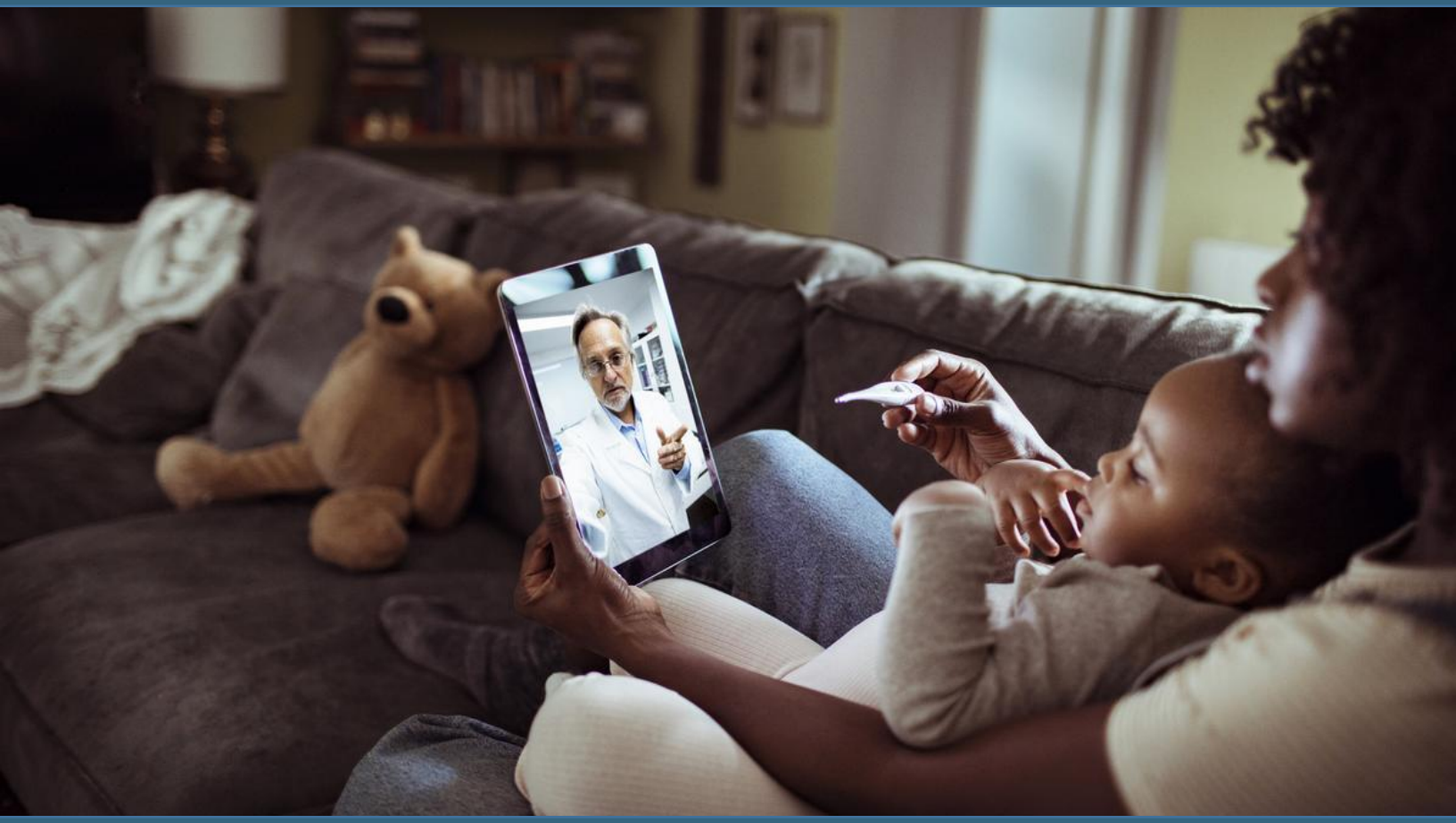

Colorado Primary Care Payment Reform Collaborative Recommendations

SECOND ANNUAL REPORT

December 15, 2020

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Executive Summary

The year 2020 has been like few others. As the Colorado Primary Care Payment Reform Collaborative (the Collaborative) began its first full year of work to strengthen Colorado's primary care infrastructure, the health care landscape in the state and the nation radically shifted. The COVID-19 pandemic exposed and exacerbated existing fractures within the U.S. health care infrastructure, shining new light on fundamental weaknesses such as provider reimbursement structures tied to the volume, rather than the value of care, and systemic inequities that continue to perpetuate racial, ethnic, and other health disparities.

Yet with great challenges come great opportunities - and the Collaborative has continued to actively pursue the charge laid out by the Colorado General Assembly in 2019 (House Bill 19-1233) to improve care delivery and health outcomes, and reduce health care costs, through increased investments in primary care. Building off recommendations included in the Collaborative's *First Annual Report* (published in December 2019), this year's report offers additional guidance around alternative payment model (APM) structures that will best support and sustain primary care providers and practices, during and beyond the COVID-19 pandemic; the types of measures that should be monitored and evaluated to ensure actions to strengthen primary care are having the desired outcomes; and actions to ensure equity is embedded in all aspects of this work. The five recommendations in this Second Annual Report include:

- **Multi-payer alignment.** Multi-payer alignment is crucial to the success of alternative payment models (APMs), and Colorado should build upon the prior and ongoing work of payers and providers to advance high quality, value-based care. Practices need common goals and expectations across payers in order to transform care delivery and shift from fee-for-service (FFS) to value-based payment at the practice-level. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices.

- **Measuring primary care capacity and performance.** Measures used to evaluate primary care APMs should be aligned across public and private payers and reflect a holistic evaluation of practice capacity and performance.

- **Measuring system-level success.** Measures to determine whether increased investment in primary care and increased use of APMs are achieving positive effects on the health care system should examine various aspects of care and value.

- **Incorporating equity in the governance of health reform initiatives.** The governance of initiatives to support and enhance primary care services should reflect the diversity of the population of Colorado.

- **Data collection to address health equity.** Data collection at the plan, health system, and practice-level should allow analysis of racial and ethnic disparities.

Colorado's Primary Care Payment Reform Collaborative

The Collaborative was established by House Bill 19-1233 (HB19-1233) in 2019 to develop recommendations and strategies for payment system reforms to reduce health care costs by increasing utilization of primary care. The Collaborative's work is rooted in an established and growing evidence base demonstrating a strong, adequately resourced primary care system will help ensure Coloradans have access to the right care, in the right place, at the right time.

The Collaborative, first convened by the Colorado Insurance Commissioner on July 8, 2019, is specifically 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 (APCD) to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado's Medicaid Program), and Children's 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 APMs by health insurers and providers and develop recommendations to address these barriers;
- **Develop** recommendations to increase the use of APMs that are not FFS in order to:
    - Increase investment in advanced primary care models,
    - Align primary care reimbursement models across payers,
    - 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;
- **Develop** and share best practices and technical assistance to health insurers and consumers.

Each year by December 15, the Collaborative is directed to publish primary care recommendations in a report that is available electronically to the general public. The Collaborative reached the findings and recommendations in this report through an open and transparent process. The report was approved in its entirety by the Collaborative by unanimous consensus.

All Collaborative meetings are open to the public, with meeting times and locations posted in advance on the Colorado Division of Insurance's (the Division, or DOI) Primary Care Payment Reform Collaborative website. Time is reserved during each meeting for public comments, and future meeting logistics, past meeting materials, and all Collaborative reports are posted publicly to the website. The Collaborative held a total of fifteen meetings in 2020.

Members of the Collaborative were selected by DOI through an open application process, and serve one-year terms with the opportunity for one year re-appointment, for a total of two years (the Collaborative's Standard Operating Procedures and Rules of Order are included as Appendix A.) Collaborative members represent a diversity of perspectives, including:

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

The Collaborative is scheduled to sunset on September 1, 2025.

Introduction

Since its inception in July of 2019, the Collaborative has assumed an important role in Colorado's ongoing efforts to optimize health system performance through achievement of the Quadruple Aim.[1] In the *First Annual Report*, members set forth the following recommendations to establish a framework and guiding principles to strengthen primary care:

The Quadruple Aim framework seeks to improve health care across four dimensions:

- **Improving the health of populations;**
- **Enhancing patient experience of care;**
- **Reducing the costs of health care; and**
- **Improving the work life of providers, including clinicians and staff.**

- The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both FFS and APMs.
- All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least one (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 APMs that offer prospective funding and incentives for improving quality.

In early 2020, the Collaborative partnered with the Center for Improving Value in Health Care (CIVHC), the administrator of Colorado's APCD, to operationalize the recommended definition of primary care.[2] The resulting improvements in the state's capacity to collect and analyze primary care and APM spending data are reflected in the recently released *Report of Colorado Primary Care Spending and Alternative Payment Model Use, 2017-2019* (included as Appendix B).

As the first wave of the COVID-19 pandemic swept across Colorado in early March, Collaborative members' attention necessarily turned to the immediate emergency response. The group resumed work in April, focusing on innovative actions that could help address the physical, emotional, and financial impacts of the virus on patients as well as providers. The rapid adoption and expansion of telehealth, which served as an important lifeline for many primary care practices and patients, was of particular interest. In July, the Collaborative released a report of *Recommendations Regarding the Use of Telehealth to Support Primary Care Delivery during the COVID-19 Pandemic and Beyond* (included as Appendix C).

This fall, the Collaborative helped inform aspects of the Division's adoption of Colorado Regulation 4-2-72 (included as Appendix D), which mandates the recommended annual one percentage point (1%) increase in the proportion of total medical expenditures allocated to primary care for commercial health insurers operating in Colorado in 2022 and 2023.[3] In keeping with the Collaborative's guidance that "increased primary care investments should be offered primarily through infrastructure investments and APMs that offer prospective funding," the regulation also directs commercial carriers to increase the percentage of total medical expenditures made through APMs to 50% by the end of calendar year 2022. The regulation further directs carriers to target 25% of total primary care expenditures, and 10% of total APM expenditures, to be made through prospective payments by the end of calendar years 2023 and 2022, respectively. These targets were set prior to the publication of the CIVHC report, and the Collaborative will continue to formulate recommendations and strategies for increasing the use of APMs by both providers and insurers.

While COVID-19 has been a backdrop for the Collaborative's work in 2020, the Collaborative recognizes the course of the pandemic has revealed, rather than caused, existing flaws in the health care system. The recommendations in the Second Annual Report are based on principles and concepts that pre-date COVID-19, but have taken on increased urgency in light of the ongoing public health crisis. Key themes informing the recommendations and overall report are:

- Payers (including commercial health insurance carriers, self-funded employers, Medicare, and Medicaid), providers, patients, and policymakers must work collaboratively with one another in order for primary care payment enhancements to have a widespread and positive effect on health care costs and quality of care; and

- The work of strengthening primary care as a foundational component of the state's health care system requires bold solutions. The Collaborative recognizes system-level changes are neither fast nor easy, and the shared goals and objectives included in this report encompass a broad scope and significant level of complexity. Fortunately, there is a strong foundation for ongoing collaboration to achieve these aims.

Role of Payment Reform in Supporting Primary Care Practices

In the *First Annual Report*, the Collaborative emphasized the role of APMs in supporting primary care, unanimously recommending that increased investments in primary care should be offered through infrastructure investments and APMs that offer prospective funding and incentives for improving quality. This recommendation was based on evidence and observations that comprehensive, patient-centered care is often not fully reimbursed by traditional FFS models, and may even reduce FFS payments (e.g., care coordination may avoid duplicate testing that otherwise would have been reimbursed).

The faults inherent in FFS payment systems, which incent volume of services rather than the value of care, were thrown into dramatic relief by the COVID-19 pandemic. The overall use of health care services in the U.S. declined by 23% in March of 2020 and 52% in April, compared to previous trends.[4] Primary care, which derives the majority of revenue from in-person evaluation and management (E&M) visits, was particularly vulnerable to the sudden cessation of in-person care.[5] The number of primary care visits between January and May of 2020 fell by 21.4% (27 million visits) compared to the same period in 2019, with office-based primary care visits decreasing by 51.2% (59.1 million visits).[6] Pediatric practices were particularly hard hit, with practice managers reporting caseloads as low as 20-30% of previous volume. In addition, many pediatricians were not eligible for initial distributions of federal provider relief funds, which focused heavily on Medicare.[7] While data from October 2020 has shown an overall rebound in outpatient visits, this trend has not applied universally across patients or providers; weekly visits are still below baseline for pediatricians, behavioral health providers, and adult primary care providers in practices with one to five clinicians.[8] The financial impacts have been severe and ongoing; a recent Health Affairs analysis estimated a net loss of nearly $15 billion across the primary care system in calendar year 2020, even under optimistic assumptions (i.e., without a return to stay-at-home restrictions).[9]

The Collaborative acknowledges a systemic shift away from FFS in Colorado toward value-based payment will require ongoing collaboration and an equal commitment from payers and providers. APMs are investments that require mutual participation by payers and providers. Payers need the flexibility to develop payment models based on their enrollee populations and business needs, as well as mechanisms to differentiate and hold providers accountable for attaining care competencies and delivering high-quality care that improves outcomes and reduces costs. Providers need adequate resources (financial, data, guidelines, etc.) to support practice transformation efforts, but must also demonstrate willingness and capacity to meet defined measures and reduce costs. Alignment across public and private payers will help facilitate continued provider adoption of APMs, by reducing administrative burdens, but is not without challenges. The recommendations for APMs in this Second Annual Report offer guidance on how to best support and facilitate relationships between payers and providers in Colorado, while recognizing the diversity of practice types and payer models, to help ensure increased investments in primary care drive value in the health care system.

Multi-payer Alignment

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COLLABORATIVE RECOMMENDATION #1
Multi-payer alignment.

Multi-payer alignment is crucial to the success of alternative payment models (APMs), and Colorado should build upon the prior and ongoing work of payers and providers to advance high quality, value-based care. Practices need common goals and expectations across payers in order to transform care delivery and shift from fee-for-service (FFS) to value-based payments at the practice-level. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices.

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Colorado's marketplace includes a diversity of private (commercial health insurance and self-funded employer plans) and public (Health First Colorado, CHP+, and Medicare) payers. Critical aspects of payer alignment across APMs, which are essential to achieving system-level goals of improved patient care quality and outcomes and reduced costs, include the following:

- **Shift toward comprehensive, prospective payments, realized at the practice-level.** Colorado has made significant strides over the past decade in moving from FFS to APMs, yet a significant portion of primary care payment still remains volume and encounter-based.[10] Further progress toward value-based payments can be achieved through alignment between various payer APMs, and reduced reliance on FFS models by both payers and providers. APM alignment will facilitate practice adoption and reduce provider burnout by minimizing the need for practices to manage different reimbursement structures and requirements for different patients (based on their insurance coverage). To increase the ability of APMs to lead to meaningful change, value-based payments should be realized at the practice-level to support care delivery changes that allow for the provision of whole-person care. The Collaborative recognizes the challenges this may pose, particularly for large national payers and health systems that have limited mechanisms to engage directly with individual practices across states. The Collaborative will continue to discuss and explore opportunities to develop mechanisms to help ensure APM payments are seen at the practice-level.

    - **Continue progress toward a majority of payments that are non-volume and non-encounter based**. Comprehensive, prospective payments include payments intended to cover comprehensive services for a period of time (e.g., a per-member, per-month [PMPM] amount), or a calculated lump sum intended to support costs for practice transformation. Also, payments can be structured around episodes of care, for managing specific conditions such as patient asthma or diabetes, and are linked to a total cost of care (TCC) arrangement.

- **Provide access to start-up funds to support practice transformation.** To ensure that practices are able to obtain support for practice transformation, the Collaborative recommends that practices who commit to meeting pre-determined care delivery changes, and develop a plan to do so, have access to start-up funds, with further APM participation contingent on achieving their planned care delivery improvements.

- **Develop a shared framework for participation in APMs and care delivery expectations.** The Collaborative proposes the use of proven models for advanced care delivery, such as the Building Blocks of High Performing Primary Care, to develop a more standardized framework of advanced care delivery in Colorado. Agreement on the core competencies identified in such models, which are essential to the delivery of whole person care, is an important step in identifying additional opportunities for further alignment around the more granular aspects of APM structures (i.e., quality measures).

  - **Provide technical support for practice transformation.** Prospective payments support care transformation but may not be sufficient without technical assistance for practices. The Collaborative plans to engage the Colorado Multi-Payer Collaborative (MPC), a self-funded, working collaborative of payer organizations[11] focused on transforming care and reforming payment, in a discussion about the potential creation of a centralized pool of funds for practice transformation assistance as part of their increased investments in primary care. The Collaborative recognizes existing public and private payer initiatives that currently support practice transformation efforts in Colorado, but this could be a first step toward creating a more stable and sustainable funding mechanism, as well as a more uniform structure for technical assistance, to support broader statewide adoption of advanced primary care models, while recognizing the multi-payer environment in which most practices operate.

  - **Build on the success of existing efforts and models in Colorado.** Payers and providers in Colorado have been at the forefront of care delivery and payment reform efforts - at the federal, state, and payer level - for well over a decade. In 2011, HCPF adopted an innovative new model, called the Accountable Care Collaborative (ACC), to connect Medicaid members to primary care and improve care coordination. Now in Phase II, the ACC has had demonstrable impacts on improving member health and reducing costs. Public and private payers in Colorado have also participated in several federal care delivery and payment reform models, including the Comprehensive Primary Care (CPC) initiative, the State Innovation Model (SIM), and Comprehensive Primary Care Plus (CPC+) model (see Appendix E for a brief description of these initiatives). The Colorado MPC, formed to facilitate and support multi-payer participation in CPC, has built upon the modified building block framework for integrated care delivery, developed under Colorado's SIM initiative, to create a “Framework for Whole-Person Care.” This framework outlines a common pathway of competencies to guide practice-level adoption of integrated care delivery and APMs. In addition, the Colorado

MPC has developed aligned sets of quality measures for adult and pediatric patients, which are being incorporated into value-based provider contracts across participating payers. Individually and collectively, these achievements provide a strong foundation for future efforts to increase multi-payer alignment.

  - **Explore solutions from other states.** While Colorado has a track record of success with care delivery and payment reform, much can be learned from other states currently pursuing initiatives to increase investments in primary care delivery. As an example, several strategies being employed by Rhode Island, such as paying practices for obtaining and maintaining a Patient Centered Medical Home (PCMH) designation and encouraging payers to support practice transformation efforts through initial infrastructure payments, followed by ongoing care management PMPM payments, could be explored by the Collaborative and may serve as a source for future recommendations.

- **Resource intensity and risk adjustment.** Value-based prospective payments should be risk adjusted to match resources to patient needs. Risk adjustment methods should incorporate measures of physical health, behavioral health, and social risk at both the individual- and community-level. In highlighting social risk as an essential component of risk adjustment, the Collaborative recognizes the time and effort that have been involved in developing risk adjustment methodologies currently in use, and acknowledges the challenges of adapting current payer-level risk adjustment tools (i.e., Hierarchical Condition Categories) that are largely based on clinical or diagnostic criteria to primary care practices. Diagnostic complexity does not fully capture resource intensity or risk, and while the Collaborative is committed to addressing social risk and creating incentives for practices to accept socially complex, resource intensive patients, it recognizes that modifying current risk adjustment methods to primary care practices will be a significant undertaking. Collaboration between private and public payers will be needed to ensure such efforts do not result in additional areas of differentiation (i.e., the creation of multiple, payer-specific models).

  - **Risk adjustment for pediatric practices.** The Collaborative further recognizes that current risk adjustment methodologies, often developed using standard populations that include adults and children, do not translate well to pediatric-only populations.[12] Risk adjustment is needed to ensure

Social Determinants of Health (SDOH): Social determinants of health, as defined by the World Health Organization, are "the conditions in which people are born, grow, live and age," and are "shaped by the distribution of money, power and resources." SDOH are social factors - such as income, education, employment, and housing - that can either increase or constrain a person's capacity to be healthy. As such, they are neither inherently negative nor positive.

Social Risk Factors: Social risk factors are specific adverse social conditions that are associated with poor health, such as food insecurity and housing instability. Alternatively defined as "individual-level adverse social determinants of health," social risks have real and significant impacts on health outcomes.

Source: H. Alderwick and L. Gottlieb. (2019.) "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Systems." Milbank Quarterly, June 2019.

APMs do not have the unintended effect of discouraging providers from accepting chronically ill and socially complex (high resource intensity) patients, and must also recognize and account for the needs of pediatric populations and providers.

Multi-payer alignment in support of care delivery and payment reform has been and will continue to be an ongoing process in Colorado. While the faults inherent in FFS payment structures have been laid bare by the COVID-19 pandemic, and given new momentum to the shift toward value-based payments, challenges nevertheless remain. Payers and providers approach APMs from different perspectives, resulting in a "chicken-egg" problem where practices feel they are unable to transform care without additional funding, while payers feel they are not justified in increasing funding without evidence of change in care delivery or outcomes. In addition, the Colorado marketplace is characterized by national payers with unique payment arrangements, which are not only difficult to adapt to state-specific models, but in many instances are considered distinguishing features from their competitors.

Despite these challenges, Colorado is well-positioned and committed to moving forward with payment reform. The Colorado MPC is a testament to payers' continued commitment and desire to support practice transformation efforts that improve health outcomes and reduce costs. In addition to the federal and state multi-payer models mentioned above, the Collaborative also recognizes the importance and contributions of payer-specific models, which have made a consistent and concerted effort to support primary care in the state.

The Collaborative is committed to finding solutions to the complex issues associated with multi-payer alignment, and developing recommendations that not only set a vision for statewide payment reform, but offer practical guidance and direction to public and private payers and providers. Efforts to address payers under the jurisdiction of the Division of Insurance, through Regulation 4-2-72 and future affordability standards, provide only partial solutions, as commercial health plans only reflect a portion of a given practice's patient panel. Alignment with Medicaid and self-funded (ERISA) plans is also needed, and the Collaborative will continue to identify opportunities to encourage voluntary participation while exploring policy and other mechanisms to further accelerate alignment.

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Measuring Primary Care Capacity and Performance

The Collaborative recognizes certain value-based payment arrangements, such as pay-for-performance, may increase provider and practice burden while having a very modest or minimal impact on comprehensive outcomes. This issue is exacerbated when reimbursement structures have a singular focus on the achievement of quality metrics, as opposed to a more holistic evaluation of practice capacity and performance, and when metrics are inconsistent across payers.

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COLLABORATIVE RECOMMENDATION #2
Measuring primary care capacity and performance.

Measures used to evaluate primary care APMs should be aligned across public and private payers and reflect a holistic evaluation of practice capacity and performance.

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While accounting for variations in individual practice characteristics, evaluation measures should be structured in a manner to:

- **Support system-level metrics for improved primary care.** Measures at the practice-level (micro) should be correlated with and contribute to the achievement of measures used to evaluate system-level (macro) goals to evaluate the impact of increased investment in primary care. Metrics that do not contribute to desired system reforms around care delivery, health outcomes, and cost reduction, may unnecessarily add to provider burden and impede or preclude provider participation.

- **Engender continuous practice improvement.** Any use of quality metrics should recognize improvement on metrics in addition to high performance on metrics. Practices will vary in both characteristics and capacities, and need an accessible "on ramp" to engage in practice transformation and APMs, but also need to be accountable for demonstrating progress and increased competencies to deliver advanced care.

    - **Age relevancy**. In designing APMs and selecting quality metrics, practice-level characteristics, such as the age of the population served, must be considered. Pediatric practices should not be evaluated on adult-based metrics; providers should have an equal opportunity to achieve success, and receive comparable payment incentives, based on measures that are relevant to the age of the population served.

- **Prioritize equity and address health disparities.** Differences in the demographics of various patient and payer populations must be considered in the design of APM measures. As noted in the previous recommendation around multi-payer alignment, risk adjustment models should incorporate a patient's social as well as diagnostic risks to adequately account for resource intensity. Systemic inequities negatively impact access to social determinants of health, and are key drivers of health disparities experienced by marginalized populations and communities. APM measures should not penalize or disadvantage providers who serve those with the greatest needs and least access to resources. Additional recommendations to incorporate equity into system-level measures and to develop a data collection framework that will allow for evaluations of the impact of strategies to improve primary care on different populations are included in recommendations three (measuring system-level success) and five (data collection) in this report.

- **Consider sustained practice contributions toward total cost of care (TCC) savings and high performance (at baseline) on quality measures.** Primary care payment models that reward incremental improvement are important, but at a certain point may penalize high performing practices, and create a disincentive to continue improvement (i.e., it is difficult for a practice that is performing at 95% of a given metric to achieve a full 100%). Benchmarks for shared savings arrangements based on historic performance may be structured in a manner that unintentionally rewards providers who are less efficient at baseline over higher performers. As we strive to shift resources toward preventive and primary care based models, we must develop payment models that capture and reward sustained contributions to quality and TCC savings.

- **Engender practice and provider stability and satisfaction.** The quality of work life for providers, including clinicians and staff, is widely recognized as an essential component of the Quadruple Aim.[13] Increasing and sustaining provider satisfaction, through actions that reduce burnout and support providers' physical, mental, and financial well-being, must be a priority for Colorado's efforts to strengthen primary care.

    - **Simplify reporting requirements.** Limiting the overall number of reporting requirements for practices through multi-payer alignment will reduce administrative burden on providers and payers.

    - **Address the challenges of independent primary care practices.** Independent primary care practices, which are typically smaller in size and patient panels, often struggle with value-based payment models. Relatively small patient populations make measurement challenging (i.e., both the numerator and denominator for metrics related to a given condition are extremely volatile and harder to manage). Such practices also lack resources available to larger practices, or those that are part of larger organizations or systems, which causes additional strain on staff capacity and practice financial stability. The preservation of independent practices is important not only in maintaining health care access for Coloradans, but in balancing the increasing trend toward provider consolidation, which has been shown to increase health care costs.[14] APMs should take into account the challenges associated with such payment arrangements, and consider ways in which to encourage participation of independent practices.

- **Include patient voice.** Patient experience is another core component of the Quadruple Aim, and is essential to understanding and improving quality of care. While acknowledging the challenges and limitations of current patient satisfaction measures (such as the Consumer Assessment of Healthcare Providers and Systems data), the Collaborative agrees information about patient experience of care is essential to guide practice transformation efforts. Provider-level data is needed to identify practice strengths and weaknesses, and could be collected through mechanisms such as validated patient experience surveys or patient and family advisory councils. The person-centered primary care measure is a recently validated patient assessment of primary care practice functions that could also be considered for this purpose.[15]

Given the heterogeneity of practices and patient populations, as well as the range of payer models in the state, the Collaborative has discussed a "menu approach" to measure selection that would allow payers and providers to agree on a set of metrics that are best suited to their setting. While alignment and standardization of quality metrics is a challenging and longer-term goal, as a potential first step in developing a common menu, payers could be encouraged to shift to using only nationally recognized measures (such as National Quality Forum measures), which would limit the "universe" of APM measures as conversations around multi-payer alignment continue. The adult and pediatric measures developed by the Colorado MPC, which are already in use by multiple payers in Colorado, offer another starting point.

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Measures of Success

The ultimate goal of the Collaborative's work is to advance Colorado's achievement of the Quadruple Aim through the enhanced delivery of high-quality primary care services. As the state builds upon existing work and begins to implement new strategies to strengthen primary care – through increased investments in advanced primary care delivery models, offered primarily through infrastructure investments and APMs - a measurement and evaluation framework is needed to ensure such efforts are having the desired impact on health care quality and costs.

In the *First Annual Report*, the Collaborative highlighted the importance of identifying measures of success in the short-, medium-, and long-term. In this Second Annual Report, the Collaborative is proposing metric "types" or categories, ranging from short- to long-term, to help guide and evaluate the actions of payers, providers, and policymakers to move Colorado toward the ultimate goals of improving health care delivery and outcomes while reducing health care costs.

In considering measures, the Collaborative has discussed shorter-term metrics, centered on practice-level changes (micro data), as well as longer-term metrics that yield information on populations and larger system impacts (macro data). While some metrics might be better suited for one particular timeframe, they should be interrelated, in that practice-level measures may be expanded to include the larger system, and system-level measures should inform data being collected at the practice-level.

The previous (second) recommendation in this report focuses on measures that should be considered at the practice-level (micro) in the design and implementation of APMs. The recommendation in this section considers the types or "categories" of system-level (macro) measures to evaluate the success of Colorado's efforts to improve care delivery, health outcomes, and reduce costs through increased investment in primary care.

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COLLABORATIVE RECOMMENDATION #3
Measuring system-level success.

Measures to determine whether increased investment in primary care and increased use of APMs are achieving positive effects on the health care system should examine various aspects of care and value.

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The Collaborative recommends inclusion of the following categories of measures to evaluate system-level impacts of increased investment in primary care and increased use of APMs, using the Quadruple Aim as an organizing framework:

Quality of care (improving population health)

As Colorado strives to optimize health care value, it is critical that that quality of care be maintained and enhanced over time.

- **Health Outcomes (quality of care).** Selected clinical quality measures, such as indicators of chronic disease control, use of preventive services, and patient reported outcomes (including self-reported view of health and health-related quality of life) could be helpful across all timeframes, and should be disaggregated based on demographics so health disparities can be better examined and addressed. Conditions that disproportionately affect Black, Indigenous, and People of Color (BIPOC) and other marginalized populations and communities, should be prioritized. Additional information about the Collaborative's proposed framework for data collection, with an initial focus on racial equity, is contained in the fifth recommendation in this report.

- **Adoption of advanced primary care models and movement toward APMs.** Quality of care can be evaluated by looking at provider adoption of advanced primary care models, which are designed to increase patient access to care, improve provider continuity, and enhance the comprehensiveness of care delivered. Movement toward APMs, to support the development of competencies for whole person care, can be measured by tracking the proportion of an insurer's covered lives under these arrangements, as well as the proportion of primary care payments in an APM.

Costs of care

Enhanced primary care services are expected to reduce health care costs in Colorado by preventing or avoiding unnecessary (and often more expensive) utilization of downstream services. To monitor and assess the overall impacts of strategies to increase primary care investments, the Collaborative recommends the following categories of measures:

- **Decreases in unnecessary and preventable acute care.** Measures that track the avoidance (or decrease) of unnecessary and preventable acute care, such as ambulatory sensitive emergency department (ED) visits and ambulatory-sensitive hospitalizations and readmissions, will help evaluate cost savings achieved through the

reduction of high costs services. In addition, tracking metrics such as laboratory, diagnostics, and medication usage will help identify increases in the delivery of high-value care (and conversely, decreases in low-value care).

- **Affordability for patients.** Cost savings resulting from system-level changes should be shared with consumers. Colorado's health insurance rate review process will ensure carriers direct actual cost savings to consumers through mechanisms such as premium decreases, reduced cost sharing, and improved or enhanced benefits. To better identify impacts on consumers, the Collaborative suggests reviewing data points such as the average premium for commercial health insurance plans, medical and pharmaceutical trend data, and the proportion of the population that is insured, noting such metrics will be impacted by other factors and will provide directional indicators of success of investments in primary care.

- **Total cost of care (TCC).** Reducing health care costs in Colorado is a core priority for Governor Polis' administration, and a primary objective of the Collaborative's work to strengthen primary care. Measuring practice-level contributions to TCC savings is included in the previous recommendation as an important "micro" level metric. Measuring the overall, long-term impact of increased investments in primary care and the adoption of APMs on TCC will be a key measure of system-level success.

    - **Variation by provider and practice type.** If practice-specific costs of care are included, they will likely vary by specialty. For example, pediatrics may have fewer cost saving opportunities, and a longer term return on investment, than internal medicine. Consideration of practice-level costs of care will also need to be risk adjusted.

Patient experience

Patient assessments of quality of care, highlighted in the previous recommendation as an important practice-level measure, are also essential for measuring and informing system-level changes in the short-, medium-, and long-term.

- **Patient satisfaction.** Patient satisfaction surveys offer an immediate mechanism for collecting patient experience information, but should be disaggregated by demographics and other population characteristics to identify disparities. Equity can be examined through targeted measures such as perceived unfairness of care.

- **Primary care service utilization (patient access to care).** While increased utilization of primary care services, as a measure of increased access to care, is a desired outcome, the Collaborative recognizes current challenges associated with measuring utilization of non-encounter or non-visit based services, an essential component of whole-person centered, advanced primary care delivery models. Key considerations in the development of specific measures will be: what are the components of primary care utilization that we are most interested in tracking, and how will they indicate increased investments are having the desired impacts? Despite these challenges, collecting data about patient perceptions of access to care, as part of patient experience, will offer initial insights, as additional measures are developed.

Provider satisfaction

The overall satisfaction and well-being of primary care providers are essential to sustaining and strengthening primary care in Colorado. Measures to evaluate the impact of strategies to increase primary care investments on the workforce must be a component of system-level evaluations.

- In the short term, potential measures include clinician and staff turnover, and surveys to evaluate burnout, joy of practice, and fulfillment in work.
- The primary care provider to population ratio can also be tracked to help assess retention and potential expansion of the primary care workforce in Colorado. A strong, highly-qualified, culturally competent workforce of primary care providers is foundational to Colorado's health care infrastructure, and has been identified as an important area for future work. Additional workforce considerations are included in the Future Work section of this report.

SUMMARY OF PROPOSED MEASURES OF SUCCESS

Quality of Care	Costs of Care	Patient Experience	Provider Satisfaction
Disease management	Ambulatory-sensitive ED utilization	Patient satisfaction surveys	Provider and staff surveys
Preventive services	Ambulatory-sensitive hospitalizations	Perceived unfair treatment	Primary care provider to population ratio
Patient-reported health outcomes	Hospital readmissions	Patient-reported access to care	
Adoption of advanced care delivery models	Affordability for patients		
Proportion of covered lives in APMs & payments made through APMs	Total cost of care		

The Collaborative recognizes certain categories pertain more to the shorter term goals, others to longer term objectives, while some may include metrics for both. Future work is needed to determine which metrics have short-, medium-, and long- term implications for desired goals, and such metrics will need to be refined over time. The timing and duration of measures must also be considered to balance the need for timely value-based payments and provider accountability for delivering change.

The collection and analysis of the types of data outlined above, as well as the achievement of long-term outcomes and objectives, will require ongoing collaboration, communication, and partnership across multiple stakeholders. Strategies will need to be developed to identify how, where, when, and by whom the measures are gathered and assessed. Care

should also be taken to ensure data can be collected, measured, and reported on without introducing significant new administrative and reporting burdens into the system; an existing mechanism, such as CIVHC and the Colorado APCD, should be considered for reporting on many measures. In addition, the Collaborative acknowledges that other health care initiatives in the state are happening simultaneously, which will also have an impact on many of the outcome measures discussed above. In interpreting and reporting metrics data, it will be important to note that observed changes - either positive or negative - cannot be entirely attributed to primary care enhancements.

* * * * *

Ensuring Equitable Access to Care and Reducing Health Disparities

Due to centuries of systemic racism, Black, Indigenous, and other People of Color (BIPOC) face significantly greater barriers in accessing affordable, quality health care services and health insurance coverage in comparison to white people. BIPOC communities also face significant inequity in health outcomes as compared to white communities.[16] According to the U.S. Centers for Disease Control and Prevention (CDC), Black Americans face a lifetime of poorer health outcomes, beginning with higher infant and maternal mortality rates and ending in lower life expectancy.[17] The COVID-19 pandemic has accentuated and exacerbated inequitable outcomes for racial and ethnic minorities, in Colorado and nationally, when measured by rates of COVID-19 cases, hospitalizations, and deaths per 100,000 people.[18]

As defined by the Robert Wood Johnson Foundation: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[19] In the *First Annual Report*, the Collaborative established equity as a foundational principle of its work by incorporating the equitable provision of services into the recommended definition of primary care. Moving forward, the Collaborative is putting forth the following initial recommendations to help ensure equity is operationalized in efforts to strengthen primary care.

Governance of Initiatives

The Collaborative recognizes the importance of a diversity of perspectives in creating policy recommendations. To create truly equitable solutions, the governance of initiatives, including the Collaborative, must reflect the diversity of the populations they serve.

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COLLABORATIVE RECOMMENDATION #4
Incorporating equity in the governance of health reform initiatives.

The governance of initiatives to support and enhance primary care services should reflect the diversity of the population of Colorado.

♦ APPROVED BY UNANIMOUS CONSENSUS ♦

Agencies and organizations engaged in initiatives to improve the health of Coloradans should approach the design, development, and implementation of such work with an equity lens. People of diverse backgrounds should occupy a variety of roles throughout the process, from leadership of the group, to planning and implementation, to data collection and analysis, and the evaluation of outcomes. To truly create equitable solutions, the governance of initiatives, including the Collaborative, must reflect the diversity of the population it serves.

Diversity is included as a selection criterion for Collaborative members (as set forth in the Standard Operating Procedures and Rules of Order, included as Appendix A), and is a priority for the Collaborative and the Division, which is responsible for member selection and group facilitation. While the annual member recruitment process is an ongoing opportunity to increase the diversity of Collaborative leadership, it should not be a singular point of engagement with all organizations and communities whose voices are critical to informing the group's work. Rather, the successful recruitment and retention of diversified leadership on the Collaborative relies on the development of relationships with community organizations and representatives, so they are not only aware of but become connected to and part of the mission and work of the Collaborative to strengthen primary care.

The Colorado Office of Health Equity, part of CDPHE, has developed a community engagement continuum to assist organizations in operationalizing community engagement across a variety of categories. The Collaborative can potentially use this model to guide initial outreach and consultation with organizations and representatives from diverse communities, including those disproportionately impacted by health disparities, as an important first step towards diversified leadership.

Colorado's Community Engagement Spectrum

Increasing Level of Community Involvement, Impact, Trust and Communication Flow Increasing Ownership, Empowerment Skills, Opportunities and Supports of Both Staff and Community Please note: Each level has value				
Participation		Engagement		Partnership
Outreach	Consult	Involve	Collaborate	Share Leadership
Communication flows from the program or initiative to **inform** community members.	Community members **provide one-time or periodic feedback**.	Communication flows both ways and community members provide **ongoing participation**.	Community members **influence decision-making**.	Community members **share power and responsibility** making decisions together.
Outcome: Optimally establishes communication and outreach channels while sharing information with the community.	Outcome: Develops connections.	Outcome: Establishes visibility of the partner and increased cooperation.	Outcome: Increased trust and partnership-building.	Outcome: A strong partnership with bidirectional trust that affects broader community health outcomes.
Adapted from CDC: McCloskey et al. (2011). Community Engagement: Definitions and Organizing Concepts from the Literature, Principles of Community Engagement: Concepts and Definitions from the Literature (p 8).				

Source: "Authentic Community Engagement to Advance Equity." CDPHE. https://drive.google.com/file/d/119lenK B-zvTeQHUjanB0MS7rkx-Wr-UJ/view

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Data Collection

The COVID-19 pandemic has highlighted the long-standing racial and ethnic health disparities noted above, and revealed important gaps in the collection and analysis of demographic and other data that is essential to both understanding and addressing disparate health outcomes. To identify health disparities and create data-driven solutions, data collection to determine the magnitude of these health disparities must be improved across the health system. The Collaborative acknowledges that multiple populations and communities face structural inequities - based on race and ethnicity; sexual orientation and gender identity; socio-economic status; immigration status; and physical, mental, and developmental disabilities - and is proposing racial and ethnic disparities as a first priority area. As a data collection framework is developed and refined, it can be adapted and applied to other populations.

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COLLABORATIVE RECOMMENDATION #5
Data collection to address health equity.

Data collection at the plan, health system, and practice-level should allow analysis of racial and ethnic disparities.

♦ APPROVED BY UNANIMOUS CONSENSUS ♦

Access to standardized data, disaggregated by race and ethnicity, is an essential first step in identifying racial and ethnic health disparities. Information about underlying social determinants of health is equally important in developing person-centered, data-driven solutions. To the degree data sources currently exist (i.e., claims data, patient social risk screening scores, etc.), they are often isolated and incomplete, making it difficult for payers, providers, and policymakers to develop a comprehensive understanding of the sources and drivers of racial and ethnic disparities.

Strategies to improve data collection to address racial and ethnic disparities should be multifaceted and address a variety of questions: Who is collecting the data? Who will it be shared with and why? How will it be shared? How will it be analyzed and reported? To whom? Underlying all of these questions is the issue of trust. The Collaborative recognizes the implementation of any recommendations around data collection must be predicated upon trust, and will require relationship building and open and transparent communication about the needs and uses of such data.

The Collaborative recommends the following types of data be collected and improved:

1) **Accessibility**: Communities of color often have social risk factors, driven by inequities in how they experience the social determinants of health, which result in barriers to accessing quality health care. Data on social risk factors and the underlying drivers (i.e., lack of transportation, lack of childcare, inability to get paid time off work) are crucial to understanding and addressing the causes of poor health outcomes among marginalized populations. Increased investments in primary care and value-based payments can play a key role in developing solutions, by not only supporting but

incentivizing providers to adopt strategies that increase access, such as extended office hours (on nights and weekends), and creating family-friendly office environments. Payers and providers can also engage with policymakers to develop solutions for issues that are beyond their scope or capacity to address.

2) **Health outcomes**: Communities of color often experience higher rates of chronic conditions and poorer health outcomes compared to white communities.[20] Data on clinical conditions and diagnostic risk for patients and practice panels are often reviewed by payers and providers, to identify "high utilizers" and inform care management protocols and practices. However, data on social risk factors, such as food or housing insecurity, are less available (if available at all). To develop payment structures that adequately reimburse providers for addressing patients' social needs (i.e., hiring a social worker as part of the care delivery team), or provide additional incentives for improving outcomes for populations with high social risk or needs, data are not only required, but must be actionable and shared between payers and providers. The Collaborative acknowledges the intensely personal and sensitive nature of this information, and fully respects the high level of trust involved with sharing such data. Engaging patients and communities in conversations about their wishes and needs, educating them on the purpose and value of gathering such information, and developing mechanisms for keeping this data protected and secure, is a requisite and ongoing dialogue that should be prioritized by payers, providers, and policymakers.

3) **Affordability**: Health care costs are an increasing concern in Colorado; according to the most recent Colorado Health Access Survey, nearly one in five Coloradans report having had trouble paying medical bills, and more than one in six avoided seeing a general doctor or specialist due to cost.[21] Affordability concerns are often heightened for racial and ethnic minorities. A recent analysis by Bell Policy Center showed Black Coloradans and Native Americans are more than two times as likely to be impoverished as non-Hispanic white Coloradans.[22] Data on health care affordability should be disaggregated by race and ethnicity and other demographic characteristics. The Collaborative's examination of disparities should be used to inform, and conducted in coordination with, other state efforts outlined in the Future Work section of this report.

Once disparities have been identified, payers, providers, patients, policymakers, and other community stakeholders should come together to develop appropriate solutions, using the unique tools and mechanisms at their disposal. Value-based payment arrangements have to date shown limited impacts on racial and ethnic health disparities; as noted by Ojo et al. in Health Affairs, quality measures have often been focused around central tendencies of populations, which lead to improvements in care "on average" but may leave certain populations behind.[23] However, APMs may offer new opportunities to address health equity, by incorporating quality measures and incentives that tie payments to the reduction of health disparities. Such solutions will only be effective to the degree they positively impact diverse populations and do not inadvertently create additional barriers to health equity or disadvantage providers caring for those with high social needs.

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Future Work

The Collaborative looks toward 2021 with a mixture of uncertainty and optimism. The challenges of the ongoing COVID-19 public health crisis still loom large, and will remain a steady drumbeat underlying the Collaborative's future work. Priorities in the coming year include:

Practice transformation

The COVID-19 pandemic has placed severe and ongoing financial strain on primary care practices in Colorado and across the nation, and renewed the impetus to shift from FFS to APMs. However, increased adoption of APMs is not a goal in and of itself; rather, the true "value" of value-based payments lies in their capacity to support care delivery changes that allow for the achievement of the Quadruple Aim. While key features of advanced care delivery models that provide whole person care have been discussed in both this and the *First Annual Report*, pursuing alignment between such models remains an important area of future work.

Much of Colorado's progress in transforming primary care delivery, made through statewide initiatives including CPC, SIM, and CPC+ was due in large part to the aligned set of payer expectations for practice improvement incorporated into such models. Yet Collaborative members also recognize the myriad of differences among practices and payer models makes it challenging, and in some cases detrimental, to focus too narrowly on a single, unified solution. Finding an appropriate balance between the alignment of care delivery models and practice transformation framework (which will reduce provider administration burden), with preserving flexibility to meet provider and payer needs (and enhance provider buy-in), will be an important and ongoing discussion.

Workforce

The Collaborative's recommendations and proposed strategies for strengthening primary care will ultimately fall short in the absence of a well-trained, culturally competent, and diverse health care workforce. The fundamental role that provider satisfaction and quality of work life play in advancing care delivery and payment reform at both the practice- and system-level is reflected in their inclusion in the micro and macro level measures recommended in this report (recommendations two and three).

Yet actions to improve the satisfaction and well-being of providers currently practicing in the state are insufficient to build and sustain a future primary care workforce that can meet the health needs of all Coloradans. In the coming year, the Collaborative plans to examine issues related to provider capacity and distribution (including areas with a shortage of primary care providers), as well as the recruitment of new clinicians into the field of primary care. Potential topics for future discussion include:

- **Training:** developing strategies to improve clinician recruitment and promote primary care as a specialty choice, and to strengthen the talent pipeline through medical schools and residencies.

- **Loan repayment and practice incentives:** exploring opportunities to advance or expand programs such as the Colorado Health Service Corps, the use of tax credits, and reimbursement of public payers.
- **Practice economics and sustainability:** examining the drivers and impacts of vertical and horizontal integration, and identifying needs for practice coaching and capital; and
- **Non-physician components of team care model:** identifying crucial roles within team-based care models, and actions that can be taken to support the training, retention, and reimbursement of non-clinician providers.

Relationship between primary care and public health

While advanced primary care models will play a key role in advancing the Quadruple Aim in Colorado, the delivery of whole person care that can lead to improvements in population health necessarily requires collaboration with entities outside of the four walls of a practice, including public health. As noted by the National Academy of Medicine (formerly the Institute of Medicine) in a seminal 2012 report: "Primary care and public health are uniquely positioned to play critical roles in tackling the complex health problems that exist both nationally and locally. They share a similar goal of health improvement and can build on this shared platform to catalyze intersectoral partnerships designed to bring about sustained improvements in population health. In addition, they have strong ties at the community level and can leverage their positions to link community organizations and resources."[24]

Traditional areas of collaboration between primary care and public health, including immunizations and emergency preparedness,[25] have taken on heightened importance during the COVID-19 pandemic. A multitude of enhanced, simultaneous public health efforts are needed to stem individual and community spread of the virus, including contact tracing, dissemination of timely information to the public, and widespread testing. Primary care practices are integrated into almost every community in Colorado, and are trusted sources of information and care. Primary care providers should partner with CDPHE and local public health agencies to provide a coordinated public health-primary care response. Actions could include a multi-media campaign stressing the importance and safety of preventive care, well-visits, and vaccinations, as well as the availability of alternatives to in-person office visits, such as telehealth. Coordination and cooperation will also be essential to the successful administration of a COVID-19 vaccine over the coming weeks and months.

Beyond the immediate response to the COVID-19 public health crisis, population health management is essential to the successful adoption of certain types of APMs. As APMs reorient the way providers care not only for individual patients but for populations, public health can offer valuable resources. As explained by the American Academy of Family Physicians: "some of the challenge for physicians and practices [in adopting population based payments] is limited resources for health educators, community health workers, and outreach services. With the public health sector already doing many of these things, it is imperative that practices connect to ensure they can dedicate personnel resources to alternate areas and not duplicate work that is already being done."[26]

Policy Alignment

Policymakers played an instrumental role in establishing the Primary Care Payment Reform Collaborative, and by the design of HB19-1233, will continue to be active participants in the implementation of the recommendations and strategies put forth by members. Alignment across federal (CMS) and state agencies (DOI, HCPF, and CDPHE) is inherent in the membership structure, creating a forum to build off existing partnerships and collaborations.

The Polis Administration has prioritized the reduction of health care costs as one of its "core four" issues, and included support for primary and preventive care as an action item on the 2020 Polis-Primavera Roadmap to Saving Coloradans Money on Health Care.[27] To have maximum impact, strategies to increase investment in primary care should be pursued in concert with additional efforts to make health care affordable. The Collaborative's work should align with state initiatives currently underway to address health access, quality, and costs. Examples of such initiatives, which the Collaborative could discuss in the future, include the following:

- The development and sharing of all-payer strategies and tools to reduce costs, such as tools to modify provider prescribing practices, care compacts to increase the effectiveness of referrals, and e-consult tools and infrastructure.
- Efforts to encourage community investment through participation in hospital needs assessments. Primary care providers and payers have an important role in identifying needs and holding hospitals accountable for investing in community-driven solutions.

Conclusion

Over the last eighteen months, the Collaborative has made significant strides in addressing the duties assigned by HB19-1233. In the *First Annual Report*, members set forth a series of recommendations that established a framework and guiding principles for efforts to strengthen primary care. The Collaborative's recommended definition of primary care was subsequently operationalized, in partnership with CIVHC and the DOI, to inform the methodology used in the *Report of Colorado Primary Care Spending and Alternative Payment Model Use, 2017-2019*. In addition, the recommendation for a primary care investment target included in the Collaborative's *First Annual Report* is being implemented for commercial health insurance carriers through the Regulation 4-2-72.

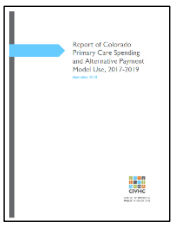
The recommendations this report build upon these efforts by offering additional guidance around the use of APMs to support primary care practices and the adoption of advanced primary care delivery, outlining metrics that can be used to gauge progress toward desired outcomes, and proposing strategies to ensure equity is incorporated into the Collaborative's work. Much work remains to be done, and the Collaborative looks forward to tackling the issues outlined in the Future Work section. The year 2020 has acutely demonstrated the need for all Coloradans have access to the right care, in the right place, at the right time.

Appendices

Appendix A - Primary Care Collaborative -- Standard Operating Procedures and Rules of Order (Revised May 18, 2020)

A copy of the Primary Care Collaborative - Standard Operating Procedures and Rules of Order is available at the following link:
https://drive.google.com/file/d/1moO5F73U3A8IG-qz75ZQSPTunEhnbc8Q/view

Appendix B – Report of Primary Care Spending and Alternative Payment Model Use, 2017-2019

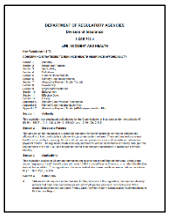


A copy of the *Report of Primary Care Spending and Alternative Payment Model Use, 2017-2019* is available at the following link:
https://drive.google.com/file/d/1LTvjvQlwg0xUqcJ6xnodKez-6o_akJP6/view?usp=sharing

Appendix C - Recommendations Regarding the Use of Telehealth to Support Primary Care Delivery during the COVID-19 Pandemic and Beyond

A copy of the *Recommendations Regarding the Use of Telehealth to Support Primary Care Delivery during the COVID-19 Pandemic and Beyond* is available at the following link:
https: //drive.google.com/file/d/1czt_tWseRHoIxbHNKgzk_wYhIHfzQiMu/view

Appendix D - Colorado Division of Insurance Regulation 4-2-72



A copy of the Colorado Division of Insurance Regulation 4-2-72 is available at the following link:
https://drive.google.com/file/d/19NzPs786iToCYw9XSQAOmzvI0QfxTjED/view

Appendix E - Multi-payer Initiatives in Colorado

The following provides a brief overview of Colorado's participation in several national, multi-payer initiatives, which were developed and implemented in partnership with the CMS Innovation Center.

- **Comprehensive Primary Care (CPC):**
  The Comprehensive Primary Care (CPC) initiative was a national four-year multi-payer initiative aimed at strengthening primary care through a core set of "comprehensive" primary care functions. These functions included: support by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology. In Colorado, over 70 practices, serving more than 400,000 patients participated in CPC. CPC ended on December 31, 2016.

  http://centerforevidencebasedpolicy.org/wp-content/uploads/2019/10/Colorado-Case-Study.10.19.pdf

- **State Innovation Model (SIM):**
  The State Innovation Model (SIM) initiative was a national initiative aimed at advancing multi-payer health care payment and delivery system reform models at the state level. Participating states received federal funds to develop and test innovative, state-based, multi-payer, health care delivery and payment systems designed to improve health for their populations while reducing costs. In 2014, Colorado received up to $65 million from the Center for Medicare and Medicaid Innovation (CMMI) to test a model to improve the health of Coloradans by increasing access to integrated physical and behavioral health care. Over the course of the initiative, SIM supported 344 primary care practices and four Community Mental Health Centers across the state as they progressed along a continuum of integrated care, and partnered with seven public and private payers, through the Colorado Multi-Payer Collaborative, to support participating practices through alternative payment models. Colorado's SIM initiative ended in July 2019.

  https://innovation.cms.gov/innovation-models/state-innovations; for additional information about Colorado's SIM initiative, please contact Tara Smith at the Colorado DOI (tara.smith@state.co.us).

- **Comprehensive Primary Care Plus (CPC+):**
  Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ is a unique public-private partnership that gives practices additional financial resources and flexibility to make investments, improve quality of care, and reduce the number of unnecessary services their patients receive. Additionally, CPC+ provides practices with a robust learning system, as well as actionable data feedback to guide their decision making. The care delivery redesign ensures practices have the infrastructure to deliver better care, resulting in a healthier patient population. CPC+ ends after December 31, 2021.

  https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus

Endnotes

[1] T. Bodenheimer and C. Sinsky. (2014). "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/

[2] CIVHC is the administrator of Colorado's APCD, and is statutorily required to produce a report of primary care and APM spending for use by the Collaborative; see Colorado Revised Statutes (C.R.S.) § 25.5-1-204.

[3] Regulation 4-2-72 was adopted by the Insurance Commissioner on November 24, 2020, with an effective date of January 15, 2021. A copy of the regulation is available on the Division of Insurance website at: https://drive.google.com/file/d/19NzPs786iToCYw9XSQAOmzvI0QfxTjED/view

[4] Whaley, C. et al. (2020.) "Changes in Health Services Use Among Commercially Insured US Populations During the COVID-19 Pandemic." Journal of the American Medical Association. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772537?resultClick=3.

[5] Basu, S. et al. (2020). "Primary Care Practice Finances in The United States Amid The COVID-19 Pandemic." Health Affairs. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00794

[6] Alexander, G. (2020.) "Use and Content of Primary Care Office-Based vs Telemedicine Care Visits During the COVID-19 Pandemic in the US." Journal of the American Medical Association. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771191

[7] American Academy of Pediatrics. (2020.) Letter to Secretary Alex M. Azar II, dated April 16, 2020. https://downloads.aap.org/DOFA/AAP_CARESfunding_HHS_16Apr2020.pdf

[8] Mehrota et al. (2020.) "The Impact of the COVID-19 Pandemic on Outpatient Visits: Visits Return to Prepandemic Level, but Not for All Providers and Patients." Commonwealth. https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels

[9] Basu, S. et al. (2020). "Primary Care Practice Finances in The United States Amid The COVID-19 Pandemic." Health Affairs. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00794

[10] CIVHC's *Report of Colorado Primary Care and Alternative Payment Model, 2017-2019* indicates 41.0% of all total primary care spending across all reported lines of business was through FFS payments in 2019. This calculation includes the FFS component of APMs in categories 2A, 2B, and 2C of the Health Care Payment Learning and Action Network (HCPLAN) APM Framework in the numerator, as part of APM spending. In addition, this figure is also impacted by specific carriers with a high percentage of payments flowing through integrated care delivery systems (in particular LAN categories 4A and 4C), which increase reported payments through APMs. CIVHC and the Division will continue to work with carriers to better understand reported APM payments for primary care, and ensure data is being reported consistently across carriers.

[11] Current members of the Colorado MPC include: Anthem Blue Cross Blue Shield, Centers for Medicare and Medicaid Services, Cigna, HCPF, Rocky Mountain Health Plans, UnitedHealthcare.

[12] Khan, H. et al. (2013). "Risk adjustment for pediatric populations." https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2013/risk-adjustment-for-pediatric-populations-healthcare-reform-bulletin.ashx

[13] Bodenheimer and Sinsky (2014). "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/

[14] L. Tollen and E. Keating. (2020). COVID-19, Market Consolidation, and Price Growth. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20200728.592180/full/

[15] Etz, R. et al. (2019). A New Comprehensive Measure of High-Value Aspects of Primary Care. Annals of Family Medicine. https://www.annfammed.org/content/annalsfm/17/3/221.full.pdf

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[18] T. Sheldon and T. Berdahl. (2020). "COVID-19 And Racial/Ethnic Disparities In Health Risk, Employment, And Household Composition." Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00897

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