Colorado's Primary Care Payment Reform Collaborative

THIRD ANNUAL RECOMMENDATIONS REPORT

DECEMBER 2021

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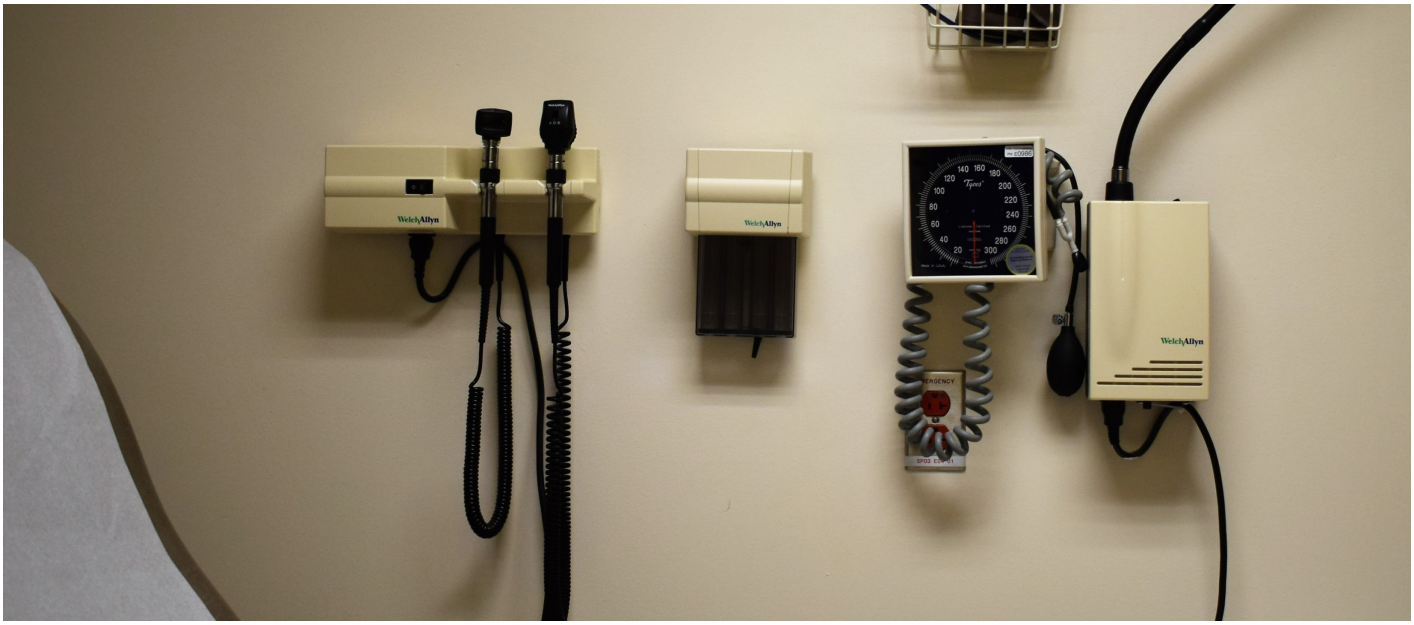


Executive Summary

The Primary Care Payment Reform Collaborative is pleased to present this third annual recommendations report. As the COVID-19 pandemic presented ongoing challenges in 2021, the Collaborative has continued its work to strengthen the primary care system in Colorado with increased resolve. This third annual report builds on recommendations made by the Collaborative in previous years and focuses on opportunities to further guide investments in primary care, center equity in care delivery and payment methodologies, advance behavioral health integration, and enhance coordination with public health.

In this report, the Collaborative puts forth the following recommendations:

- The Collaborative reaffirms that increased investments in primary care should be offered primarily through value-based payments and infrastructure investments. Value-based payments include alternative payment models that offer prospective funding, that provide incentives for improving quality, and that also improve the accessibility and affordability of primary care services for all Coloradans.
- Health equity must be a central consideration in the design of any alternative payment model. Value-based payment arrangements should provide resources to support providers and patients in achieving better care and more equitable outcomes.
- A variety of effective models for the integration and coordination of behavioral health and primary care should be encouraged and supported through alternative payment models and other strategies.
- Increased investments in primary care should support collaboration with public health agencies to advance prevention and health promotion to improve population health.

Colorado's Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative (the Collaborative) was established by House Bill 19-1233 in 2019. The Collaborative works to develop recommendations and strategies for payment system reforms to reduce health care costs by increasing use of primary care. Additional information about the history of the Collaborative, including previous recommendation reports, is available on the Colorado Division of Insurance (DOI)'s Primary Care Payment Reform Collaborative website.

The Collaborative's work is grounded 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 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 (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 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 (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 publishes 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 a process of iterative discussion.

All Collaborative meetings are open to the public, with meeting times and locations posted in advance on the Collaborative's website. Time is reserved during each meeting for public comments. Future meeting logistics, past meeting materials, and all Collaborative reports are posted publicly to the website. The Collaborative held a total of 12 meetings in 2021.

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

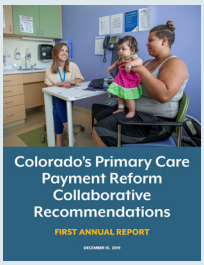
- Health care providers
- Health care consumers
- Health insurance carriers
- Employers
- U.S. Centers for Medicare and Medicaid Services (CMS)
- Experts in health insurance actuarial analysis
- Primary Care Office, Colorado Department of Public Health and Environment (CDPHE)
- Colorado Department of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

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

Introduction

This third annual report builds on the Collaborative's previous recommendations to strengthen the primary care system in Colorado through payment reform.

First Annual Report 2019



- **Definition of 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.
- **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.
- **Measuring the impact of increased primary care spending.** The State should identify and track short-, medium-, and long-term metrics that are expected to be improved by increased investment in primary care.
- **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.
- **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.

Second Annual Report 2020

- **Multi-payer alignment.** Multi-payer alignment is crucial to the success of alternative payment models, 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 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 alternative payment models 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 alternative payment models 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 for analysis of racial and ethnic disparities.

The recommendations in this year's report focus on four key themes:

1. Guiding increased investment in primary care
2. Centering health equity in primary care
3. Integrating behavioral health care within the primary care setting
4. Increasing collaboration between primary care and public health

Guiding increased investment in primary care: In prior reports, the Collaborative emphasized the need for increased investment in primary care and offered recommendations for how those investments should be made. In this report, the Collaborative reaffirms that increased investment in primary care should be offered primarily through value-based payments and infrastructure investments, and that payers should direct increased investment primarily through non-FFS mechanisms.

Centering health equity in primary care: In prior years, the Collaborative highlighted the need for increased diversity and inclusion in the governance of health care initiatives and the need for data collection efforts to include more granular racial and ethnic information. In this report, the Collaborative asserts health equity must be a central consideration in the design of any APM and discusses the key actions for building a foundation for equity in APMs and the roles of key actors in doing so.

Integrating behavioral health care within the primary care setting: In its first annual report, the Collaborative recommended a definition of primary care that included behavioral health care and recognized behavioral health integration as an important component of advanced primary care delivery models. With this report, the Collaborative expands on that recommendation by adopting a definition of behavioral health integration and offering additional guidance on increasing access to behavioral health services in a primary care setting.

Increasing collaboration between primary care and public health: The COVID-19 pandemic has made clear the importance of collaboration between primary care and public health, which the Collaborative recognized in the 2020 report. In this year's report, the Collaborative identifies some potential areas for increased collaboration, recommends that increased investment in primary care should support collaboration with public health agencies, and highlights the need to elevate health promotion and disease prevention in the policy discussion.

The Collaborative acknowledges a lack of timely data to inform these recommendations. Due to existing timelines for payers to submit data to the Colorado APCD, the Center for Improving Value in Health Care (CIVHC) is unable to provide the annual Primary Care and Alternative Payment Model Spending Report prior to the month of November. As a result, this spending data, which is crucial to the work of the Collaborative, is not available until a month before the legislatively mandated deadline to produce the annual primary care recommendations report. The Collaborative therefore emphasizes the need to balance the timelines for both reports, so that primary care and APM spending data are available to inform the development of future recommendations, while also understanding the need for deadlines that work with the schedules of the payers who submit the data. Providing more time to analyze the data will allow the Collaborative to better assess the current state of primary care investment and APM adoption in Colorado, and incorporate findings from that analysis in this report.

The Collaborative also recognizes and applauds the convening of the Colorado APM Alignment Initiative, an effort led by the Office of Saving People Money on Health Care in the Lieutenant Governor's Office, in collaboration with DOI, HCPF, and the Department of Personnel Administration (DPA), to align payers' efforts to shift away from FFS to value-based payment. This initiative was set in motion by the Collaborative's recommendation regarding multi-payer alignment in the Second Annual Recommendations Report: "multi-payer alignment is crucial to the success of 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 to value-based payments at the practice-level." The Collaborative has established a process to provide ongoing input into Colorado APM Alignment Initiative discussions and looks forward to contributing its expertise to the development of statewide recommendations for aligned primary care and maternal health APMs. Additional information is available on the Division's Colorado Alternative Payment Model Alignment Initiative website.

RECOMMENDATION 1: Guiding Increased Investment in Primary Care

The Collaborative reaffirms that increased investments in primary care should be offered primarily through value-based payments and infrastructure investments. Value-based payments include alternative payment models that offer prospective funding, that provide incentives for improving quality, and that also improve the accessibility and affordability of primary care services for all Coloradans.

♦ *Approved by unanimous consensus* ♦

In its first annual report, the Collaborative recommended that increased investments in primary care should be offered primarily through infrastructure investments and APMs that offer prospective funding and incentives for improving quality. In its first annual report, the Collaborative defined infrastructure investments to include "workforce development incentives, system transformation initiatives, quality improvement initiatives, and other structural investments supporting the development of advanced primary care delivery."

In considering this recommendation, the DOI subsequently issued Regulation 4-2-72, which establishes a requirement for commercial carriers to increase investments in primary care spending by one percentage point in 2022 and 2023, and requires carrier reporting of strategies for increasing primary care spending through annual implementation plans.[1] Additional data on primary care and APM spending is now also available on an annual basis in CIVHC's Primary Care Spending and Alternative Payment Model Use report. Primary care spending as a percentage of all medical spending (excluding pharmacy) in Colorado was 7.3% (excluding Kaiser Permanente and Denver Health)* in 2020. Primary care spending has been relatively consistent since 2018.[2]

As this additional data is becoming available, the Collaborative is updating the initial recommendation in this report to further inform the ongoing implementation of the established primary care expenditure target and inform additional strategies that will strengthen the impact of this goal. Updates are as follows:

- Increased investments in primary care should be offered primarily through value-based payments and infrastructure investments. The one percentage point increased investment in primary care required in 2022 and 2023 should primarily be directed through non-FFS mechanisms, including APMs that offer prospective funding and infrastructure investments.
- All commercial payers should offer at least one APM that includes prospective payments for advanced primary care delivery by 2023.** In its second annual report, the Collaborative defined advanced primary care models as those that are designed to increase patient access to care, improve provider continuity, and enhance the comprehensiveness of care delivered. Most commercial payers operating in Colorado offer some kind of value-based payments, such as care coordination and practice transformation per-member per-month payments, shared savings payments, and incentive payments for completing process measures or meeting quality metrics. However, not all payers offer an APM that includes prospective payments for advanced primary care delivery. The Collaborative recognizes that payers do not typically require all providers to participate in specific APMs; the future work section below discusses the work required to support provider adoption of APMs, including the challenges related to payment reconciliation that are associated with some types of prospective payments.
- The Collaborative's ultimate goal is to increase the number of Coloradans who receive the right care in the right place at the right time at an affordable cost. Effective APMs support this goal, and the percentage of covered lives receiving care under an APM is an important measure of progress toward the adoption of APMs. While total dollar amounts spent through APMs provide important business-centered insights, the percentage of lives covered through an APM provides a person-centered view. The Collaborative acknowledges

** Kaiser Permanente and Denver Health are not currently subject to the required targets for primary care investment established through Colorado Regulation 4-2-72 due to their unique integrated payer-provider systems. Primary care spending as a percentage of all medical spending in Colorado, across all reported lines of business in 2020 including Kaiser Permanente and Denver Health, was 9.4%.*

*** The Collaborative notes that the complexity of benefit plan designs needs to be considered in implementing this recommendation.*

the additional cost and reporting effort required from payers to track this information and emphasizes the importance of tracking progress toward both business- and person-centered goals to better understand the full impact of APM adoption.

The Collaborative recommends a phased approach to collecting and analyzing these data:

1. Starting in 2023, payers should include the percentage of covered lives receiving care under APMs in annual implementation plans submitted to the DOI; and,
2. The state should consider implementing a target for the percentage of covered lives receiving care under an APM, starting in 2025. The target percentage should be based on the data reported by payers starting in 2023 and should be vetted by the Collaborative and other impacted groups before going into effect.

- Every health insurance plan member should be encouraged to select their preferred primary care provider (PCP). Increasing the number of patients enrolled in APMs should not come at the expense of patient preference. Regardless of whether a member is enrolled in an APM, member preference should determine how members are assigned to PCPs. This is an equity issue. Members should be able to choose a new in-network PCP at any time, to ensure that patients can see providers that they feel connected to and trust. Plans should only assign members to PCPs based on other factors when member preference is not known.
- Increased investments should be designed to support the delivery of high quality care and should hold providers accountable for doing so. To be effective, such investments must reach the primary care providers who deliver care. Providers, payers, and health systems should work collaboratively to ensure that investments flow to the practice level where they can impact quality care. This is especially important for practices that are part of large systems.

Future Work

In this report, the Collaborative recommends that all payers must offer an APM with prospective payments for advanced primary care delivery starting in 2023. But offering an APM does not have any effect on improving care delivery or patient outcomes if providers do not participate in the APM. The Collaborative will continue to discuss factors that affect provider adoption of APMs, including the characteristics of APMs that encourage or discourage provider participation and the barriers that prevent providers from participating. This includes considerations for pediatric providers, and other providers who may serve specific patient populations. The Collaborative would also like to explore potential mechanisms for collecting and reviewing data on provider willingness and readiness to join various APM models, to better understand opportunities and barriers to participation.

In previous reports, the Collaborative has recognized that alignment across payer APMs plays a crucial role in the successful adoption of APMs. In the second annual report, the Collaborative specifically addressed the benefits of quality measure alignment to reduce provider administrative burden but noted that, due to the heterogeneity of practices and patient population, alignment and standardization of quality metrics is a challenging and longer-term goal. The Collaborative will continue to actively engage in the Colorado APM Alignment Initiative discussions and provide ongoing expertise on the development of recommendations for primary care and maternal health APMs.

The Collaborative will continue exploring the characteristics of effective APMs, in coordination with the APM Alignment Initiative and into the future, with the goal of increasing provider participation and the number of covered lives in APMs that drive improvements in care quality and health outcomes.

The Collaborative also plans to further explore the feasibility of pooling payer funds to support practice transformation. While many payers are already supporting practice transformation efforts, the impact of these efforts, when occurring in a siloed manner, may be limited. The Collaborative continues to be interested in opportunities to better leverage those funds across payers to reduce duplication of effort and increase impact. The Collaborative has identified several considerations that would need to be further explored, including the appropriate entity to administer a pooled fund, provider eligibility criteria, appropriate payer participation, and appropriate stipulations to direct funding toward effective practice transformation activities.

RECOMMENDATION 2: Centering Health Equity in Primary Care

Health equity must be a central consideration in the design of any alternative payment model. Value-based payment arrangements should provide resources to support providers and patients in achieving better care and more equitable outcomes.

♦ *Approved by unanimous consensus* ♦

In the second annual report, the Collaborative highlighted the need for increased diversity and inclusion in the governance of health care initiatives, including initiatives to support and enhance primary care services. Initiatives should reflect the diversity of Colorado's population. The Collaborative also emphasized the need for data collection efforts to include more granular racial and ethnic information. These data are vital to enabling more robust analyses to understand and address racial and ethnic disparities.

As the state continues to deal with the impacts of the COVID-19 pandemic, the Collaborative recognizes the increasing need for payers and providers to take more action to address health disparities in the short, medium, and long term. This report explores the roles of various engaged parties in ensuring all Coloradans have access to high-quality, whole-person care, as well as opportunities for APMs to support effective action to improve health equity. To promote a common understanding of the topic, this report also establishes definitions of health equity, health disparities, whole-person care, and person-centered care.

Participant roles to advance equity in primary care

Everyone in the health care system has a role to play in addressing systemic inequities in health care access and health outcomes. To identify individual and collective actions that can be taken to advance health equity in primary care, the Collaborative proposes examining the roles of various participant types in the development, implementation, and support of whole-person care delivery systems. Table 1 provides a starting point for establishing these participant roles.

These roles are interconnected: each participant type must engage for the others to succeed. Value-based payment arrangements can offer a structure to coordinate and incentivize action by many different parties. These arrangements can also hold all engaged participants accountable for advancing health equity, both individually and collectively.

Table 1. Roles of Participants in Advancing Equitable Primary Care

Payers
• Engage members in the development of new models and initiatives and empower them to make key decisions.
• Develop and apply an equity lens to all existing and new payment models and practice transformation initiatives.
• Align payment incentives to reduce health disparities among populations.
• Reduce administrative burden on providers to free up time and resources for community engagement.
• Collect and analyze data by factors including race and ethnicity, as well as social determinants of health factors such as income level, neighborhood, and others to better understand patient populations and measure and track health outcomes. An iterative process will be needed to collect meaningful and reliable data.
Purchasers
• Leverage purchasing power to advance health equity by factoring equity considerations into purchasing decisions.
• Align around common priorities for advancing equity to pull payers and providers in the same direction.
• Engage beneficiaries (i.e., employees, members) in developing equity considerations to inform health care purchasing strategies.
• Partner with payers and providers committed to reducing disparities and improving health equity.
• Forge federal and state partnerships, which are crucial to advancing equitable primary care.
Providers
• Establish an organizational commitment to improving health equity through an actionable strategic plan.
• Engage patients in developing plans to improve health equity.
• Leverage alternative payment models and other investments to support plans to improve health equity.
• Commit time with patients to develop relationships and trust.
• Commit time to build community connections.
• Lead or participate in implicit bias and cultural competency training.
• Consider changes to business processes to improve equity (e.g., ability to access care after hours).
• Collect and analyze data by factors including race and ethnicity, as well as social determinants of health factors such as income level, neighborhood, and others to better understand patient populations and measure and track health outcomes. An iterative process will be needed to collect meaningful and reliable data.
Individuals and Families
• Participate in community engagement opportunities when possible.
• Support others in participating in engagement opportunities.
• Hold providers accountable for providing culturally competent care.
Policymakers
• Adopt an anti-racist approach to policymaking.
• Develop and apply an equity lens when evaluating, considering, or drafting legislation and policy.
• Establish common classification categories for collecting and reporting race and ethnicity and other demographic data, in alignment with other state and national efforts.
Associations and Advocacy Groups
• Develop clinician education and Continuing Medical Education programs that address health equity and related concepts.
• Provide grant funding for health equity initiatives developed within the community.
• Offer resources for providers, such as validated and trusted toolkits, that are available in various languages.

Inspired by the Roadmap to Reduce Disparities funded by the Robert Wood Johnson Foundation.[3]

The Collaborative recognizes the challenge of engaging and coordinating so many participants, and the importance of developing or refining APMs to prioritize equity while avoiding unintended consequences. To begin this process, the Collaborative suggests the following step-by-step approach:

- Step 1: Building a Foundation for Equity – Participants recognize disparities, develop shared understanding, and begin to work together.
- Step 2: Focusing on Equity – Participants coordinate targeted actions to reduce disparities and improve health equity.
- Step 3: Advancing Equity through APMs – Participants collaborate through shared plans to eliminate disparities and achieve health equity.

Step 1: Building a Foundation for Equity

The ultimate goal is for APMs not only to improve health care quality and outcomes, but to do so in a manner that reduces health disparities and actively advances health equity. To reach that goal, all engaged parties first need to build a foundation for equity. This report focuses on that foundation, and lays out the Collaborative's goal to build on that foundation to further advance equity. Future reports will both fill in additional detail, including specific goals or targets, and make course corrections as necessary.

The Collaborative recognizes that traditional FFS methodologies can both disadvantage practices and perpetuate health disparities by failing to meet the needs of patients with the highest barriers to care. The Collaborative also recognizes that without deliberate attention to center health equity in the design and implementation process, APMs can exacerbate disparities.

The Collaborative proposes three key actions for building a foundation for equity in APMs:

- Proposing an initial definition for what constitutes an equitable APM
- Investing in foundational capabilities for equity
- Guarding against exacerbation of disparities

Proposing an initial definition for what constitutes an equitable APM

Before defining an equitable APM, it is worth revisiting how the Collaborative defines the concept of equity. In its second annual report, the Collaborative adopted a definition of health equity from 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." [4]

An equitable APM incentivizes comprehensive and customized whole-person or whole-family care, including providing support and resources to eliminate barriers to care and address social needs.

The Collaborative proposes a definition of whole-person care, developed by John Snow, Inc., as "the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources." [5]

Equitable APMs also guard against the exacerbation of disparities. The Collaborative proposes the following definition of health disparity, put forth by Healthy People 2020: "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." [6]

Equitable APMs also promote person-centered care. In developing a definition of person-centered care, the Collaborative relied on the conceptual framework of the Health Care Payment Learning & Action Network definition of person-centered care and expanded the focus to include patient families, which are a critical component particularly for pediatric patients: "Person-centered care is defined as care in which patients, families and their

care teams form partnerships around high-quality, accessible care, which is both evidence-based and delivered in an efficient manner, and in which patients' and caregivers' individual preferences, needs, and values are paramount." [7]

Investing in foundational capabilities for equity

In 2020, the Collaborative recommended that data collection at the plan, health system, and practice levels should allow analysis of racial and ethnic disparities. Collecting and analyzing the data to detect and measure disparities is a foundational capability for advancing equity. In this recommendation, the Collaborative recognizes that all parties play a role in collecting this data, but also acknowledges the difficulties in doing so, as the voluntary reporting of such information requires trust, relationship building, and open communication about the needs and uses of such data. In suggesting the development of principles, classification standards, and processes for collecting demographic and other information, the Collaborative appreciates that similar efforts are underway at the state and national level - including by the National Association for Insurance Commissioners' Race and Insurance Committee — and cautions that care should be taken not to develop duplicating or conflicting requirements.

In addition, the Collaborative recommends all parties undertake cultural competency training, including implicit bias training. To avoid redundancy, payers, providers, and other organizations should identify and consider existing training before developing new programs. Providers should be incentivized to invest time and resources in other process improvements, such as establishing a community advisory board.

Guarding against exacerbation of disparities

Payers should carefully consider how APMs may exacerbate inequities, such as by disproportionately penalizing physicians serving the poorest and most vulnerable populations, and establish guardrails to prevent that from happening. For example, a payer could require providers to identify and report on existing disparities to be eligible for incentive payments. Payers might also ensure that providers are not excluded from incentives based on their patient populations or payer mixes.

In the 2020 report, the Collaborative urged payers to ensure APMs do not penalize or disadvantage the providers who serve those with the greatest needs and least access to resources. Financial incentives must be designed carefully to avoid excluding those providers and therefore their patients from the resources needed to drive progress toward reducing disparities.

Future Work: Focusing on Equity and Advancing Equity through APMs

In this report the Collaborative recommends widespread adoption of cultural competency training, but acknowledges that training in and of itself is not the end goal. Future work will explore how to quantify the measurement of cultural competency. For example, potentially using patient-reported measures of perceived fairness of care received as a quantifiable measure of cultural competency.

Laying the groundwork for equity is just the first step. Future reports will explore further actions in more detail, but a few guiding principles are included here to inform participants who are further along in efforts to improve equity.

Guiding principles

- **Elevate the voices of individuals and families alongside experts in the healthcare field:** Ensure people who are impacted by programs intended to improve equity also have a role in designing, evaluating, and improving data collection and programs.
- **Incentivize action to reduce disparities:** While payers must first guard against APMs worsening disparities, more advanced models should specifically incentivize providers to take action to reduce disparities.
- **Focus on whole-person care:** Those designing equitable APMs must consider the importance of factors outside the clinic walls for patient health, including social determinants of health such as housing stability, social support, and food insecurity.

These guiding principles will serve as a starting point for future Collaborative discussions on the importance of APMs in advancing health equity.

RECOMMENDATION 3:
Integrating Behavioral Health Care Within the Primary Care Setting

A variety of effective models for the integration and coordination of behavioral health and primary care should be encouraged and supported through alternative payment models and other strategies.

♦ *Approved by simple majority* ♦

In its first annual report, the Collaborative included behavioral health care in the recommended definition of primary care. Specifically, the definition included behavioral health providers, including psychiatrists that provide mental health and substance use disorder services in an integrated primary care setting. The report also recognized behavioral health integration as an important component of advanced primary care delivery models and worthy of increased investment.

The Collaborative recommends behavioral health integration as a continued priority for primary care payment reform efforts. Building upon previous recommendations in the first and second annual reports, this report proposes a definition of behavioral health integration and offers additional guidance on how APMs and other investment strategies can increase access to behavioral health services in a primary care setting.

The Collaborative specifically proposes using the Lexicon for Behavioral Health and Primary Care Integration, developed by the Agency for Healthcare Research and Quality, for definitions of behavioral health integration and related concepts:

"The care which results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization." [8]

Integrated Care Delivery Model Considerations

A wide variety of care models can facilitate the delivery of high-quality integrated behavioral health care, depending on how they are implemented. Examples of such models include having a fully integrated behavioral health provider who can provide services in person or via telehealth. However, not every practice will have the physical space or resources to implement fully integrated, team-based care. Other features of improved behavioral health services in integrated care delivery models can include closed-loop referrals and consultation between providers, known as "peer-to-peer" consultation. Because of these limitations, payment models should measure, track, and reward integrated care inclusive of different models of implementation.

- **Communication between providers:** Referrals, for example, will continue to be vital to coordinated care delivery, especially for practices without resources such as physical space to fully integrate care within one building. However, to constitute a form of integrated care, referrals must be closed-loop, where the physician follows up to confirm the patient connected with and received the service for which they were referred. Peer-to-peer consultation, including e-consultation, provides an opportunity for a treating provider to consult an expert in determining treatment plans and may avoid unnecessary visits to specialized providers. These consultations must occur in a way that ultimately improves patient outcomes.
- **Cross-sector collaboration:** Coordination across health care, public health, education, and social services is necessary to bring together the full scope of resources involved in a patient's well-being. For example, a pediatric patient may receive services from a pediatrician; a school-based health center; a school special education team, including a psychologist; and a county welfare office. To understand the full scope of needs and services received by that particular patient, efforts must be coordinated across all participating providers and entities.
- **Site of care delivery:** For practices with space to offer behavioral health services on site, physically sharing the same space can make integrating care easier; however, co-location alone is not the same as truly integrated care. In

addition, telehealth can also play an important role in improving access to services. Payment models must support services delivered both virtually via telehealth and in person.

Funding Behavioral Health Integration

All effective models of behavioral health integration should be incentivized and supported via appropriately designed APMs.

- **Value-based payments:** Value-based payments should be made available to support closer integration of behavioral health within the primary care setting. When possible, APMs should be structured to provide prospective payments, which provide a more effective incentive for providers to integrate care.
- **Transition from FFS:** The Collaborative acknowledges the shift away from the FFS system will take time. Providers and payers still working in a FFS environment should nonetheless work toward integrating behavioral health care. This work can and should be supported through additional codes made available by all payers for behavioral health delivered in a primary care setting. This specifically includes opening up the use of Health Behavior Assessment and Intervention codes, which can be used to bill for services related to assisting patients with physical health conditions, and Collaborative Care Model (CoCM) codes such as G2214, which can be used to bill for integrated behavioral health services delivered via the CoCM. [9, 10] Multiple studies have shown the CoCM approach to behavioral health integration can improve health outcomes.[11, *]
- **Measuring investment:** Increased resources directed to integrating behavioral health should be tracked more closely, so policymakers and other interested parties have line of sight into the investments that are being made. Payers should report investments in behavioral health integration in their annual implementation plan reporting as part of the data they share on increased investments in primary care.
- **Investing in infrastructure:** Additional infrastructure investments should support behavioral health integration. For example, the newly established Behavioral Health Administration (BHA) is an intentional step toward increased coordination, alignment, and integration of impacted groups and efforts to provide Coloradans with affordable access to the services they need. In a recent report to the legislature, the BHA committed to working "with HCPF and DOI to identify payment models that improve the sustainability of integrated care in order to (1) expand access to integration in primary care, and (2) expand access to medical care for those with serious mental illness." [12] The Collaborative applauds this coordinated approach and looks forward to opportunities to engage in future discussions of how the BHA can direct investment to behavioral health integration in the primary care setting.
- **Eliminating copayment for same-day behavioral health visits occurring in an integrated care setting:** Patients face many barriers to receiving behavioral health care, one of which is the financial burden of copayments. For some patients, a second copayment can be a barrier to receiving a behavioral health service if it is offered on the same day within an integrated, team-based care setting. States such as Rhode Island have eliminated patient copays for behavioral health services occuring on the same day as a primary care visit. The benefit to patients of removing a barrier to access is clear. However, the Collaborative recognizes the complexity of insurance plan design requires careful consideration of existing regulations and the potential impacts on payer and provider operations and finances, as well as member premiums, as the Collaborative recognizes that lower cost sharing can result in higher premiums.

Future Work: New Approaches to Increase Access to Behavioral Health

The Collaborative recognizes that there is more work to be done to improve access to comprehensive

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*The Colorado Department of Health Care Policy & Financing has developed its delivery system and payment mechanisms to support the delivery of integrated behavioral health within primary care practices without opening up new fee-for-service codes. The Department is committed to exploring new and additional options through value based payment to further behavioral health integration but must ensure any actions align with the administration's goals, are approved by the Centers for Medicare & Medicaid Services, and that expenditures are approved by the Colorado General Assembly.

care. In the next year, the Collaborative plans to consider additional barriers to behavioral health services. Creative approaches that holistically examine and seek to address the myriad of barriers, in addition to financial and affordability concerns, that affect access to behavioral health are worth additional exploration. APMs should be designed to reduce barriers to access, including financial barriers such as high premiums or copays. Lowering barriers will encourage the use of primary and preventive care, including behavioral health services, that can prevent or mitigate downstream health impacts for patients that increase costs to the health system.

RECOMMENDATION 4: Increasing Collaboration Between Primary Care and Public Health

Increased investments in primary care should support collaboration with public health agencies to advance prevention and health promotion to improve population health.

♦ *Approved by unanimous consensus* ♦

In its second annual report, the Collaborative acknowledged the heightened importance of traditional areas of collaboration between primary care and public health, such as immunizations and emergency preparedness, during the COVID-19 pandemic. Increased collaboration, communication, and coordination between primary care and public health will strengthen the state's capacity to respond to COVID-19 and future public health emergencies, while shifting systems to more effectively address the economic, mental, and social issues that contribute to health inequities.

In this year's report, the Collaborative is focusing on the important and complementary roles primary care and public health play in supporting and promoting the health and well-being of people and communities. A strong relationship between primary care and public health can increase the efficiency and effectiveness of prevention and health promotion strategies and improve the treatment of health concerns.

Figure 1. Exploring Integration to Improve Public Health [13]

Integrating Primary Care and Public Health Efforts

The public health and health care sectors work together to keep people healthy by addressing both the supply of health care services (treatment) and the demand for health care services (prevention). These sectors work independently and in collaboration to protect and restore health in people and communities. As noted by the Institute of Medicine, public health plays a key role in helping to ensure societal conditions in which people can be healthy and thrive. Primary care provides integrated and accessible health services by clinicians who are accountable for addressing personal health care needs, developing sustained partnerships with patients, and practicing in the context of family and community. How the two sectors of public health and primary care can integrate efforts to achieve gains in population health is represented in Figure 1.

The goal of creating the conditions in which people in society can be healthy requires the prevention

Figure 2. Public Health and Primary Care[14]

The relationship of the prevention workforce and the clinical workforce in promoting healthy people and communities

*The public health and health care sectors work together to keep people healthy by addressing both the **supply** of health care services (treatment) and the **demand** for health care services (prevention). These sectors work independently and in collaboration to protect and restore health in people and communities.*

- Public Health Intervention
- Joint Intervention
- Health Care Intervention

1 Primary Prevention — Prevent: Activities to Prevent the Occurrence of Disease in Healthy People	2 Secondary Prevention — Intervene: Activities to Alleviate Preclinical Disease and Measurable Risk Factors	3 Tertiary Prevention — Treat: Clinical Care That Reduces the Consequences and Severity of Disease and Disability
Access Care (Workforce/ Infrastructure/systems)	Health Insurance Coverage/Sufficiency	
Alcohol/Drug Education and Control	Screening, Brief Intervention, Referral to Treatment	Substance Abuse Rehabilitation/Antidepressants
Stigma Reduction/Safe "Means" Storage/Resiliency Training	MH First Aid/Safety Planning/ Question, Persuade, Refer	Crisis Intervention/ Psychiatric Treatment
Tobacco Education and Control	Tobacco Cessation Interventions	Heart Surgery/Chemotherapy/ Radiation/Hospice
Water Fluoridation/ Oral Hygiene Education	Dental Sealants/ Fluoride Varnish	Fillings/Crowns/ Extractions
Immunization	Communicable Disease Diagnosis/Treatment	
Sexual and Reproductive Health Education	Family Planning/ Harm Reduction	Prenatal Care and Delivery/ STI-HIV Treatment
Healthy Food Access	Healthy Diet Promotion	Statins/Antihypertensives/ Bariatric Surgery
Built Environment*	Physical Activity Promotion	Cardiac/Orthopedic Surgery

Examples of Prevention Interventions That Result in Significant Health Care Cost Savings and Reduced Demand for Clinical Care:

For every dollar invested in substance use disorder prevention and early treatment, **$36 is saved in Medicaid costs.**

For every dollar invested in community water fluoridation, **$32 is saved in dental care.**

For every HIV infection prevented, an estimated **$355,000 is saved in the cost of providing lifetime HIV treatment.**

In one study, for each dollar invested in community based falls prevention, **more than $20 in health savings was returned.**

*The built environment "encompasses places and spaces created or modified by people including buildings, parks, and transportation systems." In recent years, public health research has expanded the definition of built environment to include healthy food access, community gardens, walkability, and bikeability (https://www.sciencedirect.com/topics/engineering/built-environment).

of injury and disease; the promotion of healthy behaviors and social interactions; the assurance of conditions that promote and protect health; and the provision of timely, effective, and coordinated primary health care. The integration of primary care and public health, by linking programs and activities where the two realms overlap, can both reduce the burden of preventable disease and the costs associated with tertiary and/or acute treatment for late stage disease. When the work of the two sectors is uncoordinated and conducted in isolation, the benefits of prevention can be difficult to recognize. Furthermore, the return on investment of effective prevention interventions often accrues long after the investment is made, and the return may not be realized by the investing entities; as such, such investments therefore do not yield returns on the time frame typically considered important by some policymakers and payers. Finally, acute health care needs often overwhelm policy discussions, reducing the perceived critical importance of long-term and upstream investment, as evidenced by poorly funded national, state, and local prevention investment. While this report does not offer comprehensive solutions to these challenges, the Collaborative recommends the following initial steps and future areas of exploration:

- **Elevate health promotion and disease prevention in the policy discussion.** Primary care and public health are together the primary and secondary prevention workforce. Prevention is complementary to treatment, yet in primary care and pediatrics in particular, prevention is a central objective. Prevention must therefore be on at least equal footing in policy discussions. In addition to funding considerations, policymakers also can promote other forms of collaboration to support both prevention and treatment, such as increased data sharing between primary care and public health, that would be beneficial.
- **Highlight potential areas of intersection between primary care and public health.** A shared understanding of the roles and activities of primary care and public health is an important first step in identifying areas of intersection. Figure 2, adapted from a graphic developed by the Colorado Department of Public Health & Environment, illustrates the continuum of activities across public health and health care. The Collaborative recommends payers, providers, and policymakers review these activities as they begin to identify key areas for increased investment and coordination between primary care and public health.

Figure 2 is not presented as a comprehensive list of interventions; rather it should be considered a starting point to spark ideas for collaboration between primary care and public health. Payers, policymakers, providers, and public health leaders in each community should work closely with community members to determine the interventions best suited for their population.

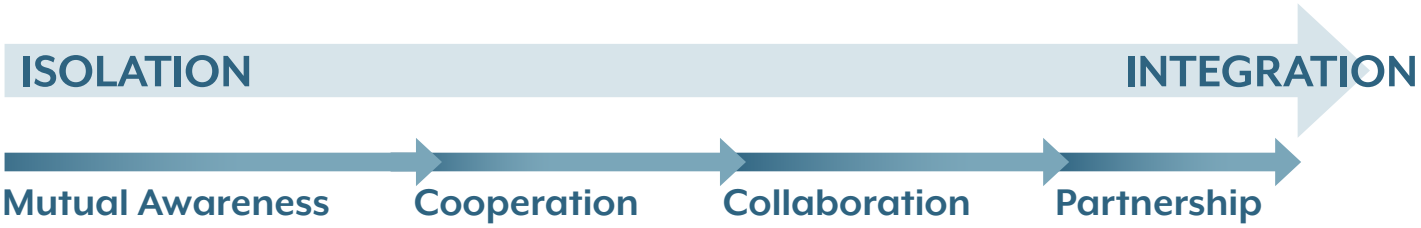
Future Work

The Collaborative acknowledges that there is more work to be done to realize the potential of coordinated action by primary care and public health partners. Using Figure 2 as a starting point for discussion, the Collaborative plans to continue exploring key areas of opportunity to inform future recommendations.

The Collaborative will also explore promoting and creating incentives for primary care and public health to move toward increased partnership. Colorado's ability to support people with chronic illness, substance use disorders, and other conditions that drive health care costs and impact community wellness — and to reduce health disparities in populations disproportionately impacted by these conditions — will depend in large part on the state's capacity to adequately address and fund high-quality preventive care. Investments in areas of intersection between primary care and public health can amplify the ability of both to address individual and population health needs.

Creative solutions will be required — and the Collaborative is interested in exploring how payers might incentivize partnerships between primary care and public health through quality and process measures that reward practices for coordinating prevention, intervention, and treatment services with local public health agencies. For example, payers could incentivize practices to develop shared goals, exchange data, and coordinate with local public health agencies to improve immunization rates.[15]

Figure 3. Degrees of Integration [16]

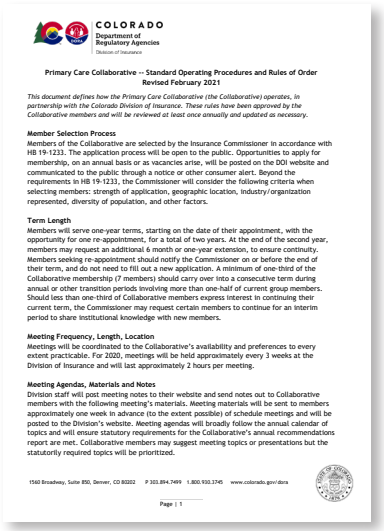


Conclusion

The recommendations in this report build on prior efforts by offering additional guidance around increased investment in primary care, building a foundation for improving health equity via whole-person care and APMs, integrating behavioral health within the primary care setting, and the importance of and opportunities for collaborating with public health agencies.

Colorado continues to be a national leader in health care delivery and payment innovation, but much work remains to be done. The Collaborative looks forward to continuing to develop recommendations and strategies for payment system reforms to reduce health care costs by strengthening primary care. Specifically, the Collaborative looks forward to continuing the conversation around the issues identified in the future work sections of the report, such as continuing to refine the role of APMs in advancing health equity, increasing adoption of equitable APMs, additional opportunities for investing in practice transformation, new approaches to increase access to behavioral health care, and creating incentives for primary care and public health to move toward increased partnership.

Appendix A



COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Collaborative -- Standard Operating Procedures and Rules of Order
Revised February 2021

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. Opportunities to apply for membership, on an annual basis or as vacancies arise, will be posted on the DOI website and communicated to the public through a notice or other consumer alert. 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, starting on the date of their appointment, with the opportunity for one re-appointment, for a total of two years. At the end of the second year, members may request an additional 6 month or one-year extension, to ensure continuity. 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 minimum of one-third of the Collaborative membership (7 members) should carry over into a consecutive term during annual or other transition periods involving more than one-half of current group members. Should less than one-third of Collaborative members express interest in continuing their current term, the Commissioner may request certain members to continue for an interim period to share institutional knowledge with new members.

Meeting Frequency, Length, Location
Meetings will be coordinated to the Collaborative's availability and preferences to every extent practicable. For 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 to members approximately one week in advance (to the extent possible) of schedule meetings 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 recommendations report are met. Collaborative members may suggest meeting topics or presentations but the statutorily required topics will be prioritized.

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Primary Care Payment Reform Collaborative Standard Operating Procedures and Rules of Order (Revised February 2021)

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/12AvTBMuNE--OIeK0qZ2IG4G1e7CKzgPr/view

Endnotes

[1] Colorado Department of Regulatory Agencies, Division of Insurance. (2020). New Regulation 4-2-72. https://drive.google.com/file/d/19NzPs786iToCYw9XSQAOmzvl0QfxTjED/view

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[13] Adapted from Committee on Integrating Primary Care and Public Health: Board on Population Health & Public Health Practice; Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington (DC): NAM: 2021 Mar 28.

[14] Adapted by the Collaborative from a graphic provided by the Primary Care Office, Colorado Department of Public Health & Environment.

[15] AAFP. (2020). Integration of Primary Care and Public Health (Position Paper). https://www.aafp.org/about/policies/all/integration-primary-care.html

[16] Adapted from Committee on Integrating Primary Care and Public Health: Board on Population Health & Public Health Practice; Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington (DC): NAM: 2021 Mar 28.