COLORADO
Department of Regulatory Agencies
Division of Insurance

December 15, 2019

Dear Fellow Coloradans,

House Bill 19-1233 tasked the Colorado Division of Insurance with developing a Primary Care and Payment Reform Collaborative (PCPRC) to make progress on increasing investments in high-quality primary care. We know that primary care access is a critical component of our larger health care system, and disparities in access, quality, and investment impact consumers in our state.

For these reasons, I am grateful for the work of the PCPRC over the last several months. The Collaborative's recommendations will help shape and refine the work of the Division and we take their recommendations in this report seriously. Their deliberative and thoughtful input has resulted in a report that provides a framework for the Division's work in advancing primary care moving forward.

We look forward to considering the PCPRC's recommendations in our forthcoming affordability standards and furthering the progress of primary care access and investment in Colorado. Additionally, these recommendations will inform the development of Colorado's public option plan, an example of how the Collaborative's work is already expanding beyond what the General Assembly tasked them with.

The DOI wishes to sincerely thank the members of the PCPRC for their time and investment in these recommendations so far. The DOI looks forward to working with the PCPRC in future years to further refine and increase investment in high-quality primary care for all Coloradans.

Sincerely,

Michael Conway
Commissioner of Insurance

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Colorado's Primary Care Payment Reform Collaborative Recommendations

FIRST ANNUAL REPORT

DECEMBER 15, 2019

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Special thanks to:

The members of the Primary Care Payment Reform Collaborative, who devoted many hours to the findings and recommendations presented in this report:

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COLORADO HEALTH INSTITUTE
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About the Colorado Health Institute

The Colorado Health Institute (CHI), which produced this report, is a nonprofit and independent health policy research organization that is a trusted source of objective health policy information, data, and analysis for the state's health care leaders. CHI's work is made possible by generous supporters who see the value of independent, evidence-based analysis. Those supporters can be found on our website: coloradohealthinstitute.org/about-us.

EXECUTIVE SUMMARY

The cost of health care is an increasing concern in Colorado. Nearly one in five Coloradans (18.1 percent) report having had trouble paying their medical bills in the past year, and more than one in six said they avoided seeing a general doctor or a specialist in the past year due to cost.[1] Delaying or skipping medical care as a result of financial barriers can have serious consequences.[2]

Primary care can help. A growing body of evidence shows that high quality primary care produces better, more equitable health outcomes at a more affordable cost.[3]

Colorado's policymakers are taking action to improve health and reduce health care costs by increasing access to comprehensive primary care. House Bill 19-1233: Investments in Primary Care to Reduce Health Costs directs the Colorado Insurance Commissioner to convene a primary care payment reform collaborative (the Collaborative) to explore this approach. Colorado is one of 10 states across the country pursuing similar initiatives.[4]

This report provides initial findings and the following recommendations from the Collaborative:

- ***The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both fee-for-service and alternative payment models.***
- ***All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least 1 percentage point annually through 2022.***
- ***The State should identify and track short-, medium-, and long-term metrics that are expected to be improved by increased investment in primary care.***
- ***Increased investments in primary care should support providers' adoption of advanced primary care models that build core competencies for whole person care.***
- ***Increased investments in primary care should be offered primarily through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality.***

In summary, the Collaborative recommends a measured shift in health care spending toward a primary care-centered model. All stakeholders must closely monitor the shift to ensure that the recommended changes are resulting in more affordable care and better outcomes for all Coloradans.

INTRODUCTION

The United States consistently spends more on health care than other high-income nations, but its people do not have better health outcomes.[5] Colorado is not exempt from this trend. While Colorado often scores well on common measures of health and health care spending, a deeper look at the data reveals a more complex picture.

Colorado's insured rate is at an all-time high: Since 2015, more than 93 percent of Coloradans have had health insurance.[6] However, many Coloradans still cannot afford health care. In 2019, nearly one in five Coloradans (18.1%) reported having trouble paying their medical bills in the past year.[7] One in six Coloradans said they avoided seeing a general doctor or specialist in the past year due to cost.[8]

Delaying or skipping medical care as a result of financial barriers can have serious consequences. In one study, researchers found that individuals who faced financial barriers to care were more likely to be readmitted to the hospital within one year after suffering a heart attack.[9]

Primary care can help. Primary care providers offer patients a first point of contact into the health system and provide accessible, cost-effective medical care.[10] A growing body of evidence shows that improved access to comprehensive primary care is associated with better, more equitable health outcomes at a more affordable cost. For instance:

- In Oregon, claims data analysis showed that for every $1 increase in primary care expenditures through the state's Patient-Centered Primary Care Home program, $13 was saved on other services such as specialty care and emergency department visits.[11]
- A study across 29 states found that people who live in states that spend more on primary care also had fewer visits to the emergency room and fewer hospitalizations.[12]
- Higher ratios of primary care providers to population are associated with reductions in health disparities across racial and socioeconomic groups, including reductions in racial disparities in mortality rates.[13]

Policymakers across the nation are taking note of the connection between robust primary care systems and overall health outcomes and spending. Several states have implemented statewide policies to increase investment in primary care. Rhode Island, which became the first state to take this approach in 2010, required its commercial payers to meet primary care

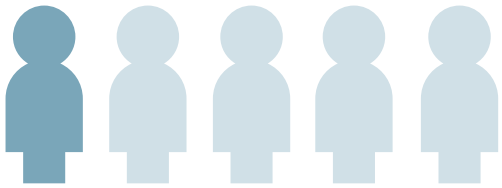
CHRIS SCHNEIDER/SPECIAL TO CHI

spending targets as part of a broad set of affordability standards and has reported a reduction in total spending growth as a result.[14] Rhode Island set and achieved a target of 10.7 percent of total medical expenditures spent on primary care. Oregon and Delaware are each pursuing targets of 12 percent.[15] In Colorado, the current percentage of total medical expenditures spent on primary care is between 5 to 10.6 percent, according to recent estimates.[16]

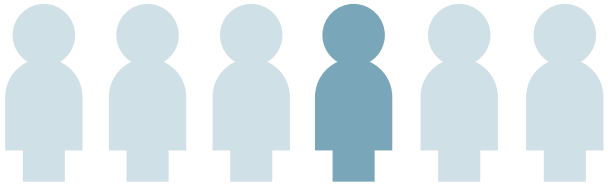
This year, Colorado established a primary care payment reform collaborative (the Collaborative) to advise the Colorado Division of Insurance (DOI) in the development of affordability standards and targets for commercial payer investments in primary care. The Collaborative will focus on developing strategies for increased investments in primary care that deliver the right care in the right place at the right time. This report describes the Collaborative's approach to this work and provides initial findings and recommendations.

In 2019 …

Nearly one in five Coloradans (18.1%) reported having trouble paying their medical bills in the past year.



One in six said they avoided seeing a general doctor or a specialist in the past year due to cost.



SOURCE: 2019 COLORADO HEALTH ACCESS SURVEY

Colorado's Primary Care Payment Reform Collaborative

In 2019, the General Assembly of the State of Colorado set out a bold vision for achieving more affordable care and better outcomes by increasing access to comprehensive primary care. House Bill 19-1233: Investments in Primary Care to Reduce Health Costs, directs the Colorado Insurance Commissioner to convene a primary care payment reform collaborative. Colorado is one of 10 states across the country pursuing similar initiatives.[17]

At a high level, the Collaborative is tasked with the following:

- **Recommend** a definition of primary care to the Insurance Commissioner;
- **Advise** in the development of broad-based affordability standards and targets for commercial payer investments in primary care;
- **Coordinate** with the All Payer Claims Database to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado's Medicaid Program), and Child Health Plan *Plus* (CHP+);
- **Report** on current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation and care improvement in primary care;
- **Identify** barriers to the adoption of alternative payment models (APMs) by health insurers and providers and develop recommendations to address these barriers;
- **Develop** recommendations to increase the use of APMs that are not fee-for-service in order to:
  - *Increase investment in advanced primary care models,*
  - *Align primary care reimbursement models across payers, and*
  - *Direct investment toward higher-value primary care services with an aim at reducing health disparities;*
- **Consider** how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care; and
- **Develop** and share best practices and technical assistance to health insurers and consumers.

The Collaborative initially convened on July 8, 2019 and held a total of nine meetings in 2019.

The Collaborative reached the findings and recommendations in this report through an open and transparent process. All Collaborative meetings are open to the public, with meeting times and locations posted in advance on the DOI website. Time is reserved during each meeting for public comments. Future meeting logistics, past meeting materials, and all Collaborative reports (including this report) are posted publicly to the website. Each of the recommendations provided in this report was approved by the Collaborative through simple majority vote when unanimous consensus couldn't be reached. *For more information on the Collaborative's Standard Operating Procedures and Rules of Order, please see Appendix H.*

Members of the Collaborative were selected by DOI through an open application process in June 2019. Twenty-two members with diverse perspectives were chosen, including one representative from the Department of Health Care Policy and Financing, one representative from the Department of Public Health and Environment, and one representative from the U.S. Centers for Medicare and Medicaid Services, as required by legislation. Members will serve one-year terms with the opportunity for one re-appointment, for a maximum total of two years.

The Collaborative is required to publish primary care payment reform recommendations by December 15th of each year. This report provides the Collaborative's first set of recommendations. The Collaborative is scheduled to sunset on September 1, 2025.

Members of the Collaborative include:

- Health care providers
- Health care consumers
- Health insurance carriers
- U.S. Centers for Medicare and Medicaid Services (CMS)
- Experts in health insurance actuarial analysis
- Employers
- Primary Care Office in the Department of Public Health and Environment
- Department of Health Care Policy and Financing

The Collaborative's Approach

The Colorado General Assembly envisions a highly functional health system built on the foundation of a robust primary care system in House Bill 19-1233. This vision includes a shift toward increased investment in advanced primary care models, which focus on quality of care and health outcomes rather than the volume of patients treated. Many of Colorado's providers and payers have already started to adopt these models.

Practices in Colorado began the transition toward advanced primary care models in 2001 with the Colorado Medical Home Initiative.[18] In recent years, hundreds of organizations across the state have aligned similar transformation efforts through programs like the Colorado Multi-Payer Patient-Centered Medical Home Pilot, the Comprehensive Primary Care and Comprehensive Primary Care Plus Initiatives, the Colorado State Innovation Model, the Transforming Clinical Practice Initiative, and the Hospital Transformation Program.

As a national leader in health care delivery and payment innovation, Colorado is exceptionally well-positioned for a statewide push to increase investments in primary care to deliver the right care in the right place at the right time.

While the benefits of increased investment in advanced primary care models are well-documented, key questions must be answered to effectively put that evidence into practice:

- What counts as primary care? What types of services are included? What types of providers deliver those services?
- How much should be invested for optimal results?
- How should that investment be delivered?

The Collaborative considered a large body of evidence before answering these questions. Members reviewed statewide and national data on primary care spending, discussed lessons learned both in Colorado and in other states, and offered personal insights from their own experiences as consumers, providers, payers, and policymakers. These and other sources of evidence have informed the findings and recommendations presented in this report. *For more detail on the items discussed by the Collaborative, please see Appendix A.*

The following recommendations are based upon the best available evidence; however, the Collaborative acknowledges that there are still lessons to be learned and questions to be answered, and that the implementation process must be closely monitored. With measured action and diligent follow-through, the Collaborative believes these recommendations will result in more affordable care and better health for all Coloradans.

Definition of Primary Care

The first task of the Collaborative was to define primary care in Colorado (See box on page 8). A statewide definition is needed to direct future investments in primary care by clarifying which payments will be included when calculating primary care spending.

To develop a recommendation, the Collaborative relied on the conceptual framework of the Institute of Medicine definition of primary care and added a focus on the equitable provision of services:

> *Primary care is the provision of integrated, **equitable**, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated care encompasses the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care.*[19]

The Collaborative also reviewed the definitions used by other states pursuing similar initiatives (for more information, see page 9). Based on these examples and robust discussion in Collaborative meetings, the members of the Collaborative determined that a broad and inclusive definition of primary care would best serve Coloradans.

The Collaborative unanimously recommends applying this definition to care and payments provided under both fee-for-service reimbursement and alternative payment models. Calculations of primary care spending should include infrastructure investments such as workforce development incentives, system transformation initiatives, quality improvement initiatives, and other structural investments supporting the development of advanced primary care delivery. This information must be collected in a format that is consistent, standardized, and comparable across payers. The Collaborative therefore recommends further research and work, in coordination with the Center for Improving Value in Health Care (CIVHC), on how to accurately collect, analyze, and report data.

The Collaborative intends to add dental services to the definition of primary care; however, current limitations in data gathering make it impractical to include dental services in the initial recommendation. Dental services are often covered under separate insurance and billing processes. Data collected from commercial payers that focus on dental services would not be comparable to data collected from commercial payers that do not cover these services. This will be an area of further research and discussion for the Collaborative.

Primary Care Investment Initiatives in Other States

Colorado is one of 10 states pursuing similar primary care investment initiatives through legislative action. Colorado, Delaware, Maine, Oregon, Rhode Island, Vermont, Washington, and West Virginia have passed legislation to increase investment in primary care, enhance primary care services and quality, and ensure affordability. Hawaii and Missouri have introduced similar legislation that has not yet passed. While these efforts are relatively new in most states (five states, including Colorado, passed legislation in 2019), Rhode Island, Oregon, and Delaware are further along in the process.

Rhode Island's 2010 affordability standards directed commercial payers to implement specific conditions in contracts with hospitals and to increase the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014.[20] Two commercial payers were subject to these requirements and both met the investment targets through 2012.[21] After payers successfully met the annual percentage point increase for several years, Rhode Island's Insurance Commissioner set a minimum standard that commercial payers' primary care expenses must be at least 10.7 percent of annual medical expenses for all insured lines of business.[22] The Commissioner stipulated that increasing the primary care spending could not result in increased patient premium costs or

COLLABORATIVE RECOMMENDATION

Definition of Primary Care

The Collaborative recommends a definition of primary care based primarily but not exclusively on the type of provider as follows:

Primary care includes services provided by and payments to:

- Family medicine physicians in an outpatient setting and when practicing general primary care
- General pediatric physicians and adolescent medicine physicians in an outpatient setting and when practicing general primary care
- Geriatric medicine physicians in an outpatient setting when practicing general primary care
- Internal medicine physicians in an outpatient setting and when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care)
- OB-GYN physicians in an outpatient setting and when practicing general primary care
- Providers such as nurse practitioners and physicians' assistants in an outpatient setting and when practicing general primary care
- Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting

APPROVED BY UNANIMOUS CONSENSUS

Figure 1. State Leaders in Primary Care Investment[27]

	Rhode Island	Oregon	Delaware
Primary Care Definition	• All payments to family physicians, internists, pediatricians, and affiliated advanced practice providers (e.g., physician assistants, nurse practitioners) • Payments for approved "common good" services (health information technology, loan repayment, and practice transformation)	• Payments for selected services to family physicians, general medicine physicians, pediatricians, OB-GYNs, psychiatrists, geriatricians, physician assistants, nurse practitioners, naturopaths, and homeopaths	• Payments to family physicians, pediatricians, internists, and geriatricians.
Investment Target	• At least 10.7% after 2014 • 1 percentage point annual increase between 2010–2014	• At least 12% by 2023 • 1 percentage point annual increase	• At least 12% by 2024 • 1 percentage point annual increase
Additional Spending Requirements	At least 50% of medical payments should be under an APM, with a minimum downside risk for providers	Primary care spending requirements follow a series of delivery and payment model reforms	Primary care investment should include upfront investment of resources to build infrastructure and capacity

an increase in overall medical expenses.[23] A recent study found that the affordability standards contributed to a 2.7 percent reduction in total spending growth in Rhode Island between 2007–2016 , saving $55 per enrollee per quarter in total health care spending after the policy was implemented.[24]

Following Rhode Island's lead, Oregon and Delaware are also pursuing primary care spending targets.

Oregon will require its coordinated care organizations, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board to spend at least 12 percent of total medical expenditures on primary care by 2023. In addition, the Oregon Department of Consumer and Business Services may hold commercial payers to the same 12 percent target starting in 2023.[25] Public and commercial payers that do not meet the 12 percent threshold are required to submit plans to increase primary care spending by 1 percentage point each plan year.

In Delaware, the Primary Care Collaborative has recommended that all public and commercial payers (including Medicaid and Medicare Advantage plans) be required to progressively increase primary spending to 12 percent of total health care spending within five years.[26] Payers that don't meet the target would be required to increase the amount of total expenditures spent on primary care by 1 percentage point every year.

Targets for Investment in Primary Care

The Collaborative is charged with advising the Insurance Commissioner in the development of affordability standards and targets for commercial payer investments in primary care. The investment targets will be a critical element of broader affordability standards.

COLLABORATIVE RECOMMENDATION

Primary Care Investment Target

All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least 1 percentage point annually through 2022. The Collaborative recommends that baseline data be collected in 2020, with 1 percentage point increases occurring in both 2021 and 2022. The target should be reevaluated after two years of implementation.

APPROVED BY SIMPLE MAJORITY

To develop the investment target recommendation, the Collaborative reviewed available data on the current level of spending on primary care in Colorado, as well as the methodologies used by other states and national organizations to calculate state-level spending on primary care. Estimates vary widely, depending on how primary care is defined (i.e., the scope of service and provider types). A recent national analysis estimates that primary care accounts for between 5 and 10.6 percent of total health care spending in Colorado, depending on whether a narrow or broad definition is used.[28]

The Collaborative is coordinating with the Center for Improving Value in Health Care (CIVHC), the administrator of the Colorado All Payer Claims Database (APCD), to analyze the level of primary care spending in Colorado. The Collaborative asked CIVHC to include spending through APMs in order to align with the recommended definition of primary care. Data on spending through APMs have recently been added to the Colorado APCD. Health First Colorado (Colorado's Medicaid program) and all commercial payers were required to submit detailed information on APM payments for the first time on September 30, 2019. At the time of this report, CIVHC had received APM payments data from the required payers and was working closely with several payers to resolve inconsistencies and gaps in the submission documents.

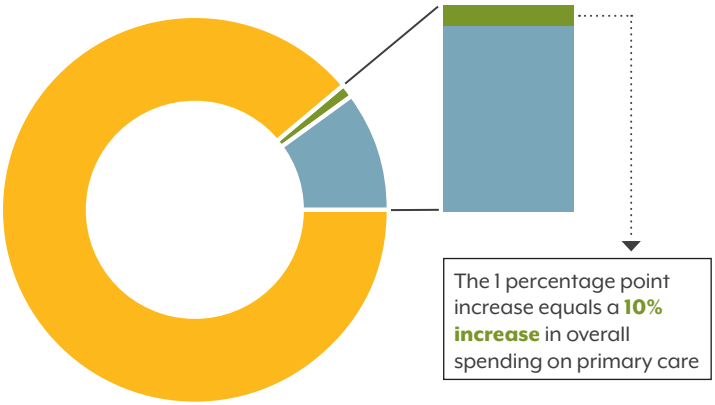
In late November 2019, CIVHC calculated preliminary estimates of primary care spending using claims data, the new APM payments data, and a broad definition of primary care that is closely aligned (but not an exact match) with the Collaborative's recommendation. The preliminary results predict that an average primary care spending percentage in Colorado will fall within the 5 to 10.6 percent estimated by the national analysis; however, the preliminary results also show significant variation between payers, with major carriers spending anywhere between 1.5 and 13.5 percent of total medical spending on primary care.[29] While this analysis represents an important first step in understanding payments for primary care currently made through fee-for service and APM arrangements, the preliminary results do not yet provide a comprehensive picture of current primary care spending percentages. The Collaborative will continue working closely with CIVHC to address the remaining gaps in data submissions, as well as several methodological challenges. The updated data and methodology should be used to establish a reliable baseline percentage for each payer in 2020 and to calculate percentage point increases in 2021 and 2022. *For more information on the preliminary results and the updates needed to improve the analysis, please see Appendix D.*

The Collaborative recommends a measured approach to increasing primary care investment, starting with a set percentage point increase for commercial payer investments in primary care that will be reevaluated two years after implementation. This recommendation is based on a review of the targets set in other states and the preliminary results available from CIVHC. An initial annual 1 percentage point increase will require improvement across payers in the short-term, while allowing time for refined spending estimates to inform a long-term target. Drawing from the experience in Rhode Island and the planned increases in Oregon and Delaware, the Collaborative considered a 1 percentage point annual increase as an initial target. The recommendation was approved by the Collaborative through a simple majority vote.

The Collaborative acknowledges that additional work is needed to translate this recommendation into regulation. Payers will need clarification in several areas, including calculation methodologies and reporting requirements. The Collaborative will continue to provide feedback to DOI throughout the regulation development process.

From the primary care perspective, the recommended annual increase could translate to a significant surge in investment. At a high level, if primary care currently accounts for approximately 10 percent of total health care spending across payers, an increase to 11 percent represents a 10 percent increase over current spending on primary care (see Figure 2). The Collaborative intends for the increased spending to offer new opportunities for primary care: Payers might offer higher payments to providers through APMs or

Figure 2. Percentage Point Increase Impact on Primary Care Spending.



invest additional capital funds into data infrastructure improvements. The required percentage point increase should prioritize investments in capacity building and improved care delivery, and not be achieved solely through reductions in other types of spending or shifts in current fee schedules.

The recommended percentage point investment target is based on the best-available data and the experience of similar initiatives in other states; however, the Collaborative recognizes that the implementation of the policy must be closely monitored to ensure the intended outcomes. The need for evaluation and iteration is particularly pronounced for the initial percentage point investment target, which represents Colorado's first statewide step in this direction.

COLLABORATIVE RECOMMENDATION

Measuring the Impact of Increased Primary Care Spending

The State should identify and track short-, medium-, and long-term metrics that are expected to improve through increased investment in primary care.

APPROVED BY UNANIMOUS CONSENSUS

The Collaborative unanimously recommends that a set of short-, medium-, and long-term metrics be identified and tracked to determine whether increased investments are having the desired impact. The metric set should focus on evaluating the statewide impact of the increased investment, including cost, health outcomes, patient experience, and health disparities. The Collaborative will review potential metrics over the next year.

The Collaborative plans to track the identified metrics over time, with the expectation that short-term metrics

PRIMARY CARE INVESTMENT TARGETS

One Component of New Affordability Standards

HB 19-1233 directs the Colorado Insurance Commissioner to promulgate rules establishing affordability standards, which must include primary care investment targets. The Collaborative recognizes that increased primary care investment must be implemented alongside other efforts to address overall health care spending.

In promulgating affordability standards, the Collaborative notes that the Insurance Commissioner will have to address the risk that investments to expand and improve the primary care infrastructure might be passed on to consumers in the form of higher premiums. Instead, a well-coordinated effort should offset the cost of increased investments through the anticipated benefits of increased investment in primary care or other statewide efforts to address high costs. The affordability standards should provide clear guidance on acceptable practices and processes for increasing spending on primary care, which should align with other statewide efforts, including the public option and the state reinsurance program.

The Division of Insurance's rate review process will play a central role in the ongoing monitoring of commercial payer compliance with the primary care investment target and broader affordability standards. The Collaborative will continue to advise the Insurance Commissioner on important trends in primary care and alternative payment models, which will help ensure that affordability standards are resulting in the intended impacts on health outcomes and costs.

(e.g., emergency department utilization) may show improvement in the first two years while long-term metrics (e.g., growth in total cost of care) may take up to a decade to improve. Metrics will be analyzed in aggregate and by demographic categories to evaluate the impact of the increased investment within different populations.

Delivery System and Payment Reform for Primary Care

The Collaborative has recommended an initial primary care investment target based on the evidence that comprehensive primary care can help to reduce costs and improve health in Colorado. The evidence reviewed by the Collaborative is primarily focused on the impact of advanced primary care models, which focus on quality of care and health outcomes rather than the volume of patients treated. The Collaborative predicts that an increase in fee-for-service rates alone would not produce the intended results; therefore, the Collaborative unanimously recommends that new primary care investments be directed towards evidence-based care models with demonstrated results and toward building the infrastructure needed to support adoption of those models.

COLLABORATIVE RECOMMENDATION

Investing in Advanced Primary Care Models

Increased investments in primary care should support providers' adoption of advanced primary care models that build core competencies for whole person care.

APPROVED BY UNANIMOUS CONSENSUS

Several advanced primary care models that focus on developing core competencies around whole person care are currently in use in Colorado. The Patient-Centered Medical Home and the Building Blocks of High Performing Primary Care models have recently been used in statewide initiatives and have gained wide acceptance by the state's payers and providers. These and other similar models share several common elements:

- **Continuity of care:** Providing quality care over time though a continuous relationship between patient and primary care team.
- **Comprehensive care:** Providing most of the care a person needs to be healthy, including physical and behavioral health services.
    - **Focus on behavioral health integration:** The Collaborative recommends a specific focus on behavioral health integration in the implementation of comprehensive care. This focus should build upon Colorado's progress on integrating physical and behavioral health services made through the Colorado State Innovation Model and other initiatives.
- **Team-based care:** A group of multi-disciplinary providers (e.g., a doctor, a medical assistant, and a nutritionist) working together to care for the patient.
- **Patient-centered care and the patient-team partnership:** Approaches emphasizing the importance of engaging the patient as a valued and respected member of the care team.
- **Care coordination:** Services that help patients arrange and receive care outside the primary care office (e.g., visits to a specialist).
- **Prompt access to care and accessible services:** Making the care team more available to patients (e.g., extending hours or offering telephone consultations).
- **Quality and safety and data-driven improvement:** Holding providers accountable for continuously improving the care offered by tracking progress and implementing evidence-based changes.
- **Equity:** Ensuring that all elements of advanced primary care models are implemented with the goal of reducing health disparities (e.g., cultural competency training and hiring multilingual staff to support effective patient-centered care, disaggregating data to ensure data-driven improvement for all populations)

These common elements are considered foundational to the success of each model. The Collaborative recommends that increased investment in primary care focus on increasing the adoption of models that include these elements in order to ensure alignment with existing efforts and to leverage the evidence that these models work to improve health care outcomes and reduce costs.[30] For example, a payer might offer an incentive for providers to extend

office hours (prompt cccess to care and accessible service) or pay providers to hire a community health worker to work with patients in a specific neighborhood (team-based care, patient-centered care, patient-team partnership, and equity).

Many of Colorado's providers and payers have already adopted advanced primary care models, but there are barriers that are preventing wider adoption. The Collaborative finds that barriers vary by practice type (i.e., adult vs pediatric), practice size (i.e., small, medium, large), and geographic location (i.e., urban vs rural).

Among these differences, the common theme is that successful adoption of advanced primary care models is tied to alternative payment models. Traditional fee-for-service payments do not incentivize providers to adopt advanced primary care models. Comprehensive, patient-centered care is often not fully reimbursed in a traditional fee-for-service model and may even reduce fee-for-service payments (e.g., care coordination may avoid duplicate testing that otherwise would have been reimbursed). Alternative payment models are needed to align provider incentives with advanced primary care models.

COLLABORATIVE RECOMMENDATION

Increasing Investments Through Alternative Payment Models

Increased investments in primary care should be offered primarily through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality.

APPROVED BY UNANIMOUS CONSENSUS

The Collaborative unanimously recommends that increased investment in primary care be directed towards increasing the prevalence of alternative payment models. Collaborative members have discussed many different types of alternative payment models and identified two types of investment that are essential to effectively support providers in a shift toward advanced primary care models:

- **Upfront Investment** – Members of the Collaborative report that many primary care providers in Colorado are currently stretched to the limit of administrative capacity and financial reserves. New models of care take both time and money to implement. Yet there is no extra time and no extra money available in most primary care practices today. To increase adoption of advanced models of primary care, it is critical that funding is available upfront to support additional staff time and other necessary investments such as adding a care coordinator to the staff or improving electronic medical records to track quality measures. Therefore, the Collaborative recommends that the increased investment for primary care include an upfront payment component to support providers, especially small practices and rural providers, in getting started.

- **Incentives for Improving Quality of Care** – One of the most important lessons from past attempts at health care payment reform is that new methods of payment must be tied to the quality of care. The evidence from more recent attempts suggests that several methods can effectively link payment reform efforts to quality of care, and that the most effective method may be different for different provider types. For example, a global budget that is contingent on meeting certain performance goals may be appropriate for a large health system, while incentive payments linked to specific quality metrics might be appropriate for a small independent practice. No matter the method used, the Collaborative recommends that the increased investment in primary care include incentives for improving the quality of care to ensure that patient outcomes improve as intended.

Future Work for the Collaborative

The findings and recommendations provided in this report mark the beginning of the Collaborative's work. The current members of the Collaborative have completed the first half of their initial one-year terms, with the opportunity for reappointment to an additional one-year term starting in July 2020. The Collaborative will continue beyond its inaugural members' terms: it is scheduled to sunset in 2025.

In the first six months, the Collaborative has already identified several opportunities for future work. These opportunities range from specific, short-term tasks (e.g., advise CIVHC in updating estimates of primary care spending) to aspirational, long-term goals (e.g., promote alignment between payers). The next step for the Collaborative will be to consider the identified opportunities and to prioritize the items that the Collaborative will focus on in the next year.

Several of these opportunities for future work have been discussed throughout this report, such as

continued discussion about affordability standards and exploring the inclusion of dental claims. The Collaborative also identified the following additional opportunities:

- **Support alignment of alternative payment models across payers.** In reviewing current public and commercial payer practices and methods of reimbursement, the Collaborative has found that the current variety of APMs offered by different payers is resulting in undue administrative burden for primary care providers. The need to report on different quality measures and track different methods of payment for each payer can detract from providing consistent quality patient care to all patients. To improve patient care and reduce provider burnout, payers must do more to align requirements across APMs.

  The Collaborative commends the members of the Colorado Multi-Payer Collaborative (MPC), a group of private and public payers that joined together to support payment reform and practice transformation efforts, for their work to address this issue. The Collaborative has identified multi-payer alignment as a priority for future work and will explore opportunities to support the work of the MPC and other efforts to align APMs requirements across payers.

- **Leverage and improve existing alternative payment models with high provider participation.** Colorado's payers, providers, and other partners have collectively invested billions of dollars into existing models. Future efforts should leverage existing models with significant provider participation (as measured through number of providers participating or lives covered), such as Comprehensive Primary Care Plus (CPC+) and the Accountable Care Collaborative (ACC) Alternative Payment Model (APM). While more data are needed to evaluate the successes and shortcomings of these relatively new programs, the existing provider participation in these models cannot be overlooked. The Collaborative will consider opportunities to build upon these models in future work.

- **Improve the data available on primary care in Colorado.** Successful payment reform programs rely on timely and accurate data. Without reliable data, it is impossible to make informed recommendations or to track progress towards goals. Specifically, the Collaborative has identified opportunities for improvement in the collection and analysis of the following data:

  - ***Primary care spending in the All Payer Claims Database (APCD)*** – *The initial submissions of alternative payment model data to the Colorado APCD this fall have provided valuable, if preliminary, information to the Collaborative and other stakeholders. Given the growing adoption of APMs in the state, this information is critical to evaluating the current spending on primary care and tracking improvements through increased adoption of APMs. In the near term, the Collaborative supports changes to Data Submission Guide rules to address limitations in the current data submission format, including changes that give CIVHC the ability to capture data for all Coloradans covered by large national carriers, to include all infrastructure investments in primary care, and to analyze data by line of business (e.g., commercial, Medicaid, Medicare). The Collaborative will continue to work with CIVHC to identify opportunities for improvement and to support CIVHC's work with payers to improve the quality and reliability of these data. In addition, the Collaborative will work with CIVHC to refine the calculation of primary care spending based on the Collaborative's recommended definition of primary care. The Collaborative recognizes that changes to the definition may be contingent on the availability of data (e.g., dental claims data).*

  - ***Electronic clinical quality measures in the Health Data Colorado system*** – *Colorado has made significant investments in coordinated health information technology (HIT) infrastructure, known as Health Data Colorado (HDCo), to collect and validate electronic clinical quality measures across payers. HDCo supports multi-payer alignment on measures and provides a coordinated source of quality data for policymakers. The system is operational; however, there is more work to be done to refine the validation processes, to capture additional measure types, and to onboard more practices.*

  - ***Detailed descriptions of commercial payer APMs through the Colorado Multi-Payer Collaborative*** – *Colorado's commercial payers have made significant progress in adopting alternative payment models and have reported*

improvements as a result of those models; however, publicly available information about the design of those models is scattered and incomplete. In order to learn from the successes of commercial APMs, more information is needed about the details of the models and the results that have been achieved.

- ***Workforce data through the Colorado Provider Directory*** *– The Colorado Department of Public Health and Environment (CDPHE) has created a provider directory to inform workforce planning discussions in the state. This information will be critical to planning and tracking improvements to access to primary care statewide.*

The Collaborative looks forward to continuing to build upon Colorado's history of payment reform and delivery system innovation.

Conclusion

In the first six months of its existence, the Colorado Primary Care Payment Reform Collaborative has developed a series of recommendations that offer concrete guidelines for increasing investment in primary care:

- The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both fee-for-service and alternative payment models.
- All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least 1 percentage point annually through 2022.
- The State should identify and track short-, medium-, and long-term metrics that are expected to be improved by increased investment in primary care.
- Increased investments in primary care should support providers' adoption of advanced primary care models that build core competencies for whole person care.
- Increased investments in primary care should be offered primarily through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality.

The Collaborative looks forward to continuing this work by playing an active role in monitoring the implementation of these recommendations and helping to address any new obstacles that arise.

ALEC WILLIAMS/COLORADO HEALTH INSTITUTE

Endnotes

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APPENDIX A:

Primary Care Payment Reform Collaborative Agendas

8th July 2019

Collaborative Member Introductions

Welcome from Lieutenant Governor Dianne Primavera

Remarks from Commissioner Conway

HB 19-1233 Bill History and Collaborative's Charge

- Timeline and Responsibilities Infographic, See Appendix B

Diving In- Rhode Island Discussion

- Baum, A. et al. (2019). "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers." *Health Affairs* 38, 2: 237-245.

Logistics and Scheduling

Public Comment

Wrap Up and Next Steps

31st July 2019

Introductions, Initial Meeting Recap, Agenda Review

Rules of Order

CIVHC APM Presentation & Q&A

- Presentation by CIVHC Representative, See Appendix C
- Report of Primary Care Spending, based on Carrier-Submitted Alternative Payment Model Data—DRAFT: Addendum, See Appendix D

Definition Primary Care

- Considered Definitions of Primary Care, See Appendix E
- Primary Care Definition Codes, See Appendix F
- What has been done Elsewhere?, See Appendix G

Public Comment

Wrap Up and Next Steps

19th August 2019

Introductions, Agenda Review

Rules of Order – Approval

- Primary Care Collaborative—Standard Operating Procedures and Rules of Order, See Appendix H

Defining Primary Care – Follow up

- Pham, H. and A, Greiner. (2019). "The Importance of Primary Care—And of Measuring It." *Health Affairs*. https://www.healthaffairs.org/do/10.1377/hblog20190802.111704/full/

Carrier Reimbursement Practices, Q& A

Presentation by Colorado Association of Health Plans, See Appendix I

Public Comment

Wrap Up and Next Steps

10th September 2019

Introductions, Agenda Review

Defining Primary Care – Approval

Carrier Reimbursements Practices—APCD Data Review

Report of Primary Care Spending, based on Carrier-Submitted Alternative Payment Model Data—DRAFT: Addendum, See Appendix D

Barriers to Alternative Payment Models, Q& A

Presentation by Dr. Stephanie Gold, See Appendix J

Park, B. et al. (2018). "How Evolving United States Payment Models Influence Primary Care and Its Impact on the Quadruple Aim." *Journal of the American Board of Family Medicine*. 31, 4: 588-604

Public Comment

Wrap Up and Next Steps

30th September 2019

Introductions, Agenda Review

Barriers to Alternative Payment Models—Discussion

Colorado Health Access Survey Review

Colorado Health Institute. (2019). "2019 Colorado Health Access Survey: Progress in Peril." https://www.coloradohealthinstitute.org/research/CHAS

Executive Summary—Investing in Primary Care—Discussions

Patient Centered Primary Care Collaborative. (2019). "Investing in Primary Care." *Robert Graham Center*. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf

Public Comment

Wrap Up and Next Steps

22nd October 2019

Introductions, Agenda Review

Current Status of Recommendations—Discussion

Investing in Primary Care—Discussion

- Primary Care Investment—National and State Analyses, See Appendix K
- Primary Care Investment Targets—Other States, See Appendix L
- Fan, N. (2019). "Letters: Primary Care Spending in the Fee-for-Service Medicare Population." *Journal of the American Medical Association*. 179, 7: 977-980.
- Bailit, M. et al. (2017). "Standardizing the Measurement of Commercial Health Plan Primary Care Spending." *Milbank Memorial Fund*.

Public Option Proposal (SB 2004)

Affordability Standards—Discussion

Public Comment

Wrap Up and Next Steps

12th November 2019

Introductions, Agenda Review

Current Status of Recommendations—Discussion

- PCPRC Primary Care Investment Targets—Discussion Summary, See Appendix M

Primary Care Investment and Affordability Standards—Discussion

- Presentation by Department of Insurance, See Appendix N

Public Comment

Wrap Up and Next Steps

2nd December 2019

Introductions, Agenda Review

Primary Care Spending Report (APM data)

- Report of Primary Care Spending, based on Carrier-Submitted Alternative Payment Model Data—DRAFT: Addendum, See Appendix D

Review and Finalize Collaborative Recommendations—Discussion

Public Comment

Wrap Up and Next Steps

APPENDIX B:

Timeline and Responsibilities Infographic

HB19-1233 INVESTMENTS IN PRIMARY CARE TO REDUCE HEALTH CARE COSTS

START HERE

BY JULY 15, 2019 (through September 1, 2025)

The Commissioner of Insurance convenes the Primary Care Payment Reform Collaborative ("the Collaborative")

BY AUGUST 31, 2019 (and every year thereafter)

The Administrator for the All Payer Health Claims Database (APCD) provides a ***Primary Care Spending Report*** to the Commissioner of Insurance & the Collaborative

BY DECEMBER 15, 2019 (and every year thereafter)

The Collaborative publishes recommendations for primary care payment reform based on the Primary Care Spending Report

The Commissioner of Insurance makes rules ***establishing Affordability Standards***, including appropriate targets for insurance carriers to invest in primary care based on the recommendations from the Collaborative

Insurance Carriers, Medicaid, & State Employee Health Plans adopt targets for investments in primary care aligned with Affordability Standards

Result:
Investing in the right place at the right time ***decreases*** the overall spend on healthcare

WHO IS AT THE TABLE?

RESPONSIBILITIES

⇒ Advise in the development of affordability standards and targets for carrier investments in primary care

⇒ Analyze the % of medical expenses allocated to primary care provided by the APCD

⇒ Develop a recommendation for the definition of primary care

⇒ Report current practices of carrier reimbursement that direct greater resources to care innovation and improving primary care

⇒ Identify barriers to the adoption of Alternative Payment Models and develop recommendations to address barriers

⇒ Consider how to increase investment in advanced primary care w/out increasing the total cost of health care or costs to consumers

APPENDIX C:

CIVHC Presentation

Alternative Payment Models Primary Care Definition

July 31st, 2019

CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Presentation Outline

Goal: Describe Colorado Alternative Payment Models Primary Care definition in the context of existing primary care spending measures.

- Primary Care (PC) Definitions
  - State highlights: Oregon, Rhode Island
- Elements to estimate PC Spending
  - State reports and others: Milbank, Colorado Multi-Payer Primary Care Spending
- Colorado PC Alternative Payment Models (APM) Definition
- PC Spending Rates Comparisons
- Questions

American Academy of Family Physicians

"In defining primary care, it is necessary to describe the nature of services provided to patients, as well as to identify who are the primary care providers.

The domain of primary care includes the primary care physician, other physicians who include some primary care services in their practices, and some non-physician providers. However, central to the concept of primary care is the patient."

https://www.aafp.org/about/policies/all/primary-care.html

American Academy of Family Physicians

Five definitions taken together:

- Primary care
- Primary care practice
- Primary care physician (MD, DO)
- Non-primary care physicians providing primary care services
- Non-physician primary care providers (Nurse Practitioners, Physician Assistants)

https://www.aafp.org/about/policies/all/primary-care.html

Rhode Island Definition of Primary Care

All payments to family physicians, internists, pediatricians, and affiliated advanced practice providers and for approved "common good" services (health information technology, loan repayment, and practice transformation).

Non-FFS investments include Health Information Technology (HIT), Patient Centered Medical Homes (PCMHs), CurrentCare (State's HIE), incentives to providers, and other methods like investments in loan forgiveness for training physicians, flu clinics or rewards for provider reporting.

Oregon State Definition of Primary Care

All payments for selected services to family physicians, general medicine physicians, pediatricians, obstetrician/gynecologists, psychiatrists, geriatricians, physicians assistants, nurse practitioners, and naturopaths and homeopaths.

This definition excludes costs associated with services provided in hospital and ambulatory surgical centers.

To calculate the total of primary care spending, claims and non-claims based payments are added.

Estimating Primary Care Spending: Reports Used for Comparison

- Rhode Island
- Oregon
- Milbank Report Definition 4 – provider and service based
- Colorado Multi-payer Share of Primary Care Spend Report: Three definitions, provider-based (taxonomies) and service-based (procedures at claims header line)
- National Committee of Quality Assurance (NCQA) Primary Care definition for measure purposes (HEDIS)

https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report-.jpg

Estimating Primary Care Spending: Who are Primary Care Providers?

Individual Provider Categories	Rhode Island	Oregon	Milbank Definition 4 PCP-C*	CO Definition 3	PCP defined by HEDIS measure (NCQA)
Preventive Medicine	X	X			
Family Medicine	X	X	X	X	X
General Practice	X	X	X	X	X
Internal Medicine	X	X	X	X	X
Pediatrics	X	X	X	X	X
Geriatrics	X	X	X	X	X
Adolescent Medicine			X	X	
Obstetrics and Gynecology		X	X		X
Nurse Practitioners/Physician Assistants	X	X	X	X	X
Behavioral Health Services		X			
Homeopathy/Naturopathy		X			

* The Milbank definition also included health plan designation as PCP, which is not available in the Colorado APCD

Estimating Primary Care Spending: Who are Primary Care Providers? Continued

Organization Provider Categories	Rhode Island	Oregon	Milbank Definition 4 PCP-C	CO Definition 3	PCP defined by HEDIS measure (NCQA)
Community Health				X	
Federally Qualified Health Center		X		X	
Public Health, Federal				X	
Public Health, State or Local				X	
Primary Care Clinic		X		X	
Rural Health Clinic		X		X	
Student Health Clinic				X	

Estimating Primary Care Spending: What is Considered Primary Care Services? CPT/HCPCS Procedures

CPT/HCPCS	Description	Rhode Island	Oregon	Milbank Definition 4 PCP-C	CO Definition 1-2	PCP defined by HEDIS measure (NCQA)
99201-99205 99211-99215 99241-99245 99341-99345 99347-99350	Office, outpatient, or home visits		X	X	X	X
99339-99340	Individual physician supervision patient not present			X	X	
99381-99387 99391-99397 99401-99404 99411-99412 99420 99429	Preventive medicine, evaluation or counseling		X	X	X	X
59400 59510 59610 59618	Routine obstetric care, including delivery		X (*.60 to exclude deliveries)			
90460-90461 90471-90472 90473-90474	Immunizations administration		X			
G0402	Welcome to Medicare visit		X	X	X	X
G0438-G4039	Annual wellness visit		X	X	X	X
T1015	Clinic visit, all-inclusive		X			X

Estimating Primary Care Spending: What Is Considered Primary Care Services? ICD Codes

Primary ICD-10 Code	Description	Rhode Island	Oregon	Milbank Definition 4 PCP-C	CO Definition 1-3	PCP defined by HEDIS measure (NCQA)
Z00 Z000 Z0000 Z0001 Z001 Z0011 Z00110 Z00111	Encounter for general exam, all ages without complaint		X			X
Z0012 Z00121 Z00129	Encounter for routine child health exam		X			X
Z008	Encounter for other general examination		X			X
Z014 Z0141 Z01411 Z01419	Encounter for gynecological examination		X			X

Primary Care Spending Percent of Total Medical Spending

$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}} = \text{Percentage of medical spending allocated to primary care}$$

Alternative Payment Models in CO APCD

- Modeled after Oregon's Primary Care definition 2018.
- Rule change: October 2018, the Department of Health Care Policy and Financing required data collection on alternative payment models.
  - Alternative payment models (APMs) are defined as payments made to providers outside traditional fee-for-service model.
- First 2016 test files submission: July 1, 2019.
- Final files submission, 2016-2018: September 30, 2019.
- APM data files are meant to capture all payments and include four payment categories:
  - Total PC claims payments and total PC non-claims payments
  - Total claims payments and total non-claims payments

Primary Care Spending CO APMs Claims Payments

Payments to primary care providers and practices.

Primary Care Providers: Physicians specializing in primary care, including family medicine, general medicine, OB/GYN, pediatrics, general psychiatry, and geriatric medicine; naturopathic and homeopathic providers, physician assistants and nurse practitioners.

OR

Primary Care Practices: Primary care clinics, FQHCs, and Rural Health Centers

For Primary Care Services: Any of the services listed in the procedure and diagnoses codes table rendered by primary care providers. The sum of payments made for the services listed equal the sum of primary care payments.

Note: Costs associated with services provided in hospital and ambulatory surgical center settings do not count toward primary care spending.

Primary Care Spending CO APMs: Non-Claims Payments

Rhode Island	Oregon	Colorado
▪ Health Information Technology ▪ Patient Centered Medical Homes ▪ CurrentCare (State's HIE) ▪ Incentives to providers ▪ Loan forgiveness for training physicians ▪ Flu clinics ▪ Reward for provider reporting	▪ Capitation payments and provider salaries ▪ Risk-based payments ▪ Patient-centered primary care home or patient-centered medical home recognition ▪ Reward achievement of quality or cost-savings ▪ Developing capacity to improve care for a defined population of patients, such as patients with chronic conditions ▪ Help providers adopt health information technology ▪ Supplemental staff or activities, such as practice coaches, patients educators, patient navigators or nurse care managers	

Colorado APM vs. Oregon Primary Care Definitions

- Most differences between the two States' definitions are due to Oregon's recent updates
  - Oregon has already updated expired codes. Colorado will update codes as needed moving forward.
  - Oregon included new codes that are not part yet of the Colorado definition: alcohol and substance abuse structured screening, physician visits provided in rest homes (such as assisted living facilities), and annual wellness visits that include personalized prevention plans; smoking cessation counseling and annual depression screening.
- An error has been discovered with the Colorado's APM data submission guide, that does not exclude deliveries from obstetric codes. CIVHC will attempt to work with payers to correct this error.

Primary Care Spending Rates

	Rhode Island (2013)	Oregon (2015)	Milbank Definition 4 PCP-C (2017)	CO Definition 3 (2018)**
Year	2013	2015	2014	2010-2017
Populations	Commercial (3 major insurers)	Commercial, Medicare, Medicaid	9 Commercial payers (HMO, PPO)	Commercial Medicaid
Primary Care Spending (%)	10.6% for largest insurer (vs. 5.8% in 2008)	10.2% 8.9% 12.5%	HMO 4.7% PPO 4.5%	8.7% - 9.8% 5.9% - 8.6%
Includes Non-FFS	Yes	Yes	No*	No

* The Milbank report collected non-FFS payments but these percentages represent only FFS primary care spending.
** In the CO Multi-Payer report, definition 3 is a provider-based definition.

Takeaways

- Conceptual definitions include notions of patient centeredness that cannot be captured through claims data
  - Best captured through non-claims based measures, including APMs
- Most comprehensive definitions are based on a combination of provider specialties and selected services as well as claims and non-claims payments.
- CO APMs data collection will contribute to capture PC non-claims spending
  - It is essential that Colorado has a unique primary care definition that guides Primary Care Spending efforts and APM's data collection
- Colorado Alternative Payment Model definition closely resembles Oregon's Primary Care definition.
  - This seems to be one of the most inclusive definitions among reports reviewed.
  - Updated Oregon definition will account for more behavioral health services like depression and substance use screening.

Considerations for a Primary Care definition

- Providers specialties: Who are considered primary care providers?
- Services: What type of services are primary care services (procedure codes, ICD codes)?
- Health Care Setting: What settings should be included or excluded?
- Pharmacy spending: Should it be included?
- Other additional measures?

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APPENDIX D:

Report of Primary Care Spending Based on Carrier-Submitted Alternative Payment Model Data — DRAFT: Addendum

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Report of Primary Care Spending, based on Carrier-Submitted Alternative Payment Model Data – DRAFT: **ADDENDUM**

November 26, 2019

After the draft report of primary care spending was published on November 15, CIVHC received Alternative Payment Model submissions from three carriers whose data was not included in the report. Unfortunately, the data from these carriers are still not final and cannot be used to update the report. However, CIVHC was able to use these data to produce better estimates of their potential impact on the total percentage of primary care spending and on medical expenditures and percentage of primary care spending by alternative payment model.

The results indicate the total percentage of primary care spending would not be materially changed. Also, the percentage of total medical expenditures paid under APMs would not be materially changed. However, CIVHC anticipates that medical expenditures and the percent of primary care spending under pay-for-performance, shared savings and global budget arrangements will significantly increase.

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Report of Primary Care Spending, based on Carrier-Submitted Alternative Payment Model Data - DRAFT

This report of primary care spending as a percentage of total medical spending is provided in partial fulfillment of a request from the Colorado Division of Insurance for information to support the Primary Care Payment Reform Collaborative, which was established by Colorado House Bill 19-1233, to reduce health care costs by increasing utilization of primary care.

The report is based on carrier-submitted information about primary care and total medical expenditures from claims and non-claims payments under fee-for-service and alternative payment models (APM).

This report is a draft, because three carriers have not finalized their APM data submission. Despite these gaps, the reported calculation of primary care spending as a percentage of total medical spending may not be materially different after the missing data are added. Efforts to receive data from the three remaining carriers are ongoing. A final report will be issued by December.

Report Content

Primary care spending as a percentage of medical spending is presented for 2016, 2017 and 2018 by payment arrangement (Table 1). Primary care spending as a percentage of medical spending is also presented by carrier and payment model for 2018 (Table 2). The definitions of payment model categories are presented in Appendix 1.

In these reports, primary care spending and total medical spending exclude prescription drug expenditures and are calculated for Commercial, Medicaid and Medicare Advantage lines of business combined. Medicare Fee-for-Service is not included.

The approach to defining and collecting primary care and total medical expenditures paid as fee-for-service claims or as APM non-claims payments was modeled after the Oregon Health Authority's APM program.

Important Caveats

- The reported results are based on APM data submitted by carriers for the first time. A considerable effort was made to validate the data after it was submitted on September 30, but there are gaps and errors that must still be resolved. Submissions from Humana, United's Medicare and Retiree plan and Colorado Access have not been finalized; spending for fee-for-service is reported for one of these carriers (calculated from the CO APCD) but not for alternative payment models. All have APMs and two employ global budgets.

  The impact of these gaps on the percentage of primary care spending was tested utilizing informed estimates of the missing data. The results indicate the percentage of primary care spending would not be materially changed. Also, the percentage of total medical expenditures paid under APMs will not be materially changed. However, CIVHC anticipates medical expenditures under global budget arrangements will increase.

- Carriers were instructed to submit APM data for members covered by group policies sold/issued in Colorado (situs) and members residing in Colorado for policies sold on the individual market. These criteria

were established to help carriers collect APM data from their accounting systems, which track enrollment by situs. Unlike the Oregon experience, CIVHC discovered that, for several of the large national carriers, using the situs definition captures only about 50% of their Colorado resident members. The impact of the inclusion criteria on total medical expenditures and total primary care expenditures is unknown. Changing these criteria will require a Data Submission Guide rule change.

- Finally, APM data cannot be segmented by line of business (e.g., Commercial, Medicaid) because carriers were not required to submit the necessary data. As a consequence, spending is reported for Commercial, Medicaid and Medicare Advantage lines of business combined. Again, a Data Submission Guide rule change is needed to permit reporting by line of business.

Key Observations

Key observations are limited to highlights from the report of primary care spending for 2016-2018 by payment model. (Table 1). It is premature to make observations about primary care spending by insurance carrier, because of current gaps in the information for some carriers.

- In 2018, primary care spending as a percentage of total medical spending was 9.7%. This number was the same as in 2016, but slightly higher than the 9.5% in 2017.
- In 2018, 73% of medical spending was paid fee-for-service. Twenty-seven percent was paid under an APM. (Please see the list of alternative payment model categories and their definitions from our APM submission guide in Appendix 1)
- APMs built on a fee-for-service model (Pay-for-Performance, Shared Savings and Bundled Payments) account for a small percentage (1%) of total medical expenditures. By contrast, population-based APMs (Patient-Centered Medical Home (PCMH), Capitation, Limited and Global Budgets and Integrated Delivery Systems) account for 17% of medical expenditures.
- Fee-for-service payment arrangements account for 52% and population-based APMs 40% of total primary care spending. The population-based APM with the highest percent primary care spending is PCMH.
- The percentage of total medical expenditures paid as fee-for-service decreased 4% from 2016-2018, while the percentage for APMs for Other, Non-FFS and Integrated Delivery Systems both grew more than 10%.

Methodology

The calculation of primary care spending as a percentage of total medical spending can be represented by this equation.

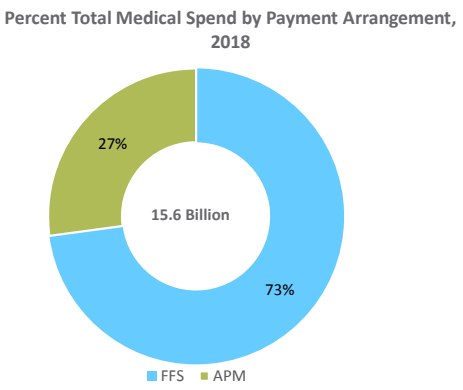
$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}}$$

Carriers submitted claims-based payments in total and for primary care. Claims-based payments for primary care were calculated based on the definition of primary care provided in Appendix 2.

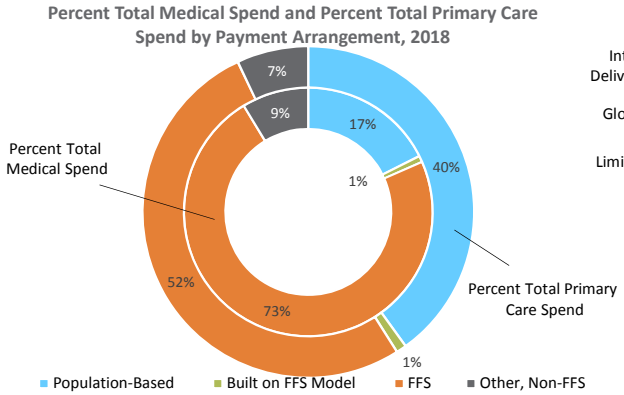
Carriers also submitted non-claims-based payments in total and for primary care and by APM. Non-claims-based payments for primary care were defined differently by carrier, but were mostly based on provider taxonomy and services delivered by providers with specialties listed in Appendix 2.

Table 1. Primary Care Spending as a Percentage of Total Medical Expenditures by Payment Arrangement, 2016-2018

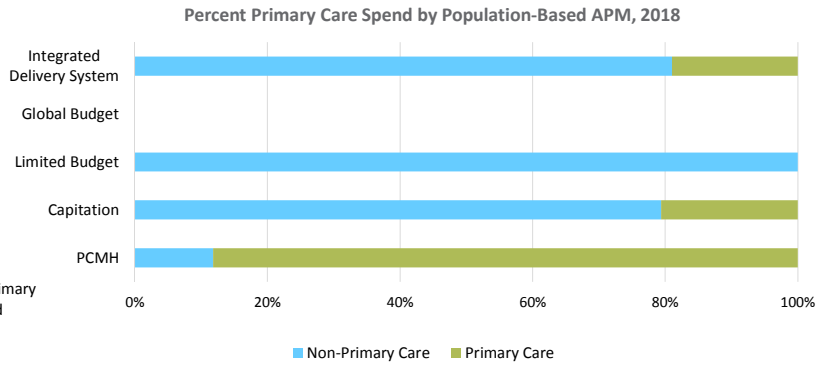
			Fee-for-Service and Alternative Payment Arrangements									
Year	Measure	Total	FFS	P4P	Shared Savings	Bundled Payment	Other, Non-FFS	PCMH	Capitation	Limited Budget	Global Budget	Integrated Delivery System
2018	Total Medical Spend	$ 15,583,077,966	$ 11,360,691,221	$ 67,666,259	$ 59,257,985	$ 53,442	$ 1,355,495,794	$ 156,497,322	$ 160,779,278	$ 147,621,555	$ -	$ 2,275,015,111
	Primary Care Spend	$ 1,512,969,879	$ 786,741,261	$ 15,117,778	$ 189,454	$ 2,139	$ 105,677,382	$ 138,072,249	$ 34,334,784	$ -	$ -	$ 432,834,831
	Pct. Primary Care Spend	9.7%	6.9%	22.3%	0.3%	4.0%	7.8%	88.2%	21.4%	0.0%		19.0%
2017	Total Medical Spend	$ 13,817,042,436	$ 10,431,480,667	$ 44,968,654	$ 58,381,478	$ 36,362	$ 1,201,814,386	$ 119,862,507	$ 100,817,051	$ 189,830,941	$ -	$ 1,669,850,389
	Primary Care Spend	$ 1,307,586,875	$ 662,374,113	$ 13,533,547	$ 778,788	$ 3,017	$ 94,905,827	$ 103,557,806	$ 36,357,752	$ -	$ -	$ 396,076,026
	Pct. Primary Care Spend	9.5%	6.3%	30.1%	1.3%	8.3%	7.9%	86.4%	36.1%	0.0%		23.7%
2016	Total Medical Spend	$ 13,027,253,917	$ 9,897,429,541	$ 38,301,713	$ 49,262,299	$ 747,074	$ 1,024,895,203	$ 96,926,277	$ 87,281,152	$ 206,336,145	$ -	$ 1,626,074,512
	Primary Care Spend	$ 1,259,044,415	$ 658,587,774	$ 12,631,283	$ 508,054	$ 13,257	$ 90,081,770	$ 96,926,263	$ 26,949,701	$ -	$ -	$ 373,346,313
	Pct. Primary Care Spend	9.7%	6.7%	33.0%	1.0%	1.8%	8.8%	100.0%	30.9%	0.0%		23.0%



Payments under fee-for-service arrangements accounts for 73% of total medical expenditures



Payments under population-based APMs account for 17% of the total medical expenditures but 40% of total primary care spending



Primary Care Medical Home is the population-based APM with the highest percentage of primary care spending

Reported results are based on APM data submitted by carriers for the first time. A considerable effort was made to validate the data after it was submitted on September 30, but there are gaps and errors that must still be resolved. Submissions from Humana, United's Medicare and Retiree plan and Colorado Access have not been finalized; spending for fee-for-service is reported for one of these carriers (calculated from the CO APCD) but not for alternative payment models. All have APMs and two employ global budgets.

Table 2. Primary Care Spending as a Percentage of Total Medical Expenditures by Carrier and Payment Arrangement, 2018

			Fee-for-Service and Alternative Payment Arrangements									
Carrier	Measure	Total	FFS	P4P	Shared Savings	Bundled Payment	Other, Non-FFS	PCMH	Capitation	Limited Budget	Global Budget	Integrated Delivery System
Aetna	Total Medical Spend	$ 154,186,324	$ 107,900,801	$ 26,717,850				$ 19,567,673				
	Primary Care Spend	$ 10,346,099	$ 5,792,866	$ 3,410,633				$ 1,142,600				
	Pct. Primary Care Spend	6.7%	5.4%	12.8%				5.8%				
Cigna	Total Medical Spend	$ 751,181,432	$ 702,999,218	$ 11,786,456	$ 48,398	$ 6,914	$ 4,542,939		$ 6,295,132	$ 25,502,376		
	Primary Care Spend	$ 11,158,495	$ 11,158,495	$ -	$ -	$ -	$ -		$ -	$ -		
	Pct. Primary Care Spend	1.5%	1.6%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%		
HCPF	Total Medical Spend	$ 5,015,731,572	$ 3,539,430,730	$ 11,305,362			$ 1,328,065,832	$ 136,929,649				
	Primary Care Spend	$ 606,347,123	$ 358,054,179	$ 11,305,362			$ 100,057,933	$ 136,929,649				
	Pct. Primary Care Spend	12.1%	10.1%	100.0%			7.5%	100.0%				
Kaiser	Total Medical Spend	$ 4,082,689,642	$ 1,729,381,323	$ 467,936	$ 57,725,433	$ 46,528			$ 20,053,310			$ 2,275,015,111
	Primary Care Spend	$ 459,006,524	$ 25,867,812	$ 232,129	$ 69,612	$ 2,139			$ -			$ 432,834,831
	Pct. Primary Care Spend	11.2%	1.5%	49.6%	0.1%	4.6%			0.0%			19.0%
RMHP	Total Medical Spend	$ 320,234,939	$ 275,020,141				$ 8,335,927		$ 36,878,872			
	Primary Care Spend	$ 33,310,286	$ 21,026,447				$ 5,619,449		$ 6,664,391			
	Pct. Primary Care Spend	10.4%	7.6%				67.4%		18.1%			
United Employer	Total Medical Spend	$ 1,494,190,031	$ 1,491,092,409	$ 170,485	$ 136,891				$ 2,790,247			
	Primary Care Spend	$ 201,826,158	$ 200,990,827	$ 169,654	$ 119,842				$ 1,972,795			
	Pct. Primary Care Spend	13.5%	13.5%	99.5%	87.5%				70.7%			
Anthem	Total Medical Spend	$ 2,064,346,761	$ 2,035,464,684	$ 6,182,566	$ 1,347,263		$ 8,816,430		$ 12,535,817			
	Primary Care Spend	$ 104,593,368	$ 92,679,376	$ -	$ -		$ -		$ 11,913,993			
	Pct. Primary Care Spend	5.1%	4.6%	0.0%	0.0%		0.0%		95.0%			
USHG	Total Medical Spend	$ 13,256,614	$ 13,256,614									
	Primary Care Spend	$ 49,700	$ 49,700									
	Pct. Primary Care Spend	0.4%	0.4%									
Denver Health	Total Medical Spend	$ 278,094,282	$ 195,868,381						$ 82,225,900			
	Primary Care Spend	$ 25,562,103	$ 11,778,497						$ 13,783,606			
	Pct. Primary Care Spend	9.2%	6.0%						16.8%			
Beacon	Total Medical Spend	$ 167,489,644	$ 28,600,194	$ 11,035,605			$ 5,734,666			$ 122,119,179		
	Primary Care Spend	$ -	$ -	$ -			$ -			$ -		
	Pct. Primary Care Spend	0.0%	0.0%	0.0%			0.0%			0.0%		
CIGNA HealthCare of Colorado (CHC CO)	Total Medical Spend	$ 2,418,252	$ 2,418,252									
	Primary Care Spend	$ 142,359	$ 142,359									
	Pct. Primary Care Spend	5.89%	5.89%									
Humana - Humana Insurance Company *	Total Medical Spend	Missing	Missing		Missing		Missing	Missing	Missing			
	Primary Care Spend											
	Pct. Primary Care Spend											
Humana - Humana Health Plans *	Total Medical Spend	Missing	Missing		Missing		Missing	Missing	Missing			
	Primary Care Spend											
	Pct. Primary Care Spend											

			Fee-for-Service and Alternative Payment Arrangements									
Carrier	Measure	Total	FFS	P4P	Shared Savings	Bundled Payment	Other, Non-FFS	PCMH	Capitation	Limited Budget	Global Budget	Integrated Delivery System
Humana Medicare	Total Medical Spend	$ 13,349	$ 13,349									
	Primary Care Spend	$ 955	$ 955									
	Pct. Primary Care Spend	7.16%	7.16%									
UnitedHealthcare Individual	Total Medical Spend	$ 18,998,698	$ 18,998,698									
	Primary Care Spend	$ 901,743	$ 901,743									
	Pct. Primary Care Spend	4.75%	4.75%									
UnitedHealthcare Medicare and Retiree *	Total Medical Spend	Missing	Missing	Missing	Missing		Missing	Missing			Missing	
	Primary Care Spend											
	Pct. Primary Care Spend											
UnitedHealthcare Student Resources Group	Total Medical Spend	$ 13,419,613	$ 13,419,613									
	Primary Care Spend	$ 665,957	$ 665,957									
	Pct. Primary Care Spend	4.96%	4.96%									
UnitedHealthcare Medicare Supplemental	Total Medical Spend	$ 161,018,667	$ 161,018,667									
	Primary Care Spend	$ -	$ -									
	Pct. Primary Care Spend	0.00%	0.00%									
UnitedHealthcare Physical Health	Total Medical Spend	$ 9,311,430	$ 9,311,430									
	Primary Care Spend	$ -	$ -									
	Pct. Primary Care Spend	0.00%	0.00%									
UMR	Total Medical Spend	$ 318,262,685	$ 318,262,685									
	Primary Care Spend	$ 16,499,006	$ 16,499,006									
	Pct. Primary Care Spend	5.18%	5.18%									
Colorado Community Health Alliance	Total Medical Spend	$ 38,768,420	$ 38,768,420									
	Primary Care Spend	$ 1,864,690	$ 1,864,690									
	Pct. Primary Care Spend	4.81%	4.81%									
American Family Mutual Insurance Company	Total Medical Spend	$ 251,959,845	$ 251,959,845									
	Primary Care Spend	$ 3,385,815	$ 3,385,815									
	Pct. Primary Care Spend	1.34%	1.34%									
State Farm	Total Medical Spend	$ 13,735,523	$ 13,735,523									
	Primary Care Spend	$ 644,369	$ 644,369									
	Pct. Primary Care Spend	4.69%	4.69%									
Colorado Access *	Total Medical Spend	$ 210,288,840	$ 210,288,840		Missing				Missing		Missing	
	Primary Care Spend	$ 25,532,308	$ 25,532,308									
	Pct. Primary Care Spend	12.14%	12.14%									
BHI	Total Medical Spend	$ 29,576,452	$ 29,576,452									
	Primary Care Spend	$ 2,063,957	$ 2,063,957									
	Pct. Primary Care Spend	6.98%	6.98%									
Physicians Mutual	Total Medical Spend	$ 5,132,510	$ 5,132,510									
	Primary Care Spend	$ 249,745	$ 249,745									
	Pct. Primary Care Spend	4.87%	4.87%									

			Fee-for-Service and Alternative Payment Arrangements									
Carrier	Measure	Total	FFS	P4P	Shared Savings	Bundled Payment	Other, Non-FFS	PCMH	Capitation	Limited Budget	Global Budget	Integrated Delivery System
USAA Enterprise	Total Medical Spend	$ 9,759,542	$ 9,759,542									
	Primary Care Spend	$ 312,286	$ 312,286									
	Pct. Primary Care Spend	3.20%	3.20%									
Colorado Choice	Total Medical Spend	$ 19,526,967	$ 19,526,967									
	Primary Care Spend	$ 992,873	$ 992,873									
	Pct. Primary Care Spend	5.08%	5.08%									
Friday Health Plans	Total Medical Spend	$ 34,104,949	$ 34,104,949									
	Primary Care Spend	$ 1,239,471	$ 1,239,471									
	Pct. Primary Care Spend	3.63%	3.63%									
Ameriben	Total Medical Spend	$ 11,029,973	$ 11,029,973									
	Primary Care Spend	$ 1,128,075	$ 1,128,075									
	Pct. Primary Care Spend	10.23%	10.23%									
HealthSCOPE Benefits	Total Medical Spend	$ 11,897,560	$ 11,897,560									
	Primary Care Spend	$ 577,363	$ 577,363									
	Pct. Primary Care Spend	4.85%	4.85%									
UCHealth Plan	Total Medical Spend	$ 8,295,014	$ 8,295,014									
	Primary Care Spend	$ 696,893	$ 696,893									
	Pct. Primary Care Spend	8.40%	8.40%									
HealthSmart	Total Medical Spend	$ 20,947,466	$ 20,947,466									
	Primary Care Spend	$ 570,466	$ 570,466									
	Pct. Primary Care Spend	2.72%	2.72%									
Allegiance Benefit Plan Management	Total Medical Spend	$ 48,086,395	$ 48,086,395									
	Primary Care Spend	$ 1,710,113	$ 1,710,113									
	Pct. Primary Care Spend	3.56%	3.56%									
Navitus Health Solutions	Total Medical Spend	$ 4,988,057	$ 4,988,057									
	Primary Care Spend	$ 164,619	$ 164,619									
	Pct. Primary Care Spend	3.30%	3.30%									
Aflac	Total Medical Spend	$ 136,517	$ 136,517									
	Primary Care Spend	$ -	$ -									
	Pct. Primary Care Spend	0.00%	0.00%									

* Submissions not finalized

Appendix 1. Payment Arrangement Categories

Code	Value	Definition/Example
FS	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.
PP	Pay for Performance /Payment Penalty	Annual payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.
SH	Shared Savings /Shared Risk	Annual payments or penalties made to the billing provider for performance against spending targets during reporting year.
BU	Bundled/Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types
OT	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.
PC	Patient-Centered Primary Care Home / Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of Patient-Centered Medical Home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.
CU	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.
LB	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)
GB	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: • Comprehensive set of services for a broadly defined population • Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.
ID	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision-making rights are shared across entities, and reimbursement is not dependent on services provided.

APMs built on a FFS model: Pay-for-Performance, Shared Savings and Bundled Payments

Population-based APMs: Primary Care Medical Home, Capitation, Limited Budget, Global Budget and Integrated Delivery System

Appendix 2. Claim-Based Primary Care Definition

Primary care payments are defined as payments made to a primary care provider for a primary care service, according to these definitions:

1. **Primary Care Provider**: Any providers that practice within one of the state's designated Patient Centered Primary Care Home (PCPCH) practices* or any providers that have one of the taxonomy codes below, and
2. **Primary Care Service:** Services listed in the table of procedure codes shown below. (Note that for the four procedure codes describing global services for obstetric care, payments should be multiplied by 60% to exclude a portion of the payment that is estimated for deliveries)

Primary Care Provider Taxonomy

Taxonomy code	Description
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

* The PCPCH component of the definition is only applicable to non-claims based payments; it was not used to produce this report.

Primary Care Services

CPT Codes	Description
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99385	Preventive medicine initial evaluation
99391-99395	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counsel and/or risk reduction intervention
99411-99412	Group prev. medicine counsel and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
59400	Routine obstetric care incl. vaginal delivery * 60% of payment
59510	Routine obstetric care incl. cesarean delivery * 60% of payment
59610	Routine obstetric care incl. VBAC delivery * 60% of payment
59618	Routine obs. care incl. attempted VBAC * 60% of payment
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
99386-99387	Initial preventive medicine evaluation
99396-99397	Periodic preventive medicine reevaluation
G0402	Welcome to Medicare visit
G0438-G4039	Annual wellness visit
T1015	Clinic visit, all-inclusive
ICD-10 Code	**Description**
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routing child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routing gynecological examination
Z01411	Encounter for gynecological exam, general, routing with abnormal findings
Z01419	Encounter for gynecologic exam, general, routing without abnormal findings

APPENDIX E:

Considered Definitions of Primary Care

Definitions of Primary Care

Conceptual Definitions

Definition	Source
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated encompasses "the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care."	**Institute of Medicine (IOM)** Primary Care: America's Health in a New Era, 1996, p. 1, 5) (http://books.nap.edu/openbook.php?record_id=5152&page=5 This definition (first sentence) also used in the **Affordable Care Act**.
Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis." Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care. The AAFP recognizes the term "primary care" and that family physicians provide services commonly recognized as primary care. However, the terms, "primary care" and "family medicine" are not interchangeable. "Primary care" does not fully describe the activities of family physicians nor the practice of family medicine. Similarly, primary care departments do not replace the form or function of family medicine departments.	**American Academy of Family Physicians (AAFP)**

Primary care services are basic or entry-level health care services, rather than specialized health care services, provided by physicians or non-physician health care practitioners, and are generally provided in an outpatient setting. (1) "Comprehensive primary care" means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. "Comprehensive primary care", at a minimum, includes providing or arranging for the provision of the following services on a year-round basis: Primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. "Comprehensive primary care" may also include optional services based on a patient's needs. For the purposes of this subsection (1) and subsection (2) of this section, "arranging for the provision" means demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity. An entity in a rural area may be exempt from this requirement if it can demonstrate that there are no providers in the community to provide one or more of the comprehensive primary care services.	**Colorado HCPF CO Medicaid/ Colorado HCPF statute 25.5-3-301**
"Primary Care Practice" means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. [Component of larger definition]	**Rhode Island** OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 2
(1) Primary care, especially care that incorporates mental health and substance use disorder services, is critical for sustaining a productive community. (2) Primary care provides a setting in which patients can present a wide range of health problems for appropriate attention and, in most cases, can expect that their problems will be resolved without referral. (3) Primary care providers and practices assist patients in navigating the health care system, including by providing referrals to other health care providers for appropriate services. (4) Primary care providers and practices facilitate an ongoing relationship between patients and clinicians and foster participation by patients in shared decision-making about their health and their care. (5) Primary care provides opportunities for disease prevention, health promotion, and early detection of health conditions. (6) Primary care helps build bridges between personal health care services and patients' families and communities that can assist in meeting patients' health care needs.	**Vermont proposed legislation SB-53 and HB-89** (both have same language for primary care)

Broad-Based Definitions (Provider- AND Service-Based or more inclusive)

Definitions	Source
‘‘(2) DEFINITIONS.—In this subsection: ‘‘(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual— ‘‘(i) who—‘‘(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or ‘‘(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and ‘‘(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary. ‘‘(B) PRIMARY CARE SERVICES.—The term ‘primary care services’ means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary): ‘‘(i) 99201 through 99215. ‘‘(ii) 99304 through 99340. ‘‘(iii) 99341 through 99350. ‘‘(2) PRIMARY CARE RESIDENCY PROGRAM.—The term ‘primary care residency program’ means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.	**Affordable Care Act** TITLE V—HEALTH CARE WORKFORCE Subtitle F—Strengthening Primary Care and Other Workforce Improvements SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES
Primary Care Provider*: **Narrow:** family practice, internal medicine, pediatric medicine, and general practice **Broad:** Narrow def. + nurse practitioners, physician assistants, geriatric medicine, and gynecology. *Both definitions excluded hospitalists **Primary Care Services**:** **Narrow:** Healthcare Common Procedure Coding System codes on professional claims, including evaluation and management visits, preventive visits, care transition or coordination services, and in-office preventive services, screening, and counseling **Broad:** all professional services billed by PCPs. **Excluded facility fees for outpatient primary care services billed in the Carrier File and did not include services ordered but not performed directly by PCPs (eg, tests and medications)	**(Journal of the) American Medical Association (JAMA)** *Primary Care Spending in the Fee for Service Medicare Population* (April 15, 2019) Rachel Reid, MD, MS Cheryl Damberg, PhD Mark W. Friedberg, MD, MPP

Claim Header Definition – Primary care services are identified based on the HCPCS codes listed in Appendix C for all Outpatient and Professional medical claims. Under this definition of primary care, the total dollars for all services billed on a claim that includes a HCPCS code for primary care services are included in the estimate of primary care spending. This Claim Header definition captures more services and dollars than the narrower Claim Line definition of primary care. This is a broad version of Definition 3 (service-based, claims version) used in the Milbank report.	**CIVHC** **Colorado Multi-Payer Share of Primary Care Spend Report** [also included in services-based below]
To be eligible for Section 1202 rates, a physician must **satisfy both of the following requirements: A physician must self-attest that he or she practices in family medicine, general internal medicine, or pediatric medicine or a related subspecialty** recognized by the American Board of Medical Specialties he or she is board certified in a qualified specialty or subspecialty; OR for the most recently completed calendar year, **at least 60% of the Medicaid codes for which the physician had been paid were for the services eligible for the Section 1202 rates.** A newly eligible physician, defined as a physician who does not yet have a full calendar year of paid Medicaid claims, must self-attest based on the Medicaid codes for which he or she was paid during the prior month. Services provided by non-physician practitioners, such as physician assistants, nurse practitioners, and nurse midwives, are eligible for payment of 85% of the Section 1202 rates, as follows. Such services must be provided under the personal supervision of an eligible primary care physician, and otherwise be properly billed under the supervising physician's national provider identifier (NPI). Due to recent CMS guidance, physicians with an Allergy & Immunology specialty board certification from the American Board of Allergy & Immunology and who also practice in an eligible specialty/subspecialty are eligible for the Section 1202 rates. Such physicians should complete the attached Physician and Certification Self-Attestation Form and submit it to MassHealth.	**Massachusetts: MassHealth All Provider Bulletin 235** (August 2013 http://www.mass.gov/eohhs/docs/masshealth/bull-2013/all-235.pdf) **Note: Some practitioners (ex: General Surgeons, Allergists, OB/GYNs...) may practice in a way such that over 60% of their claims are for codes specified above. In many states these providers are considered PCPs.
• Definition 4 (provider- and service-based): All office visits and preventive services delivered by primary care providers (defined by specialty). This is a subset of definition 1, which includes all services delivered by specialty-defined primary care providers (not limited to office visits and preventive services). • Definition 5 (system-based): Health systems that support fulfillment of the cardinal functions of primary care. This option is most attractive for fully capitated systems, where service-based definitions cannot be operationalized, but measuring fulfillment of cardinal functions was outside the feasible scope of work for this study. [PCP-A: family medicine, general internal medicine, general pediatrics, general practice and designated by health insurer as a PCP; PCP-B: family medicine, general internal medicine, general pediatrics, general practice, NP, or PA; PCP-C: family medicine, general internal medicine, general pediatrics, NP, PA, geriatrics, adolescent medicine, and designated by health insurer as a PCP; PCP-D: designated by health insurer as a PCP (no specialty requirement)]	**Milbank Memorial Fund: Standardizing the Measurement of Primary Care Spending** https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf

Given the factors considered, the following investments by health insurers fit within the definition of primary care for the purposes of the Affordability Standards: 1. Money spent by insurers in payments to primary care physicians and primary care practices. Priorities are: fee¬for-service payments, pay¬for¬performance incentives for documented improvements in population goals set by the affordability standards, payments for structural changes at the practice (e.g. electronic records, data reporting capacity from those electronic records), and payments for supplemental staff or supplemental activities not traditionally considered within the scope of primary care (e.g .patient educators, patient navigators and payments to other providers by the primary care physician). 2. Money spent by insurers for services provided by a third party integrated into the primary care setting - to either patients or the practice itself. Priorities are practice training, nurse care managers, behavioral health and pharmacy co-location. 3. Money spent by insurers in support of multi-payor collaboration for primary care, including the All Payor Patient Centered Medical Home Project and its administration A. Afterhours telephone calls B. Email communication C. Provision of sick and well child care at the same office visit D. Developmental screening E. Vision screening F. Hearing G. Postpartum Depression screening H. Evening, weekend and holiday office hours I. Office used in an emergency J. Vaccine administration K. Care coordination 5. Money spent by insurers to build primary care workforce capacity, including support for loan forgiveness programs targeting new Rhode Island primary care physicians, nurse practitioners, physician's assistants and clinical social workers; and money spent for training and mentoring of those clinicians by primary care physicians. **"Primary Care Practice"** means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Internal Medicine and Pediatrics; and providers with the following professional credentials: o Doctors of Medicine and Osteopathy o Nurse Practitioners o Physicians' Assistants o Except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on	**Rhode Island** Guidance on Primary Spend for Health Insurers Office of the Health Insurance Commissioner (March 2011) **Rhode Island** OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 2

a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider **"Direct Primary Care Expenses"** means payments by the Health Insurer directly to a primary care practice for: (1) providing health care services, including fee-for service payments, capitation payments, and payments under other alternative, non-fee-for-service methodologies designed to provide incentives for the efficient use of health services; (2) achieving quality or cost performance goals, including pay-for-performance payments and shared savings distributions; (3) infrastructure development payments within the primary care practice, which the practice cannot reasonably fund independently, in accordance with parameters and criteria issued by order of the Commissioner, or upon request by a Health Insurer and approval by the Commissioner **"Indirect Primary Care Expenses"** means payments by the Health Insurer to support and strengthen the capacity of a primary care practice to function as a medical home, and to successfully manage risk-bearing contracts, but which do not qualify as Direct Primary Care Expenses. Indirect Primary Care Expenses may include a proper allocation, proportionate to the benefit accruing to the Primary Care Practice, of Health Insurer investments in data, analytics, and population-health and disease registries for Primary Care Practices without the foreseeable ability to make and manage such infrastructure investments, but which do not qualify as acceptable Direct Primary Care Spending, in accordance with parameters and criteria issued in a bulletin issued by the Commissioner, or upon request by a Health Insurer and approved by the Commissioner. Such payments shall include financial support, in an amount approved by the Commissioner, for the administrative expenses of the medical home initiative endorsed by RIGL Chapter 42-14.6, and for the health information exchange established by RIGL Chapter 5-37.7. By May 1, 2016 the Commissioner shall reassess this obligation by Health Insurers to provide financial support for the health information exchange.	
"Primary care practitioners are defined as: 1. A physician who has a primary specialty designation o**f family medicine, internal medicine, geriatric medicine, or pediatric medicine** for whom **primary care services accounted for at least 60 percent of the allowed charges** under Part B for the practitioner in a prior period as determined appropriate by the Secretary; or 2. A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined appropriate by the Secretary."	**United States Medicaid** (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf)

Provider-Based Definitions or Definition Components

Definition	Source
Primary Care Provider:	**Accountable Care Collaborative (ACC)**

• An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology, OR • A Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or a clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.	
[part of broader definition] ‘‘(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual— ‘‘(i) who—‘‘(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or ‘‘(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and ‘‘(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.	**Affordable Care Act** TITLE V—HEALTH CARE WORKFORCE Subtitle F—Strengthening Primary Care and Other Workforce Improvements SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES
[part of broader definition] **<u>Primary Care Provider*:</u>** **Narrow:** family practice, internal medicine, pediatric medicine, and general practice **Broad:** Narrow def. + nurse practitioners, physician assistants, geriatric medicine, and gynecology. *Both definitions excluded hospitalists	**(Journal of the) American Medical Association (JAMA)** *Primary Care Spending in the Fee for Service Medicare Population* (April 15, 2019) Rachel Reid, MD, MS Cheryl Damberg, PhD Mark W. Friedberg, MD, MPP
Primary Care Physician means a medical doctor who attests to the Department that he or she has a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association.	**Colorado HCPF (8.200.6.B) CO Medicaid Implementation of PCP Rate Increase (2013-14)**

Provider Taxonomy Definition – Under this definition, primary care providers are identified based on taxonomy codes listed in Appendix D. This list of primary care provider taxonomy codes is the same as that developed to support the Colorado State Innovation Model (SIM) initiative with only a few minor exceptions. Total dollars for all services billed on Outpatient and Professional claims associated with providers identified by these codes were summed to generate an estimate of the total amount spent on primary care. This definition is similar to Definition 1 (provider-based) identified in the Milbank report.	**CIVHC** **Colorado Multi-Payer Share of Primary Care Spend Report**
"PRIMARY CARE SERVICES" MEANS HEALTH SERVICES REGARDING FAMILY MEDICINE, GENERAL PRACTICE, GENERAL INTERNAL MEDICINE, PEDIATRICS, GENERAL OBSTETRICS AND GYNECOLOGY, ORAL HEALTH, OR MENTAL HEALTH THAT ARE PROVIDED BY HEALTH CARE PROFESSIONALS.	**Colorado Reinsurance bill HB19-1168** (i.e. the services that would be omitted from reduced rates)
"Primary Care" means services delivered by a person licensed under Title 24 and providing services in (1) family medicine, primary care pediatrics, primary care internal medicine, and (2) primary, preventive, or screening services provided in obstetrics and gynecology and psychiatry	**Delaware** SB199 (ACTIVE)
"Primary care" means health care provided by a physician or an individual licensed under Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.	**Delaware** Title 24 State Gov. Public Officers and Employees Chapter 52 Health Insurance
• Definition 1 (provider-based): All medical services delivered by primary care providers (including non-evaluation and management [E&M] services, such as office-based procedures). In this definition, primary care providers are identified by specialty, the setting in which the provider typically delivers care, and health insurer designation. m Specialty: Most agree that family medicine, general internal medicine, general pediatrics, and general practice are primary care specialties. Some may argue that geriatrics, adolescent medicine, and gynecology also can be primary care specialties. It is worth noting that nurse practitioners (NPs) and other allied health professionals lacked specialty information for all but one plan; no plan was able to input missing specialty information. However, we also note that in many practices, these professionals are likely to bill under a physician's name. m Setting: A large share of the provider's billings must be for services delivered in ambulatory settings. m Plan designation: A provider must be designated as a primary care provider (PCP) by health insurers. Most health insurers have such designations, especially in their HMO products, where a referral from an insurer-designated PCP is necessary for many services.	**Milbank Memorial Fund: Standardizing the Measurement of Primary Care Spending** https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf
"Primary care", family medicine, internal medicine, pediatrics, ***obstetrics, or gynecology***;	**Missouri HB-879** (proposed)

"Primary care provider", a licensed or certified physician or other health 8 professional who practices in family medicine, internal medicine, pediatrics, ***obstetrics, or gynecology***, and whose clinical practice is in the area of primary care;	
"Primary care" = family medicine, internal medicine, or pediatrics; "Primary care provider", a licensed or certified physician or other health professional who practices in family medicine, internal medicine, or pediatrics, and whose clinical practice is in the area of primary care	**Missouri SB-417** (proposed)
"Primary care" means family medicine, general internal medicine, naturopathic medicine, pediatrics and care provided by primary care integrated behavioral health clinicians and primary care integrated women's health clinicians. **"Primary care integrated behavioral health clinician" means:** A) A psychiatrist; (B) A psychologist licensed under ORS 675.010 to 675.150 (C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psychiatric mental health; (D) A clinical social worker licensed under ORS 675.530 (E) A marriage and family therapist or professional counselor licensed under ORS 675.715; (F) A clinical social work associate certified under ORS 675.537 (G) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or (H) Other care team members, as defined in ORS 414.025 (15)(b), providing care to individuals and families in a patient centered primary care home (PCPCH) to address one or more of the following: (i) Mental illness (ii) Substance use disorders (iii) Health behaviors that contribute to chronic illness Life stressors and crises (v) Developmental risks and conditions (vi) Stress-related physical symptoms (vii) Preventive care (viii) Ineffective patterns of health care utilization. **"Primary care integrated women's health clinician"** means one of the following clinicians whose practice is focused on women's health and primary care and who is providing a range of the services within a patient centered primary care home: (A) A physician who is an obstetrician or gynecologist; (B) A nurse practitioner; (C) A physician assistant; or (D) Another health professional licensed or certified in this state.	**Oregon SB-765** (proposed)

Physicians specializing in primary care including: • Family medicine, General medicine, Obstetrics and gynecology, Pediatrics, General psychiatry, and Geriatric medicine • Naturopathic providers Physicians' assistants • Nurse practitioners • Primary care clinics Federally qualified health centers (FQHCs) Rural health centers	**Oregon Spending Report 2019** https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf
"Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry. "Primary care provider" includes: (A) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care. (B) A health care team or clinic that has been certified by the Oregon Health Authority as a patient centered primary care home (PCPH).	**Oregon: SB 231** (2015) https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB231/Enrolled
[part of broader definition] **"Primary Care Practice"** means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Internal Medicine and Pediatrics; and providers with the following professional credentials: o Doctors of Medicine and Osteopathy o Nurse Practitioners o Physicians' Assistants o Except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider	**Rhode Island** OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 2
Primary Care Specialties: Family Medicine, Family Practice, General Practice, Obstetrics/Gynecology, General Internal Medicine, General Pediatrics, Medicine-Pediatrics, **Psychiatry**, Geriatrics	**Texas Department of State Health Services (DSHS)**

Service-Based Definitions or Definition Components

Definition	Source
[part of broader definition] **Primary Care Services**:** **Narrow:** Healthcare Common Procedure Coding System codes on professional claims, including evaluation and management visits, preventive visits, care transition or coordination services, and in-office preventive services, screening, and counseling **Broad:** all professional services billed by PCPs. **Excluded facility fees for outpatient primary care services billed in the Carrier File and did not include services ordered but not performed directly by PCPs (eg, tests and medications)	**(Journal of the) American Medical Association (JAMA)** *Primary Care Spending in the Fee for Service Medicare Population* (April 15, 2019) Rachel Reid, MD, MS Cheryl Damberg, PhD Mark W. Friedberg, MD, MPP
Primary care services are defined as HCPCS Codes: 1. 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits; 2. 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home or custodial care E/M services; and domiciliary, rest home or home care plan oversight services; and 3. 99341 through 99350 for new and established patient home E/M visits.	**Colorado Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)**
Claim Line Definition – Primary care services were identified in the CO APCD based on specific Healthcare Common Procedural Coding System (HCPCS) codes for primary care services. This definition was applied to Outpatient and Professional medical claims – no pharmacy claims are reflected in this analysis. In addition, primary care services delivered in a hospital care setting were not included in this analysis. Total dollars for each claim line that includes a HCPCS primary care service code are summed by payer type (commercial insurance, Medicaid, Medicare) to generate estimates of total primary care spending at the claim line level. This is a narrow version of Definition 3 (service-based, claims version) from the Milbank report. **Claim Header Definition** – Primary care services are identified based on the HCPCS codes listed in Appendix C for all Outpatient and Professional medical claims. Under this definition of primary care, the total dollars for all services billed on a claim that	**CIVHC** **Colorado Multi-Payer Share of Primary Care Spend Report**

includes a HCPCS code for primary care services are included in the estimate of primary care spending. This Claim Header definition captures more services and dollars than the narrower Claim Line definition of primary care. This is a broad version of Definition 3 (service-based, claims version) used in the Milbank report. [codes used: 9920X, 9921X, 9924X, 99339 – 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99420 - 99429, 99495, 99496, G0402, G0438, G0439]	
• Definition 2 (service-based, Starfield version12): Services that support the fulfillment of four cardinal functions of primary care (comprehensive care, first-contact care for a wide variety of conditions, coordinated care, longitudinal care). There are no widely accepted claims-based measures corresponding to these cardinal functions. The closest approximations to one of these dimensions (longitudinal care) might be continuity of care indices. There are many such indices (e.g., Bice-Boxerman13), each with its relative strengths and weaknesses. In addition, researchers at the Robert Graham Center have recently developed a claims-based definition of comprehensiveness, which has shown modest correlation with physician self-reported measures of comprehensiveness.14 • Definition 3 (service-based, claims version): All office visits and preventive services (e.g., immunizations), regardless of provider. The Medicare Payment Advisory Commission has used this definition implicitly in some older reports to Congress.15 [codes used: 9920X, 9921X, 9924X, 99339 – 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99420 - 99429, 99495, 99496, G0402, G0438, G0439]	**Milbank Memorial Fund: Standardizing the Measurement of Primary Care Spending** https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf

APPENDIX F:

Primary Care Definition Codes

Taxonomy Codes to Define Primary Care Service Providers

Primary Care Definitions Codes

Provider_Taxonomy_Cd	Provider_Taxonomy1	Provider_Taxonomy2	Provider_Taxonomy3	CO Multi-Payer Report	Oregon/CO APM
163W00000X	Nursing Service Providers	Nurse	Non Practitioner	N	X
175F00000X	Other Service Providers	Naturopathic Medicine		N	X
175L00000X	Other Service Providers	Homeopathic Medicine		N	X
207Q00000X	Allopathic & Osteopathic Physicians	Family Medicine	[NULL]	X	X
207QA0000X	Allopathic & Osteopathic Physicians	Family Medicine	Adolescent Medicine	X	N
207QA0505X	Allopathic & Osteopathic Physicians	Family Medicine	Adult Medicine	X	N
207QB0002X	Allopathic & Osteopathic Physicians	Family Medicine	Obesity Medicine	X	N
207QG0300X	Allopathic & Osteopathic Physicians	Family Medicine	Geriatric Medicine	X	N
207QS0010X	Allopathic & Osteopathic Physicians	Family Medicine	Sports Medicine	X	N
207R00000X	Allopathic & Osteopathic Physicians	Internal Medicine	[NULL]	X	X
207RA0000X	Allopathic & Osteopathic Physicians	Internal Medicine	Adolescent Medicine	X	N
207RB0002X	Allopathic & Osteopathic Physicians	Internal Medicine	Obesity Medicine	X	N
207RG0300X	Allopathic & Osteopathic Physicians	Internal Medicine	Geriatric Medicine	X	X
207RS0010X	Allopathic & Osteopathic Physicians	Internal Medicine	Sports Medicine	X	N
207V00000X	Allopathic & Osteopathic Physicians	Obstetrics & Gynecology	[NULL]	N	X
207VG0400X	Allopathic & Osteopathic Physicians	Obstetrics & Gynecology	Gynecology	N	X
208000000X	Allopathic & Osteopathic Physicians	Pediatrics	[NULL]	X	X
2080A0000X	Allopathic & Osteopathic Physicians	Pediatrics	Adolescent Medicine	X	N
2080B0002X	Allopathic & Osteopathic Physicians	Pediatrics	Obesity Medicine	X	N
2080P0006X	Allopathic & Osteopathic Physicians	Pediatrics	Developmental - Behavioral Pediatrics	X	N
2080P0008X	Allopathic & Osteopathic Physicians	Pediatrics	Neurodevelopmental Disabilities	X	N
2080S0010X	Allopathic & Osteopathic Physicians	Pediatrics	Sports Medicine	X	N
2083P0500X	Allopathic & Osteopathic Physicians	Preventive Medicine	Preventive Medicine/Occupational Environmental Medic	N	X
2084P0800X	Allopathic & Osteopathic Physicians	Psychiatry & Neurology	Psychiatry	N	X
2084P0804X	Allopathic & Osteopathic Physicians	Psychiatry & Neurology	Child & Adolescent Psychiatry	N	X
208D00000X	Allopathic & Osteopathic Physicians	General Practice	[NULL]	X	X
261QC1500X	Ambulatory Health Care Facilities	Clinic/Center	Community Health	X	N
261QF0400X	Ambulatory Health Care Facilities	Clinic/Center	Federally Qualified Health Center (FQHC)	X	X
261QP0904X	Ambulatory Health Care Facilities	Clinic/Center	Public Health, Federal	X	N
261QP0905X	Ambulatory Health Care Facilities	Clinic/Center	Public Health, State or Local	X	N
261QP2300X	Ambulatory Health Care Facilities	Clinic/Center	Primary Care	X	X
261QR1300X	Ambulatory Health Care Facilities	Clinic/Center	Rural Health	X	X
261QS1000X	Ambulatory Health Care Facilities	Clinic/Center	Student Health	X	N
363A00000X	Physician Assistants & Advanced Practice Nursing Providers	Physician Assistant	[NULL]	X	X
363AM0700X	Physician Assistants & Advanced Practice Nursing Providers	Physician Assistant	Medical	X	X
363L00000X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	[NULL]	X	X
363LA2200X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Adult Health	X	X
363LC1500X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Community Health	X	N
363LF0000X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Family	X	X

363LG0600X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Gerontology	X	N
363LP0200X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Pediatrics	X	X
363LP0808X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Psychiatry	N	X
363LP2300X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Primary Care	X	X

Provider_Taxonomy_Cd	Provider_Taxonomy1	Provider_Taxonomy2	Provider_Taxonomy3	CO Multi-Payer Report	Oregon/APM
363LS0200X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	School	X	N
363LW0102X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Women's Health	X	X
363LX0001X	Physician Assistants & Advanced Practice Nursing Providers	Nurse Practitioner	Obstetrics & Gynecology	X	X
364S00000X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	[NULL]	X	X
364SA2200X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Adult Health	X	N
364SC1501X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Community Health/Public Health	X	N
364SC2300X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Chronic Care	X	N
364SF0001X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Family Health	X	N
364SG0600X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Gerontology	X	N
364SH0200X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Home Health	X	N
364SH1100X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Holistic	X	N
364SL0600X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Long-Term Care	X	N
364SP0200X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Pediatrics	X	N
364SS0200X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	School	X	N
364SW0102X	Physician Assistants & Advanced Practice Nursing Providers	Clinical Nurse Specialist	Women's Health	X	N

APPENDIX G:

What Has Been Done Elsewhere?

What has been done elsewhere?

Organization	Definition	Percentage of TCC
Rhode Island	All payments to PCPs (FM, IM, peds, incl. NPs/PAs) Includes loan repayment, HIT, transformation	10.6%
Oregon	All payments to PCPs, included NPs, PAs, naturopaths, OBGYNs, psychiatry, geriatrics	Commercial 10.2% Medicaid 12.5% Medicare 8.9%
Graham Center (MEPS)	All office and outpatient services for PCPs (FM, GP, IM, peds, geriatrics)	6.5-7.5%
JAMA (Medicare FFS)	Payments to PCPs (narrow – FM, IM, peds, GPs)	2.12% PC /3.79% all
	Payments to PCPs (broad – incl. NPs, PAs, geri, gyn)	2.67% PC/ 4.88% all
Milbank (commercial only)	All payments to insurer-designated PCPs: A- FM/IM/peds/GP; B – incl PAs, NPs; C- incl geri, adolescent med, gyn; D- any designated by insurer	7.1% PPO/7.6% HMO (range 5.8-7.1 by PCP definition in PPOs)
	All office visits and preventive services to PCPs	4.6% PPO/4.8% HMO

APPENDIX H:

Primary Care Collaborative — Standard Operating Procedures and Rules of Order

COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative -- Standard Operating Procedures and Rules of Order
Approved August 19,2019

This document defines how the Primary Care Collaborative (the Collaborative) operates, in partnership with the Colorado Division of Insurance. These rules have been approved by the Collaborative members and will be reviewed at least once annually and updated as necessary.

Member Selection Process
Members of the Collaborative are selected by the Insurance Commissioner in accordance with HB 19-1233. The application process will be open to the public. Beyond the requirements in HB 19-1233, the Commissioner will consider the following criteria when selecting members: strength of application, geographic location, industry/organization represented, diversity of population and other factors.

Term Length
Members will serve one-year terms with the opportunity for one re-appointment, for a total of two years. Members seeking re-appointment should notify the Commissioner on or before the end of their term, and do not need to fill out a new application. A maximum of ⅔ of the Collaborative membership can carry over into a consecutive term to ensure continuity in future years.

Meeting Frequency, Length, Location
Meetings will be coordinated to the Collaborative's availability and preferences to every extent practicable. For 2019 -2020, meetings will be held approximately every 3 weeks at the Division of Insurance and will last approximately 2 hours per meeting.

Meeting Agendas, Materials and Notes
Division staff will post meeting notes to their website and send notes out to Collaborative members with the following meeting's materials. Meeting materials will be sent approximately a week in advance (to the extent possible) to members and will be posted to the Division's website. Meeting agendas will broadly follow the annual calendar of topics and will ensure statutory requirements for the Collaborative's annual report and recommendation requirements are met. Collaborative members may suggest meeting topics or presentations but the statutorily required topics will be prioritized.

Scheduling and Logistics
Division staff will coordinate meeting times, location, materials, and other logistics.

Attendance, Absences, Proxies
Collaborative members are expected to make every attempt to attend every meeting either in person or by phone. When a member knows they will be absent for a meeting, they may assign a proxy (either another member, or different person representing their organization) by email to Division staff prior to the meeting. The proxy will have voting privileges equal to the member. For extended absences (family leave, illness, etc.) the Collaborative member will work with the Division to identify an appropriate longer-term proxy. If a member is absent and has not identified a proxy, they forgo their opportunity to vote for that meeting.

Decisions and Voting
The Collaborative may make decisions by informal group consensus or may elect to vote on issues when they determine it's appropriate. Voting will be conducted by member roll call with a simple majority. Formal votes will follow Roberts Rules of Order for style of motion, second, discussion and vote. The minority opinion of a vote may issue their reasonings in writing, following the majority's recommendation.

Recommendations and Reports to the Commissioner and General Assembly
Collaborative members individually or collectively may provide recommendations in writing to the Commissioner at any time. Division staff will support and facilitate the creation of reports required by HB 19-1233 using input and recommendations gathered during Collaborative meetings.

Member Replacement Process
Members who can no longer participate in the Collaborative will notify the Commissioner in writing. The Commissioner will appoint a replacement member from the most recent applicant pool. The Commissioner may ask for additional applicants as necessary.

Interactions with the Public
All Collaborative meetings will be open to the public with time for public comment. Meeting materials and Collaborative recommendations will be public on the Division's website.

Interactions with the Media
If Collaborative members receive media requests related to their Collaborative work and participation, please notify Assistant Commissioner Vince Plymell at vincent.plymell@state.co.us.

APPENDIX I:

Presentation by Colorado Association of Health Plans

Carrier reimbursement practices in primary care

Presentation for the Primary Care Collaborative

August 19, 2019

Overview

Who we are:

We are the trade association of the health insurance industry and we advocate for high quality, affordable and evidenced based health care on behalf of more than 3 million Coloradans.

Primary care collaborative interest:

- Incentivize plan members to appropriately access high quality primary care
- Define primary care inclusively, with appropriate consideration of scope, site and credentials
- Ensure investment in primary care is transformative and focused on value-based payments that drive efficiency and effectiveness

CAHP
Colorado Association of Health Plans

Carrier reimbursement practices – primary care

Survey of innovative payment practices in Colorado (beyond fee for service)

- Bundled payments for managing acute episodes of care and chronic conditions
- Reimbursement for high-value services like e-consults and chronic condition management, which have been proven to reduce utilization and improve member experience
- Increased reimbursement for bringing in social workers
- Additional funding for pilot programs designed to improve care effectiveness, quality, redirection and technology
- Payments for data and analytics and particularly implementation of electronic records to enhance data collection for quality assessment and improvement

CAHP
Colorado Association of Health Plans

Carrier reimbursement practices – primary care

Other incentive payments for primary care providers by payers:

- Reimburse at a higher percent of Medicare for PCPs than for specialists
- Per member per month payment for care coordination in addition to fee for service work
- Payment of coordination fee through performance outcomes
- Payments above fee for service contract based on trend, cost, and quality
- Annual shared savings for high performing PCP's
- Incentives and episodic payment models for evidence-based Medication Assisted Treatment (MAT)
- Incentive dollars for behavioral health providers and per member per month payments in Regional Care Collaborative Organizations

CAHP
Colorado Association of Health Plans

Carrier reimbursement practices – primary care

In Colorado, carriers have implemented alternative payment models and invested millions of dollars in physician practice transformation.

Key Colorado programs:

- Colorado Health Extension System (CHES)
- Colorado Beacon Community
- Comprehensive Primary Care and Comprehensive Primary Care +
- Colorado Multi-payer Collaborative
- State Innovation Model

CAHP
Colorado Association of Health Plans

Carrier reimbursement practices – primary care

Scope of value-based reimbursement practices:

- For some carriers, up to 72% of their patients are aligned in accountable care programs in CO
- For some carriers, more than 50% of their medical spend is directed to value-based care

Outcomes of value-based reimbursement practices:

- Increased investment in these programs has shown decreases in costs and increases quality care
- Fewer in-patient admissions
- Reduction in ER visits
- Lower outpatient costs
- Reduction in hospital re-admission rates
- Lower surgery costs
- Evidence-based, cost-effective pharmacy prescribing
- High percent of providers meeting quality measures for care

CAHP
Colorado Association of Health Plans

Thank you

amassey@colohealthplans.org
www.colohealthplans.org
@coloradoplans

APPENDIX J:

Presentation by Dr. Stephanie Gold

Alternative Payment Models and Primary Care

Stephanie Gold, MD

Primary Care Payment Reform Collaborative
September 2019

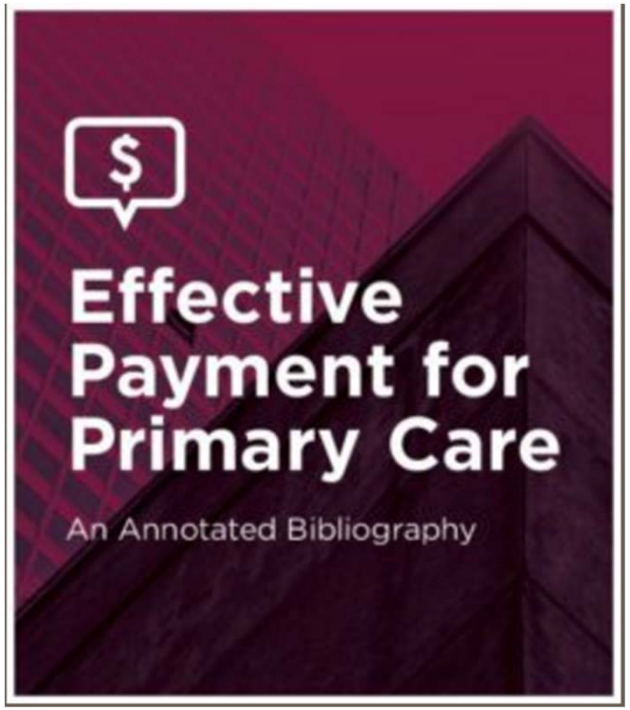
With thanks to: Brian J. Park, MD MPH; Andrew Bazemore, MD MPH; Winston Liaw, MD MPH

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER

ROBERT GRAHAM CENTER
Policy Studies in Family Medicine and Primary Care

FAMILY MEDICINE for AMERICA'S HEALTH

Background



SPECIAL COMMUNICATION

How Evolving United States Payment Models Influence Primary Care and Its Impact on the Quadruple Aim

Brian Park, MD, MPH, Stephanie B. Gold, MD, Andrew Bazemore, MD, MPH, and Winston Liaw, MD, MPH

Introduction: Prior research has demonstrated the associations between a strong primary care foundation with improved Quadruple Aim outcomes. The prevailing fee-for-service payment system in the United States reinforces the volume of services over value-based care, thereby devaluing primary care, and obstructing the health care system from attaining the Quadruple Aim. By supporting a shift from volume-based to value-based payment models, the Medicare Access and Children's Health Insurance Program Reauthorization Act may help fortify the role of primary care. This narrative review proposes a taxonomy of the major health care payment models, reviewing their ability to uphold the functions of primary care, and their impacts across the Quadruple Aim.

Methods: An Ovid MEDLINE search and expert opinion from members of the Family Medicine for America's Health payment and research tactic teams were used. Titles and abstracts were reviewed for relevance to the topic, and expert opinion further narrowed the literature for inclusion to timely and relevant articles.

Findings: No payment model demonstrates consistent benefits across the Quadruple Aim across a limited evidence base. Several cross-cutting lessons from available payment models several recommendations for primary care payment models, including the following: implementing per member per month–based models, validating risk-adjustment tools, increasing investments in integrated behavioral health and social services, and connecting payments to patient-oriented and primary care-oriented metrics. Along with ongoing research in emerging payment models, data systems integrated across health care and social services settings using metrics that can capture the ideal functions of primary care will be critical to the development of future payment models that most optimally enhance the role of primary care in the United States.

Conclusions: Although the ideal payment model for primary care remains to be determined, lessons learned from existing payment models can help guide the shift from volume-based to value-based care. To most effectively pay for primary care, future payment models should invest in a primary care infrastructure, one that supports team-based, community-oriented care, and measures the delivery of the functions of primary care. (J Am Board Fam Med 2018;31:588–604.)

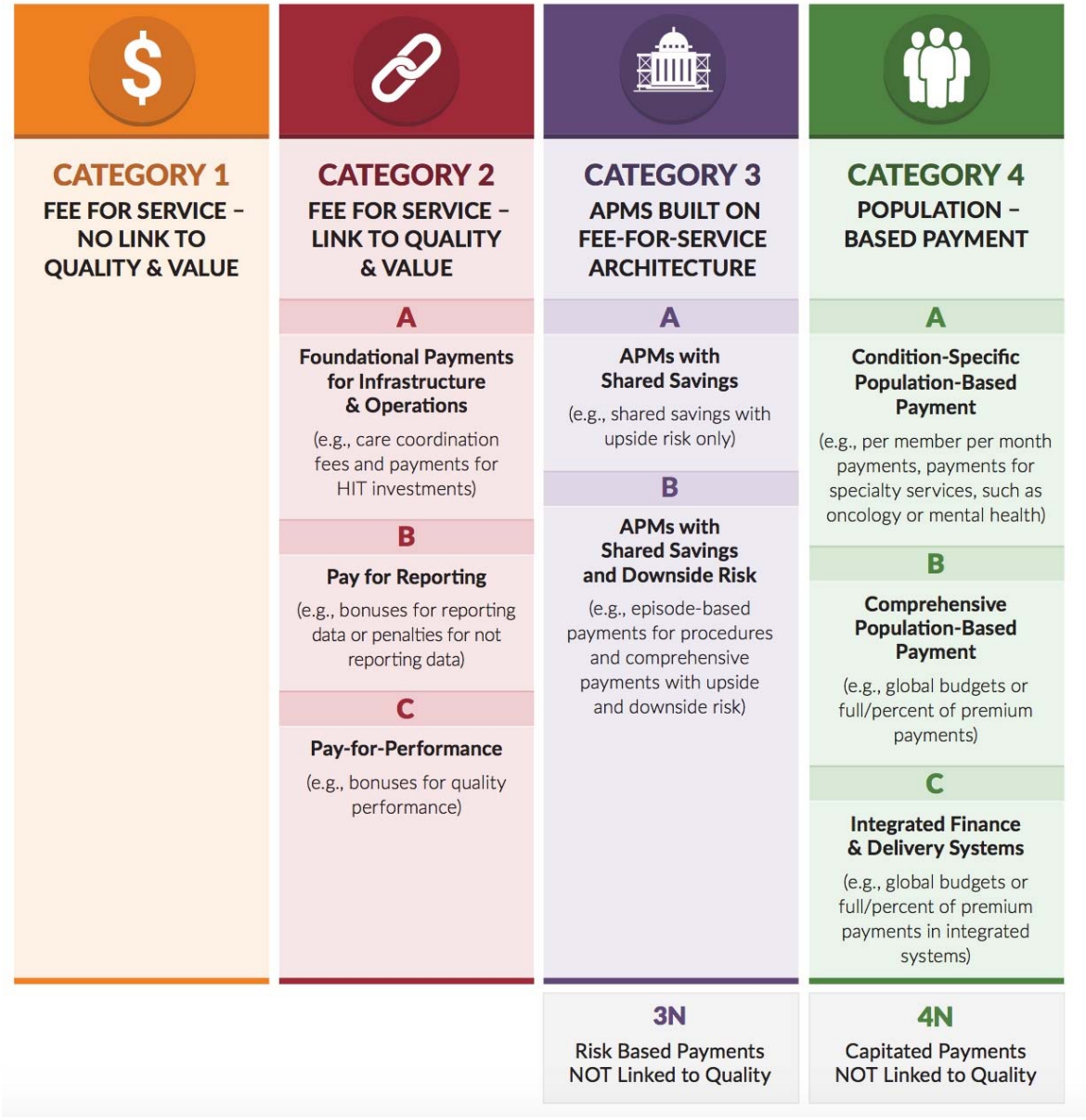
Keywords: Delivery of Health Care, Family Medicine, Health Expenditures, Primary Health Care

Objectives

- Define the current major payment models in the United States
- Understand the strengths and limitations of different payment models for primary care
- Describe the evidence for different payment models
- Explain barriers to optimal alternative payment model design and implementation

What are we trying to pay for?

HCP-LAN Framework



Payment Models

- Fee for Service
- Traditional Capitation
- Pay for Performance
- Shared Savings
- Blended FFS and Capitation
- Bundled Payment
- [Direct Primary Care]
- Comprehensive Primary Care

Fee For Service

- Patient sees provider → provider bills for services → insurance reimburses services rendered*

Positives	Negatives
Role for low-cost, under-utilized services (e.g., vaccines)	Incentivizes volume of services, without regard to what is appropriate
	No incentive to control costs
	No linkage to quality

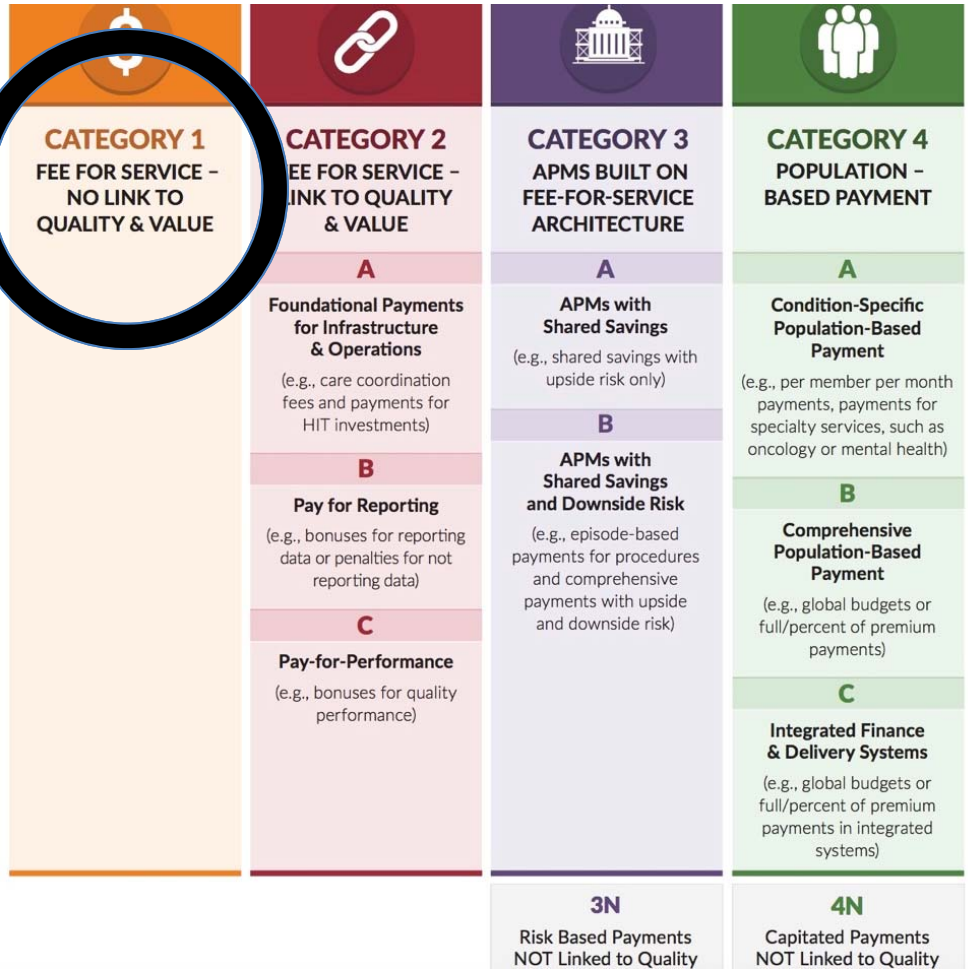
- Who bears risk?
  - Insurers, patients via cost-sharing (copays, deductibles)

*Specialty-dominated RUC largely defines payment for different services

FFS- The Evidence

- What we have now: increasing costs, widespread variation in care delivery, poor population health outcomes, primary care workforce shortage and high burnout levels

FFS


CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE
CATEGORY 2
EE FOR SERVICE – INK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)
B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance
(e.g., bonuses for quality performance)
CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE
A
APMs with Shared Savings
(e.g., shared savings with upside risk only)
B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N
Risk Based Payments NOT Linked to Quality
CATEGORY 4
POPULATION – BASED PAYMENT
A
Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)
C
Integrated Finance & Delivery Systems
(e.g., global budgets or full/percent of premium payments in integrated systems)
4N
Capitated Payments NOT Linked to Quality

Traditional Capitation

- Insurance pays PMPM independent of services to practice → patient sees provider

Positives	Negatives
Allows for proactive care (e.g., invest in primary care infrastructure)	Significant financial risk to practices/clinicians
Incentivizes cost savings	Encourages inappropriate under-delivery of services, "cherry-picking" patients
	No linkage to quality (except to avoid downstream utilization for cost control)

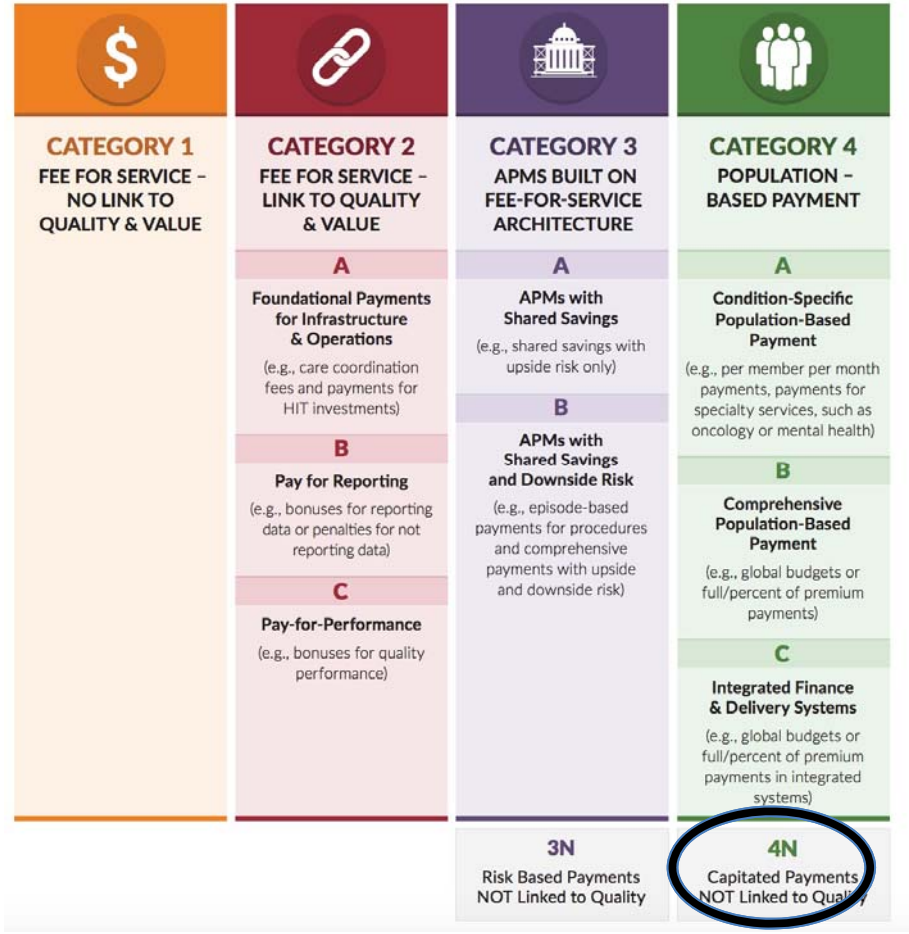
- Who bears risk?
  - Clinicians/practices

Traditional Capitation - The Evidence

- Example: growth under managed care (HMOs) in the 80s and 90s

- Takeaway: Results mixed, some suggest lower costs and lower patient satisfaction. Growth under managed care led to patient and provider backlash concerning gatekeeping/decreased choice and financial risk.

Traditional Capitation



Pay for Performance

- FFS/Capitation +/- payment for specific quality targets

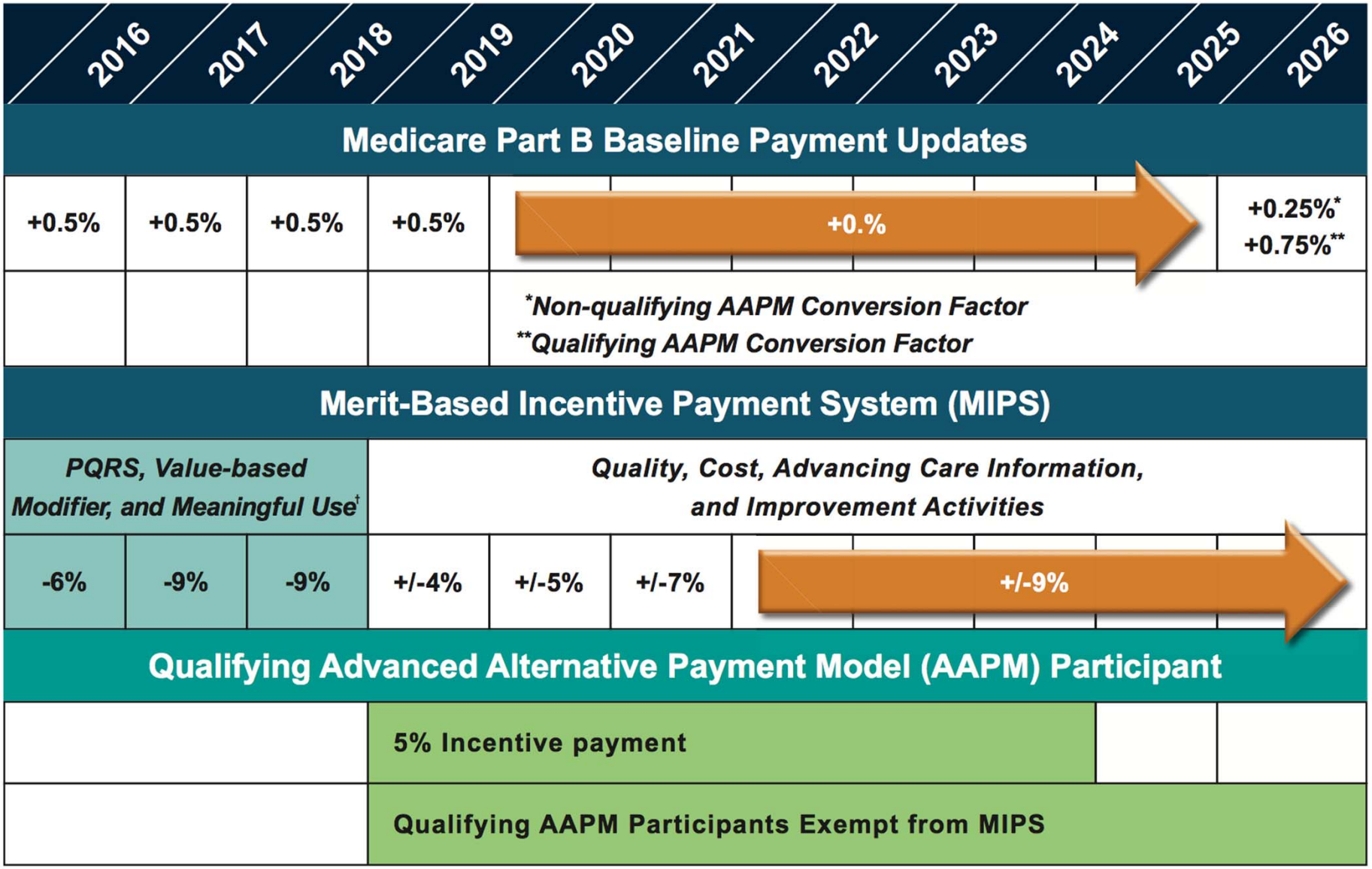
Positives	Negatives
Links care to quality	Shortcomings of underlying payment system prevail
May improve targeted metrics	Non-targeted metrics may worsen or not improve
	Quality often measured via disease-oriented, process metrics (vs. patient-centered, true outcomes)
	Significant administrative burden

- Who bears risk?
  - Same as underlying payment model, with some more risk to providers for meeting/not meeting targets

Pay for Performance - The Evidence

- Example: Quality Outcomes Framework (QOF)
- Takeaway: P4P may improve what it pays for but results may stagnate over time. Overall results and ROI are modest. Can lead to significant administrative burden and negatively affect patient-centered care.

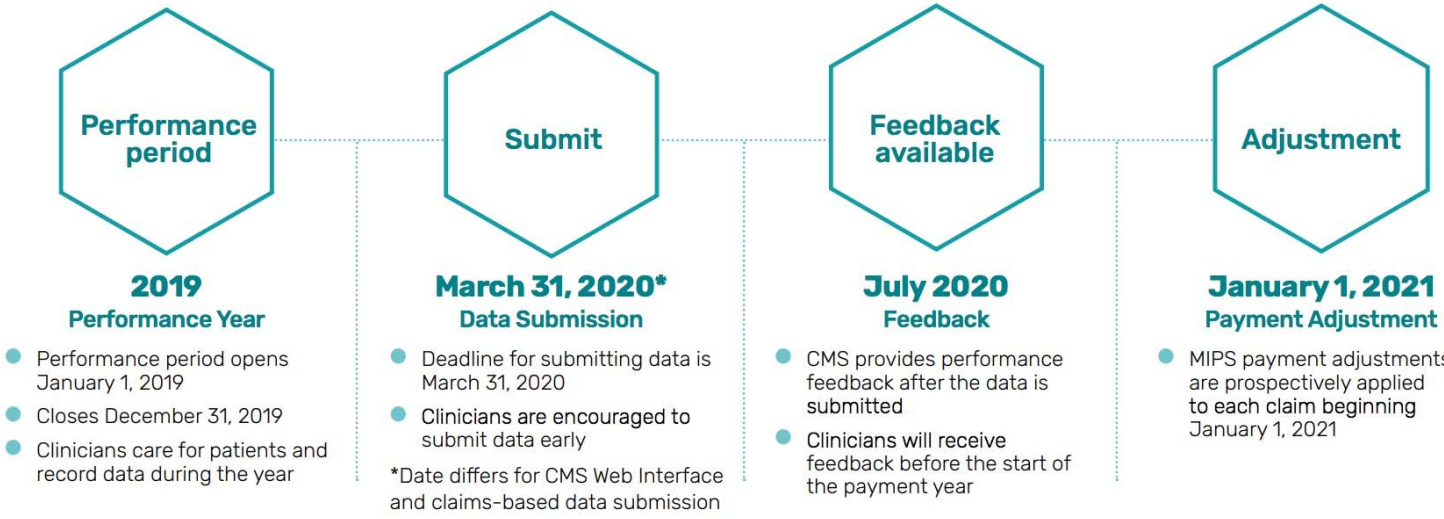
MACRA Quality Payment Program: 2 Tracks



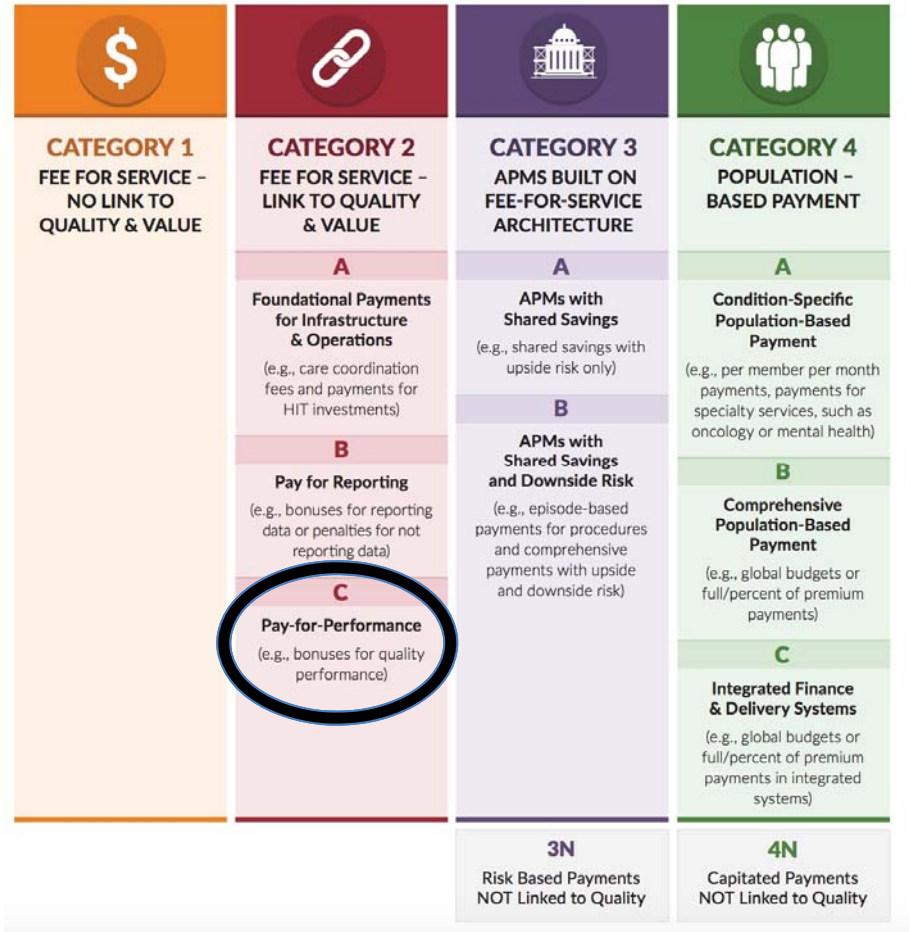
† – *Cumulative maximum penalty for a 10-provider clinic.*

MIPS


Quality
Promoting Interoperability
Cost
Improvement Activities
=
100%
of MIPS Final Score
45%
of MIPS Final Score
25%
of MIPS Final Score
15%
of MIPS Final Score
15%
of MIPS Final Score


Performance period
Submit
Feedback available
Adjustment
2019
Performance Year
Performance period opens January 1, 2019
Closes December 31, 2019
Clinicians care for patients and record data during the year
March 31, 2020*
Data Submission
Deadline for submitting data is March 31, 2020
Clinicians are encouraged to submit data early
*Date differs for CMS Web Interface and claims-based data submission
July 2020
Feedback
CMS provides performance feedback after the data is submitted
Clinicians will receive feedback before the start of the payment year
January 1, 2021
Payment Adjustment
MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

Pay for Performance



Shared Savings and ACOs

- Insurance pays risk-adjusted PMPM to organization (ACO) → organization reimburses providers → patient sees provider → savings are shared between insurer and organization*

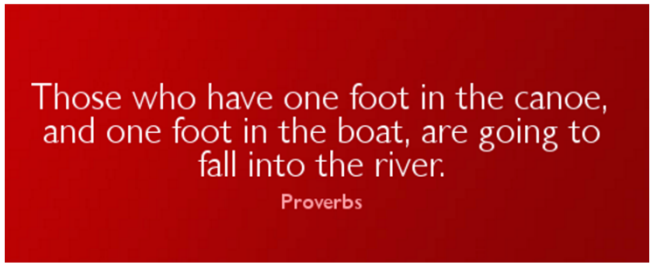
Positives	Negatives
Incentivizes cost savings	Encourages inappropriate under-delivery of services
Allows for proactive care (e.g., invest in primary care infrastructure)	Lag in receiving savings can limit ability to invest upfront in needed primary care infrastructure
	Payments and cost benchmarks often based on prior years → can reward high spenders

- Who bears risk?
  - Overarching organization (ACO)

*can have one-sided or two-sided risk models

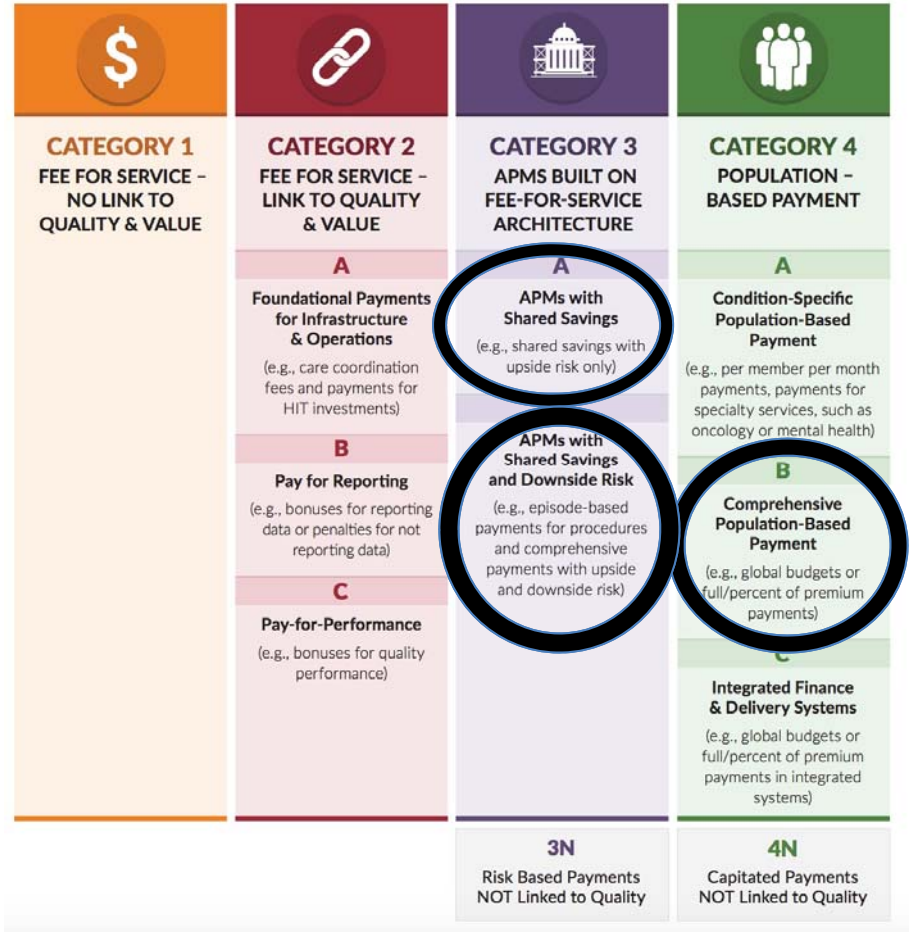
Shared Savings - The Evidence

- Examples:
  - Medicare Shared Savings Program
  - Hennepin Health



- Takeaway: Promising results after ~ 5 years participation – more if physician-group led. Providers still often paid on FFS basis. May unintentionally reward baseline inefficiency. Inclusion of social services (addressing needs and sharing data) may be beneficial.

Shared Savings



Blended FFS and Capitation

- FFS + PMPM (e.g., payments for: PCMH, care management, etc.)

Positives	Negatives
Partially allows for proactive care	Shortcomings of underlying payment system prevail
Risk-adjustment (if done) mitigates against cherry-picking	No explicit linkage to quality

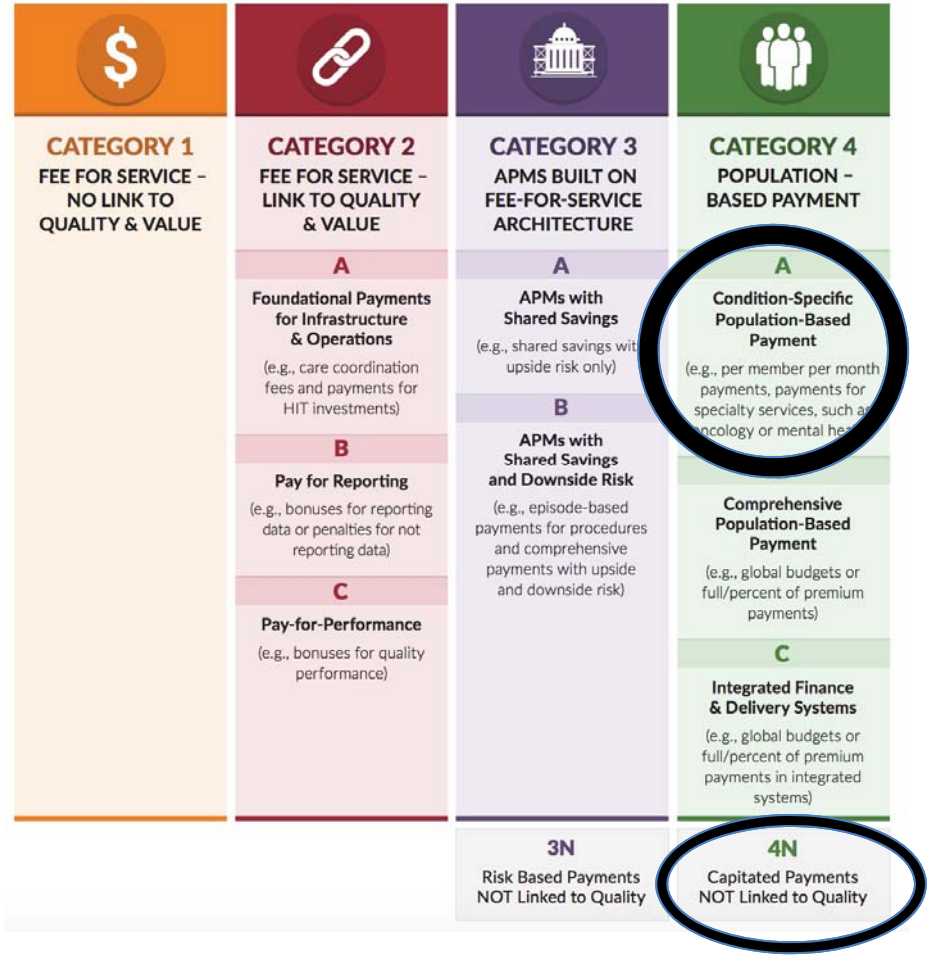
- Who bears risk?
  - Similar to whichever model is predominant

Blended FFS / Capitation - The Evidence

- Examples:
  - Community Care of North Carolina
  - Comprehensive Primary Care Initiative

- Takeaway: Mixed results. Lessons learned from effective programs: multipayer collaboration, real-time data sharing, targeting high utilizers.

Blended FFS and Capitation



Bundled payment

- Patient seeks care for a defined episode → insurance reimburses practice/organization with a global payment

Positives	Negatives
Incentivizes control of costs within the episode	Could incentivize inappropriate under-delivery of services
Global payment allows for flexibility in how money is used	No incentive to decrease number of episodes
	Very difficult to define an “episode” in primary care

- Who bears risk?
  - Practices/organizations

Bundled Payment - The Evidence

- Example:
  - PROMETHEUS

- Takeaway: Defining episodes of care for primary care patients with multimorbidity is near impossible.

Bundled Payment

Comprehensive Primary Care Payment

- Insurance pays risk-adjusted PMPM to the practice [plus bonuses for meeting quality targets] → patient sees provider

Positives	Negatives
Allows for flexible, proactive care (e.g., invest in primary care infrastructure)	Encourages inappropriate under-delivery of services
Incentivizes control of (primary care) costs	Same limitations on using quality metrics as with P4P
Risk-adjustment mitigates against cherry-picking	
Includes linkage to quality	

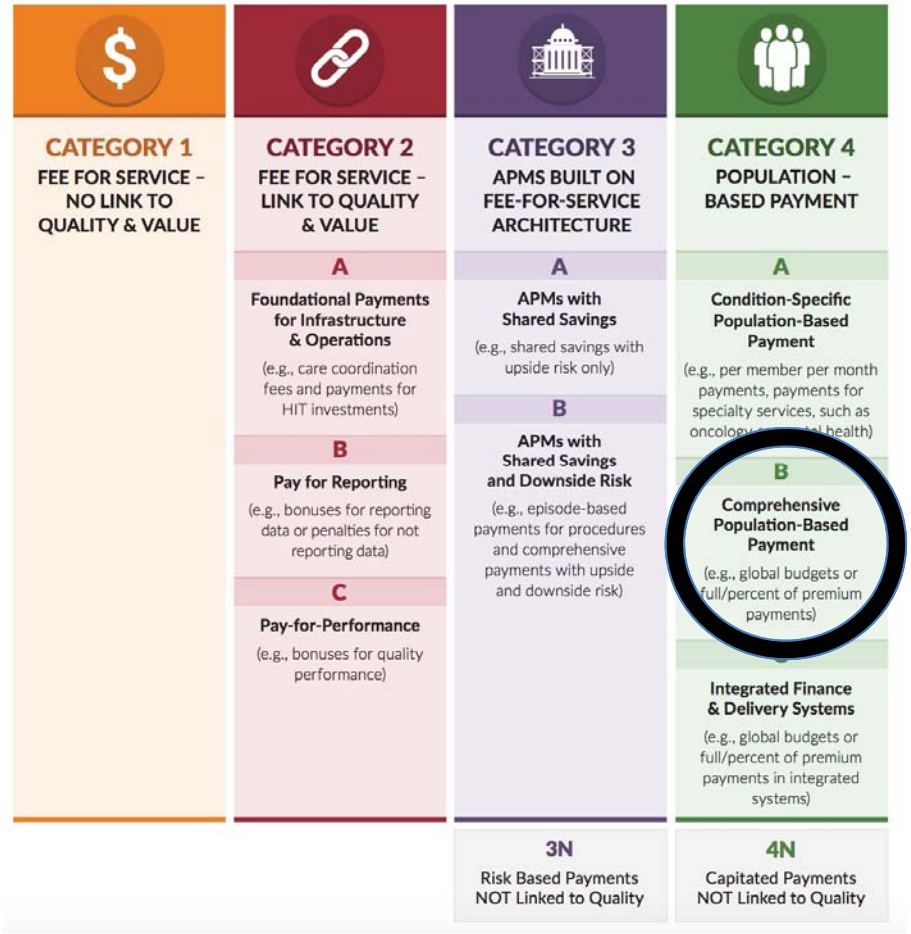
- Who bears risk?
  - Clinicians/practices

Comprehensive Primary Care - Evidence

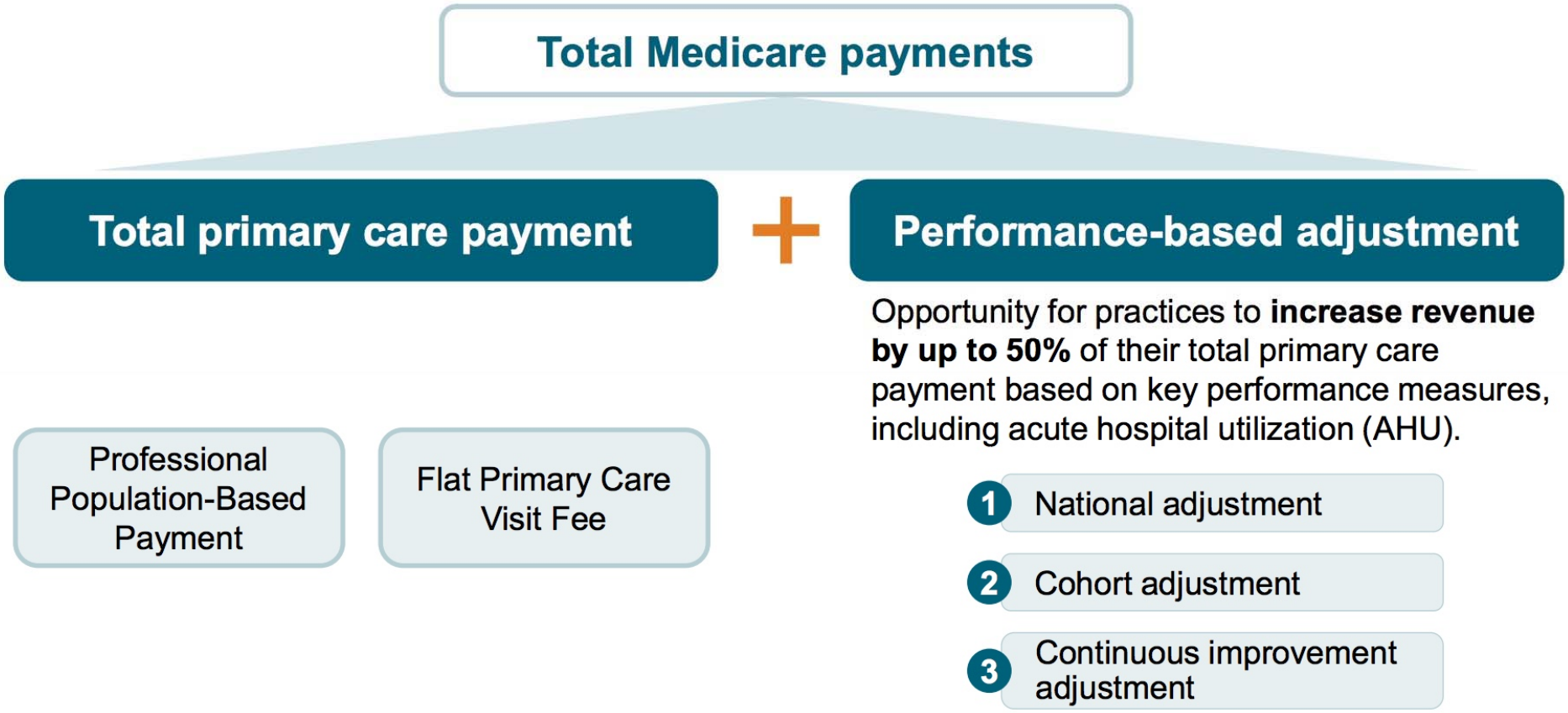
- Example: Iora Health
  - (CPC+ Track 2 close to this)

- Takeaway: Possible improvements in patient satisfaction, health outcomes, decreased costs.

Comprehensive Primary Care



Primary Care First



It’s not that simple

- Mixed models (capitation+ FFS +/- shared savings +/- P4P)
- A given practice has multiple contracts with multiple payers
- Significant time required to see a change in outcomes from practice or system (ie ACO) transformation
- Outcomes reflect change in *delivery* model, but change in payment model enables change in delivery
- How the practice is paid is not the same as how the clinicians are paid
- Separated payment streams for behavioral health, social services, public health

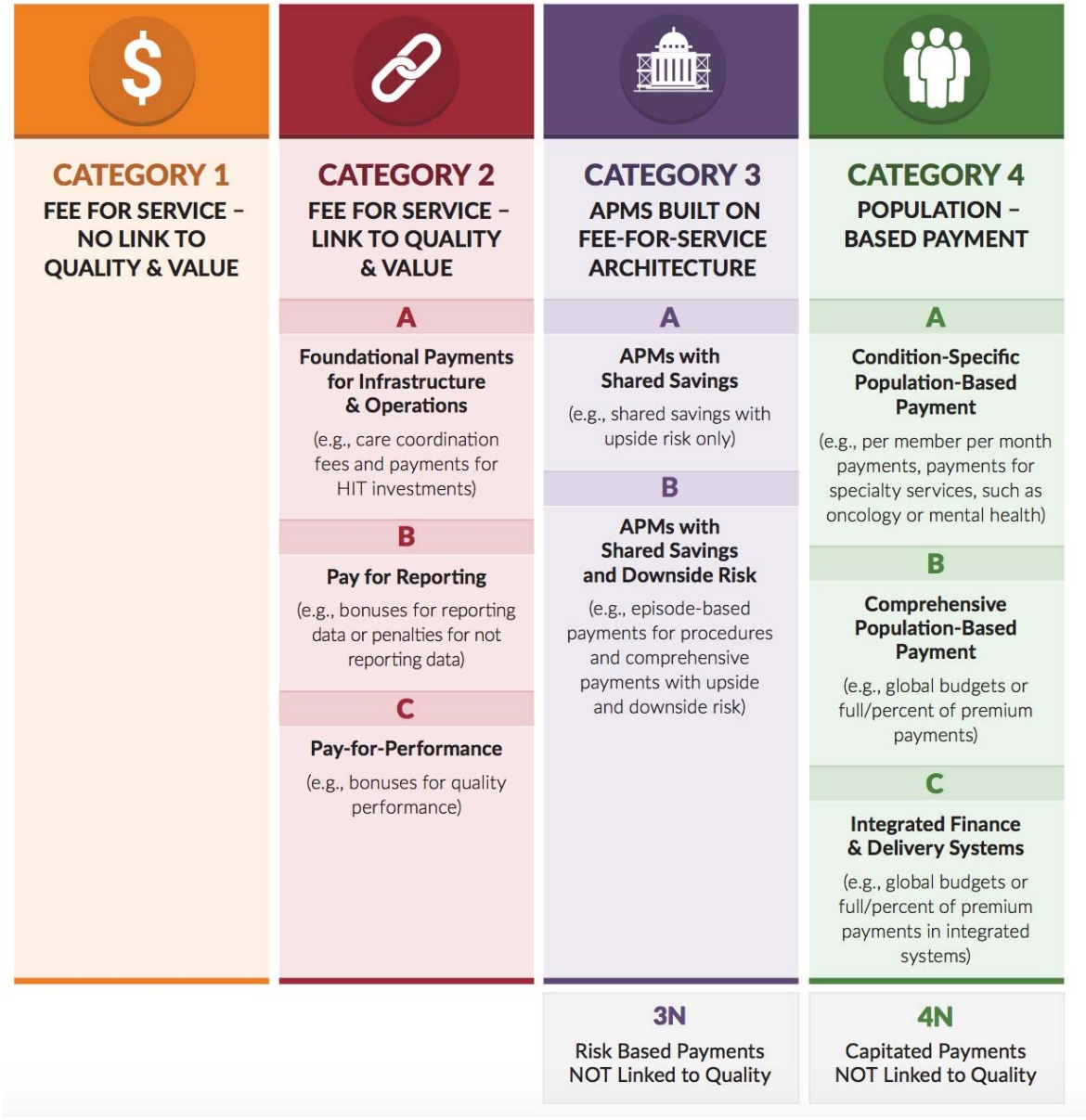
The bigger picture

- Why US health care has worse outcomes at higher costs:
  - Higher prices (eg for pharmaceuticals)
  - Increased use of expensive medical technology
  - Greater administrative costs
  - Less spending proportionally on social services
  - Lack of universal coverage

The Devil is in the Details

Payment Model	Pitfalls in Operationalizing
FFS	• Fee schedule favors procedural over cognitive care • Overall inadequate primary care reimbursement
Traditional Capitation	• Lack of adequate risk adjustment for patient needs • Basing rates in historic inadequate FFS payments
Pay for Performance	• Measures largely disease-focused, often process rather than outcomes, not patient-oriented or reflective of key components of primary care • Delays in receiving incentives
Shared Savings/ACOs	• Providers still paid FFS • Basing benchmarks on historic expenditures rewards prior inefficiency • Lag in receiving savings
Blended FFS and Capitation	• Predominance of FFS over PMPMs may not reach a tipping point that enables restructuring practice

Returning to the HCP-LAN Framework



Overcoming Design and Implementation Barriers

Barrier	Possible Solution
Retroactive payment for specific services limits flexibility and proactivity	Require increases in primary care spend to consist of non-FFS spending
Measuring quality primary care	Consider newer measures on continuity, comprehensiveness, person-centered primary care measure (Etz)
Fragmentation of physical, behavioral, and social health services	Include payment for behavioral and social health in a primary care global budget or supplemental PMPM
Concerns about financial risk in taking on higher needs patients	Risk adjust at the patient and community level
Lack of alignment across carrier payment policies	Continue and bolster multipayer collaborative – consider greater state involvement for antitrust protection

Thank you!

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER

ROBERT GRAHAM CENTER
Policy Studies in Family Medicine and Primary Care

FAMILY MEDICINE for AMERICA'S HEALTH

APPENDIX K:

Primary Care Investment — National and State Analyses

Primary Care Investment - National and State Analyses

PCPCC/Robert Graham Center	Milbank	Reid et al
Focus: Examine state-level PC spend by all payer types (private, public, uninsured); assess associations between PC spend and utilization outcomes *Data/methodology:* MEPS data (2011-2016); narrow & broad definitions of PCP; measure spending in offices and outpatient settings; first to calculate state-level PC spend by payer type *Findings* ● Proportion of health care expenditures on PC low in U.S. ● Considerable variation, both interstate and within states, for narrow and broad definitions ● Variability across payer types and age groups ● Negative association between PC spend and ED visits, total hospitalizations, and avoidable hospitalizations *Colorado-specific findings:* Narrow (N) = 5.0% (5.6% national avg) Broad (B) = 10.6% (10.2% national avg) Private-Public-Uninsured (N) = 5.2; 4.4; 5.1 Private-Public-Uninsured (B) = 10.4; 7.4; 9.2 Medicare-Medicaid-Dual (N) = 10.0; 4.4; 3.1 Medicare-Medicaid-Dual (B) = 16.0; 7.1; 7.3 *Questions/take-aways:* • How do state demographics impact PC spend? • How does payer mix impact PC spend? • What is "right" PC spend? • How should we invest increased PC investment?	*Focus:* Test feasibility of calculating spending paid to primary care providers comparably across commercial insurers; gain preliminary insights into primary care spending *Data/methodology:* Health insurer data (in response to detailed research request); 5 definitions (1 provider-based; 4 provider- and service-based) *Findings:* ● Possible to measure PC spend using insurers' financial info and consensus definitions of PC, but difficult (particularly when voluntary) ● Most PC spend occurred via FFS payments ● Differences in spending between narrow and broad definitions of PC providers less than differences between definitions of PC services ● PC spend as a % of total spending varies widely across insurers, and is influenced by population characteristics *Colorado-specific findings:* N/A- study conducted across regions *Questions/take-aways:* • Potential need for separate benchmarks for children and adults (large differences in spend) • Can generation of spending estimates be partially or fully automated? • What are the non-primary care services that account for a substantial proportion of total FFS billing by primary care providers?	*Focus:* Identify PC spending as a proportion of total spending among Medicare FFS beneficiaries; examine variation by beneficiary characteristics and state *Data/methodology:* Medicare MBSF data; narrow & broad definitions of PCP and PC services; assessed PC spend as a % of total medical and prescription spending *Findings:* • PC represented 2.12 - 4.88% (narrow vs broad) of total medical spending • For all definitions, PC spend lower for beneficiaries who were older, black or NA, dually eligible, or with chronic medical conditions • PC spend varied by state, and was not significantly correlated with per capita PCP headcounts *Colorado-specific findings:* Narrow = 2.14 - 2.22% Broad = 3.87 - 4.11% *Questions/take-aways:* • Study estimates provide reference points for researchers, policy-makers • Future research needed to evaluate impact of state efforts to institute minimum PC spending on quality or outcomes

APPENDIX L:

Primary Care Investment Targets — Other States

PRIMARY CARE INVESTMENT TARGETS - OTHER STATES

Rhode Island	Oregon	Delaware	Connecticut
• Each health insurer's annual, actual primary care expenses (direct and indirect) shall be at least 10.7% of annual medical expenses for all insured lines of business • At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers	• Prominent carriers (annual health insurance premium income ≥ $200 million) offering commercial and MA plans, state public employee board plans, and Medicaid CCOs must spend at least 12% of total expenditures for physical and mental health on primary care services by 2023 • If spend less, must document how will increase spending by at least 1% annually	• *Recommendation:* State should mandate payers to progressively increase PC spending to reach percentage milestones that eventually account for 12% of total health care spending (based on RI and OR) • Increase will occur either through 1% point increase per year or within 5 years, whichever is faster • Standard will apply to at least Medicaid, MA, self-insured, fully insured, state employees' health plans • Performance measured by standard definition of primary care spending and total medical spending	• Developing primary care bundled payments that cover office visits, with supplemental bundles that include a PMPM fee to allow practices to hire care managers or invest in HIT, as part of multi-payer model • Multi-payer reform model aims to gradually double revenue stream to primary care providers while maintaining TCC trend through combination of upfront supplemental payments to PC providers who agree to assume risk on controlling TCC
Background: PC spending increased through combination of structural payments (loan repayment, care management fees, and value-based payment opportunities) while hospital rates were capped	*Background:* Primary care spending requirements follow a series of delivery and payment model reforms over the past decade, which had already boosted primary care spending on average to the 12% benchmark	*Background:* State facing acute PC workforce issues, growing health care costs; series of legislative resolutions and EOs focused attention on costs and quality; first state to set health care spending growth target and track quality and health measures	*Background:* Planned investment is strictly in upfront supplemental payment revenue made with the expectation that primary care providers transform practices to offer alternative means of accessing primary care services that are not billable and by using a more extensive care team

Other key features:
• 2010 - OHIC required each insurer to annually increase total commercial medical payments to PC
• Capital investments in PC, including supporting PT and EHR systems, count toward primary care spending
• Each payer must contract with specified share of PC physicians in PCMHs, increasing annually
• To help contain costs, hospital rates are capped at CPIU+1% and ACO total cost of care budgets are capped at CPI-U+1.5%
	Other key features:
	• 2015-2016 - legislation required state to report on percentage of PC spend
	• Analysis includes claim-based and non-claims-based payments
	  ○ Claims-based collected through state's APCD
	  ○ Non-claims based collected through reporting template
	• SB 231- established PC Payment Reform Collaborative, tasked with helping develop and implement the Primary Care Transformation Initiative
		Other key features:
		• PC spend increase should include upfront investment of resources to build infrastructure and capacity, not just increase in FFS rates for PCPs
		• Support/incentives for use of HIT, support for team-based model of care across range of PC setting, value-based incentive payments
		• PC spend requirements should be compatible with state benchmarking process of promoting only sustainable increases in TCC
			Other key features:
			• Building off SIM (thru Jan 2020)
			• Goal: enhance provider performance on shared savings or shared risk arrangements via PC payment reform
			• State priorities: building diverse care teams; expanding patient access to PC via email, home visits, telemedicine; adopting technology with likely ROI; integrating care to better treat behavioral health, address SDOH; developing practice specializations to better treat certain patient subpopulations

APPENDIX M:

PCPRC Primary Care Investment Targets — Discussion Summary

PCPRC Primary Care Investment Targets – Discussion Summary

Highlights from readings:

- Multiple methods of calculating PC spend, at state and national level – different methodologies provide varying ranges of spend

PCPCC/RGC- ALL PAYER TYPES		Reid et al – MEDICARE SPECIFIC	CIVHC – FFS ONLY
Narrow	*Broad*		
Private = 5.2%	Private = 10.4%	Narrow = 2.14 – 2.22%	Commercial = 6.18%
Public = 4.4%	Public = 7.4%	Broad = 3.87 – 4.11%	Medicaid = 6.40%
Uninsured = 5.1%	Uninsured = 9.2%		Medicare Advantage = 4.86%
			Medicare FFS = 5.47%

- Variations greater when based service type (vs provider type); CO compares more favorably using broad definition
- Difficult to set threshold for entire population – differences in spending by age, between urban and rural, etc.

Considerations in setting a PC investment target:

- Want to look at total cost of care (TCC) when calculating PC as a percentage of spend for Colorado
  - Can we do this as a per capita measure? (know hospital percentage)
- Do we need separate targets for subpopulations? How can carriers with different population mixes meet a single target? Do we need to come up with a blended rate?
- Should target be focused on dollars spent or type of payment? Insurers may not be able to break out PC spend separately in some payment models (i.e., capitation), won't have insight
- Level of payment (total dollars), form of payment, scale, population, community all matter – focusing a target on one or more specific component(s) may miss others; recommendations and limits are better placed around where PC investment should be directed to ensure it builds/supports PC infrastructure and capacity
- How can we improve access? Requires investments in workforce- both in terms of compensation (increased payments to providers) and infrastructure (the supports that allow this care to place)
- What is the appropriate timeframe for a target? Do we start with short-term targets, and adjust over time? Or can we project a target once we have the available data?

Goals for increased PC investment:

- Improve access
- Change patient behavior (improved access one component- are there others?)
- Focus on outcomes, not just process
- Reduce provider burden
- Support team-based care (practicing at the top of scope, utilizing navigators/coordinators/social workers)
- Create a support "primary care environment"

PROPOSED STRATEGY: % increase in spend over time, rather than a single target

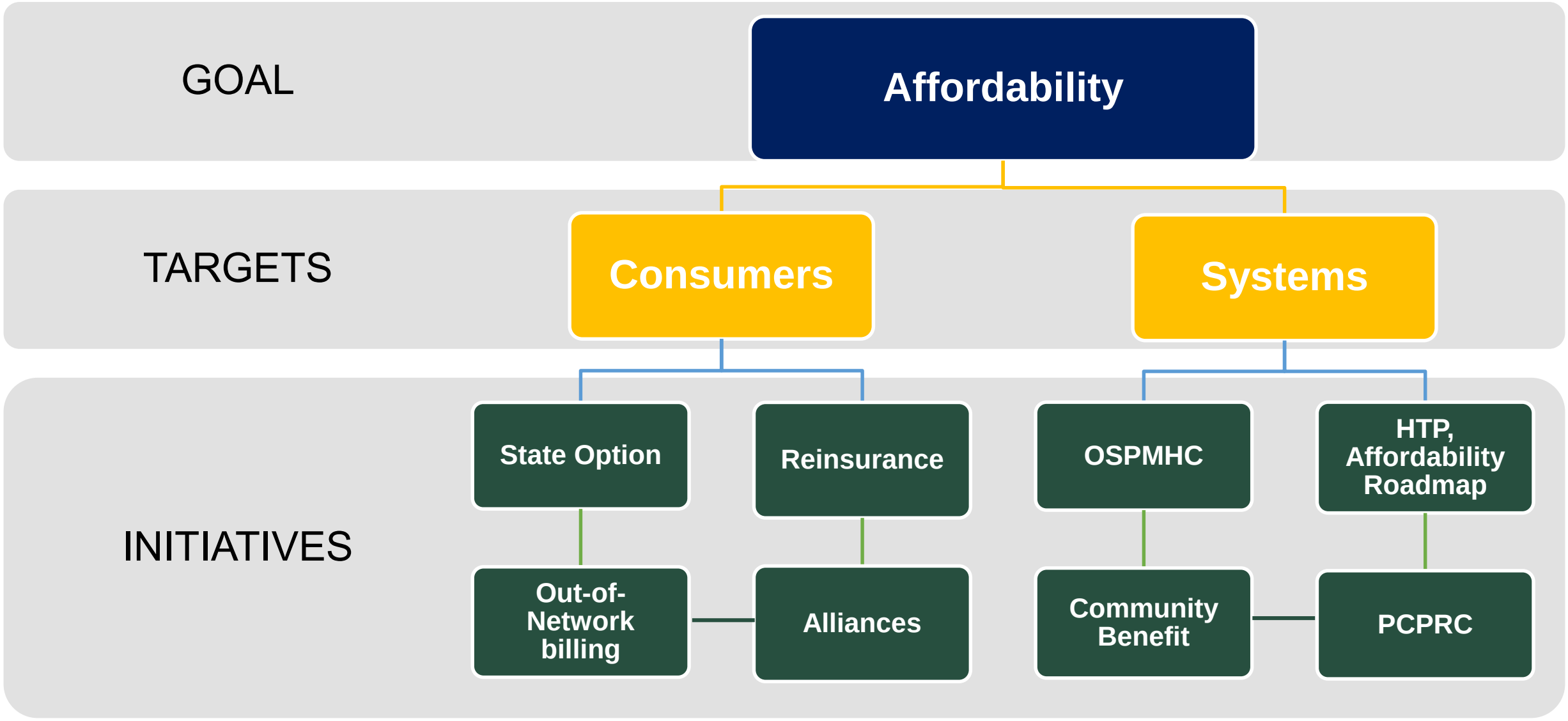
APPENDIX N:

Presentation by Department of Insurance

Primary Care Investment & Affordability

Primary Care Payment Reform Collaborative
November 12, 2019

COLORADO
Department of Regulatory Agencies
Division of Insurance



COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care & Affordability - Alignment

HB 1233 - PCPRC

Definition of primary care

Primary care is the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated encompasses 'the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care.'

HB 1004 – State Option

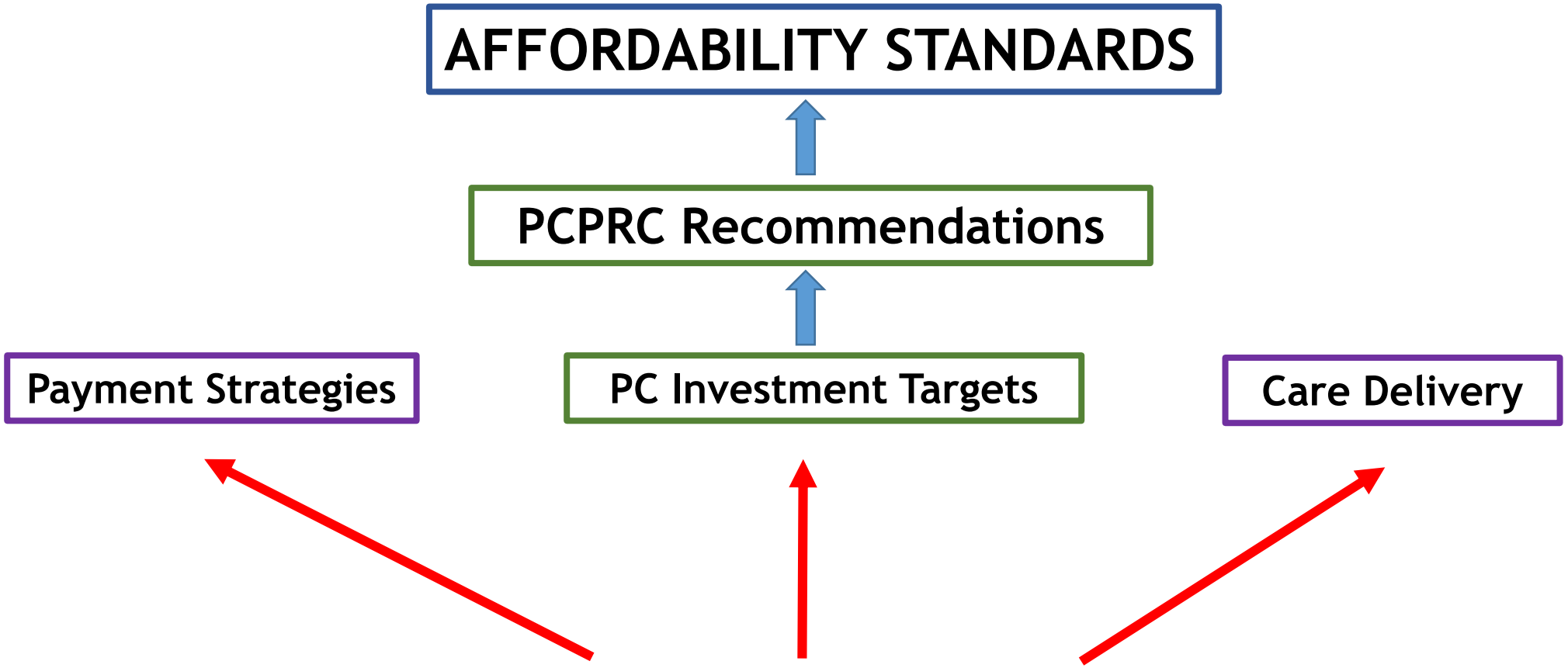
Definition of affordability

✓*Total out-of-pocket costs, including premiums, co-pays, co-insurance, deductibles, and out-of-pocket maximums*

✓*Ability to be purchased without sacrificing other budgetary priorities required for basic self-sufficiency irrespective of family size, location, income level or degree of illness*

Definition of Affordability

- HB19-1004 instructs State to determine a definition of affordability to guide development and implementation of State Option
- Draft proposal language:
  - "Meeting this standard may ultimately require reliance on a variety of new funding sources such as federal waiver dollars, State funds, or other levers to realize cost savings for consumers"
  - Will "align with DOI affordability standards as described in HB19-1233 and developed through rulemaking throughout 2019-2020"



PCPRC recommendations for DOI's future affordability standards should focus on the levers unique to primary care

Preliminary PCPRC Recommendations

PC Investment Targets

- Consider setting percentage increase targets for carrier investments in primary care, rather than setting an absolute value target
  - ➢**Recommend 1% annual increase in PC investment across all carriers as an appropriate initial target**
- Should update target only when complete data on PC spend in Colorado is available
- ANYTHING ELSE?

Preliminary PCPRC Recommendations

Payment Strategies

- Support increased adoption of APMs that offer upfront investments and incentives for improving quality in primary care
- Support efforts to align APM methods across payers
- Leverage and improve existing models, rather than attempting to create new models
- ANYTHING ELSE?

Preliminary PCPRC Recommendations

Care Delivery

- Develop definitions and models that are inclusive of any practice that serves as the usual source of preventive care for an individual
- ANYTHING ELSE?

Preliminary PCPRC Recommendations

OTHER IDEAS (from meeting discussions)

- Data reporting and analysis of PC spend (for FFS and APMs)
  - Preferred methodology, template for collection, etc.
- Outcomes – what do we hope to achieve through increased investment
  - Specific guardrails on investment vs. flexibility
- Decrease provider administrative burden, unnecessary procedures
  - Specific guidance vs. general recommendation
- ANYTHING ELSE?

APPENDIX O:

Explanation of Vote to Primary Care Collaborative

December 12, 2019

Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Commissioner Conway, Deputy Commissioner Harris, and fellow members of the Primary Care reform Collaborative,

As members of the Primary Care Reform Collaborative, we appreciate being part of this important work and look forward to ongoing participation in the next years of the Collaborative. As the first set of recommendations from this group is released publicly, we write to explain our vote in opposition to the one of the recommendations contained in the report as provided for in the Standard Operating Procedures and Rules of Order.[1]

As active and engaged participants in this committee throughout its tenure, we have concerns about the recommendation for a mandatory primary care spending increase and we believe that there are certain aspects of the report which do not reflect the charge as outlined in HB19 – 1233. Below, we would like to explain our vote and our specific concerns.

Explanation of vote – opposition to investment target

We are strongly supportive of the goal of investing more in primary care to help Coloradans to stay healthy, access care at their medical home, and reduce health care costs. We agree that primary care doctors should be appropriately compensated, and carriers are approaching primary care investments in a variety of innovative ways in order to drive value-based care in the primary care setting.

As we discussed on December 2, 2019, simply increasing fee-for-service payments in primary care is not the charge of the Collaborative and does not promote the expansion of value-based payments. The goals for the Collaborative are to increase value-based payments that transform primary care practices, reduce fee-for-service arrangements, and lead to better patient outcomes. The intention is, and should remain, to achieve those goals without increasing the total cost of care. Specifically, the bill calls for the Collaborative to:

> "Develop recommendations to increase the use of alternative payment models that are not paid on a fee-for-service or per-claim basis to:
>
> - Increase the investment in advanced primary care delivered by practices that are patient-centered medical homes;[2]
>
> Direct investment towards higher value primary care services with an aim toward reducing health disparities;[3]

[1] Standard Operating Procedures and Rules of Order.
https://drive.google.com/file/d/1Ggf8nwLHV9K8IJBqb2JLYtfFdtcyFULN/view
[2] Ibid, Section 2 10-16-150 (g).
[3] Ibid, Section 2 10-16-150 (III).

- Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of care.[4]"

We voted in opposition to the recommendation to increase fee-for-service payments in primary care by 1% annually for the next two years, because:

1. It does not reflect the charge of the Primary Care Reform Collaborative as stated in HB19 – 1233;
2. It is not based in data, including an understanding of either current or appropriate levels of primary care spend;
3. It assumes all levels of primary care spend in Colorado today are insufficient;
4. It does not provide guidance or tools for plans to increase their investment in the current environment of escalating health care costs;
5. It does not provide clarity around how the significant additional dollars should be spent, and increasing spend without discipline will likely increase, rather than decrease, cost trends;
6. It does not promote alternative payment models;
7. It is a spending increase without a funding source.

We would welcome the opportunity to continue the robust discussions that occurred on December 2 with the provider and consumer communities where we agreed that investments should be tied to the expansion of value-based payments.

If we want to incentivize more investment in primary care via alternative payment models, we should be looking at how to increase the prevalence of alternative payment models in primary care -- not just spending on primary care. Additionally, we must ensure that investment returns value to employers, taxpayers and consumers, with commensurate focus on quality metrics, integration of physical and behavioral health, and appropriate utilization of other, costly acute health care and pharmacy services.[5] Lastly, we feel that additional evaluation of data must occur to determine the current levels of primary care spend in Colorado, as well as determination of the appropriate level of primary care spend, before setting a target. We do not agree with setting a target, which adds millions of dollars to the healthcare system, without first understanding whether that target is appropriate to reduce costs long-term.

The bill also expressly states that the Primary Care Reform Collaborative is to, "Advise in the development of the affordability standards and targets for carrier investments in primary care established in accordance with Section 10-16-107 (3.5)[6]. However, the Commissioner of Insurance reiterated at the December 2 meeting that input about affordability was unnecessary. We are concerned that we are not fulfilling our charge as Collaborative members, particularly because "In developing these [affordability] standards, the Commissioner shall consider the recommendations of the Primary Care Reform Collaborative."[7]

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[4] Ibid, Section 2 10-16-150 (III) (h).
[5] Ibid, Section 2 10-16-150 (I) (II) (IV).
[6] Section 2 (b). Concerning Payment System Reforms to Reduce Health Care Costs by Increasing Utilization of Primary Care, and, in Connection Therewith, Making an Appropriation.
https://leg.colorado.gov/sites/default/files/2019a_1233_signed.pdf
[7] Ibid, Section 4 10-16-107 (3.5).

We appreciate the opportunity to provide this explanation as part of our membership on the Primary Care Reform Collaborative. We are committed to ensuring that the Collaborative follow through on the charge provided in HB19 – 1233 and to work with all of the Collaborative members to achieve the goal of increasing investment in alternative payment models for primary care. We ask that this explanation be included in the final report of the Collaborative in order to guide our future discussions on these topics.

Sincerely,

Gretchen McGinnis, MSPH

Sr. Vice President of Healthcare Systems and Accountable Care

Colorado Access

Miranda Ross, FSA, MAAA

Executive Director, Actuarial Services

Kaiser Permanente

Patrick Gordon

President & CEO

Rocky Mountain Health Plans