Colorado's Primary Care Payment Reform Collaborative

Fourth Annual Recommendations Report

FEBRUARY 2023

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The Colorado Health Institute facilitated the preparation and publication of this report.

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Executive Summary

The Primary Care Payment Reform Collaborative (the Collaborative) is pleased to present this fourth annual recommendations report. The Collaborative has worked with increased resolve to strengthen the primary care system in Colorado. This report builds on recommendations from previous years and focuses on opportunities to further guide payment methodologies in ways that ensure equity and positive outcomes for patients. In this report, the Collaborative makes the following recommendations:

Recommendation 1:
Aligning Quality Measures

The Collaborative recommends that quality measures be aligned across payers to ensure accountability, standardization, and continuous improvement of primary care alternative payment models. To best meet the needs of different patient populations, the Collaborative recommends adopting an aligned quality measure set that includes a menu of optional measures, reducing the administrative burden on providers while still allowing for flexibility and patient-centered care.

Recommendation 2:
Improving Patient Attribution

The Collaborative recommends that patient attribution methodologies for primary care alternative payment models be patient-focused, clearly communicated to providers, and include transparent processes for assigning and adjusting patient attribution lists (e.g. adding or removing patients).

Recommendation 3:
Improving Risk Adjustment

The Collaborative reaffirms the importance of incorporating social factors into risk adjustment models as a tool to advance health equity by ensuring providers have adequate support to treat high-need populations. The Collaborative recommends ongoing exploration of existing and emerging risk adjustment models for primary care that include inputs related to both medical and social needs. Additionally, the Collaborative recommends increased transparency around the components of current payer-level risk adjustment models to (1) improve provider understanding of risk adjustment and (2) identify areas for potential payer alignment.

Colorado's Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative was established by House Bill 19-1233 in 2019. It works to develop recommendations and strategies for payment system reforms to reduce health care costs by increasing use of primary care.

The Collaborative's work is grounded in an established and growing evidence base demonstrating that 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 Child Health Plan *Plus* (CHP+).
- **Report** on current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation and care improvement in primary care.
- **Identify** barriers to the adoption of alternative payment models (APMs) by health insurers and providers and develop recommendations to address these barriers.
- **Develop** recommendations to increase the use of APMs that are not fee-for-service in order to:
    - Increase investment in advanced primary care models;
    - Align primary care reimbursement models across payers; and
    - Direct investment toward higher-value primary care services with an aim of 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 with health insurers and consumers.

Historical information about the Collaborative, including previous recommendation reports, is available on the Colorado Division of Insurance (DOI)'s Primary Care Payment Reform Collaborative website. Each year, the Collaborative's primary care recommendations report is made available electronically to the public on the Collaborative's website.

The Collaborative reached the findings and recommendations in this report through a process of iterative discussion. The Collaborative held 12 meetings in 2022. All Collaborative meetings are open to the public, with meeting times and locations posted in advance on the Collaborative's website. Time for public comments is reserved during each meeting. Past meeting materials and reports are also available on the website.

DOI selects members of the Collaborative through an open application process. Each serves a one-year term with the opportunity for reappointment, for a maximum of three years (the Collaborative's Standard Operating Procedures and Rules of Order are linked in Appendix A.) Collaborative members represent a diversity of perspectives, including:

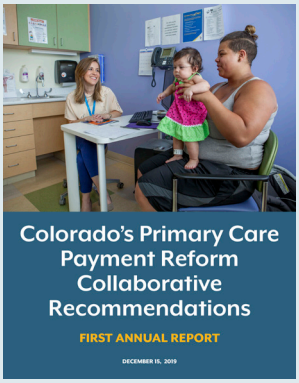
- Health care providers;
- Health care consumers;
- Health insurance carriers;
- Employers;
- U.S. Centers for Medicare & Medicaid Services (CMS);
- Experts in health insurance actuarial analysis;
- Primary Care Office, Colorado Department of Public Health & Environment (CDPHE); and
- Colorado Department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

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

Introduction

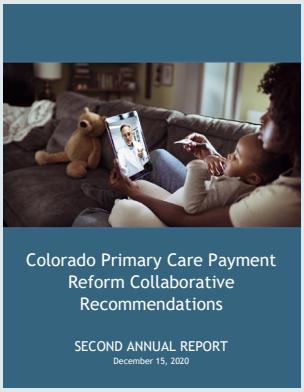
This fourth annual report builds on the Collaborative's previous recommendations to strengthen the primary care system in Colorado through payment reform.

First Annual Report 2019



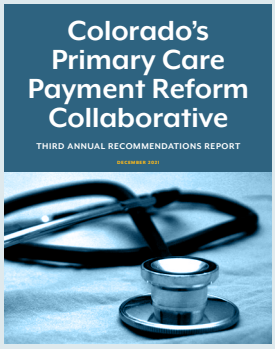
- **Definition of primary care.** The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both fee-for-service and APMs.
- **Primary care investment target.** All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least one 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 APMs.** Increased investments in primary care should be offered primarily through infrastructure investments and APMs 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 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 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 levels should allow for analysis of racial and ethnic disparities.

Third Annual Report 2021



- **Guiding increased investment in primary care.** 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, provide incentives for improving quality, and improve the accessibility and affordability of primary care services for all Coloradans.
- **Centering health equity in primary care.** Health equity must be a central consideration in the design of any APM. Value-based payment arrangements should provide resources to support providers and patients in achieving better care and more equitable outcomes.
- **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 APMs and other strategies.
- **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.

As the Collaborative has progressed in its work over the last four years, the primary care landscape in Colorado has continued to evolve. Key developments in 2022 have influenced the Collaborative's recommendations in this report, including updated data on primary care and APM spending in Colorado, Colorado's selection to participate in the State Transformation Collaborative (a new federal initiative to accelerate the implementation of APMs), and the passage of House Bill 22-1325.

Update on Investments in Primary Care

Since 2019, the Center for Improving Value in Health Care (CIVHC) has supported the Collaborative by analyzing primary care spending and APM use in Colorado, using data from the Colorado APCD. In its first annual report in 2019, the Collaborative made the following recommendation regarding primary care spending:

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

DOI subsequently incorporated this recommendation into Colorado Regulation 4-2-72, which requires carriers to increase the proportion of total medical expenditures in Colorado allocated to primary care by one percentage point annually in calendar years 2022 and 2023. Regulation 4-2-72 also requires carriers to report certain data on APM expenditures to DOI.

Figure 1. Primary Care Spending as a Percentage of All Medical Spending in Colorado Across Applicable Payers[1]

Excludes pharmacy and dental

2019	2020	2021
7.4%	7.5%	8.8%

The most recent APCD data presented to the Collaborative by CIVHC in November 2022 show that in 2021 primary care spending as a percentage of all medical spending (excluding pharmacy and dental) in Colorado across all applicable payers subject to the requirements of Regulation 4-2-72* was 8.8%. This represents a slight increase compared to 2020 and 2019; primary care spending across applicable payers accounted for 7.5% of total medical spending in 2020 and 7.4% of total medical spending in 2019 (see Figure 1).

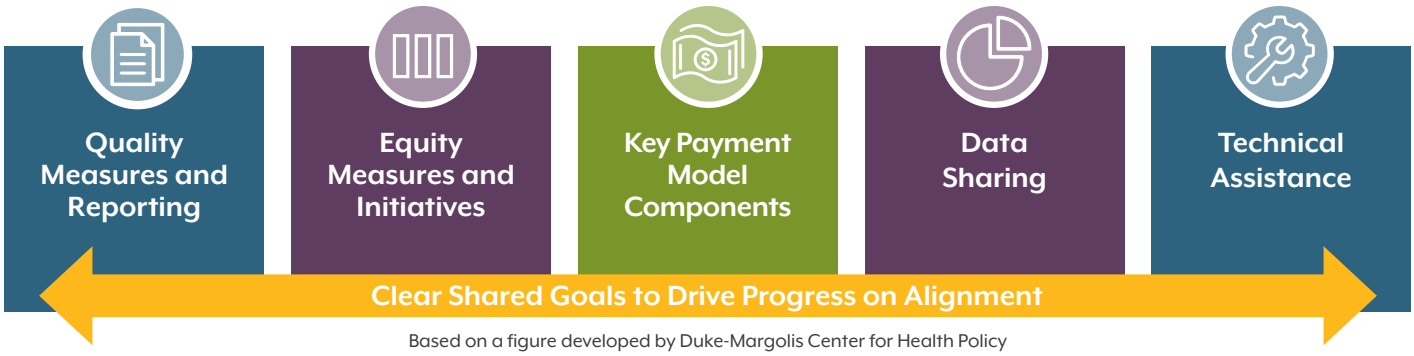
The Collaborative has consistently recognized the importance of prospective payments to support primary care providers' adoption and delivery of high-quality, advanced primary care. The Collaborative recommended that payers adopt APMs for primary care, especially those that include prospective payment, in both the first and third annual reports. CIVHC reports that in 2021 value-based APMs accounted for 26% of all medical spending across all reported lines of business and 40.5% of total primary care spending. Prospective payments under APMs accounted for 17% of all medical spending in 2021 and 91.0% of total primary care spending.[1]

See Appendix B for the full report on primary care spending and APM use.

State Transformation Collaborative

In December 2021, CMS announced the launch of the State Transformation Collaborative (STC), a state-based initiative in partnership with the Health Care Payment Learning & Action Network (LAN) to accelerate the movement toward advanced APMs that drive higher quality and more equitable care. Colorado was selected as one of four states, along with Arkansas, California, and North Carolina, to participate in the STC. Over the course of 2022, Colorado worked with leadership at the CMS, the Center for Medicare & Medicaid Innovation (CMMI), and the LAN to determine how the STC could best support the state's movement toward APMs that improve health care outcomes, equity, and value for all Coloradans. In the immediate term, CMMI and LAN experts will be part of ongoing stakeholder discussions related to payer alignment of APM parameters for primary care. As the STC progresses, Colorado looks forward to working with CMS, CMMI, LAN, and fellow STC states to gain additional insights, learnings, strategies, and support to iteratively advance five key areas of multi-payer alignment: 1) quality measures and reporting; 2) equity measures and initiatives; 3) key payment model components; 4) data sharing; and 5) technical assistance (see Figure 2).

Figure 2. State Transformation Collaborative, Five Key Elements of APM Alignment



Based on a figure developed by Duke-Margolis Center for Health Policy

* Certain payers are excluded from the primary care investment requirements of Colorado Regulation 4-2-72. The figures cited in this report include primary care spending reported by all payer types (Medicare Advantage, commercial, Medicaid, and CHP+); however, the data are variable when broken out by payer type. For additional information, please see Appendix B for the full CIVHC report on primary care spending and APM use.

House Bill 22-1325

In the 2022 legislative session, the General Assembly passed House Bill 22-1325 (HB22-1325) which directs the DOI to partner with HCPF, the Department of Personnel, CDPHE, and the Collaborative to develop and promulgate rules for APMs for primary care services offered through health benefit plans. The APM parameters must include, at minimum:

- An aligned quality measure to be set across payers that includes quality measures that are patient-centered and patient-informed;
- Patient attribution methodologies that are transparent and reattribute patients on a regular basis;
- Transparent risk adjustment parameters that ensure primary care providers are not penalized for or disincentivized from accepting vulnerable, high-risk patients and are rewarded for caring for patients with more severe or complex health conditions and patients who have inadequate access to affordable housing, healthy food, or other social determinants of health; and
- A set of core competencies focused on whole-person care delivery.[2]

The provisions in HB22-1325 build upon and complement the work of the Collaborative over the past four years. In accordance with HB22-1325, DOI will promulgate rules detailing the requirements for aligned APM parameters by December 1, 2023. To help inform the DOI's ongoing implementation of HB22-1325, the Collaborative has focused the recommendations in this fourth annual report on the topics of quality measures, patient attribution, and risk adjustment.

Recommendation 1:

Aligning Quality Measures

The Collaborative recommends that quality measures be aligned across payers to ensure accountability, standardization, and continuous improvement of primary care alternative payment models. To best meet the needs of different patient populations, the Collaborative recommends adopting an aligned quality measure set that includes a menu of optional measures, reducing the administrative burden on providers while still allowing for flexibility and patient-centered care.

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In its second annual report, the Collaborative stressed the importance of common goals and expectations across payers. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices. At the same time, the Collaborative recognized that payers and providers also need flexibility to choose quality measures that are relevant for practices and the populations they serve and the need for alignment across primary care services more broadly. Balancing the benefits of quality measure alignment with the need for flexibility to determine the measures best suited for different practices and patient populations was identified as a challenging but important goal.

Quality Measure Definition

Quality measures are tools that measure or quantify health care processes, outcomes, patient perceptions, and organizational structures and systems that are associated with the ability to provide high-quality health care or that relate to one or more quality goals for health care. These goals can include effective, safe, efficient, patient-centered, equitable, and timely care.[3]

HB22-1325 requires the DOI to promulgate rules for APM parameters for primary care, including requiring an aligned quality measure set across payers. In light of DOI's current implementation of HB22-1325, the Collaborative reviewed the work completed by the Colorado Alternative Payment Model Alignment Initiative (APM Alignment Initiative), which included recommended aligned quality measure sets for adult and pediatric populations. The Collaborative discussed the value of a common set of core quality measures to track continuous improvement of key metrics and the need to adapt and innovate as APMs improve and as population needs change. Ultimately, the Collaborative agreed that the aligned measure set should have built-in flexibility, so that providers and payers can work collaboratively to choose from a menu of options. The Collaborative recognizes that this arrangement requires both payers and providers to commit to transparent quality improvement activities.

The Collaborative appreciates the work completed by the APM Alignment Initiative and considers its proposed measure sets for adults and pediatric patients to be good starting points for discussion about an aligned measure set (see Tables 1 and 2). The Collaborative recommends the following approach toward deciding on a measure set:

1. Each payer should consider the APM Alignment Initiative's proposed measures as a starting point when developing measure sets for its programs.
    - **a.** Payers may consider adding additional measures beyond those proposed by the APM Alignment Initiative, as appropriate, to create a more comprehensive list.
    - **b.** For all measures considered, the reporting specifications should be consistent with nationally endorsed methodologies to the extent possible.
2. Payers' programs should be flexible to allow providers to choose measures from the measure set that are appropriate for each practice.
    - **a.** The full list of proposed measures from the APM Alignment Initiative should not be mandatory in payer-provider contracts; instead, payers should provide guidelines for selecting measures, including the number selected.

b. If a provider wishes to consider quality measures that are outside the scope of the measure set, they should supply evidence to demonstrate why the measure is relevant to their practice. The payer should provide a clear petitioning process and work with the provider to incorporate such measures.

3. Payers should require practices that serve a significant pediatric population to select pediatric quality measures in their programs in addition to adult measures.

a. The Collaborative recommends that payers set clear thresholds (such as number or percentage of pediatric patients) for a practice to qualify for these measures.

The Collaborative also recommends that an aligned measure set be regularly reviewed to ensure the measures are appropriately updated or removed as the primary care landscape continues to evolve in Colorado and nationally.

The APM developed by HCPF for Health First Colorado provides an example of how payers and providers can collaboratively determine quality measures. For example, in Health First Colorado's APM, each practice reports on 10 measures, three of which are mandatory and seven of which are chosen by the practice (details are available in HCPF's Primary Care Alternative Payment Model Guidebook).

In addition to the framework outlined above for collaboratively determining quality measures, the Collaborative recommends the following:

Flexibility in Performance Thresholds and Reporting Methods

While the reporting specifications for each quality measure should be consistent with nationally endorsed methodologies to the extent possible, performance targets and thresholds should be allowed to differ by practice. Allowing for this variation will let payers and providers make quality of care and improvement of care determinations for the specific populations they serve. Flexibility for individual practices should be balanced by tailored performance thresholds to ensure accountability. Payers should consider and incorporate three types of performance thresholds: maintenance of practice performance standards, continuous improvement (aka closing the gap), and benchmarking across practices.

The Collaborative supports standardizing quality measure reporting across providers, including the method of reporting. However, it recognizes that many practices do not yet have the infrastructure necessary to report on all types of quality measures, especially electronic health record (EHR)-based metrics. While practices should continue to improve reporting systems to support all types of quality measures, they should be allowed flexibility in reporting methods, choosing either administrative or EHR metrics as appropriate.

Person-Centered Measures

In considering an aligned quality measure set, the Collaborative emphasizes the importance of including measures that support and emphasize person-centered care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is widely used to capture patient experiences with health care. However, utilizing CAHPS data in quality measures presents challenges. Collaborative members noted several concerns related to selection bias of respondents to the CAHPS surveys and whether the pool of respondents is representative of total patient populations. Additionally, some metrics captured by CAHPS may be overly generic or subjective and, therefore, should not be used as a driving force for provider payment. To support person-centered quality measures that prioritize positive patient experiences, the Collaborative plans to investigate alternative person-centered primary care measures or data collection methods that better capture patient experience. One example is the Person-Centered Primary Care Measure developed by the Larry A. Green Center.

Supporting Population Health Approaches

Providers should understand health needs in communities they serve to support a population-level view of health. Payers should ensure that quality measures do not unintentionally penalize providers for increased outreach and screening efforts that lead to more diagnoses. For example, if a provider increases depression screening and identifies more patients with the disorder, they will

increase the percentage of their patients with depression. If the provider can't treat the additional patients quickly enough, quality measure scores related to depression will decline, penalizing the provider. Quality measures should be designed to avoid negative consequences for providers that identify patient needs.

Pediatric Quality Measures

To address the differing needs of adult and pediatric patients, the Collaborative recommends that the aligned measure set include a set of pediatric measures, using the APM Alignment Initiative measures as a starting point for determining the appropriate set. It also supports the development and research of additional pediatric measures, particularly at the national level.

Discussion questions for HB22-1325 stakeholder engagement

As stakeholder engagement for HB22-1325 continues, the Collaborative has identified the following questions for discussion:

- What person-centered primary care measures or data collection methods are currently available as an alternative to CAHPS? Does evidence exist to support these alternative measures and methods?
- What additional adult or pediatric quality measures should be included (or should be removed) in an aligned quality measure set?
- Should any of the measures included in an aligned set be prioritized, for either reporting or payment, or is this approach inconsistent with the flexibility needed by payers and providers?
- What should the process for reviewing and potentially adjusting an aligned measure set look like?

Table 1 – APM Alignment Initiative Adult Measure Set, Primary Care

Domain	Measure	Number	Data Source	Steward	CMS 2022 Core	Core Quality Measure Collaborative
Preventive Care	Breast Cancer Screening	NQF 2372	Claims	NCQA	Yes	Yes
Preventive Care	Cervical Cancer Screening	NQF 0032	Claims/ Clinical	NCQA	Yes	Yes
Preventive Care	Colorectal Cancer Screening	NQF 0034	Claims/ Clinical	NCQA	Yes	Yes
Preventive Care	Screening for Depression and Follow-Up Plan	NQF 0418	Claims/ Clinical	CMS	Yes	Yes
Chronic Conditions	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NQF 0059	Claims/ Clinical	NCQA	Yes	Yes
Chronic Conditions	Controlling High Blood Pressure	NQF 0018	Claims/ Clinical	NCQA	Yes	Yes
Behavioral Health	Initiation and Engagement of Substance Use Treatment	NQF 0004	Claims/ Clinical	NCQA	Yes	No
Patient Experience	CAHPS Health Plan Adult Survey	NQF 0006	Patient Survey	AHRQ	Yes	Yes

NCQA – National Committee for Quality Assurance
CMS – Centers for Medicare & Medicaid Services
AHRQ – Agency for Healthcare Research and Quality

Table 2 – APM Alignment Initiative Pediatric Measure Set, Primary Care

Domain	Measure	Number	Data Source	Steward	CMS 2022 Core	Core Quality Measure Collaborative
Preventive Care	Child and Adolescent Well-Care Visits	NQF 1516	Claims	NCQA	Yes	Yes
Preventive Care	Developmental Screening in the First Three Years of Life	NQF 1448	Claims/ Clinical	OHSU	Yes	Yes
Preventive Care	Well-Child Visits in the First 30 Months of Life	NQF 1392	Claims/ Clinical	NCQA	Yes	No
Preventive Care	Screening for Depression and Follow-Up Plan	NQF 0418	Claims/ Clinical	CMS	Yes	No
Preventive Care	Childhood Immunization Status	NQF 0038	Claims/ Clinical	NCQA	Yes	Yes
Preventive Care	Immunizations for Adolescents	NQF 1407	Claims/ Clinical	NCQA	Yes	Yes
Preventive Care	Lead Screening in Children	N/A	Claims/ Clinical	NCQA	No	No
Patient Experience	CAHPS Health Plan Child Survey	NQF 0006	Patient Survey	AHRQ	Yes	Yes

NCQA – National Committee for Quality Assurance
CMS – Centers for Medicare & Medicaid Services
OHSU – Oregon Health & Science University
AHRQ – Agency for Healthcare Research and Quality

Recommendation 2:

Improving Patient Attribution

The Collaborative recommends that patient attribution methodologies for primary care alternative payment models be patient-focused, clearly communicated to providers, and include transparent processes for assigning and adjusting patient attribution lists (e.g. adding or removing patients).

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Accurate and timely patient attribution is crucial to value-based payments and prospective payments. Current patient attribution methodologies are designed to support payment for active physician-patient relationships, where providers are actively serving and engaging patients. However, a provider's professional understanding of "who my patients are" may differ from the patients who are attributed to them for payment purposes, a source of confusion and frustration for providers. A lack of information or awareness of how patient attribution functions in payment models is also an ongoing challenge for providers. This challenge is compounded by the reality that current attribution models vary in key elements, such as the frequency of the process or reporting.

Patient choice should be the primary factor in attribution. However, current attribution methodologies do not always incorporate and prioritize inputs that elevate patient choice. Additionally, patients may not be aware of their ability to choose a provider, and how or why that choice can improve their care. They may also face challenges when seeking to change their care to a different provider.

HB22-1325 requires the DOI to promulgate rules for APM parameters for primary care and includes requirements that patient attribution methodologies be transparent and reattribute patients on a regular basis. The Collaborative recommends that efforts to improve patient attribution in primary care and align attribution methodologies across payers focus on increasing transparency, improving patient choice, instituting a method for reattribution, and promoting consistency for payment and quality measurement.

Patient Attribution Definition

Patient attribution is a method of identifying a patient-provider health care relationship. In an APM model, patient attribution is used to determine which provider group is responsible for a patient's care, including the quality and cost of the care. Patient attribution is a foundational component of population-based payment models, which are based on a simple concept: providers accepting accountability for managing the full continuum of care for their patients.[4]

Transparency

Patient attribution should be timely, actionable, and easily accessible, which requires strong, ongoing bilateral communication between payers and providers. The Collaborative recommends adoption of strategies and standards to ensure transparency and ongoing communication between these two groups. For example, the Collaborative recommends that payers adopt clear, standardized language about patient attribution methodologies, so providers understand how patients are attributed to them. Another potential strategy, which has been used with success in Colorado, is to require the provider's practice to acknowledge the acceptance of a new patient (in instances where a patient is requesting to switch providers) before the patient is added to their attributed population.

Each practice should be able to view their attribution lists at all times. Ideally, patient attribution lists should be integrated into existing EHR and scheduling software, allowing providers to view attribution information about patients in a clear and usable way, at the point of scheduling patients and care delivery. The Collaborative acknowledges that some practices may need additional support to transition to EHRs that can accommodate additional data requirements necessary to receive patient attribution lists.

Improving Patient Choice

Patient choice should drive patient attribution — allowing patients to choose their providers and to change providers as desired is widely

considered to be the "gold standard" of patient attribution methods. To facilitate patient choice, the Collaborative recommends that payers and providers educate patients about the concepts of a primary care provider and patient attribution in a clear, uncomplicated manner that emphasizes the patient's ability to choose. Patients should be told up front that they can change providers when interacting with a practice. The Collaborative will continue exploring specific strategies to extend transparency to patients, which will support patient choice and person-centered care.

Attribution methodologies should incorporate and prioritize inputs that reflect patient choice, such as frequency of encounters or a patient-selected provider designation in a patient portal. To the extent possible, factors that are automatically assigned, such as geographic location, should be deprioritized or excluded from attribution methodologies tied to payment or quality measurement.

While the Collaborative encourages strategies that increase patient engagement in and awareness of patient attribution, these should not add an additional burden on consumers. While most patients will not have a detailed understanding of the payment models that are influencing their care, medical professionals should give patients confidence that their needs and feedback will be prioritized.

Reattribution

The Collaborative recommends that payers establish a clear process for reattribution, or adding or removing patients from a practice's attribution list. Providers should be able to review their practice's attribution list on a regular basis and have clear information about how frequently it is updated. If a provider wants to remove a patient from their list, they should have a clear mechanism for petitioning the payer to remove that patient. To remove a patient, providers should supply evidence supporting their petition; this could include documentation of outreach efforts, frequency of visits, or other pertinent care information.

Quality Measurement

The Collaborative recognizes the significant impact of patient attribution on quality measurement. While attribution at the time of a patient's first visit supports timely care and payment, it can have a negative impact on quality metrics when new patients enter the practice with significant health concerns. Payers should consider ways to account for newly attributed members in quality measurement strategies, allowing time for patients and providers to follow up on additional screenings, tests, referrals, or visits necessary to support the patient's care after their initial visit. Providers should be incentivized to care for all new patients; therefore, payers must ensure that new patients with complex needs do not negatively affect a provider's quality scores. Providers also should not be incentivized to alter the care they provide in a way that increases payments at the expense of providing the most appropriate care.

Pediatric Attribution

The Collaborative wishes to draw attention to the special considerations necessary for newborn/infant and pediatric patient attribution. Many newborns are covered under their mother's insurance and are not insured as individuals for several months after birth. This becomes an issue due to the frequent visits in the initial weeks and months of life, which occur before attribution has been assigned, and causes delays in payment. The Collaborative recommends that parents/guardians be given support in the hospital setting to enroll their newborns in insurance immediately so that patient attribution is possible sooner. Additionally, the Collaborative recognizes that patient attribution for pediatric patients in general requires more frequent revision than attribution for adults. The Collaborative encourages payers to establish pediatric-specific protocols for patient attribution that revise attribution on timelines that match how patient needs change with age.

Alignment on Patient Attribution Across Payers

While the Collaborative acknowledges the benefits of aligning patient attribution methods — such as look-back periods and the timing of attribution (prospective vs. retrospective) — across payers it also notes that differences between the patient populations in commercial insurance and Medicaid present unique challenges to alignment. Unlike commercial insurance, Medicaid has no meaningful "lock in;" patients faced heightened barriers and do not have strong financial incentives to use a primary care provider rather than go to an emergency room. Attribution approaches may also be complicated by a high rate of churn (movement on and off coverage) in the Medicaid population. This results in providers

often not having extended periods of continuous enrollment for adults. Differences between private insurers and Medicaid are important considerations in the design of patient attribution methods. Providers that see a high volume of Medicaid patients (including federally qualified health centers) should be able to successfully participate in primary care APMs.

Commitment to Equity

APMs must focus on promoting better outcomes and equitable access to care for all Coloradans. The Collaborative is committed to centering the needs of people with the largest barriers to accessing care and stresses that patient attribution and other components of APMs should promote equitable, patient-centered care. This includes establishing baselines for comparison that address historical disparities between populations and mitigate unintended consequences.

Discussion questions for HB22-1325 stakeholder engagement

As stakeholder engagement for HB22-1325 continues, the Collaborative has identified the following questions for discussion:

- How can improvements to patient attribution be measured? Could a process metric be developed to track how well payers, providers, and practices work together on attribution?
- Patient attribution is used for several purposes: access to care, care coordination, payment, and quality measurement. How should these different approaches to patient attribution be integrated? What are the nuances that must be considered here?
- How can payers, providers, and practices elevate patient choice in the attribution process? What is the best way to educate patients and families about their ability to choose a provider?

Recommendation 3:

Improving Risk Adjustment

The Collaborative reaffirms the importance of incorporating social factors into risk adjustment models as a tool to advance health equity and ensure providers have adequate support to treat high-need populations. The Collaborative recommends ongoing exploration of existing and emerging risk adjustment models for primary care that include inputs related to both medical and social needs. Additionally, the Collaborative recommends increased transparency around the components of current payer-level risk adjustment models to improve provider understanding of risk adjustment and to identify areas for potential payer alignment.

APPROVED BY UNANIMOUS CONSENSUS

Social Risk Adjustment

In its second annual report, the Collaborative recommended that risk adjustment methods for primary care incorporate measures of physical health, behavioral health, and social risk at both the individual and community levels. The Collaborative also acknowledged that modifying current risk adjustment methods to primary care practices will be a significant undertaking. In its third annual report, the Collaborative stressed the importance of improving data collection on social factors to support risk adjustment and other parameters of equitable APMs.

Risk Adjustment Definition

Risk adjustment is a statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or costs.[5]

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.[6]

HB22-1325 further elevates the importance of social risk in primary care by calling for the development of "transparent risk adjustment parameters that ensure primary care providers are not penalized for or disincentivized from accepting vulnerable, high-risk patients and are rewarded for caring for patients who have inadequate access to affordable housing, healthy food, or other social factors influencing health."

The Collaborative acknowledges the majority of current risk adjustment models for APMs remain focused on medical risk, and the incorporation of social risk into risk adjustment is an emerging methodology. While several states have implemented strategies to gather and incorporate social inputs into risk adjustment methodologies, widely established and effectively vetted mechanisms for gathering social data have yet to be established. Therefore, the Collaborative recommends continued exploration into currently implemented social risk models and data collection sources. The Collaborative is interested in not only social risk model design, but also social risk model evaluation around performance and how accurately social risk is captured.

The Collaborative encourages taking the following initial steps to support social risk adjustment in Colorado:

• *Data*

The Collaborative recommends that Colorado payers explore data sources that could inform social risk adjustment on both the group/neighborhood and individual levels. The Colorado APCD contains limited information that could be used to help inform individual social risk, such as some information around race/ethnicity, language preference, Z codes (particularly housing), and rural geography. Similarly, data from the American Community Survey could be used to create a group risk index, such as a social deprivation index. The Collaborative recommends continued exploration of methods of how to best use this data to influence risk adjustment.

Additionally, the Collaborative is interested in exploring how efforts in the state to support the social health information exchange (S-HIE) could support the consideration of social risk. S-HIE seeks to establish whole-person care and address social risk factors, including access to food, housing, social connectedness, and safety. Information exchanged through S-HIE could support comprehensive, real-time calculations of social risk at both the community and individual levels.

The Collaborative also recognizes the value of subjective clinical assessments and patient-reported data in the calculation of social risk. Questions that providers ask patients such as "How's your health?" and provider assessments such as "Do I expect my patient to be in the hospital one year from now?" can add to electronic health record-based data by helping create a comprehensive view of risk.

When collecting social information from patients, practices should design workflows that prioritize a positive patient experience. Providers should be mindful of any stigma associated with asking about social factors and should ensure patients feel comfortable sharing that information. To facilitate a positive experience when collecting this type of data, providers should consider (1) how data is being collected and (2) who is collecting the data. Additionally, providers should ensure that social data stored in medical records accessible to patients is displayed in non-stigmatizing ways that would not discourage patients from seeking care.

Incorporating Social Risk Into Value-Based Payment Models

Examples of how social risk can be incorporated into value-based payment models can be found in Minnesota and Massachusetts. Minnesota's Medicaid accountable care organization (ACO) contains a population-based payment that is adjusted based on social risk factors. Massachusetts' Medicaid program has also incorporated social risk factors into its methodology for risk adjustment for payments to Medicaid Managed Care Organizations and ACOs. The Massachusetts model calculates both a neighborhood stress score index and personal social risk score for individuals.[7]

To support the collection and utilization of social data, practices and payers should also consider how the collection of data will be incentivized. Incentives should reward consistent and frequent data collection, but not be prioritized over patient needs and person-centered approaches. Providers and payers should consider how data systems are structured to support data collection and utilization. Collecting social data will create additional workload for practices; therefore, practices should ensure that they have sufficient capacity to accurately collect and use social data and to ensure that data is collected evenly across all patient populations.

- *Commitment to Equity*

The Collaborative emphasizes the potential for social risk adjustment in advancing health equity. Effective social risk adjustment will ensure that providers have the resources they need to serve populations with complex needs, resulting in better care for these populations. While incorporating social inputs in risk adjustment methods for primary care, the Collaborative emphasizes that social needs and risk calculations should not be used to justify worse health outcomes for individuals and groups. High social risk calculations should be used to identify areas for investment in narrowing health disparities, and payments in these areas should be increased to support the need.

- *Importance of Pediatric Prevention*

When considering social risk for pediatrics, the Collaborative wishes to emphasize the importance of prevention. Early intervention leads to better health outcomes and lower health care costs. Therefore, investments should be made in prevention efforts that address social risks early in a patient's life. Additionally, the Collaborative recognizes the need for integrated behavioral health in pediatrics and the value of whole-family integrated care as a preventive intervention. The Collaborative would like to explore the potential of using screening results in risk adjustment methodologies to support this type of early intervention.

Components of Risk Adjustment

In addition to the incorporation of social risk into risk adjustment, the Collaborative recommends actions to improve the structure and function of existing clinically based models. Risk adjustment models involve complex methodologies that are often unclear to providers, leading to a lack of understanding (and/or agreement) about how such arrangements determine provider payments and incentives. The Collaborative recommends increasing transparency in the following components of risk adjustment models, as discussions of potential payer alignment in these areas continue through HB22-1325 implementation:

- *Type of Payment Arrangement*

An important element to consider in risk adjustment is how much of the predicted risk and cost for a patient is within the purview of a primary care physician to treat. For example, if a patient has a high medical risk due to hemophilia, what is the primary care cost predicted for that patient versus the total cost for all types of care? The allocation of these responsibilities and costs is known as the type of payment arrangement. To support transparency in the calculation of risk adjustments, payers should clearly communicate the type of payment arrangement to providers.

- *Concurrent vs. Prospective Payments*

Concurrent risk adjustment models apply risk adjustment to actual experiences at the end of a contract period and adjust prior payments to account for the risk level. Prospective models use current experience to project the appropriate rate for the next contract period. Both models offer different benefits and challenges for practices. Large providers might prefer the accuracy of concurrent models, which are based on what actually happened but may be associated with retrospective reconciliation of payments, while smaller providers may prefer the payment certainty of prospective models. Regardless of whether a payment plan is concurrent or prospective, payers should provide transparent information about how their risk adjustment is calculated. Providers should be able to understand how risk adjustment methodologies interact with payment schedules.

- *Calibration to Population Served*

Risk adjustment models should be calibrated for the population served. For instance, the patient population in commercial insurance may differ from those enrolled in Medicaid; pediatric population is different than an adult population. Risk adjustment

models should be calibrated to capture the distinctions between these populations, which raises important considerations in the context of aligned primary care APM parameters.

- *Resource Intensity*

Resource intensity refers to the relative volume of services and supports needed to promote whole-person care. Effective risk adjustment models should accurately predict the resource intensity required to serve patients and reduce barriers to accepting and treating patients who require high resource intensity.

- *Balance Between Transparency and Upcoding*

While payers should strive to make the components of risk adjustment as transparent as possible, providers should be aware of the risk of "upcoding" or coding diagnostic and health information in such a way as to boost reimbursements. Intentionally misrepresenting patient data to maximize financial incentives is fraudulent, and efforts should be made to discourage this practice. Payers should provide clear, standardized language to explain how risk adjustment is determined, but they need not provide exact details on the calculation.

- *Patient-Centered Approach*

Capturing diagnosis and information from patients is essential to risk adjustment calculations and quality measures. However, the drive to capture this information can lead to workflows that are not patient centered. For example, asking about preventive screenings during an emergency room admission may not be in the patient's best interest. Therefore, providers should prioritize, and payers should incentivize, person-centered care over data collection. The Collaborative also recommends that payers compare relative risk across practices to encourage a holistic view of the population served, rather than across patients, which focuses on individual circumstances.

- *Considerations for Pediatric Populations*

The Collaborative acknowledges that current risk adjustment models, which are often calibrated to standard combined adult and child populations, may underestimate risk for pediatric populations, who are less likely to have been diagnosed with the medical conditions that drive current models. Therefore, the incorporation of social factors is especially important to predict near-term risk more accurately for this population. While risk adjustment is necessarily focused on near-term costs, long-term prevention is especially important for this population and is key to avoiding long-term costs. Risk adjustment models should be balanced with other APM strategies that incentivize preventive care for this population.

Alignment on Risk Adjustment Across Payers

Multi-payer alignment of risk adjustment methodologies would help to improve consistency in how providers are incentivized to provide care and reduce their administrative burden. For example, if all payers began to incorporate social factors into risk adjustment methodologies for primary care, that shift would likely drive a larger focus on caring for patients experiencing higher social risks than if one payer adopted a new methodology alone.

Discussion questions for HB22-1325 stakeholder engagement

As stakeholder engagement for HB22-1325 continues, the Collaborative has identified the following questions for discussion:

- Is multi-payer alignment on risk adjustment an all-or-nothing proposition? Is there any benefit in partial alignment across payers?
- To what extent can risk adjustment be tailored to practices, patient populations, and specific APM goals (e.g. cost of care, outcomes)? Is such tailoring feasible at the payer level?
- How will risk adjustment transparency be measured and monitored?

Conclusion

The recommendations in this report build on prior efforts by offering additional guidance around key APM parameters such as quality measures, patient attribution, and risk adjustment.

Colorado continues to be a national leader in health care delivery and payment innovation, as reflected in its selection as one of only four states to participate in the State Transformation Collaborative initiative, 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 participating in upcoming stakeholder engagement related to the implementation of HB22-1325.

Endnotes

[1] Center for Improving Value in Health Care. Primary Care Spending and Alternative Payment Model Use in Colorado, 2019-2021. (2022)

[2] Colorado General Assembly. Primary Care Alternative Payment Models. (2022) https://leg.colorado.gov/bills/hb22-1325

[3] Centers for Medicare & Medicaid Services. Quality Measures. Retrieved January 1, 2023 from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures

[4] Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment Models: Patient Attribution. (2016) https://hcp-lan.org/pa-whitepaper/

[5] HealthCare.gov. Risk Adjustment. Retrieved January 1, 2023 from https://www.healthcare.gov/glossary/risk-adjustment/

[6] H. Alderwick and L. Gottlieb. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Systems. (2019) The Milbank Quarterly Volume 97. Milbank Memorial Fund. https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/

[7] State Health Access Data Assistance Center. Risk Adjustment Based on Social Factors: State approaches to filling data gaps. (2020) https://www.shadac.org/news/SHVS-social-factor-risk-adjustments-2020

Appendix A

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

Appendix B

Primary Care Spending and Alternative Payment Model Use in Colorado, 2019-2021

(Report follows this page)

Appendix C

Colorado Alternative Payment Model Alignment Initiative

In developing this report, the Collaborative reviewed the Colorado Alternative Payment Model Alignment Initiative, which included recommended aligned quality measure sets for adult and pediatric populations. The full recommendations report and more information about the APM Alignment Initiative can be found at https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-alternative-payment-model

NOVEMBER 23, 2022

PRIMARY CARE SPENDING AND ALTERNATIVE PAYMENT MODEL USE IN COLORADO, 2019-2021

Amended Version to Report
Submitted on November 16th, 2020

CIVHC
CENTER FOR IMPROVING
VALUE IN HEALTH CARE

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BACKGROUND

The Center for Improving Value in Health Care (CIVHC) provides this report of primary care and alternative payment models (APM) spending (2019-2021) to the Colorado Insurance Commissioner for use by the Primary Care Payment Reform Collaborative (the Collaborative), established by Colorado House Bill 19-1233. The Collaborative's goal is to reduce overall health care costs by increasing utilization of primary care. This report measures progress towards that goal, as required by statute:

> *CRS 25.5-1-204(3)(c)(II)* - Report includes the percentage of total medical expenses allocated to primary care, the share of payments that are made through nationally recognized alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.

The report is based on annual file information submitted by health insurance payers (also known as carriers) to CIVHC about primary care and total medical spending from claims and non-claims payments under fee-for-service (FFS) and APMs. CIVHC began collecting APM data as part of the Colorado All Payer Claims Database (CO APCD) Data Submission Guide in 2019.

REPORT CONTENT

Primary care and APM spending as a percentage of total medical spending is presented for 2021 by line of business (commercial, Medicare Advantage, Medicaid, and CHP+) in Table 1. The accompanying Excel file includes this information for all three years of data included in the analysis: 2019, 2020, and 2021. Primary care and APM spending for 2021, as a percentage of medical spending and by payer, is described in Table 2.

In this report, primary care spending and total medical spending exclude dental and prescription drug spending. This analysis includes commercial, Medicaid and Medicare Advantage payers, but does not include Medicare fee-for-service (FFS), the majority of self-insured employer covered lives, or federal health insurance programs such as the Veterans Administration, Tricare, and Indian Health Services.

Medical and primary care spending were calculated using claim payments submitted through the Colorado All Payer Claims Database (CO APCD) and non-claim payments collected through the APM files (*Appendix 1*). The approach to collecting and reporting primary care spending was informed by the Collaborative's recommended definition of primary care, and operationalized with input from the Collaborative members and the Division of Insurance (*Appendix 2*). The Collaborative also recommended using the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model framework to categorize APMs (*Appendix 3*). More information on the HCP LAN initiative and the APM framework can be found here.

In 2021, based on the recommendations of the Collaborative and in consultation with the Division of Insurance, CIVHC updated the file specifications to include plan paid amounts in order to assess payer investment in primary and value-based care. The specifications were also

updated to include a prospective payment indicator to analyze prospective versus retrospective payments. Additional details on these changes can be found in *Appendix 1*.

This report is an amended version of the report submitted on November 16th, 2022.

FINDINGS

Key observations include highlights from the report of primary care spending for 2019-2021 by payment model (Table 1).

CIVHC collected qualitative information from all payers who submit an APM file to assess the impact of the COVID-19 pandemic on their organizations' investments in primary care and alternative payment models. For primary care, the general consensus was that utilization decreased during the stay-at-home order but has since rebounded to pre-pandemic levels or higher in some cases. The data demonstrates that investments in primary care, as a percentage of medical spending, increased overall between 2020 and 2021.

No payers reported a decrease in investment or cessation of APMs as a direct result of the COVID-19 pandemic in their qualitative responses. Most payers described no significant changes to their arrangements with providers. Some payers reported increased investment through the implementation of new pilot programs, one-time relief payments, or increased prospective payments in response to a decrease in utilization. The data shows that APM investment, as a percentage of medical and primary care spending, increased for all payers from 2020 to 2021.

PRIMARY CARE SPENDING

- In 2021, primary care spending as a percentage of ***all medical spending*** (excluding pharmacy and dental) in Colorado across all reported payer types was 10.3%. This percentage increased slightly compared to 2020 and 2019. Primary care spending accounted for 9.6% of total medical spending in 2020 and 9.4% of total medical spending in 2019.
    - The percentage of primary care spending in Colorado, excluding Kaiser Permanente and Denver Health payments[1], is 8.8% in 2021, 7.5% in 2020 and 7.4% in 2019.
- Primary care spending as a percentage of ***all medical spending*** varies by payer type. In 2021, primary care accounted for 8.9% of commercial medical spending, 16.8% of Medicare Advantage medical spending, 7% of Medicaid medical spending, and 18% of CHP+ medical spending.
    - The percentage of primary care spending in Colorado in 2021, excluding Kaiser Permanente and Denver Health payments, is 5.6% of commercial medical

[1] *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.*

spending, 18.1% of Medicare Advantage medical spending, 6.4% of Medicaid medical spending, and 15.6% of CHP+ spending.

APM Spending

- In 2021, 26% of ***all medical spending*** across all reported lines of business was paid through value-based APM arrangements[2]. This also varies by payer type - 23% of commercial, 22% of Medicare Advantage, 33% of Medicaid, and 6% of CHP+ medical spending was paid through value-based APMs.
    - Value-based APM arrangements built on an FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 14% of ***all medical spending***.
    - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 12% of ***all medical spending*** in 2021.
    - Excluding Kaiser Permanente and Denver Health, 20% of ***all medical spending*** was paid through value-based APM arrangements in 2021. With the exclusion of Kaiser Permanente and Denver Health, the percentage of all medical spending paid through value-based APM arrangements by payer type was 12% of commercial, 6% of Medicare Advantage, 34% of Medicaid, and 0% of CHP+ in 2021.
- Of ***all primary care spending*** in 2021, APMs, including non-value-based and value-based arrangements, accounted for 66% of spending. The remaining 34% of primary care spending occurred through traditional FFS payment arrangements. Of primary care spending made through APMs, the highest percentage flowed through Integrated Finance & Delivery Systems (category 4C).
    - Value-based APM arrangements built on a FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 10% of ***all primary care spending*** in 2021.
    - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 31% of ***all primary care spending*** in 2021.

Additional Metrics[3]:

Spending Per Member Per Month:

- In 2021 and across all lines of business, ***total medical*** spending per member per month (PMPM) was $91.50. ***Primary care*** spending PMPM was $9.42.

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[2] *Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).*

[3] *Note that these additional metrics are not displayed in the supplemental tables and other data.*

- ***Total medical expenditures*** expressed as spending PMPM vary by payer type. In 2021, total medical expenditures PMPM were $154.57 for commercial, $193.38 for Medicare Advantage, $48.47 for Medicaid, and $54.57 for CHP+.
- Similar to total medical expenditures, ***primary care expenditures*** expressed as spending per member per month vary also by payer type. In 2021, primary care expenditures PMPM were $13.71 for Commercial, $32.43 for Medicare Advantage, $3.40 for Medicaid, and $9.80 for CHP+.

Prospective Payments:

- Prospective payments refer to any payments made to providers in advance of services rendered, and are typically based on predetermined payment amounts for services. Across all lines of business, 17% of ***all medical spending*** in 2021 was paid on a prospective basis.
    - Excluding FFS, 56% of ***all medical spending through an alternative payment model*** was paid on a prospective basis in 2021.
    - 97% of Category 4 payments, 26% of Category 3, and 5% of Category 2 payments were made prospectively.
    - Excluding Kaiser Permanente and Denver Health, 6% of ***all medical spending*** and 27% of ***all medical spending through an alternative payment model*** was paid prospectively.
- The percentage of spending paid on a prospective basis varies by payer type; these differences are driven by both the overall percentage of spending paid through an APM arrangement as well as the predominant APM for each population. For example, Category 4 payment models are prospective by definition. Consequently, market segments that are dominated by these models will also pay a large percentage of their medical spending on a prospective basis.
    - Of ***all medical spending*** in 2021, 18% of commercial, 28% of Medicare Advantage, 9% of Medicaid, and 6% of CHP+ was paid prospectively.
    - Of ***all spending through an alternative payment model***, 70% of commercial, 88% of Medicare Advantage, 24% of Medicaid, and 97% of CHP+ was paid prospectively.

Member Cost Sharing:

- Across all lines of business, payer organizations covered 93% of ***all medical spending*** in 2021; members were responsible for 7% of the costs. Excluding Medicaid and CHP+, which has minimal member liability, payer organizations covered 89% of all medical

spending across commercial and Medicare Advantage plans, and members were responsible[4] for the remaining.

    - Excluding Medicaid and CHP+, payer organizations covered 93% of ***all primary care spending*** in 2021. Payer investment in primary care has also been increasing slightly year over year; health plans covered 89% of primary care expenditures in 2019 and 92% in 2020.

- In commercial lines of business only, payer organizations covered 86% of ***all medical spending*** in 2021; members were responsible[3] for 14% of the costs.

    - Payer investment in primary care for commercially insured members slightly decreased in 2021 compared to 2020; payer organizations covered 84% of primary care expenditures in 2019, 87% in 2020, and 86% in 2021.

[4] Note that this calculation only includes payments directly to providers. It does not include premiums paid by members to payer organizations.

Overall, the percentage of total medical spending, excluding Kaiser and Denver Health, attributed to primary care has increased slightly from 7% in 2019 to 9% in 2021.

Figure 1: Percent of Primary Care Spending by Payer Over Time, 2019-2021

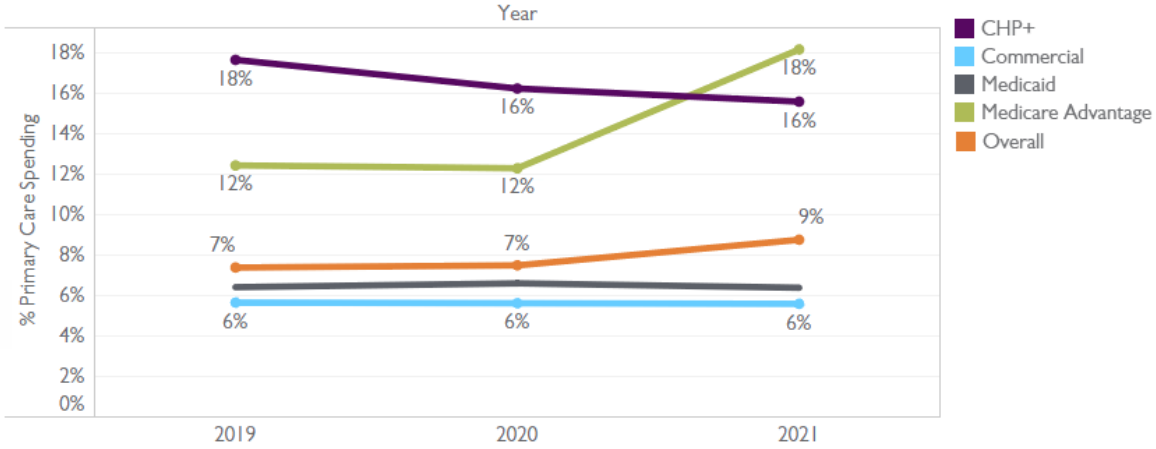


Figure 2: Share of Primary Care Spending, 2021.

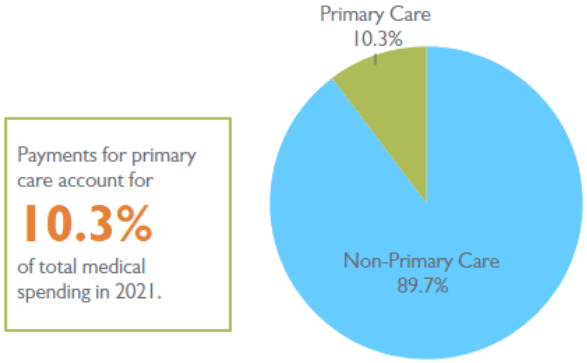
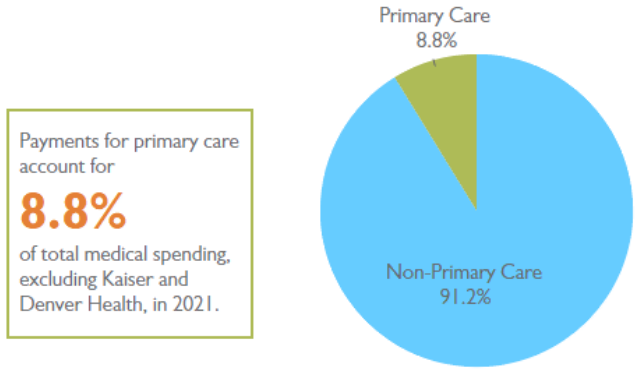


Figure 3: Share of Primary Care Spending, excluding Kaiser and Denver Health, 2021.



Note: The denominator (total medical spending) does not include pharmacy expenditures.

Figures 4: Share of Primary Care Spending by APM Category, 2021.

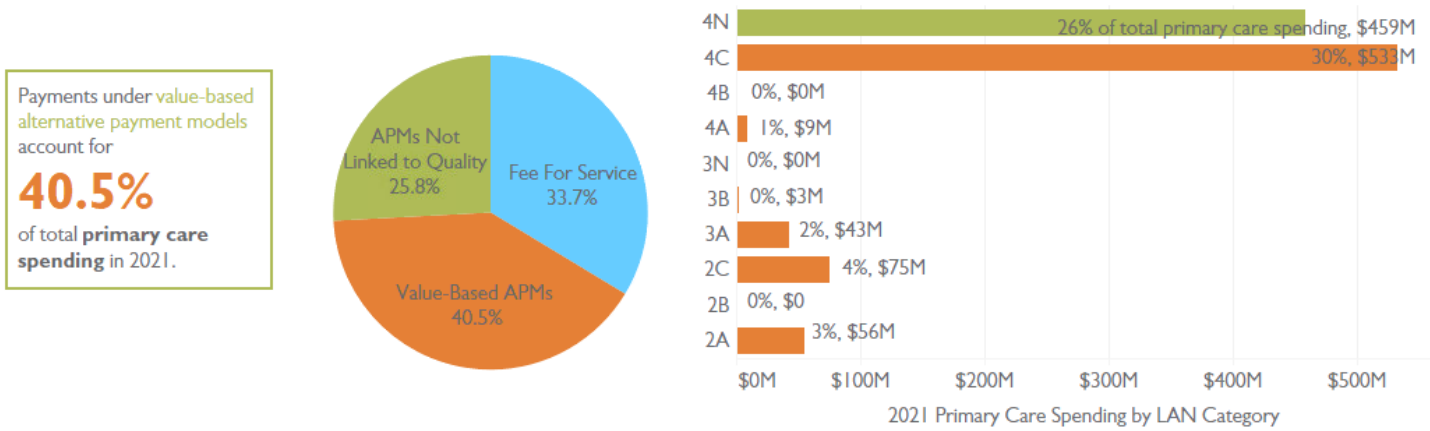
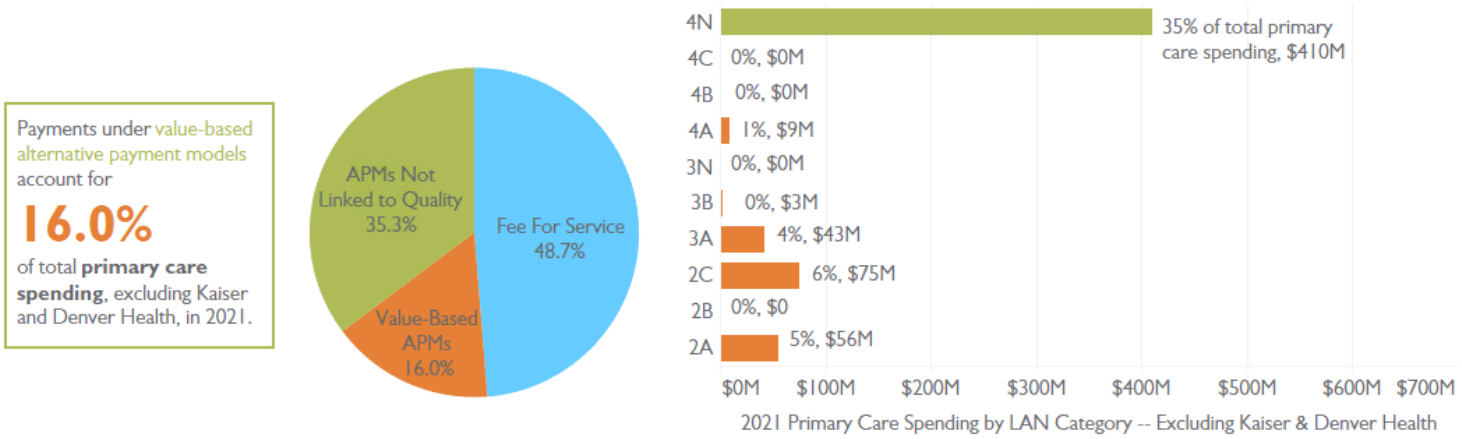


Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser and Denver Health, 2021.



Note: Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

Figure 6: Share of Total Medical Spending by APM Category, 2021.

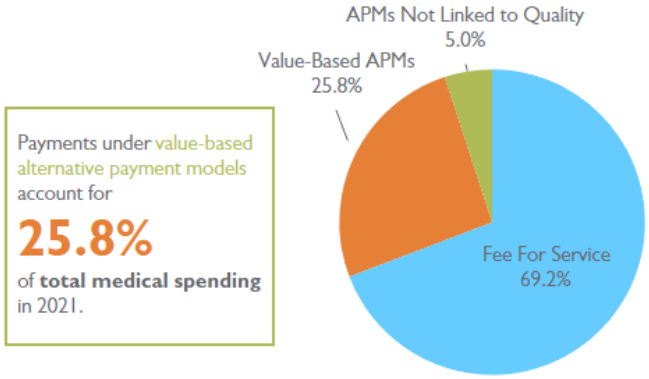
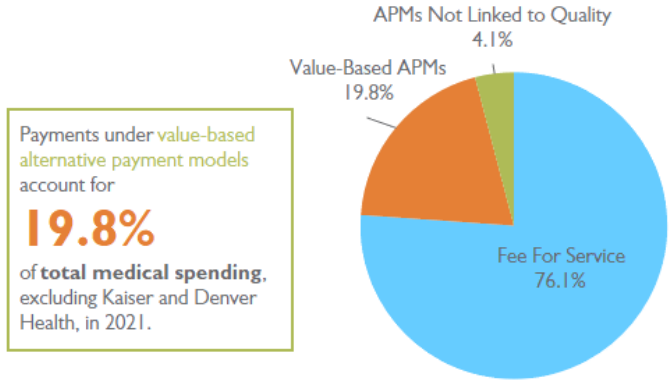


Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser and Denver Health, 2021.



Notes:
The denominator (total medical spending) does not include pharmacy expenditures.
Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

Figure 8: Primary Care Spending of Total Medical Spending by Payer Type, 2019-2021.

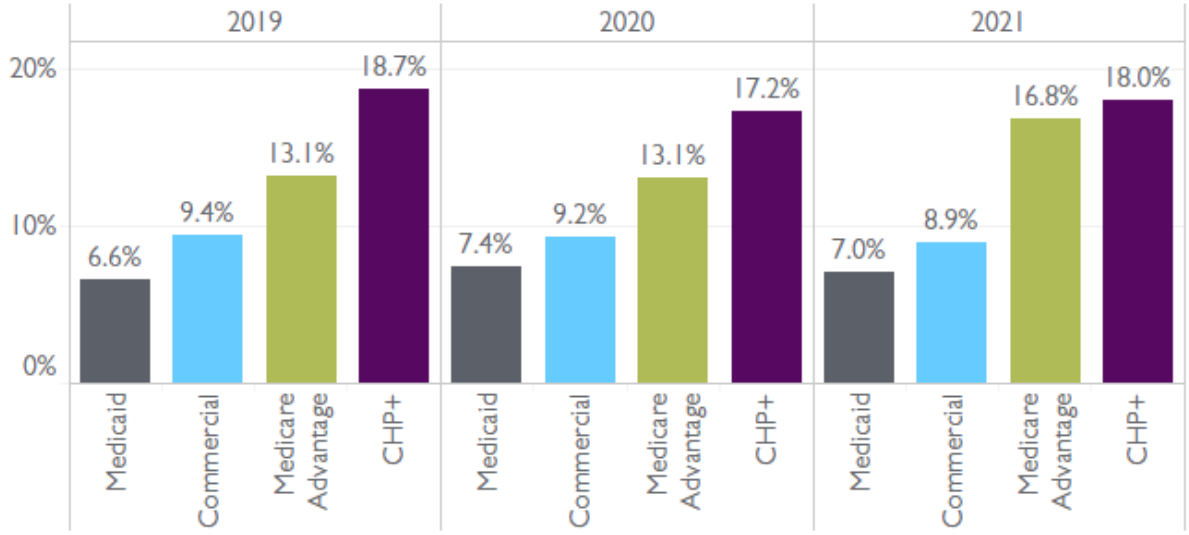


Figure 9: Primary Care Spending by Member Months by Payer, 2019-2021.

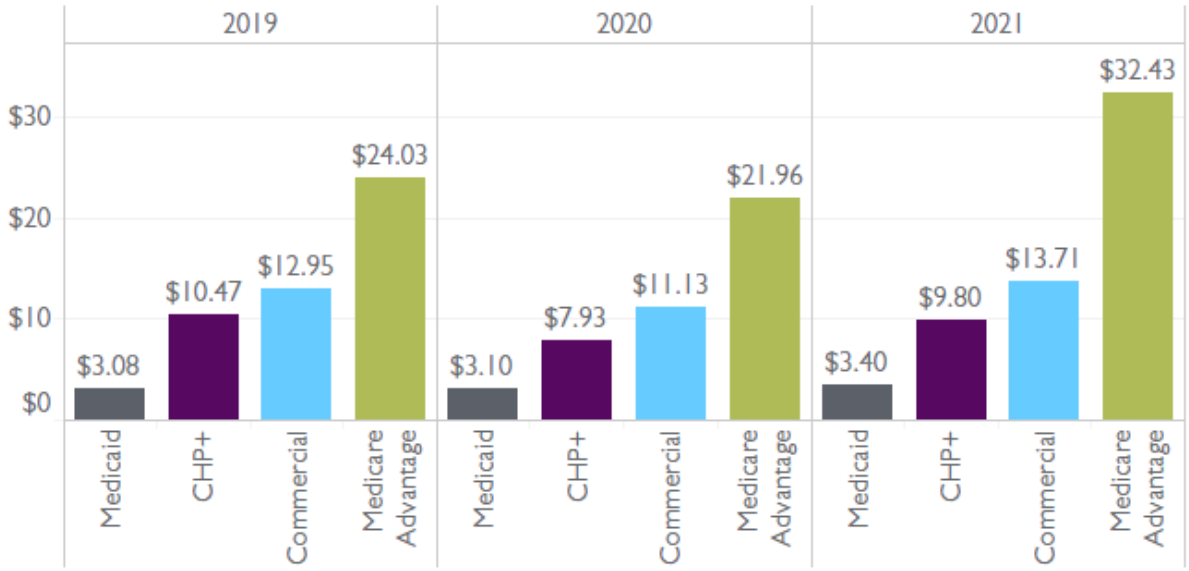


Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2021.

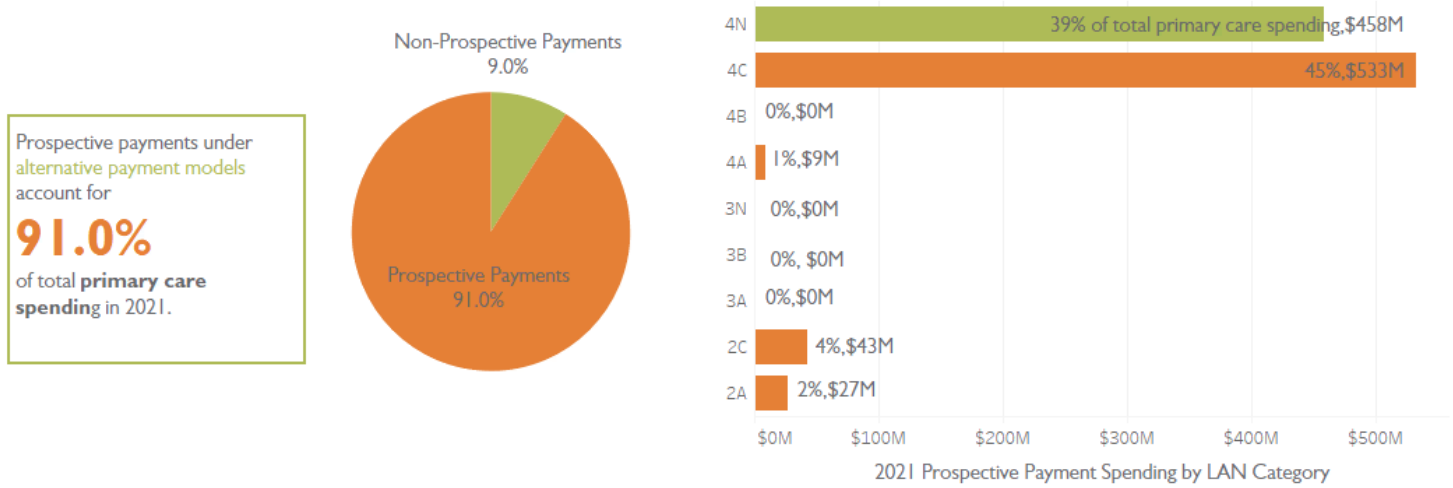


Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser and Denver Health, 2021.

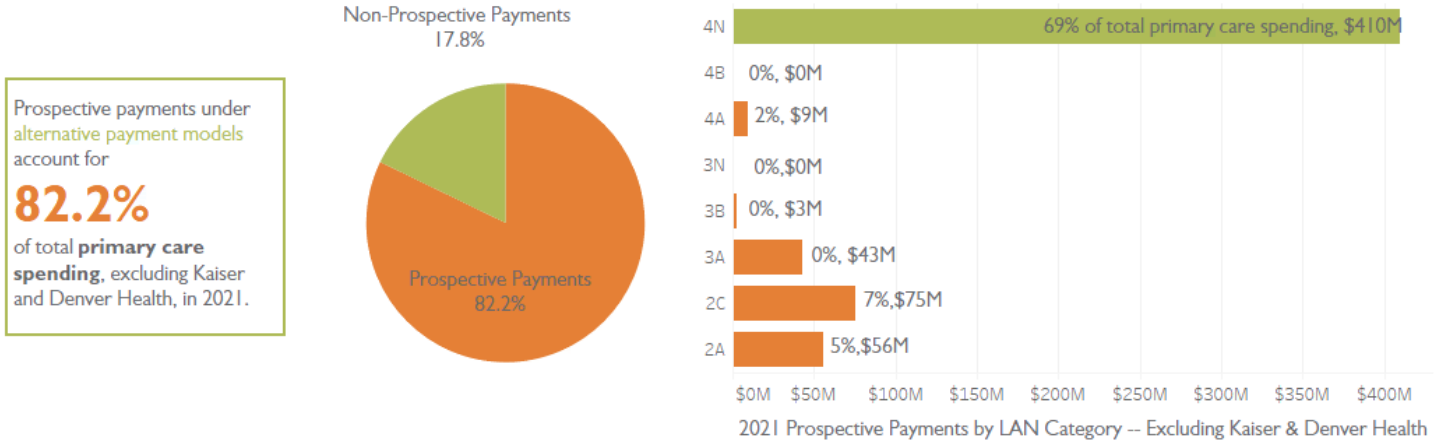


Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2021.

Prospective payments under alternative payment models account for

56.4%

of **total medical spending** in 2021.

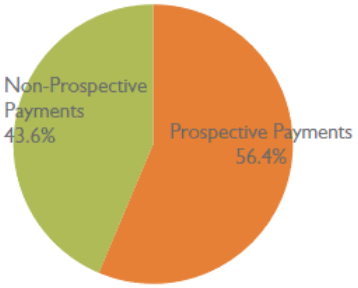
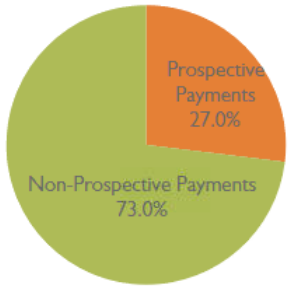


Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser and Denver Health, 2021.

Prospective payments under alternative payment models account for

27.0%

of **total medical spending**, excluding Kaiser and Denver Health, in 2021.



Data Sources

This report was developed from two sources of data: 1) the annual Alternative Payment Model (APM) files submitted by payers using alternative payments to providers, and 2) claims submitted by payers to the Colorado All Payer Claims Database (CO APCD). Details about these two data sources are described below.

In addition to data collected from the Colorado Department of Health Care Policy & Financing (HCPF), CIVHC collects Medicaid data from multiple entities, including Managed Care Organizations (MCOs), Health Maintenance Organizations (HMOs) and Regional Accountable Entities (RAEs). Each organization submits an APM file that includes payments made directly from the organization to medical providers. To ensure that Medicaid payments are not double-counted, HCPF payments to other Medicaid organizations are not included in the report. This report only includes Medicaid payments made directly to providers from HCPF, MCOs/HMOs, and RAEs. CIVHC met with each organization multiple times to confirm that the expenditures submitted in their file adhered to this instruction, that statewide programs (e.g. Accountable Care Collaborative) were represented consistently in each submission, and that CIVHC represented the complex Medicaid landscape accurately in this report.

Annual Alternative Payment Models (APM) Files:

CIVHC receives APM submissions from 13 payers. At time of submission of the November 16th, 2022 report, CIVHC was not able to include data from one health insurance payer and produced the report with APM data from 12 out of 13 payers. This amended version includes APM files from 13 payers.

The APM submission process involves each payer submitting a test file in July; a test file review period during which CIVHC validates the files and shares the findings to the payers; each payer submitting a production file in September; and a second validation period. In addition, CIVHC requires a C-suite level executive from each payer organization to attest in writing to the accuracy and validity of their APM submissions. As a result of the enhancements to the validation process implemented in 2021, as well as the continued learning from payers, CIVHC is confident the data in this year's report represents an accurate picture of APM investments across Colorado to date.

Payers were first required to submit APM files in 2019. APM files capture the payments to providers that fall outside of the traditional FFS structure. The reported information is aggregated at the billing provider and payer type level. The APM files provide important insights into spending across the health care system in Colorado beyond claims-based payments submitted on a monthly basis to the CO APCD.

Prior to the 2020 APM file submissions, CIVHC adopted the nationally recognized HCP LAN framework for categorizing APM data. This was a departure from the original methodology used to collect this data for the first time in 2019. Some payers had difficulties adjusting to the HCP LAN framework, and did not consistently report FFS dollars associated with an APM under the proper payment arrangement category. As a result, the APM investment reported in the 2020 Primary Care report was slightly understated. CIVHC prioritized this issue in the

2021 APM data collection and implemented the enhanced data collection process. In 2021, to facilitate the continued application of the HCP LAN framework for APM data submission, CIVHC and DOI held several multi-payer calls, received expert consultation from Catalyst for Payment Reform, and engaged in multiple one-on-one discussions and technical assistance with each payer. CIVHC also produced and updated a lengthy submission manual for payers to reference when developing their files. During the 2021 data submission process, CIVHC met with each payer at least once prior to submission of both test and production files and provided additional support to verify findings and aid the payers in revising their files to meet specifications.

In 2021, CIVHC added a qualitative summary of each payer's APM contracts to the submission requirements. Payers summarized the key elements of each contract (e.g. is it population based, are there measures of quality, does it include claims-based and/or non-claims payments?). This information is invaluable when validating the APM data and specifically addresses the category confusion that acted as one of the major limitations of 2020's report. For example, if a payer described their contract as including both claims and non-claims payments, CIVHC was able to validate that the APM expenditure data included in both of these payment types under the appropriate payment arrangement category. Another key benefit of the contract summary is that it often facilitates conversations between the payers' provider contracting subject matter experts and the data teams that produce the APM files to ensure that the APM files accurately reflect their business practices.

In 2021, CIVHC also implemented the attestation requirement mentioned above. Once APM files passed all validation criteria, CEO/CFOs at each organization were required to attest to the accuracy and validity of the summarized results. This attestation creates greater transparency to the payers in how CIVHC is summarizing and reporting on their data as well as an additional level of validation to ensure data quality, integrity, and accuracy. All 13 payers included in this report attested to the information submitted in their APM files.

APM submissions relate only to total medical expenses. Payers did not submit APM data for dental, vision, or pharmacy services.

Additional details about the methods to collect APM information and estimate primary care spending can be found in *Appendix 1*.

Colorado All Payer Claims Database (CO APCD) Claims

Some payers who are active medical claims submitters to the CO APCD were exempt from submitting an APM file because the payers are not involved in APM payments to providers. The spending for these payers is calculated using CO APCD claims data submissions. These expenditures are included in the total medical spending denominator used throughout the report. A list of these exempt reporters is in *Appendix 1*.

RESULTS

TABLE 1: TOTAL MEDICAL AND PRIMARY CARE SPENDING BY PAYMENT MODEL AND PAYER TYPE (2021)

Results for 2019-2021 are available in the accompanying Excel document

Payer Type	Year	Measure	Total	Fee For Service	2A - Foundational Payments for Infrastructure & Operations	2B - Pay For Reporting	2C - Pay for Performance	3A - Shared Savings with Upside Risk Only	3B - Shared Savings with Downside Risk	3N - Risk Based Payments NOT Linked to Quality*	4A - Condition-Specific Population-Based Payment	4B - Comprehensive Population-Based Payment	4C - Integrated Finance & Delivery System	4N - Capitated Payments NOT Linked to Quality
TOTAL	2021	Total Medical Spending	$ 17,250,921,194	$ 11,941,491,813	$ 93,117,014	$ -	$ 1,810,431,913	$ 358,524,767	$ 192,627,595	$ 12,296,442	$ 179,014,896	$ 284,170	$ 1,812,642,034	$ 850,490,550
		Primary Care Spending	$ 1,775,974,546	$ 597,877,224	$ 55,656,151	$ -	$ 75,426,540	$ 42,850,187	$ 2,513,540	$ 35,438	$ 9,403,676	$ 180,584	$ 533,437,552	$ 458,593,653
		% Primary Care Spending	10.3%	5.0%	59.8%		4.2%	12.0%	1.3%	0.3%	5.3%	63.5%	29.4%	53.9%
COMMERCIAL	2021	Total Medical Spending	$ 7,069,953,303	$ 5,287,177,677	$ 22,194,892	$ -	$ 200,321,718	$ 284,488,824	$ 46,542,767	$ 88,166	$ 19,243,678	$ 188,782	$ 1,021,562,872	$ 188,143,928
		Primary Care Spending	$ 627,283,721	$ 244,748,652	$ 5,956,225	$ -	$ 654,081	$ 32,985,604	$ 2,513,540	$ 34,268	$ 193,999	$ 180,584	$ 339,943,853	$ 72,916
		% Primary Care Spending	8.9%	4.6%	26.8%		0.3%	11.6%	5.4%	38.9%	1.0%	95.7%	33.3%	0.0%
MEDICARE ADVANTAGE	2021	Total Medical Spending	$ 4,335,146,744	$ 2,942,531,033	$ 1,491,535	$ -	$ 84,811,526	$ 74,029,620	$ 1,330,623	$ 6,078,480	$ -	$ 95,388	$ 785,177,179	$ 439,601,361
		Primary Care Spending	$ 726,949,952	$ 111,161,612	$ -	$ -	$ 6,228,329	$ 9,858,259	$ -	$ 1,098	$ -	$ -	$ 190,070,641	$ 409,630,012
		% Primary Care Spending	16.8%	3.8%	0.0%		7.3%	13.3%	0.0%	0.0%		0.0%	24.2%	93.2%
MEDICAID	2021	Total Medical Spending	$ 5,743,123,710	$ 3,615,269,646	$ 69,430,587	$ -	$ 1,525,222,860	$ -	$ 144,754,205	$ 6,129,796	$ 159,686,919	$ -	$ -	$ 222,629,697
		Primary Care Spending	$ 403,294,871	$ 227,226,011	$ 49,699,926	$ -	$ 68,468,320	$ -	$ -	$ 73	$ 9,125,378	$ -	$ -	$ 48,775,164
		% Primary Care Spending	7.0%	6.3%	71.6%		4.5%		0.0%	0.0%	5.7%			21.9%
CHP+	2021	Total Medical Spending	$ 102,697,437	$ 96,513,457	$ -	$ -	$ 75,810	$ 6,324	$ -	$ -	$ 84,299	$ -	$ 5,901,984	$ 115,564
		Primary Care Spending	$ 18,446,002	$ 14,740,949	$ -	$ -	$ 75,810	$ 6,324	$ -	$ -	$ 84,299	$ -	$ 3,423,058	$ 115,562
		% Primary Care Spending	18.0%	15.3%			100.0%	100.0%			100.0%		58.0%	100.0%

* The 2019 3N total expenditures include a significant provider recoupement for a single payer in addition to other payers' 3N arrangements which include primary care.

* The 3B primary care expenditures include recoupements from primary care providers for a single payer.

Additional Note: Total medical expenditures do not include pharmacy and dental spending.

TABLE 1a: ALTERNATIVE PAYMENT MODELS AS A PERCENTAGE OF PRIMARY CARE SPENDING, BY PAYER TYPE (2021)

Results for 2019-2021 are available in the accompanying Excel document

Payer Type	Year	Measure	Total	Fee For Service	2A - Foundational Payments for Infrastructure & Operations	2B - Pay For Reporting	2C - Pay for Performance	3A - Shared Savings with Upside Risk Only	3B - Shared Savings with Downside Risk	3N - Risk Based Payments NOT Linked to Quality*	4A - Condition-Specific Population-Based Payment	4B - Comprehensive Population-Based Payment	4C - Integrated Finance & Delivery System	4N - Capitated Payments NOT Linked to Quality
TOTAL	2021	Primary Care Spending	$ 1,775,974,546	$ 597,877,224	$ 55,656,151	$ -	$ 75,426,540	$ 42,850,187	$ 2,513,540	$ 35,438	$ 9,403,676	$ 180,584	$ 533,437,552	$ 458,593,653
		% of Total Primary Care Spending	100.0%	33.7%	3.1%	0.0%	4.2%	2.4%	0.1%	0.0%	0.5%	0.0%	30.0%	25.8%
COMMERCIAL	2021	Primary Care Spending	$ 627,283,721	$ 244,748,652	$ 5,956,225	$ -	$ 654,081	$ 32,985,604	$ 2,513,540	$ 34,268	$ 193,999	$ 180,584	$ 339,943,853	$ 72,916
		% of Total Primary Care Spending	100.0%	39.0%	0.9%	0.0%	0.1%	5.3%	0.4%	0.0%	0.0%	0.0%	54.2%	0.0%
MEDICARE ADVANTAGE	2021	Primary Care Spending	$ 726,949,952	$ 111,161,612	$ -	$ -	$ 6,228,329	$ 9,858,259	$ -	$ 1,098	$ -	$ -	$ 190,070,641	$ 409,630,012
		% of Total Primary Care Spending	100.0%	15.3%	0.0%	0.0%	0.9%	1.4%	0.0%	0.0%	0.0%	0.0%	26.1%	56.3%
MEDICAID	2021	Primary Care Spending	$ 403,294,871	$ 227,226,011	$ 49,699,926	$ -	$ 68,468,320	$ -	$ -	$ 73	$ 9,125,378	$ -	$ -	$ 48,775,164
		% of Total Primary Care Spending	100.0%	56.3%	12.3%	0.0%	17.0%	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	12.1%
CHP+	2021	Primary Care Spending	$ 18,446,002	$ 14,740,949	$ -	$ -	$ 75,810	$ 6,324	$ -	$ -	$ 84,299	$ -	$ 3,423,058	$ 115,562
		% of Total Primary Care Spending	100.0%	79.9%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.5%	0.0%	18.6%	0.6%

Notes:

Total medical expenditures do not include pharmacy and dental spending.

The 3B primary care expenditures include recoupements from primary care providers for a single payer.

TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2020)

The following tables report medical expenditures stratified by both named payer for 2021.
Payers with multiple lines of business appear more than once.
Results for 2019-2021 are available in the accompanying Excel document

COMMERCIAL 2021							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Aetna	5.3%	33.3%	$ 26,309,902	$ 164,182,674	$ 492,520,507	$ 6,091,853	1.2%
Anthem	5.3%	36.2%	$ 51,725,102	$ 354,627,838	$ 978,665,910	$ 5,974,728	0.6%
Blue Cross Blue Shield of Illinois	2.3%	32.7%	$ 77,476	$ 1,123,086	$ 3,436,482	$ -	0.0%
Bright Health Group	7.4%	0.0%	$ 14,303,481	$ 62,945	$ 193,589,668	$ -	0.0%
Cigna	5.9%	5.2%	$ 46,225,813	$ 41,160,951	$ 784,422,733	$ 22,455,860	2.9%
Denver Health	0.7%	0.0%	$ 1,794,332	$ -	$ 247,479,681	$ 184,689,870	74.6%
Kaiser Permanente	17.3%	49.1%	$ 360,721,419	$ 1,021,562,872	$ 2,082,284,705	$ 1,021,562,872	49.1%
Rocky Mountain Health Plans	4.3%	0.4%	$ 5,116,301	$ 480,549	$ 119,377,381	$ -	0.0%
UnitedHealthcare**	5.9%	0.8%	$ 85,293,282	$ 11,342,618	$ 1,435,647,963	$ 10,094,731	0.7%
Allegiance Benefit Plan Management*	4.8%	0.0%	$ 1,835,260	$ -	$ 38,450,598	$ -	0.0%
Ameriben*	5.0%	0.0%	$ 1,535,707	$ -	$ 30,912,248	$ -	0.0%
American Enterprise*	0.0%	0.0%	$ -	$ -	$ 823,861	$ -	0.0%
Employee Benefit Management Services Inc.*	3.8%	0.0%	$ 2,412,814	$ -	$ 63,100,695	$ -	0.0%
Friday Health Plans*	5.0%	0.0%	$ 4,193,577	$ -	$ 84,531,064	$ -	0.0%
Harrington Kaiser Permanente*	4.9%	0.0%	$ 699,914	$ -	$ 14,193,749	$ -	0.0%
HealthSCOPE Benefits*	4.1%	0.0%	$ 1,145,874	$ -	$ 27,948,123	$ -	0.0%
HealthSmart*	6.4%	0.0%	$ 48,059	$ -	$ 752,376	$ -	0.0%
Humana*	6.2%	0.0%	$ 1,860,259	$ -	$ 30,236,931	$ -	0.0%
Meritain Health*	2.9%	0.0%	$ 710,480	$ -	$ 24,501,380	$ -	0.0%
UCHealth Plan*	9.8%	0.0%	$ 954,304	$ -	$ 9,770,438	$ -	0.0%
UMR*	5.1%	0.0%	$ 20,288,959	$ -	$ 396,531,711	$ -	0.0%
USHEALTH Group*	0.3%	0.0%	$ 31,408	$ -	$ 10,775,098	$ -	0.0%

TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2021) – Continued

MEDICARE ADVANTAGE 2021							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Aetna	4.6%	0.0%	$ 5,921,663	$ -	$ 127,993,661	$ -	0.0%
Anthem	4.6%	35.8%	$ 19,631,444	$ 154,069,560	$ 429,911,313	$ 1,547,348	0.4%
Bright Health Group	5.4%	0.0%	$ 746,151	$ -	$ 13,828,698	$ -	0.0%
Denver Health	1.2%	0.0%	$ 815,266	$ -	$ 70,344,496	$ -	0.0%
Kaiser Permanente	14.6%	58.9%	$ 193,852,261	$ 785,177,179	$ 1,331,970,682	$ 785,177,179	58.9%
UnitedHealthcare**	26.9%	0.4%	$ 469,184,302	$ 7,689,131	$ 1,741,511,431	$ 439,640,936	25.2%
Humana*	5.9%	0.0%	$ 36,798,863	$ -	$ 619,586,463	$ -	0.0%

MEDICAID‡ 2021							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
HCPF	5.1%	31.7%	$ 233,096,975	$ 1,450,843,814	$ 4,573,396,941	$ -	0.0%
Rocky Mountain Health Plans: RAE 1, MCO	10.7%	37.9%	$ 25,772,161	$ 90,851,028	$ 240,016,738	$ -	0.0%
Beacon: RAEs 2 & 4 (Submitting on behalf of NHP and HCI)	20.9%	20.9%	$ 30,471,491	$ 30,471,491	$ 145,795,191	$ 30,471,491	20.9%
Colorado Access: RAEs 3 & 5	9.6%	60.7%	$ 33,355,770	$ 210,521,632	$ 347,082,906	$ 144,754,205	41.7%
Colorado Community Health Alliance: RAEs 6 & 7	13.6%	52.6%	$ 29,994,785	$ 116,406,605	$ 221,274,631	$ 116,406,605	52.6%
Denver Health: MCO	23.5%	0.0%	$ 50,603,688	$ -	$ 215,557,303	$ 139,950,199	64.9%

TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2021) – Continued

CHP+ 2021							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Colorado Access	15.5%	0.1%	$ 10,704,004	$ 75,810	$ 69,228,412	$ -	0.0%
Denver Health	38.8%	0.0%	$ 2,184,945	$ -	$ 5,626,151	$ -	0.0%
Kaiser Permanente	22.9%	38.0%	$ 3,567,006	$ 5,901,984	$ 15,547,377	$ 5,901,984	38.0%
Rocky Mountain Health Plans	16.2%	0.7%	$ 1,986,684	$ 90,623	$ 12,282,238	$ -	0.0%
Friday Health Plans*	25.4%	0.0%	$ 3,364	$ -	$ 13,259	$ -	0.0%

* Some active medical claims submitters to the CO APCD were exempt from submitting an APM file because the carriers do not currently provide APM payments to providers. Expenditures for these carriers are sourced from the CO APCD.

** UnitedHealthcare expenditures are sourced from both APM submissions and the CO APCD. The two sources represent mutually distinct populations.

‡ CIVHC collects Medicaid-adjacent data from multiple organizations, including MCO/HMOs and Regional Accountable Entities (RAEs). At this time, CIVHC is unable to differentiate between the separate RAE regions or distinguish between the different product types. As a result, the information is reported by submitting entity.

Additional Notes:

Total medical expenditures do not include pharmacy and dental spending.

Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N categories respectively).

LIMITATIONS

While this report provides a more complete picture of medical spending in Colorado with the inclusion of non-claims expenditure data, some gaps still remain. The CO APCD does not include all commercial payers, most notably self-insured employer groups, and federal health insurance programs such as the Veterans Administration, Tricare, and Indian Health Services. This analysis also excludes Medicare Fee for Service.

Beyond these broad data limitations, readers of this report should consider the following:

- CIVHC and the DOI invested a considerable amount of effort towards ensuring that the HCP LAN framework was appropriately applied by each payer, including the implementation of the enhanced validation steps described in the *Data Sources* section. Though all payers attested to the accuracy of their APM files, potential gaps in understanding may still remain.
    - CIVHC assessed the consistency of the data reported between the 2021 and 2022 submissions. We found that the medical spending and primary care spending amounts were consistent over the two submissions.
    - We observed some differences in the allocation of medical and primary care spending to either FFS or APMs, with an increase of spending classified as an APM in the 2022 submission compared to 2021, mostly driven by the Medicare Advantage line of business.
    - CIVHC and the DOI will continue working with Colorado payers to ensure consistency among payers' submissions.
- The definition of primary care (*Appendix 2*) relies heavily on provider taxonomy requirements. CIVHC could not validate some payers' claims-based primary care spending data against claims submitted to the CO APCD due to payer differences in associated taxonomy codes for providers. Whenever possible, CIVHC reviewed and validated the payers' provider taxonomy information to quantify the expected difference between the APM files and the CO APCD.
- CIVHC instructed RAEs and MCOs to only report payments to providers. Payments from HCPF to the RAEs and MCOs (i.e., payments from one payer entity to another) were not included in the APM calculations. This prevents double counting the payments HCPF made to the various RAEs and MCOs; and also impacts HCPF's reported spending through APMs, making them appear lower.

Next Steps

Looking toward the future of primary care spending reporting, CIVHC has identified the following next steps to improve data collection and reporting:

- Analyze and report on recoupment data collected this year for first time
- Continue working with carrier representatives to ensure accurate reporting
    - Use various payer forums to talk about APM data collection and criteria used to identify APM categories
    - Continue improving data collection process by clarifying instructions on contract supplement, streamlining data fields required
- Investigate and update as needed new codes that might be used to bill for primary care
- Investigate additional ways to capture Behavioral Health providers in integrated primary care settings

Appendix 1. Detailed Methodological Information

The following information provides further details related to the methodology to develop this report.

The APM submission guide differentiated between "claims payments" and "non-claims payments." Please see the definition here:

- Claims payments fields (AM010 and AM012) should include payments that were directly tied to a claim. These transactions would be found in the Medical Claims (MC) files submitted to CIVHC each month. It should include both the member portion and the plan paid portion (i.e., the total allowed amount).
- Non-claims payments fields (AM011 and AM013) should include payments made outside of the claim transaction. This would include transactions such as incentive payments, capitation payments, payments for infrastructure, and any payments from the provider to the payer (i.e., penalties) in downside risk arrangements.

Please note that claims payments are *not* synonymous with traditional FFS payments. Claims payments are often an essential part of the structure of an APM. Further, non-claims payments are also not synonymous with APMs.

Some active payers who submit medical claims to the CO APCD were exempt from submitting an APM file because the payers do not currently provide APM payments to providers. The spending for these payers is calculated using CO APCD claims data submissions and reported separately. These expenditures are included in the total medical spending denominator used throughout the report.

Further, some medical claims submitters only administrate claims on behalf of Medicare Supplemental members. Medicare Supplemental data is not intended to be included in the APM submission and is <u>not included</u> in the total medical spending denominator.

Below is the list of medical submitters that only reimburse providers on a FFS basis or only submit Medicare Supplemental data:

Payer	Exemption Reason
Allegiance Benefit Plan Management	FFS only
AmeriBen/IEC Group	FFS only
American Enterprise	FFS only
Employee Benefits Management Services Inc	FFS only
Friday Health Plans	FFS only
Harrington Kaiser Permanente	FFS only

HealthScope Benefits	FFS only
HealthSmart Benefit Solutions	FFS only
Humana*	FFS only
Meritain Health	FFS only
UCHealth Plan Administrators	FFS only
UMR	FFS only
United Health Care (Individual, student, and Med Sup submitter codes)	FFS only
Aflac	Med Sup
C.S.I. Life	Med Sup
Insurance Administration	Med Sup
Physicians Mutual	Med Sup
State Farm	Med Sup
USAA Enterprise	Med Sup

*) Humana does not use alternative payment models in their commercial line of business; and requested a waiver for their Medicare Advantage line of business.

More information on the submission instructions carriers received can be found here.

Primary Care Calculation

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

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

Claims-Based Payments for Primary Care: Payments for primary care services as defined in the Data Submission Guide (DSG) that are tied to a claim. The calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the claim-based spending identified as primary care from payers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for payers exempt from submitting an APM file.

Non-Claims-Based Payments for Primary Care: Payments made to primary care providers (providers associated with taxonomies in the DSG primary care definition, see *Appendix 2*) outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional FFS payments. Claims payments are often an essential part of the structure of an APM.

Total Claims-Based Payments: All medical services payments that are tied to a claim. This calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the total claim-based spending from carriers that were required to submit an APM file, and 2) claims for all medical spending in the CO APCD for payers exempt from submitting an APM file.

Total Non-Claims-Based Payments: All payments to medical providers made outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional FFS payments. Claims payments are often an essential part of the structure of an APM.

Plan Paid

All four of the payment values listed above also have an associated Payer Portion field. The Payer Portion is a subset of the Total Payment value (or equal to the Total Payment when there is no member liability). The claims-based Payer Portion fields correspond to the data submitted in the Plan Paid field on the monthly CO APCD claims submissions. These new fields were added in 2021 under request of the DOI to understand the impacts of their regulations on primary care spend.

Prospective Payment Flag

Prospective payments refer to any payments made to providers in advance of services rendered. Typically, these are based on predetermined payment amounts for services. In contrast, FFS reimbursement is made retrospectively.

APPENDIX 2. PRIMARY CARE DEFINITION

CIVHC is using the definition established by the Colorado Primary Care Payment Reform Collaborative. This definition was operationalized as payments made to primary care providers for primary care services. Included in this definition are services delivered by behavioral health providers who practice in an integrated primary care setting.

The primary care definition consists of two components that should be summed to produce total claim-based primary care payments:

A. **Outpatient services delivered by primary care providers** (which includes OB/GYN providers), defined by a combination of primary care provider taxonomy and primary care CPT-4 procedure codes
B. **Outpatient services delivered by behavioral health providers, nurse practitioners and physician assistants (other provider taxonomies)**, defined by a combination of the "other" provider taxonomies and primary care CPT-4 procedure codes AND billed by a primary care provider (defined by primary care taxonomy).

The definition of primary care includes services delivered in an outpatient setting and excludes facility claims and inpatient services.

The following chart provides details on the *claims-based* primary care definition:

Component	Procedure Requirement		Service Provider Taxonomy Requirement		Billing Provider Taxonomy Requirement
A	Primary Care (defined by CPT-4 codes in *Table 5* below)	+	Primary Care (defined by taxonomies in *Table 3* below)	+	None
B	Primary Care (defined by CPT-4 codes in *Table 5* below)		Other Primary Care (defined by taxonomies in *Table 4* below)		Primary Care (defined by taxonomies in *Table 3* below)

Please note that, for CPT-4 procedure codes that describe global services for vaginal or Cesarean deliveries, payments should be multiplied by 60% to approximate the payments for antepartum and postpartum services only.

The *non-claims* primary care definition includes the following:

- Providers with specialties in the primary care taxonomy (Table 3)
- Behavioral health providers with a specified taxonomy (Table 4) that deliver care that is integrated with primary care (i.e., either within the primary care practice or through

working relationships that involve close communication and collaboration with primary care providers)

- Nurse Practitioners (NP) and Physician Assistants (PA) that deliver primary care or work within a primary care practice

TABLE 3: PRIMARY CARE PROVIDER TAXONOMIES

Taxonomy Code	Description	Taxonomy Type
261QF0400X	Federally Qualified Health Center	Organization
261QP2300X	Primary care clinic	Organization
261QR1300X	Rural Health Center	Organization
261QC1500X	Community Health	Organization
261QM1000X	Migrant Health	Organization
261QP0904X	Public Health, Federal	Organization
261QS1000X	Student Health	Organization
207Q00000X	Physician, family medicine	Individual
207R00000X	Physician, general internal medicine	Individual
208000000X	Physician, pediatrics	Individual
208D00000X	Physician, general practice	Individual
363LA2200X	Nurse practitioner, adult health	Individual
363LF0000X	Nurse practitioner, family	Individual
363LP0200X	Nurse practitioner, pediatrics	Individual
363LP2300X	Nurse practitioner, primary care	Individual
363LW0102X	Nurse practitioner, women's health	Individual
363AM0700X	Physician's assistant, medical	Individual
207RG0300X	Physician, geriatric medicine, internal medicine	Individual
2083P0500X	Physician, preventive medicine	Individual
364S00000X	Certified clinical nurse specialist	Individual
163W00000X	Nurse, non-practitioner	Individual
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine	Individual
207QA0000X	Family Medicine - Adolescent Medicine	Individual

Taxonomy Code	Description	Taxonomy Type
207QA0505X	Family Medicine - Adult Medicine	Individual
207QB0002X	Family Medicine - Obesity Medicine	Individual
207QG0300X	Family Medicine - Geriatric Medicine	Individual
207QS0010X	Family Medicine - Sports Medicine	Individual
207RA0000X	Internal Medicine - Adolescent Medicine	Individual
207RB0002X	Internal Medicine - Obesity Medicine	Individual
207RS0010X	Internal Medicine - Sports Medicine	Individual
2080A0000X	Pediatrics - Adolescent Medicine	Individual
2080B0002X	Pediatrics - Obesity Medicine	Individual
2080S0010X	Pediatrics - Sports Medicine	Individual
363LC1500X	Nurse Practitioner - Community Health	Individual
363LG0600X	Nurse Practitioner - Gerontology	Individual
363LS0200X	Nurse Practitioner - School	Individual
364SA2200X	Clinical Nurse Specialist - Adult Health	Individual
364SC1501X	Clinical Nurse Specialist - Community Health/Public Health	Individual
364SC2300X	Clinical Nurse Specialist - Chronic Health	Individual
364SF0001X	Clinical Nurse Specialist - Family Health	Individual
364SG0600X	Clinical Nurse Specialist - Gerontology	Individual
364SH1100X	Clinical Nurse Specialist - Holistic	Individual
364SP0200X	Clinical Nurse Specialist - Pediatrics	Individual
364SS0200X	Clinical Nurse Specialist - School	Individual
364SW0102X	Clinical Nurse Specialist - Women's Health	Individual
207V00000X	Physician, obstetrics and gynecology	OB/GYN
207VG0400X	Physician, gynecology	OB/GYN
363LX0001X	Nurse practitioner, obstetrics and gynecology	OB/GYN
367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse	OB/GYN
207VX0000X	OB/GYN- Obstetrics	OB/GYN

TABLE 4: OTHER PRIMARY CARE PROVIDER TAXONOMIES

Taxonomy Code	Description	Taxonomy Type
363L00000X	Nurse practitioner	Nurse Practitioner
363A00000X	Physician's assistant	Physician's Assistant
2084P0800X	Physician, general psychiatry	Behavioral Health
2084P0804X	Physician, child and adolescent psychiatry	Behavioral Health
363LP0808X	Nurse practitioner, psychiatric	Behavioral Health
1041C0700X	Behavioral Health & Social Service Providers/Social Worker, Clinical	Behavioral Health
2084P0805X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry	Behavioral Health
2084H0002X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine	Behavioral Health
261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health-CMHC	Behavioral Health
101Y00000X	Counselor	Behavioral Health
101YA0400X	Counselor - Addiction (SUD)	Behavioral Health
101YM0800X	Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC)	Behavioral Health
101YP1600X	Counselor - Pastoral	Behavioral Health
101YP2500X	Counselor - Professional (Note: Counselor in FQHC)	Behavioral Health
101YS0200X	Counselor – School	Behavioral Health
102L00000X	Psychoanalyst	Behavioral Health
103T00000X	Psychologist (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TA0400X	Psychologist - Addiction	Behavioral Health
103TA0700X	Psychologist - Adult Development and Aging (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TB0200X	Psychologist - Cognitive and Behavioral	Behavioral Health
103TC0700X	Psychologist - Clinical	Behavioral Health
103TC1900X	Psychologist - Counseling	Behavioral Health
103TC2200X	Psychologist - Clinical Child & Adolescent	Behavioral Health
103TE1000X	Psychologist - Educational	Behavioral Health

Taxonomy Code	Description	Taxonomy Type
103TE1100X	Psychologist - Exercise & Sports	Behavioral Health
103TF0000X	Psychologist - Family	Behavioral Health
103TH0004X	Psychologist - Health	Behavioral Health
103TH0100X	Psychologist - Health Service	Behavioral Health
103TM1700X	Psychologist - Men & Masculinity	Behavioral Health
103TM1800X	Psychologist - Mental Retardation & Developmental Disabilities	Behavioral Health
103TP0016X	Psychologist - Prescribing (Medical)	Behavioral Health
103TP0814X	Psychologist - Psychoanalysis	Behavioral Health
103TP2700X	Psychologist - Psychotherapy	Behavioral Health
103TP2701X	Psychologist - Group Psychotherapy	Behavioral Health
103TR0400X	Psychologist - Rehabilitation	Behavioral Health
103TS0200X	Psychologist - School	Behavioral Health
103TW0100X	Psychologist - Women	Behavioral Health
104100000X	Social Worker	Behavioral Health
1041S0200X	Social Worker - School	Behavioral Health
106H00000X	Marriage & Family Therapist (Note: Psychotherapist in FQHC)	Behavioral Health

TABLE 5: PRIMARY CARE SERVICES (CPT-4 PROCEDURE CODES)

Procedure Code	Description
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10160	PUNCTURE DRAINAGE OF LESION
11000	DEBRIDE INFECTED SKIN
11055	TRIM SKIN LESION

Procedure Code	Description
11056	TRIM SKIN LESIONS 2 TO 4
11100	BIOPSY SKIN LESION
11101	BIOPSY SKIN ADD-ON
11200	REMOVAL OF SKIN TAGS <W/15
11201	REMOVE SKIN TAGS ADD-ON
11300	SHAVE SKIN LESION 0.5 CM/<
11301	SHAVE SKIN LESION 0.6-1.0 CM
11302	SHAVE SKIN LESION 1.1-2.0 CM
11303	SHAVE SKIN LESION >2.0 CM
11305	SHAVE SKIN LESION 0.5 CM/<
11306	SHAVE SKIN LESION 0.6-1.0 CM
11307	SHAVE SKIN LESION 1.1-2.0 CM
11310	SHAVE SKIN LESION 0.5 CM/<
11311	SHAVE SKIN LESION 0.6-1.0 CM
11400	EXC TR-EXT B9+MARG 0.5 CM<
11401	EXC TR-EXT B9+MARG 0.6-1 CM
11402	EXC TR-EXT B9+MARG 1.1-2 CM
11403	EXC TR-EXT B9+MARG 2.1-3CM
11420	EXC H-F-NK-SP B9+MARG 0.5/<
11421	EXC H-F-NK-SP B9+MARG 0.6-1
11422	EXC H-F-NK-SP B9+MARG 1.1-2
11423	EXC H-F-NK-SP B9+MARG 2.1-3
11720	DEBRIDE NAIL 1-5
11730	REMOVAL OF NAIL PLATE
11750	REMOVAL OF NAIL BED
11765	EXCISION OF NAIL FOLD TOE
11900	INJECT SKIN LESIONS </W 7
11976	REMOVE CONTRACEPTIVE CAPSULE

Procedure Code	Description
11980	IMPLANT HORMONE PELLET(S)
11981	INSERT DRUG IMPLANT DEVICE
11982	REMOVE DRUG IMPLANT DEVICE
11983	REMOVE/INSERT DRUG IMPLANT
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<
12042	INTMD RPR N-HF/GENIT2.6-7.5
15839	EXCISE EXCESS SKIN & TISSUE
17000	DESTRUCT PREMALG LESION
17003	DESTRUCT PREMALG LES 2-14
17004	DESTROY PREMAL LESIONS 15/>
17110	DESTRUCT B9 LESION 1-14
17111	DESTRUCT LESION 15 OR MORE
17250	CHEM CAUT OF GRANLTJ TISSUE
17281	DESTRUCTION OF SKIN LESIONS
17340	CRYOTHERAPY OF SKIN
19000	DRAINAGE OF BREAST LESION
20005	I&D ABSCESS SUBFASCIAL
20520	REMOVAL OF FOREIGN BODY
20550	INJ TENDON SHEATH/LIGAMENT
20551	INJ TENDON ORIGIN/INSERTION
20552	INJ TRIGGER POINT 1/2 MUSCL
20553	INJECT TRIGGER POINTS 3/>
20600	DRAIN/INJ JOINT/BURSA W/O US
20605	DRAIN/INJ JOINT/BURSA W/O US
20610	DRAIN/INJ JOINT/BURSA W/O US
20612	ASPIRATE/INJ GANGLION CYST
36415	ROUTINE VENIPUNCTURE
36416	CAPILLARY BLOOD DRAW

Procedure Code	Description
54050	DESTRUCTION PENIS LESION(S)
54056	CRYOSURGERY PENIS LESION(S)
55250	REMOVAL OF SPERM DUCT(S)
56405	I & D OF VULVA/PERINEUM
56420	DRAINAGE OF GLAND ABSCESS
56501	DESTROY VULVA LESIONS SIM
56515	DESTROY VULVA LESION/S COMPL
56605	BIOPSY OF VULVA/PERINEUM
56606	BIOPSY OF VULVA/PERINEUM
56820	EXAM OF VULVA W/SCOPE
56821	EXAM/BIOPSY OF VULVA W/SCOPE
57061	DESTROY VAG LESIONS SIMPLE
57100	BIOPSY OF VAGINA
57105	BIOPSY OF VAGINA
57135	REMOVE VAGINA LESION
57150	TREAT VAGINA INFECTION
57170	FITTING OF DIAPHRAGM/CAP
57410	PELVIC EXAMINATION
57420	EXAM OF VAGINA W/SCOPE
57421	EXAM/BIOPSY OF VAG W/SCOPE
57452	EXAM OF CERVIX W/SCOPE
57454	BX/CURETT OF CERVIX W/SCOPE
57455	BIOPSY OF CERVIX W/SCOPE
57456	ENDOCERV CURETTAGE W/SCOPE
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
58100	BIOPSY OF UTERUS LINING
58110	BX DONE W/COLPOSCOPY ADD-ON

Procedure Code	Description
58120	DILATION AND CURETTAGE
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
59025	FETAL NON-STRESS TEST
59200	INSERT CERVICAL DILATOR
59300	EPISIOTOMY OR VAGINAL REPAIR
59400	OBSTETRICAL CARE
59409	OBSTETRICAL CARE
59410	OBSTETRICAL CARE
59412	Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59414	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59425	ANTEPARTUM CARE ONLY
59426	ANTEPARTUM CARE ONLY
59430	CARE AFTER DELIVERY
59510	CESAREAN DELIVERY
59514	CESAREAN DELIVERY ONLY
59515	CESAREAN DELIVERY
59515	Cesarean delivery only * 60% of payment
59610	Routine obstetric care incl. VBAC delivery * 60% of payment
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) * 60% of payment
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care * 60% of payment
59618	ATTEMPTED VBAC DELIVERY
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery * 60% of payment
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care * 60% of payment
59820	CARE OF MISCARRIAGE
69200	CLEAR OUTER EAR CANAL

Procedure Code	Description
69209	REMOVE IMPACTED EAR WAX UNI
69210	REMOVE IMPACTED EAR WAX UNI
76801	OB US < 14 WKS SINGLE FETUS
76802	OB US < 14 WKS ADDL FETUS
76805	OB US >= 14 WKS SNGL FETUS
76810	OB US >= 14 WKS ADDL FETUS
76811	OB US DETAILED SNGL FETUS
76812	OB US DETAILED ADDL FETUS
76813	OB US NUCHAL MEAS 1 GEST
76814	OB US NUCHAL MEAS ADD-ON
76815	OB US LIMITED FETUS(S)
76816	OB US FOLLOW-UP PER FETUS
76817	TRANSVAGINAL US OBSTETRIC
76818	FETAL BIOPHYS PROFILE W/NST
76819	FETAL BIOPHYS PROFIL W/O NST
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90471	IMMUNIZATION ADMIN
90472	IMMUNIZATION ADMIN EACH ADD
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90785	PSYTX COMPLEX INTERACTIVE
90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
90832	PSYTX W PT 30 MINUTES
90833	PSYTX W PT W E/M 30 MIN
90834	PSYTX W PT 45 MINUTES
90837	PSYTX W PT 60 MINUTES

Procedure Code	Description
90846	FAMILY PSYTX W/O PT 50 MIN
90847	FAMILY PSYTX W/PT 50 MIN
92551	PURE TONE HEARING TEST AIR
92552	PURE TONE AUDIOMETRY AIR
92558	EVOKED AUDITORY TEST QUAL
92567	TYMPANOMETRY
92585	AUDITOR EVOKE POTENT COMPRE
92587	EVOKED AUDITORY TEST LIMITED
92588	EVOKED AUDITORY TST COMPLETE
94010	BREATHING CAPACITY TEST
94014	PATIENT RECORDED SPIROMETRY
94015	PATIENT RECORDED SPIROMETRY
94016	REVIEW PATIENT SPIROMETRY
94060	EVALUATION OF WHEEZING
94070	EVALUATION OF WHEEZING
94375	RESPIRATORY FLOW VOLUME LOOP
96101	PSYCHO TESTING BY PSYCH/PHYS
96102	PSYCHO TESTING BY TECHNICIAN
96103	PSYCHO TESTING ADMIN BY COMP
96110	DEVELOPMENTAL SCREEN W/SCORE
96111	DEVELOPMENTAL TEST EXTEND
96127	BRIEF EMOTIONAL/BEHAV ASSMT
96150	ASSESS HLTH/BEHAVE INIT
96151	ASSESS HLTH/BEHAVE SUBSEQ
96156	Health behavior assessment or re-assessment
96160	PT-FOCUSED HLTH RISK ASSMT
96161	CAREGIVER HEALTH RISK ASSMT
96372	THER/PROPH/DIAG INJ SC/IM

Procedure Code	Description
97802	MEDICAL NUTRITION INDIV IN
97803	MED NUTRITION INDIV SUBSEQ
97804	MEDICAL NUTRITION GROUP
98925	OSTEOPATH MANJ 1-2 REGIONS
98926	OSTEOPATH MANJ 3-4 REGIONS
98927	OSTEOPATH MANJ 5-6 REGIONS
98928	OSTEOPATH MANJ 7-8 REGIONS
98929	OSTEOPATH MANJ 9-10 REGIONS
98960	SELF-MGMT EDUC & TRAIN 1 PT
98961	SELF-MGMT EDUC/TRAIN 2-4 PT
98962	5-8 patients
98966	HC PRO PHONE CALL 5-10 MIN
98969	ONLINE SERVICE BY HC PRO
99000	SPECIMEN HANDLING OFFICE-LAB
99024	POSTOP FOLLOW-UP VISIT
99050	MEDICAL SERVICES AFTER HRS
99051	MED SERV EVE/WKEND/HOLIDAY
99056	MED SERVICE OUT OF OFFICE
99058	OFFICE EMERGENCY CARE
99071	PATIENT EDUCATION MATERIALS
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)
99173	VISUAL ACUITY SCREEN
99174	OCULAR INSTRUMNT SCREEN BIL
99177	OCULAR INSTRUMNT SCREEN BIL
99188	APP TOPICAL FLUORIDE VARNISH
99201	OFFICE/OUTPATIENT VISIT NEW
99202	OFFICE/OUTPATIENT VISIT NEW

Procedure Code	Description
99203	OFFICE/OUTPATIENT VISIT NEW
99204	OFFICE/OUTPATIENT VISIT NEW
99205	OFFICE/OUTPATIENT VISIT NEW
99211	OFFICE/OUTPATIENT VISIT EST
99212	OFFICE/OUTPATIENT VISIT EST
99213	OFFICE/OUTPATIENT VISIT EST
99214	OFFICE/OUTPATIENT VISIT EST
99215	OFFICE/OUTPATIENT VISIT EST
99334	DOMICIL/R-HOME VISIT EST PAT
99336	DOMICIL/R-HOME VISIT EST PAT
99337	DOMICIL/R-HOME VISIT EST PAT
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	30 minutes or more
99341	HOME VISIT NEW PATIENT
99342	HOME VISIT NEW PATIENT
99343	HOME VISIT NEW PATIENT
99344	HOME VISIT NEW PATIENT
99345	HOME VISIT NEW PATIENT
99347	HOME VISIT EST PATIENT
99348	HOME VISIT EST PATIENT
99349	HOME VISIT EST PATIENT
99350	HOME VISIT EST PATIENT
99354	PROLONG E&M/PSYCTX SERV O/P
99355	PROLONG E&M/PSYCTX SERV O/P
99358	PROLONG SERVICE W/O CONTACT

Procedure Code	Description
99359	PROLONG SERV W/O CONTACT ADD
99366	TEAM CONF W/PAT BY HC PROF
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99381	INIT PM E/M NEW PAT INFANT
99382	INIT PM E/M NEW PAT 1-4 YRS
99383	PREV VISIT NEW AGE 5-11
99384	PREV VISIT NEW AGE 12-17
99385	PREV VISIT NEW AGE 18-39
99386	PREV VISIT NEW AGE 40-64
99387	INIT PM E/M NEW PAT 65+ YRS
99391	PER PM REEVAL EST PAT INFANT
99392	PREV VISIT EST AGE 1-4
99393	PREV VISIT EST AGE 5-11
99394	PREV VISIT EST AGE 12-17
99395	PREV VISIT EST AGE 18-39
99396	PREV VISIT EST AGE 40-64
99397	PER PM REEVAL EST PAT 65+ YR
99401	PREVENTIVE COUNSELING INDIV
99402	PREVENTIVE COUNSELING INDIV
99403	PREVENTIVE COUNSELING INDIV
99404	PREVENTIVE COUNSELING INDIV
99406	BEHAV CHNG SMOKING 3-10 MIN
99407	BEHAV CHNG SMOKING > 10 MIN
99408	AUDIT/DAST 15-30 MIN
99409	Alcohol and/or drug assessment or screening
99411	PREVENTIVE COUNSELING GROUP

Procedure Code	Description
99412	PREVENTIVE COUNSELING GROUP
99420	Administration and interpretation of health risk assessments
99421	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 5-10 minutes
99422	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 11-20 minutes
99423	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 21 or more minutes
99429	UNLISTED PREVENTIVE SERVICE
99441	PHONE E/M PHYS/QHP 5-10 MIN
99442	PHONE E/M PHYS/QHP 11-20 MIN
99443	PHONE E/M PHYS/QHP 21-30 MIN
99444	ONLINE E/M BY PHYS/QHP
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes
99455	WORK RELATED DISABILITY EXAM
99456	DISABILITY EXAMINATION
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	each additional 20 minutes (List separately in addition to code for primary procedure
99461	INIT NB EM PER DAY NON-FAC
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
99484	CARE MGMT SVC BHVL HLTH COND
99487	CMPLX CHRON CARE W/O PT VSIT

Procedure Code	Description
99489	CMPLX CHRON CARE ADDL 30 MIN
99490	CHRON CARE MGMT SRVC 20 MIN
99491	Chronic care management services at least 30 minutes
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ PSYC COLLAB CARE MGMT
99494	1ST/SBSQ PSYC COLLAB CARE
99495	TRANS CARE MGMT 14 DAY DISCH
99496	TRANS CARE MGMT 7 DAY DISCH
99497	ADVNCD CARE PLAN 30 MIN
99498	ADVNCD CARE PLAN ADDL 30 MIN
0500F	INITIAL PRENATAL CARE VISIT
0501F	PRENATAL FLOW SHEET
0502F	SUBSEQUENT PRENATAL CARE
0503F	POSTPARTUM CARE VISIT
1000F	TOBACCO USE ASSESSED
1031F	SMOKING & 2ND HAND ASSESSED
1032F	PT received Tobacco Cessation Information
1033F	TOBACCO NONSMOKER NOR 2NDHND
1034F	CURRENT TOBACCO SMOKER
1035F	SMOKELESS TOBACCO USER
1036F	TOBACCO NON-USER
1111F	DSCHRG MED/CURRENT MED MERGE
1220F	PT SCREENED FOR DEPRESSION
3016F	PT SCRND UNHLTHY OH USE
3085F	SUICIDE RISK ASSESSED
3351F	NEG SCRN DEP SYMP BY DEPTOOL
3352F	NO SIG DEP SYMP BY DEP TOOL
3353F	MILD-MOD DEP SYMP BY DEPTOOL

Procedure Code	Description
3354F	CLIN SIG DEP SYM BY DEP TOOL
3355F	CLIN SIG DEP SYM BY DEP TOOL
4000F	TOBACCO USE TXMNT COUNSELING
4001F	TOBACCO USE TXMNT PHARMACOL
4004F	PT TOBACCO SCREEN RCVD TLK
4290F	Alcohol and/or drug assessment or screening
4293F	Pt screened for high risk sexual behavior
4306F	Alcohol and/or Drug use counseling services
4320F	Alcohol and/or Drug use counseling services
90848-90899	Services to patients for evaluation and treatment of mental illnesses that require psychiatric services
96158-96159	Health behavior intervention, individual face-to-face
96164-96165	Health behavior intervention, group (two or more patients), face-to-face
96167-96168	Health behavior intervention, family (with the patient present), face-to-face
96170-96171	Health behavior intervention, family (without the patient present), face-to-face
97151-97158	Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
98967-98968	Non-physician telephone services
G0008	ADMIN INFLUENZA VIRUS VAC
G0009	ADMIN PNEUMOCOCCAL VACCINE
G0010	ADMIN HEPATITIS B VACCINE
G0101	CA SCREEN; PELVIC/BREAST EXAM
G0123	SCREEN CERV/VAG THIN LAYER
G0179	MD RECERTIFICATION HHA PT
G0180	MD CERTIFICATION HHA PATIENT
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

Procedure Code	Description
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0396	ALCOHOL/SUBS INTERV 15-30MN
G0397	Alcohol or substance abuse assessment
G0402	INITIAL PREVENTIVE EXAM
G0403	EKG FOR INITIAL PREVENT EXAM
G0404	EKG TRACING FOR INITIAL PREV
G0405	EKG INTERPRET & REPORT PREVE
G0438	PPPS, INITIAL VISIT
G0439	PPPS, SUBSEQ VISIT
G0442	ANNUAL ALCOHOL SCREEN 15 MIN
G0443	BRIEF ALCOHOL MISUSE COUNSEL
G0444	DEPRESSION SCREEN ANNUAL
G0445	HIGH INTEN BEH COUNS STD 30M
G0447	BEHAVIOR COUNSEL OBESITY 15M
G0463	HOSPITAL OUTPT CLINIC VISIT
G0476	HPV COMBO ASSAY CA SCREEN
G0502	Initial psychiatric collaborative care management
G0503	Subsequent psychiatric collaborative care management
G0504	Initial or subsequent psychiatric collaborative care management
G0505	Cognition and functional assessment
G0506	COMP ASSES CARE PLAN CCM SVC
G0507	Care management services for behavioral health conditions
G0513	PROLONG PREV SVCS, FIRST 30M
G0514	Prolonged preventive service
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month;
G2064-G2065	Comprehensive care management services for a single high-risk disease
H0002	ALCOHOL AND/OR DRUG SCREENIN

Procedure Code	Description
H0031	MH HEALTH ASSESS BY NON-MD
H0049	ALCOHOL/DRUG SCREENING
H1000	PRENATAL CARE ATRISK ASSESSM
H1001	ANTEPARTUM MANAGEMENT
Q0091	OBTAINING SCREEN PAP SMEAR
S0610	ANNUAL GYNECOLOGICAL EXAMINA
S0612	ANNUAL GYNECOLOGICAL EXAMINA
S0613	ANN BREAST EXAM
S0622	PHYS EXAM FOR COLLEGE
S9444	Parenting Classes, non-physician provider, per session
S9445	PT EDUCATION NOC INDIVID
S9446	PT EDUCATION NOC GROUP
S9447	Infant safety (including cardiopulmonary resuscitation classes nonphysician provider, per session)
S9449	WEIGHT MGMT CLASS
S9451	EXERCISE CLASS
S9452	Nutrition classes non-physician provider per session
S9454	Stress management classes non-physician provider per session
S9470	NUTRITIONAL COUNSELING, DIET
T1015	CLINIC SERVICE

APPENDIX 3. PAYMENT ARRANGEMENT CATEGORIES[5]

Category Code	Value	Definition/Example
01	Fee for Service	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are included in Category 1.
2A	Foundational Payments for Infrastructure and Operations	Payments for infrastructure investments that can improve the quality of patient care (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	Pay for Reporting	Payments (incentives or penalties) to report quality measurement results.
2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance).
3A	APMs with Shared Savings	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met (e.g., shared savings with upside risk only).
3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
3N	Risk Based Payments NOT Linked to Quality	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets).
4A	Condition-Specific Population-Based Payment	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).
4B	Comprehensive Population-Based Payment	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments).

[5] *Health Care Payment Learning & Action Network. Alternative Payment Models APM Framework. 2017.*

Category Code	Value	Definition/Example
4C	Integrated Finance and Delivery System	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems).
4N	Capitated Payments NOT Linked to Quality	Payments that are prospective and population-based, but not linked to quality.

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