minutes - approval of May meeting minutes
- Scheduling
 - Hybrid meeting in September - details forthcoming
- Primary care/APM reporting stakeholder discussion
 - Targeting August 22, 10-11 am - invitation forthcoming





Federal & State Updates



Federal Updates

- Transforming Episode Accountability Model (TEAM) finalized
 - 5-year mandatory model to incentivize coordination between care providers during surgery & services provided 30 days after
 - Requires referral to primary care services to support continuity of care and drive positive long-term outcomes
- Final Rule - 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS)
 - Higher payments to hospitals for furnishing care to individuals experiencing homelessness and housing insecurity
 - Promote access to treatments for rural and underserved communities; increased new technology add-on payments to improve access to new gene therapy for sickle cell disease
 - Separate payment to small independent hospitals, including rural hospitals, for establishing/maintaining access to buffer stock of essential medicines



Federal Updates

- Final Rule - 2025 Skilled Nursing Facility Prospective Payment System (SNF PPS)
 - Updates SNF Quality Reporting Programs (QRP) to better account for adverse social conditions that impact health
 - Adding 4 new social determinants of health items (one for living situation, two for food, one for utilities) and modifying one SDOH assessment (transportation)
- Final Rule - Updates to Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
 - Includes addition of four new assessment items in the Social Determinants of Health (SDOH) category: Living Situation, Food, and Utilities to the IRF-Patient Assessment Instrument (PAI)



State Updates

- SB21-169 Stakeholder meetings
 - Health insurance meeting on [July 30](#)
 - [SB21-169 - Protecting Consumers from Unfair Discrimination in Insurance Practices](#)
- HCPF Annual Stakeholder Webinar
 - August 27 from 8-11 am
 - Register: https://us02web.zoom.us/webinar/register/WN_yr1yodo2Txa10zITMSc-Mg





AI in Primary Care



Discussion Questions

- How are you seeing AI impact primary care in Colorado?
 - Impacts on your practice (adoption/workflow)?
 - Impacts on your payments/reimbursements/costs?
 - Impact on patients?
- What are the key implications for primary care and the work of the Collaborative?
 - Payment or other policy levers that you would elevate?
 - Other strategies, considerations
 - Resource allocation
- Specific questions for: federal partners, other states, payers?



Artificial Intelligence - Health Care

Dr. James Barry
University of Colorado

- Clinical
 - Use in clinical practice
 - Benefits and harms
 - Governance and risk management frameworks
 - Garbage in is garbage out

Jason Lapham
Colorado Division of Insurance

- Insurance
 - SB21-169
 - Unfair discrimination in insurance practices
 - Governance and risk management frameworks
 - Testing big data systems, external consumer data and information sources, algorithms, and predictive models to identify unfair discrimination against protected classes



AI Terms & Definitions

Machine learning

- Algorithms and models that computers can learn to use without explicit instructions
- Underlies predictive modeling

Deep learning

- Subset of machine learning that generally uses neural networks
- Has been used to interpret images

Generative AI

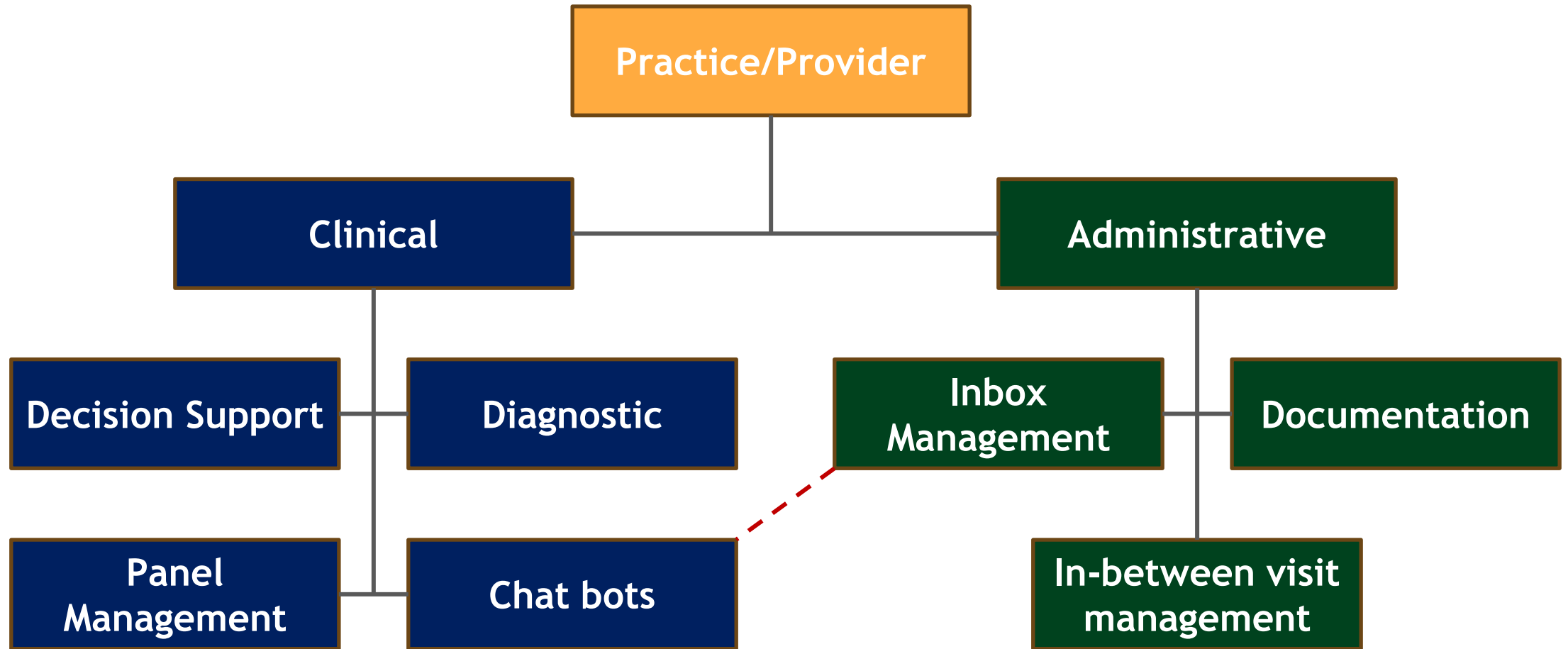
- “Technology that creates content - including text, images, video, and computer code - by identifying patterns in large quantities of training data and then creating original material that has similar characteristics”



Key Topics and Themes



Care Delivery



Care Delivery - Patients & Clinicians

- Previous use cases
 - Improve care by suggesting diagnoses or treatment based on patient data
 - Automatic interpretation of complex data
 - Process EHR to suggest additional diagnostic codes for billing
- Tool to support primary care not a substitute for human clinicians' acumen
 - Automating select aspects of work frees time for relationship building and tending
- AI implementation requires robust ethical oversight to avoid perpetuating or worsening inequities in health care
 - Pragmatic, patient-centered research needed
 - Clinicians should partner with informaticists and technology developers

Table. Potential Use Cases for AI in Primary Care

Use case	Examples of AI role
Inbox management	• Prioritize patient messages • Generate draft responses • Edit physician messages to optimize communication, including for literacy appropriateness
Clinician documentation	With transcription software: • Draft progress notes in real time during visits • Draft prior authorization, disability, and durable medical equipment requests • Draft a list of billing codes for visits
Between-visit panel management	• Accurately identify patients in need of cancer screening using unstructured and structured EHR data to determine exclusions • Identify patients with incomplete cancer screening (such as missed appointments), automate communication with patients, and provide scheduling and/or staff notification • Generate tailored messages to patients related to needed between-visit care needs
Individualized decision support	• Identify relevant information in structured and unstructured EHR data to prioritize differential diagnoses for new symptoms • Recommend medication options for chronic conditions, considering prior medication prescriptions, allergies, and intolerances noted in structured and unstructured EHR data

Abbreviations: AI, artificial intelligence; EHR, electronic health record.



Care Delivery - Patient Inbox Management

- Notable adoption, usability, and improvement in assessments of burden and burnout
 - Clinical pharmacists had highest utilization for primary care (44%);
 - Net promoter scores favorable among primary care physicians, advance practice practitioners (APPs), primary care clinical pharmacists, but unfavorable among primary care nurses
 - In primary care, modest expectations about message quality improved at end of pilot
- No improvement in overall reply time, read time, or write time
 - Clinicians overall expressed optimism about utility and ability to save time before pilot, and positive perceptions remained largely unchanged afterward
 - Feedback highlighted need for improvements in tone, brevity, personalization
- Cost each time GPT-4 is used to generate a draft response, which could represent substantial expense to US health care delivery system



Source: Artificial
Intelligence-Generated
Draft Replies to Patient
Inbox Messages - JAMA
Open Network ((2024)

Table 5. Qualitative Encoding of Free-Text Comments From Postsurveys

Theme	Representative quotations	No. of comments			
		Negative	Neutral	Positive	Total
Draft message voice and/or tone	Positive: "I was impressed by the tone that varied based on patient's concerns and questions, and felt messaging was overall very professional and clear." Negative: "I think the drafts are great but can further be improved if it did not sound robotic and had a more personable touch."	14	2	10	26
Future use	Positive: "Please continue to allow us to utilize this tool and spread to other SHC clinics!" Negative: "I still think it's a good idea but not ready for real life situations."	1	0	18	19
Draft message tool utility	Positive: "Overall this is a very helpful tool." Negative: "Also, it struggled with having draft replies of more nuanced concerns."	4	2	13	19
Draft message content relevance	Positive: "I especially appreciated the one example where a patient mentioned having frequent UTIs on a certain medication, and the response had pulled in the last 3 lab results from urinalysis!" Negative: "The Responses often did not accurately reflect the questions. Sometimes way off. Often vague."	9	1	8	18
Impact on workflow	Positive: "It helped with the 'translation' cognitive work that I hadn't ever realized I was doing before process of translating my medical understanding into patient-facing language." Negative: "I have to read the actual draft before starting to work on the actual request, as I don't know if the response is even appropriate."	9	0	7	16
Impact on time	Positive: "It helped save me a lot of time starting from scratch." Negative: "Right now, it is just piling on top of the work that we are already doing, and it is faster for me to type a prose response that I have generated myself."	1	0	12	13
Draft message length and/or brevity	Positive: "However, the responses are very thorough. I had a patient that needed a refill and the draft wrote out almost a whole letter when I typically would maybe just write a short sentence saying 'Yes, I will send!'" Negative: "Overall the responses seemed unnecessarily wordy in noncontributory ways."	8	2	1	11
Draft message content accuracy	Positive: "I found the AI-generated draft replies pretty accurate and helpful." Negative: "Sometimes, the AI response was not completely accurate, but it was not difficult to make minor tweaks to the draft."	5	0	4	9
Impact on patient engagement	Positive: "This may have a positive impact on patient satisfaction with longer messages." Negative: "Patients can tell these responses were AI generated, they are formatted like the AI responses we get on airline websites."	2	2	3	7
Draft message content completeness	Positive: "Good things are AI can capture all the elements in the message patient sent and address each element." Negative: "The AI responses were a great initial draft, though often required some additional information or editing."	4	0	1	5
Total	NA	57	9	77	143

Abbreviations: AI, artificial intelligence; NA, not applicable; SHC, Stanford Health Care; UTI, urinary tract infection.



Care Delivery – Doctor-Patient-AI Relationship

General Perceptions of AI in Medicine

- Majority held optimistic perspective (76.6%)
- Sizeable percentage did not feel comfortable communicating role of AI-based tools to patients
- 72% reported passively learning about AI (popular news sources, casual conversations) vs actively seeking education

Source: Navigating the doctor-patient-AI relationship - a mixed-methods study of physician attitudes toward artificial intelligence in primary care - BMC Primary Care (2025)

Concerns about AI in Primary Care

- Technology concerns - algorithmic bias, accuracy, safety
- Medicolegal implications
- Without augmenting system's ability to diagnose and treat patients, AI tools will not be helpful (OSA)
- Potentially lead to increase workload and physician burnout
 - Tools delegating work to physicians (need to verify or redo work)
 - Excessive focus on productivity
- May help or harm physician-patient relationship
- Current payment structures don't support innovation

Future of Primary Care Workflow

- Shift toward digital health already occurring (in unscheduled and uncompensated way)
- AI tools for chronic disease management and disease screening augmented by remote patient monitoring systems raise considerations on how to allocate physician time - hybrid in-person and virtual schedules
- Integration of AI into patient-centered, team-based care
- Role of AI in care coordination



Care Delivery – Doctor-Patient-AI Relationship

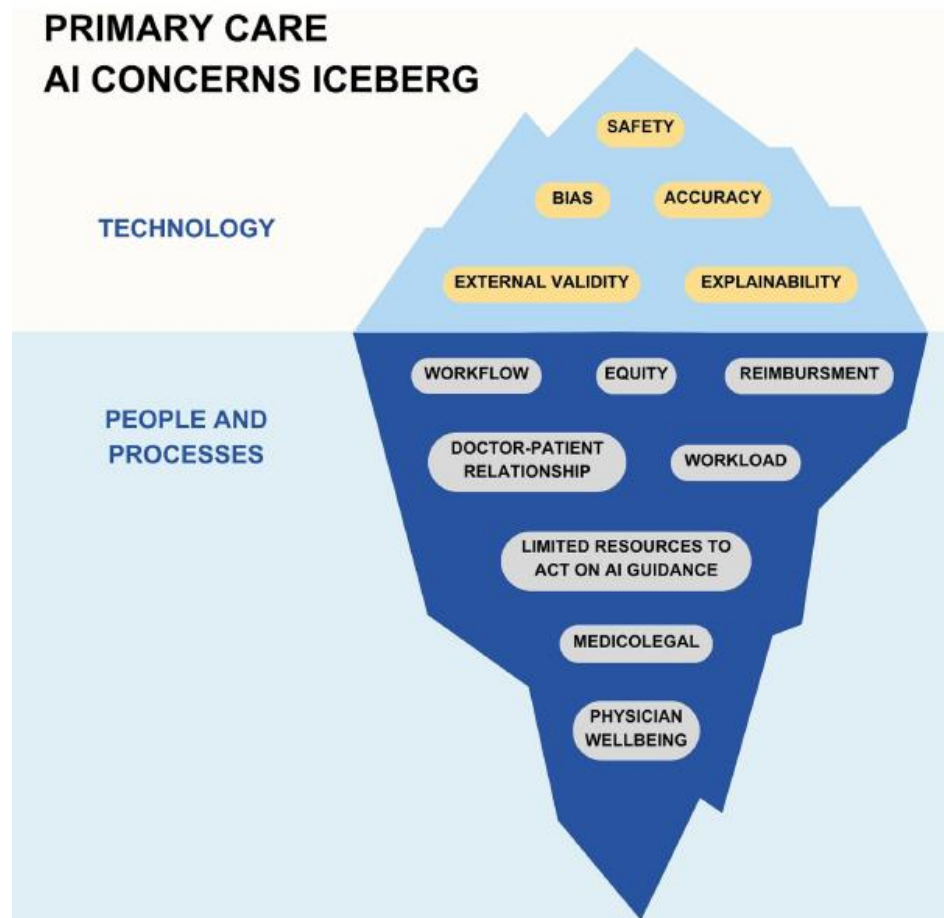


Table 2 Recommendations for primary care stakeholders

Stakeholder	Recommendation
Payors	Implement innovative reimbursement models for PCPs and other primary care team members engaging in digital health
Healthcare Systems	Schedule time and establish standards for PCPs to engage in digital health
Healthcare Systems	Provide PCPs with additional team members such as pharmacists or patient coordinators who can engage digitally with patients
Healthcare Systems	Develop and disseminate educational materials on the proper role of new AI tools to patients and physicians before tool implementation
Researchers	Run RCTs, pragmatic trials, or practice-based research between traditional and digitally enhanced PCP workflows
Researchers	Evaluate new AI-powered digital tools in the context of physician workflow instead of an isolated environment
PCPs	Advocate individually and collectively for AI tools that improve physician care quality, well-being, and the doctor-patient relationship

Source: Navigating the doctor-patient-AI relationship - a mixed-methods study of physician attitudes toward artificial intelligence in primary care - BMC Primary Care (2025)



Care Delivery

Thoughts & Reflections?



Payment - Timeline

2015-2020

FDA

- US Food and Drug Administration (FDA) cleared 222 AI devices and European Commission (EC) cleared 240 AI devices
- Approved for clinical use under “software as a medical device” or similar designation

August 2020

CMS

- CMS announced intent to provide coverage for first AI-specific Current Procedural Terminology (CPT) code & creation of first New Technology Add-On Payment (NTAP) for an AI device
- As initial policy, CMS adopted per-use payments for AI

As of 2023

FDA & CMS

- FDA has approved over 500 AI devices/AI-enabled clinical services
- CMS reimburses for at least 8 AI devices



Payment - Timeline

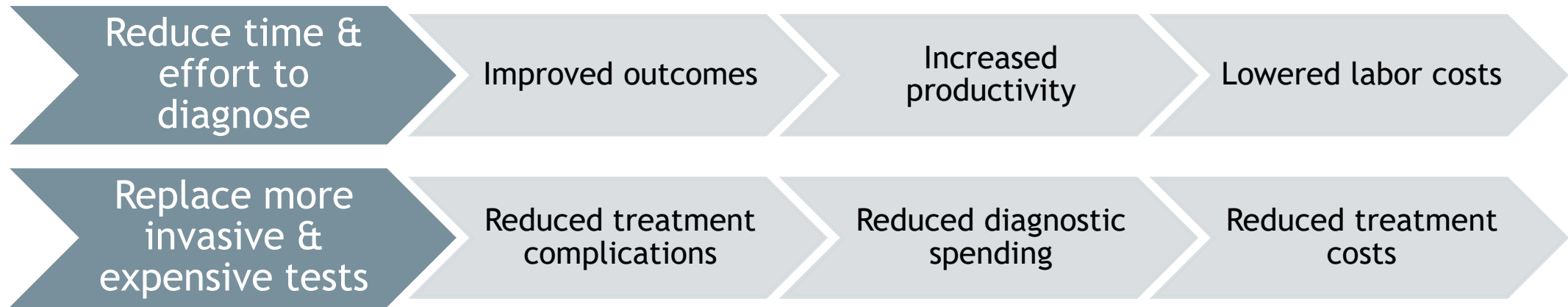
- CPT - apply to inpatient and outpatient
- NTAP - focuses on inpatient

Manufacturer	Technology	Description	Payment mechanism	Year reimbursement granted
Digital diagnostics	IDX-DR	Deep learning algorithm to diagnose diabetic retinopathy from fundoscopic images in the outpatient setting	CPT	2020
viz.ai	Viz LVO	Radiological computer-assisted triage and notification software that analyzes CT images of the brain and notifies hospital staff when a suspected large-vessel occlusion (LVO) is identified	NTAP	2020
Rapid AI Caption health	Rapid LVO Caption guidance	AI-guided medical imaging acquisition system intended to assist medical professionals in the acquisition of cardiac ultrasound images.	NTAP	2020
			NTAP	2021
viz.ai	Viz SDH	Radiological computer-assisted triage and notification software that analyzes CT images of the brain and notifies hospital staff when a suspected subdural hematoma is identified	NTAP	2022 (candidate)
Rapid AI	Rapid aspects	Computer-aided diagnostic device characterizing brain tissue abnormalities on brain CT images	NTAP	2022 (candidate)
AI Doc	Briefcase for PE	Radiological computer-assisted triage and notification software that analyzes CT images of the chest and notifies hospital staff when a suspected pulmonary embolism is identified	NTAP	2022 (candidate)
PROCEPT BioRobotics Corporation	The AQUABEAM system	Autonomous tissue removal robot for the treatment of lower urinary tract symptoms due to benign prostatic hyperplasia (BPH).	NTAP	2020



Payment - CMS Approaches

- Potential to lower spending and improve outcomes:



- Current CMS payment pathways:

Bundle new technology with existing service - no initial payment adjustment, adjust service price over time

Bundle new technology with existing service - include add-on payment for use of new technology (until new price with AI-enabled component established)

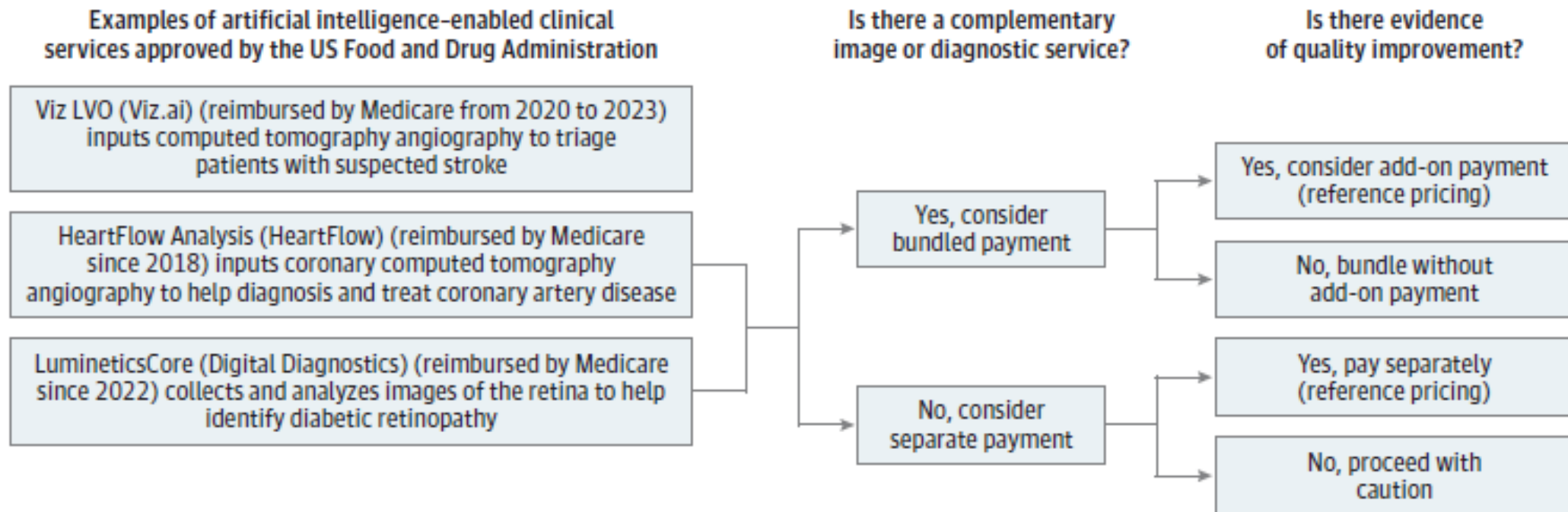
Pay as a separate service



Payment - Potential CMS Strategies

- Balancing market dynamics (charging what market will bear) and innovation

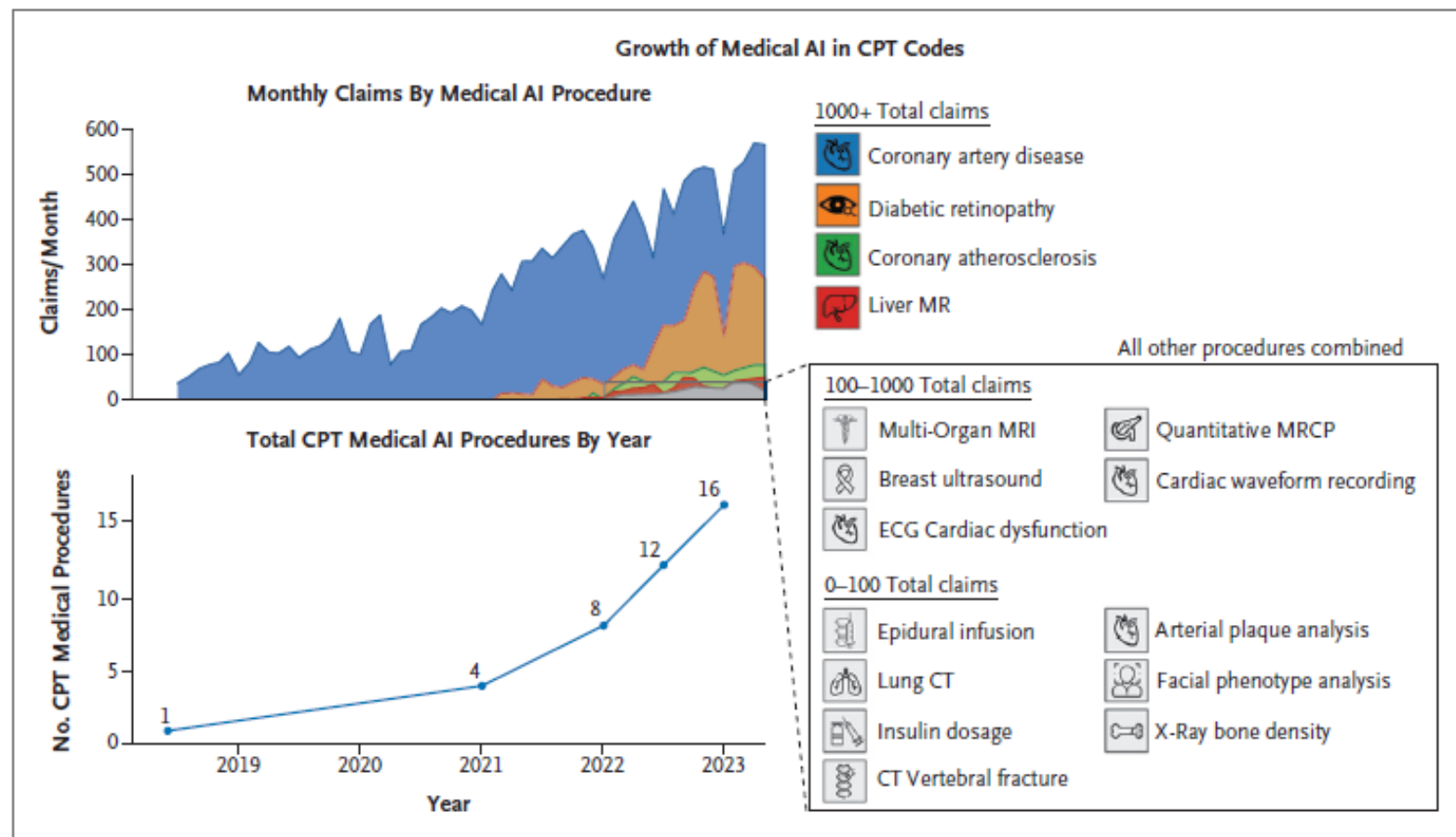
Figure. Examples of US Food and Drug Administration (FDA)-Approved Artificial Intelligence-Enabled Clinical Services and Reimbursement Considerations



Payment - Adoption and Usage

Total Claims	Condition or Medical AI Procedure
67,306	Coronary artery disease
15,097	Diabetic retinopathy
4,459	Coronary atherosclerosis
2,428	Liver MR
591	Multiorgan MRI
552	Breast ultrasound
435	ECG cardiac dysfunction
331	Cardiac acoustic waveform recording
237	Quantitative MR cholangiopancreatography
67	Epidural infusion
4	Quantitative CT tissue characterization
1	Autonomous insulin dosage
1	CT vertebral fracture assessment
1	Noninvasive arterial plaque analysis
0	Facial phenotype analysis
0	X-ray bone density

Average median age of medical AI procedure is about a year (374 days)



Payment - Adoption and Usage

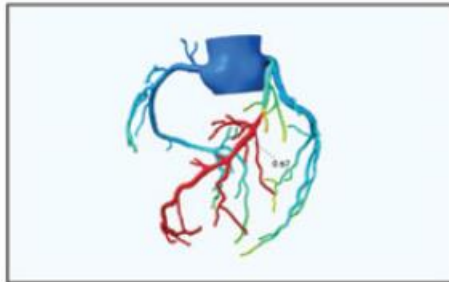
Top Medical AI Procedures and Adoption



Coronary Artery Disease
0501T-0504T



Example product:
HeartFlow Analysis



Approved: 2019
CMS: \$930.34
Private: \$909.77



Diabetic Retinopathy
92229



Example product:
LumineticsCore



Approved: 2018
CMS: \$45.46
Private: \$127.81



Coronary Atherosclerosis
0623T-0626T



Example product:
Clearly



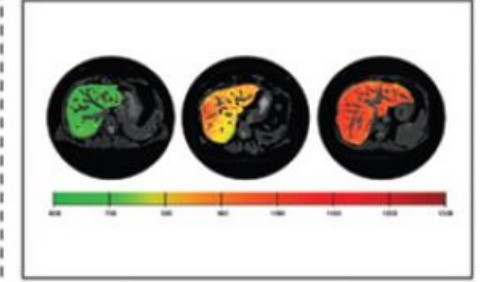
Approved: 2019
CMS: \$692.91



Liver MR
0648T, 0649T



Example product:
Perspectum LiverMultiScan



Approved: 2017
Private: \$371.55



Source: Characterizing the Clinical Adoption of Medical AI Devices through U.S. Insurance Claims - NEJM AI (2023)

Payment - Adoption and Usage

- Presence of academic hospital had largest effect on likelihood of AI adoption (17 times more likely)
- Metropolitan zip codes had second largest effect (5.25 times more likely)
- High-income zip codes had a 1.45 times likelihood of AI adoption

Table 2. A Multivariate Logistic Regression on Whether a Zip Code Has at Least One Documented Billing of a Medical AI CPT Code.*

Zip Code Characteristic	Log-Odds Coefficient
High income	0.373 [†]
Metropolitan	1.65 [†]
Has academic hospital	2.85 [†]

* Only zip codes with at least one institutional NPI (National Provider Identifier) are included in the analysis (n=22,704). AI denotes artificial intelligence, and CPT, Current Procedural Terminology.

[†] P<0.001.

Association with at least one medical AI billing:

Zip codes with academic hospital: 71%
Zip codes without academic hospital: 9%

High income: 18%
Low income: 9%

Metropolitan: 14%
Nonmetropolitan: 3%



Payment - Barriers and Considerations

IMPLEMENTATION BARRIERS

- Addition of AI may require significant changes to clinical workflow
 - Deployment factors: patient consent, internet speed/connectivity, poor lighting
- Value of AI algorithm to clinical practices is a function of health care setting
 - Clinics may operate at deficit for service provided, but patients may be incentivized to visit practices with state-of-art tech
- Medical AI devices need to have clear value proposition, but value of AI is multi-faceted and context dependent

PAYMENT ALTERNATIVES

- Do not offer separate reimbursement
 - Near zero-marginal costs of AI may lead to its overuse
- Include fixed cost with discounts or rebates if certain clinical or economic outcomes are not met
 - Revenue-sharing deal between AI developer and healthcare systems
- Higher reimbursements if certain positive outcomes demonstrated
- Factor in proportion of eligible patients who receive a given services in an “access-maximizing” model



Payment

Thoughts & Reflections?



Ethical Frameworks - Research Model

Kenneth Pimple - Heuristic Framework

True

- Trustworthy
- Accurate
- Reproduceable
- Verifiable

Good

- Improve care delivery
- Benefit patients, families, clinicians, public health
- Benefits/burdens equitably distributed
- Privacy

Wise

- Are the right people at table
- Are we asking the right questions



Ethical Frameworks - Health Equity

Objective 1: In what ways may AI effect HI in a primary care setting?

1. Algorithmic bias
 - Unrepresentative data sets
 - Underlying biases
2. Increased access and the digital divide
 - Worried well
 - Availability & functional access
3. Trust of patients
 - Privacy and security
 - Preference for AI increased with perceived underlying inequity
4. Dehumanization and biomedicalization
 - Adverse impacts on patients with complex needs
 - Older patients with co-morbidities
5. Agency for self-care
 - Socio-economic differences in attitudes/ability to self-care

Objective 2: How is the patient-doctor relationship assumed to be affected by AI and what are implications for health equity

- AI may lead to shifting emphasis from social circumstances to measurable, wider objective observations
- Diabetes support tool: AI perceived to give biomedically sound recommendations but overlooked psychosocial factors
- 94% of GPs believed AI unable to replace GPs roles requiring empathetic ability
 - Loss of knowledge, experience, and intuition in relation to AI and technological progress

Objective 3: How can the implementation of AI affect inequity

1. Participatory approaches and community involvement
 - Involvement of target community throughout entire chain
 - Need to “mainstream” fundamental understanding of AI and potential impacts on healthcare and health equity
2. Acceptance from care providers, loss of opportunity and equity
 - PCPs too busy, lack resources to effectively adopt new technologies; poor uptake leaves field open to commercial section, likely to cater to “young and well”
 - Overemphasis on rapid change & agility in regulatory environment
 - Overconfidence in AI

Ethical Frameworks - Health Equity

- Role of primary care as mitigator and improver of health equity is dependent on primary care clinician's ability to contextualize care provided, work “outside the box” and see social factors influencing a patient's health
 - Risk that AI and purely biochemical approaches that fail to address psychosocial components will worsen health equity
- How AI is implemented is integral to how well it interacts with current systems and social contexts, and by extension how it affects health equity
 - Risk of AI-augmented interventions being directed toward young, healthy, and well-off
 - Social participation crucial in developing and implementing AI
- Need to look outside isolated clinical context in assessing impact of AI in primary care on health equity
 - Most important goal of AI is to do no bad, which means it has to be explicitly and actively equity-promoting



Ethical Frameworks - Health Equity

Thoughts & Reflections?



Discussion Questions

- How are you seeing AI impact primary care in Colorado?
 - Impacts on your practice/community?
 - Impacts on your network(s)?
 - Impact on patients?
- What are the key implications for primary care and the work of the Collaborative?
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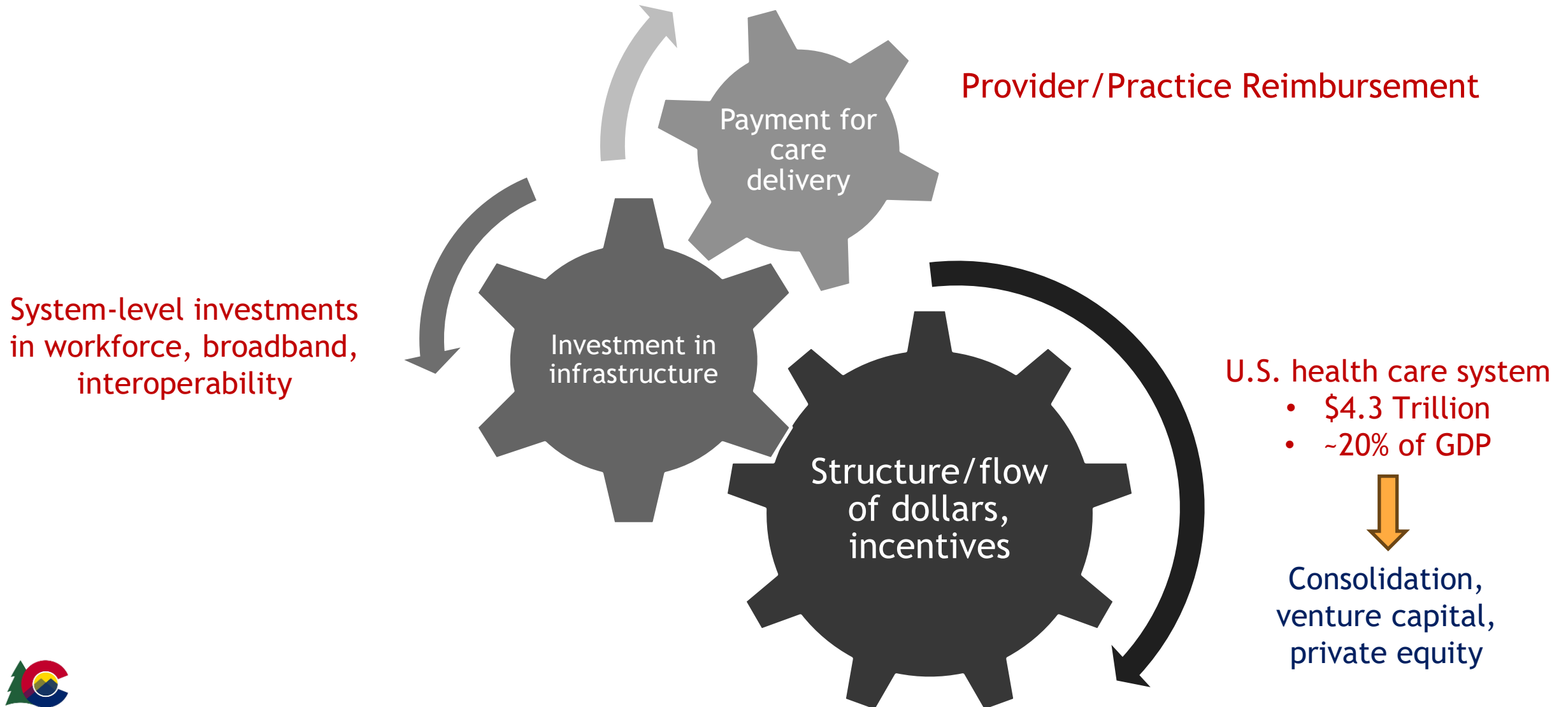




Colorado Marketplace



Flow of Health Care Dollars



Policy Challenges - Social and Health

- As health care spending continues to rise, what are we crowding out?
 - Trade-offs: education, social services, infrastructure
- Expensive, fragmented, and unequal health care system in U.S.
 - Invites predatory behavior from actors looking to exploit opportunities
- Private equity a symptom, not the cause
 - ✓ Policy levers to close loopholes/opportunities & mitigate harms to:



System/Consolidation

Workforce/Providers

Patients/Tax payers

Private Equity - Harms

- **Systemic**
 - Financialization of health care market - “value shifting”
 - Consolidation - acceleration through PE
 - Increased costs; utilization impacts; access
- **Workforce**
 - Shifting staffing patterns
 - Physician burnout - moral crisis
 - Loss of autonomy
- **Patient care**
 - Health outcomes
 - Costs - increased cost-sharing, premium impacts, wage stagnation



Why health care? Why now?

DEMAND SIDE:

- Practice of medicine increasingly complex
- Simplify regulatory compliance, value-based contracting
- Provide administrative back-end functions and supports

SUPPLY SIDE:

- Historically low interest rates; debt a cheaper vehicle to finance acquisitions
- Historically low anti-trust scrutiny of acquisitions
- Both have led to “stealth consolidation”

- Initial wave of PE started with acquisitions in hospital-based specialties (emergency medicine, anesthesiology, radiology)
- In last 5-7 years, shift to procedural specialties (dermatology, ophthalmology, GI)
- More recently shift to primary care and behavioral health



Private Equity in Colorado

- U.S. Anesthesia Partners
 - Owned in part by PE firm Welsh Carson Anderson & Stowe
 - Started purchasing anesthesiology practices in Denver Metro Area in 2015
 - By 2021, USAP bought out major competitors and established control of surgical anesthesia at two largest hospitals systems in Denver area (more than 70% of health plan reimbursements)
 - Higher costs for consumers, onerous non-compete restrictions on health care professionals, patients facing delays and cancellations of care
 - USAP charged reimbursement rates at 30-40% higher than competing groups
 - **AGREEMENT WITH COLORADO ATTORNEY GENERAL REACHED IN FEB 2024**
 - Pay \$200,000 in monetary relief
 - Divest exclusive contracts at five Colorado hospitals—St. Anthony Hospital, St. Anthony North Hospital, OrthoColorado Hospital, and Longmont United Hospital in the Denver-Boulder market, and Mercy Hospital in Durango
 - Will release and modify non-compete agreements with clinicians to make them less onerous and more narrowly tailored; completely end non-compete agreement practice within 18 months of the agreement taking effect



Additional Practice Acquisitions - Colorado

- Capitol Pain Institute
 - Platform for PE investment firm Iron Path Capital
 - Operates clinical and ambulatory surgery centers in four other states
 - In 2023, acquired 3 practices and a surgery center in CO Springs
- OptumCare
 - Physician practice company of UnitedHealth Group
 - Since 2017 has acquired New West Physicians and DaVita Medical Group (including Mountain View Medical Group in Pikes Peak area)



Themes from PCPRC Discussion

- Important to shed light and bring visibility/awareness to issues
 - Promote creative thinking about federal and state policy levers
 - Primary care not a monolithic intervention
- Workforce concerns
 - Lack of new physicians to take place of retiring primary care physicians (not purchasing practices, not pursuing primary care as specialty)
 - Impact of acquisitions on staffing, morale, burnout
- Care quality concerns
 - Harmful clinical outcomes
 - Exacerbate health disparities
- Cost concerns



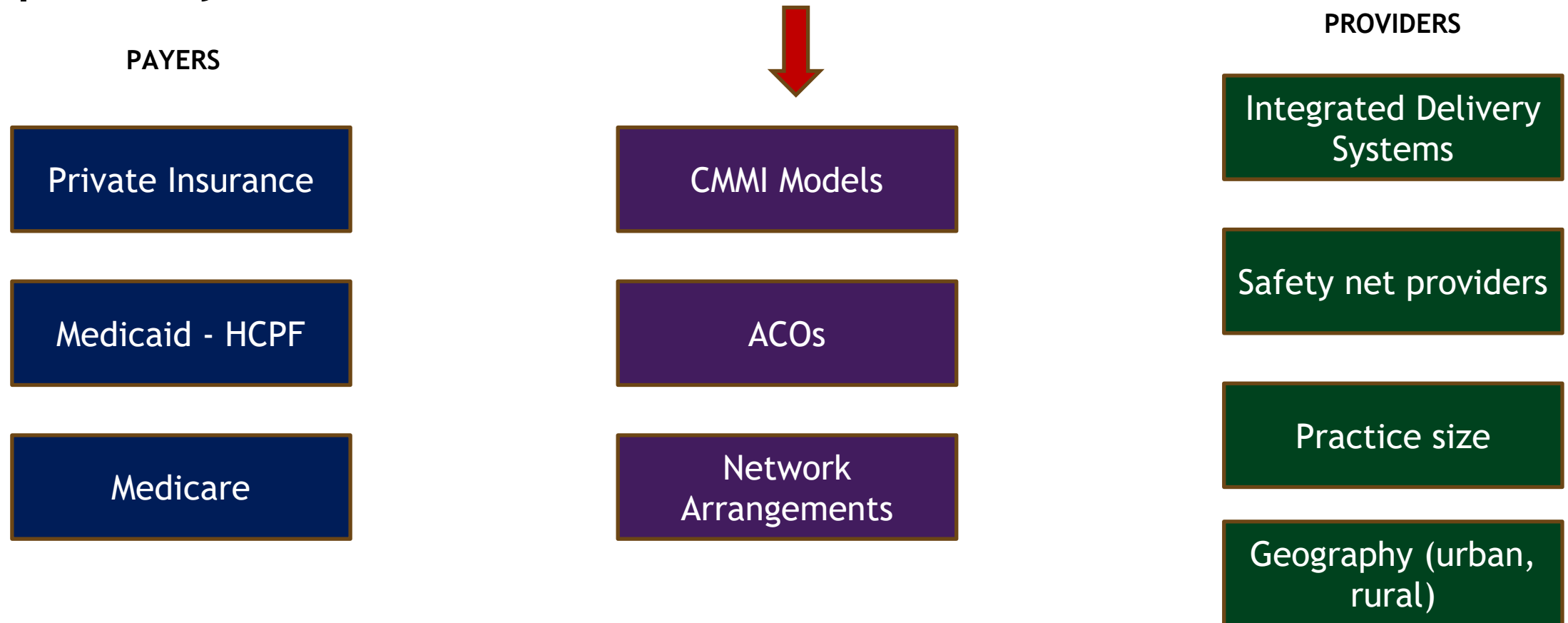
Centering Question

- Are the payments that we are putting forth by changing payment structures getting to the right places?
 - PE entities capitalizing on opportunity to make money off payment changes
 - Our goal: payments to strengthen primary care delivery and workforce
 - Is that happening, and if not, how do we get in front of that?



Today's Question

- How do market dynamics in Colorado impact flow of primary care dollars?



Participants in CMMI Models



CMMI Models in Colorado

- **Primary Care First**
 - 2021 - 2026
 - 139 provider participants
- **Making Care Primary**
 - July 2024 - Dec 2034
 - 9 participating provider organizations
- **Medicare Shared Saving Program (MSSP)**
 - 6 participating ACOs
 - 146 provider participants
- **ACO REACH**
 - 14 participants with Colorado service areas



Centering Question

- Are the payments that we are putting forth by changing payment structures getting to the right places?
 - ACO structures
 - Independent rural providers
 - Other



Draft Schedule

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Public Comment





Thank you!!

