DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Regulation 4-2-96

CONCERNING PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-107(3.5), 10-16-109, and 10-16-157, C.R.S.

Section 2 Scope and Purpose

The purpose of the regulation is to establish primary care alternative payment model parameters for primary care services offered through health benefit plans.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans in Colorado on or after January 1, 2025. This regulation excludes individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. "Aligned quality measures set" means, for the purposes of this regulation, the Adult and Pediatric measure sets included in Appendix C of this regulation.

B. "Alternative payment model" or "APM" shall have the same meaning as found at § 10-16-157(2)(b), C.R.S.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Measure steward” means, for the purposes of this regulation, an individual or organization that owns a measure and is responsible for maintaining the measure.

F. “Patient attribution” means, for the purposes of this regulation, the method used to determine which primary care practice is responsible for a patient’s care and costs.

G. “Practice panel” means, for the purposes of this regulation, the unique patients who have seen any provider within a primary care practice within the last 18 months.

H. “Primary care” shall have the same meaning as found at § 10-16-157(2)(c), C.R.S.

I. “Primary care provider” or “provider” means, for the purposes of this regulation, the provider taxonomies identified in Appendix A, when the provider is practicing general primary care in an outpatient setting.

J. “Prospective payment” shall have the same meaning as found at § 10-16-157(2)(f), C.R.S.

K. “Risk adjustment” shall have the same meaning as found at § 10-16-157(2)(g).

Section 5 General Requirements

A. Carriers must incorporate the requirements set forth in Sections 6 - 9 of this regulation in APMs for primary care services offered through health benefit plans issued or renewed on or after January 1, 2025.

B. Carriers offering managed care plans that are issued or renewed on or after January 1, 2025, and in which services are primarily offered through one medical group contracted with a nonprofit health maintenance organization, must incorporate the requirements of Section 9 only in contracts with providers participating in the carrier’s primary care APM.

Section 6 Risk Adjustment

A. Carriers must provide a detailed description of the risk adjustment methodology(ies) utilized in an APM for primary care services to all providers participating in the APM. This description must include, at a minimum:

1. Definitions of key terms used to describe the methodology, including “concurrent” and “prospective”;

2. A description of the data that is used in the methodology, including but not limited to:

    a. The general morbidity assumptions associated with the population used to calibrate the model; and

    b. The services included in the calculation of risk scores, based on the payment arrangement used in the APM in which the provider is participating; and

3. A description of adjustments made to the data in risk adjustment calculations, including:

    a. Historical adjustments;

b. Trends or future adjustments; and

c. Patient mix adjustments (across providers).

B Carriers must also provide a description of how the risk adjustment methodology interacts with provider payments, including but not limited to:

1. A clear explanation of any retrospective uses of provider data; and

2. For risk adjustment methodologies that are applied at the end of a contract period, a clear explanation of any reconciliation processes and how and when they are applied.

Section 7 Patient Attribution

A. Carriers must provide a detailed description of the patient attribution methodology(ies) utilized in an APM for primary care services to all providers participating in the APM. This description must include, at a minimum:

1. Definitions of key terms used in the model, including but not limited to “prospective”, “retrospective”, or “hybrid”; and

2. The process(es) used to attribute adult and pediatric members, including newborns and infants, to a provider. This description must include, at a minimum:

a. How patient choice is prioritized;

b. If and how claims are used to determine a provider-patient relationship, including but not limited to:

(1) the look-back period for claims data that is included in the methodology;

(2) the type (e.g., wellness visit) or number of claims that are prioritized; and

(3) tie-breaker methodologies if different providers have an equal number or type of claims;

c. If and how geographic attribution is used;

d. Any other processes or methods, such as visit-based, that are utilized; and

e. Any members that are excluded from attribution.

B. Carriers must make available updated attribution lists, in a format that is easy to interpret and analyze, to providers no less frequently than on a quarterly basis.

C. Carriers must establish and maintain a process for providers to submit requests for misattributed patients to be added or removed from their attribution list (i.e., reattributed).

1. The process for submitting reattribution requests must be clearly communicated to the provider and must identify, at a minimum:

a. The appropriate mechanism(s) for submitting a request (e.g., phone, mail, or electronic);

b. A specific point of contact for attribution-related questions and issues; and

c. The information or documentation required to submit a request.

2. Carriers must establish a process that is clearly communicated to the provider about the regular review, no less than quarterly, of patient attribution lists and provider attribution requests.

Section 8 Aligned Core Competencies

A. Carriers must incorporate the aligned core competencies contained in Appendix B into the care delivery expectations used in APMs for primary care services.

1. Carriers must provide a simple attestation form for practices to identify the appropriate Track (Track 1, 2 or 3) as set forth in Appendix B that aligns with current or anticipated practice competence with the financial support of the APM.

2. Carriers must accept a practice's current association with the Centers for Medicare and Medicaid Services' Making Care Primary or Primary Care First models, Primary Care Medical Home designation, and National Committee for Quality Assurance's Behavioral Health Integration certification as recognition that the practice is, at minimum, ready to participate in an APM in Track 1.

B. Payments to support, incentivize, or reward provider performance of the competencies in the aligned core competencies must be meaningful. Carriers may determine the level and type of financial incentive(s), including but not limited to upfront payments, incentive structures, target performance levels, and reporting requirements, in mutual agreement with the provider to align with patient panel needs and practice priorities.

C. Carriers may include other care delivery expectations, in addition to the aligned core competencies, at the mutual agreement of the carrier and the provider. Additional specified care delivery expectations may not be redundant with the aligned core competencies in Appendix B and should be based on a provider's patient panel needs and practice priorities.

D. The aligned core competencies will be reviewed annually by the Commissioner.

1. The Division will seek input on proposed modifications to the aligned core competencies through a stakeholder process that includes the Primary Care Payment Reform Collaborative, carriers and providers participating in APMs that are not participating in the Primary Care Payment Reform Collaborative, relevant state agencies and programs including the Department of Health Care Policy and Financing, and consumers.

2. The Division will provide notice of stakeholder meetings on the Division website, at least two weeks in advance, and all meetings will be open to the public.

Section 9 Aligned Quality Measure Sets

A. Carriers must include the aligned quality measures for Adult and Pediatric populations set forth in Appendix C in a quality measure set utilized in an APM for primary care services.

1. Provider performance on measures in the aligned measure set must impact payment in a meaningful way, while still allowing for prospective, upfront payments. Carriers may not incorporate any measure that is part of the aligned measure set into a payment arrangement such that performance on the measure lacks meaningful financial implications to the provider.

a. Nothing in this Section 9(A) requires a carrier to include one or more of the measures in the aligned measure set into the terms of a contract with a specific provider or practice or intermediary. The measures in the aligned quality measure set must be included in the set of quality measures that are utilized in an APM, and available for selection by payers and providers, but carriers and providers should mutually determine the appropriate measures that will be included in the terms of a specific contract.

b. Carriers and providers must determine appropriate thresholds for provider or practice's performance, based on practice capacity and experience reporting quality measures.

2. Carriers must follow the measure steward specifications for all measures included in the aligned measure set. Any deviations or exceptions must be mutually agreed upon with the provider.

3. Carriers must include the Adult measure set, the Pediatric measure set, or both in the overarching quality measure set utilized in an APM for primary care services based on the age composition of the practice's full practice panel.

a. For practices with a majority (greater than 80%) of adults in their practice panel, carriers must include the aligned Adult measure set.

b For practices with a majority of pediatric patients (greater than 80%) in their practice panel, carriers must include the aligned Pediatric measure set.

c. For practices with a pediatric population of 20%-80% of their practice panel, carriers must include both the Adult and Pediatric measure sets.

B. Carriers may include measures in addition to the aligned quality measure set at the mutual agreement of the carrier and the provider. Additional measures should consider a provider's patient panel needs, practice priorities, other state and federal requirements, and feasibility of reporting.

C. A carrier may petition the Commissioner to modify or waive one or more of the requirements of Section 9(A). Any request to waive or modify one or more of the requirements must include a clear rationale supporting the request and must demonstrate how the waiver will advance the quality, accessibility, and/or affordability of healthcare services.

D. The aligned measure set will be reviewed annually by the Commissioner.

1. The Division will seek input on proposed modifications to the aligned quality measure set through a stakeholder process that includes the Primary Care Payment Reform Collaborative, carriers and providers participating in APMs that are not participating in the Primary Care Payment Reform Collaborative, relevant state agencies and programs including the Department of Health Care Policy and Financing, and consumers.

2. The Division will provide notice of stakeholder meetings on the Division website, at least two weeks in advance, and all meetings will be open to the public.

Section 10 Reporting Requirements

A. Carriers must annually report on their use of the aligned APM parameters for primary care services as part of the APM Implementation Plan required by Colorado Insurance Regulation 4-2-72. Annual reporting must include:

1. An attestation that the carrier and/or their vendor is in compliance with the requirements of Sections 6-9 of this regulation;

2. The carrier's and/or vendor's current or planned approach (if applicable) to incorporate social risk into their risk adjustment methodology(ies), including but not limited to social factors such as housing instability, behavioral health issues, disability, and neighborhood-level stressors. This description should include a statement regarding how health equity and patients with health-related social needs, and/or severe or complex health needs are or will be considered in the design of the risk adjustment methodology and the APM;

3. The carrier's efforts to educate members about patient attribution and/or the importance of selecting a primary care provider;

4. A complete list of any additional care delivery expectations, outside of the core competencies in Appendix B, included in the carrier's APMs for primary care services; and

5. A complete list of the additional measures outside of the quality measures in Appendix C included in the carrier's APMs for primary care services, and a brief description of any deviations or exceptions to the aligned measure set in accordance with Section 9.A.2 of this regulation.

B. Carriers may submit a "Confidentiality Index" for any information submitted per the requirements of this subsection that they consider to be confidential pursuant to § 24-72-204, C.R.S., along with the APM Implementation Plan. The Division will evaluate the reasonableness of any request for confidentiality and provide notice to the carrier if the request for confidentiality is rejected.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 12 Incorporated Materials

Measure steward specifications shall mean the measure specifications located in the Partnership for Quality Measurement's Submission Tool and Repository Measure Database as published on the effective date of this regulation and does not include later amendments to or revisions to the database. A copy of the measure specifications for the quality measures included in the Aligned Quality Measure Set, as of the effective date of this regulation, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the measure specifications may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://p4qm.org/measures.

Section 13 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 14 Effective Date

This regulation shall be effective January 30, 2024.

Section 15 History

New regulation effective January 30, 2024.

Appendix A: Primary Care Provider Taxonomies

1. Family medicine physicians in an outpatient setting when practicing general primary care;

2. General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

3. Geriatric medicine physicians in an outpatient setting when practicing general primary care;

4. Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care);

5. OB-GYN physicians in an outpatient setting when practicing general primary care;

6. Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; and

7. Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

Appendix B: Aligned Core Competencies for Primary Care

The core competencies listed in the following table outline key capacities or skills that are needed for primary care providers to provide high quality, person-centered, whole-person care. Each row represents a "domain" or category of care delivery Each domain is further delineated into three (3) levels or tracks, with Track 1 reflecting competencies for practices that are starting the care transformation process and Track 3 reflecting competencies of a more advanced practice.

The aligned core competencies establish a common set of expectations around the type of care that primary care providers participating in APMs should have in order to deliver high-quality, person-centered, whole-person care. Carriers must support providers' achievement of the competencies through financial incentives. Carriers may determine the level and type of financial incentive(s), including but not limited to upfront payments, incentive structures, target performance levels, and reporting requirements, in mutual agreement with the provider to align with patient panel needs and practice priorities. Carriers and providers may determine additional competencies and activities that are appropriate within each domain, and at each level, and the process for evaluating performance and progress.

Care Delivery Domain	Track 1	Track 2	Track 3
Leadership	• Practice leadership sets practice-wide expectations for evaluating and improving clinical and operational processes and outcomes, and for incorporating health equity principles into operational processes and quality improvement initiatives. • Practice leadership allocates appropriate resources (including time for appropriate quality improvement team membership) to ensure continuous quality improvement.	• Practice leadership develops and implements a process to review and evaluate clinic level quality improvement initiatives, including the creation of an improvement plan for each area of opportunity.	• Practice leadership incorporates health equity principles into quality improvement initiatives.
Data Driven Quality Improvement	• Practice sets quality metric goals using benchmarks and reviews performance on internally validated clinical quality measures at least quarterly.	• Practice uses an organized quality improvement approach to meet quality measure goals/benchmarks for at least one clinical quality measure.	• Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach and outcomes with validated measures (e.g., PHQ-9, GAD-7,

	• Practice develops a quality improvement team that meets monthly.	• Practice discusses and develops a process to routinely gather and update patient demographics information, including race, ethnicity, language and communication needs, sexual orientation, and gender identity.	Edinburgh maternal depression scale). In practices caring for children, this includes developmental screening. • Practice uses an organized quality improvement measure goal/benchmark for at least three clinical quality measures. • Practice implements a process to routinely gather and update patient demographics information, including race, ethnicity, language and communication needs, sexual orientation, and gender identity.
Empanelment	• Practice designs and implements a process for validating primary care provider and/or care team assignments with patients.	• Practice has assessed patient panels and assigned primary care providers and/or care teams to 60% of the patient population.	• Practice has assessed patient panel and assigned primary care providers and/or care teams to 85% of the patient population.
Team Based Care	• Practice develops and reviews written roles and responsibilities for team-based care to ensure accountability for assigned tasks. • Practice identifies and implements a team-based care strategy to improve communication (team huddle, debriefs, collaborative care planning).	• Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, for primary care providers and all clinic staff.	• Practice team includes a family navigator, health coach, care coordinator, community health worker, or other team member with the responsibility of providing culturally relevant support, coordination, and service to the person and family. If these roles cannot be filled within the practice, the practice works with community-based organizations to make referrals for appropriate care.
Patient and Family Engagement	• Practice utilizes methods to obtain patient feedback on experience of care, such as through a patient experience survey or patient and family advisory council and uses data	• Practice reviews data from methods to obtain patient feedback on experience of care at least quarterly to identify areas for focus as part of their quality improvement	• Practice assesses the inclusivity of the practice through methods established to obtain patient feedback on experience of care.

	to assess their delivery of primary care services as well as patient satisfaction with care. ● Practice educates patients and family members/caregivers on availability of behavioral health services, including mental health and substance use disorder services within the practice or through referral.	process. ● Practice adopts at least one evidence-based decision aid or self-management support tool for a condition appropriate for their patient population.	● Practice acts on patient feedback to carry out identified quality improvement processes.
Population Management	● Practice implements a risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. ● Practice identifies strategies to identify care gaps (e.g., EHR prompts, patient registry, data aggregation tool). ● Practice identifies staff and develops workflows to provide care management for patients with chronic conditions and/or patients determined to be higher risk and for timely post-ED and hospitalization follow-up.	● Practice implements workflow for improving proactive care gap management and tracks specific outcomes. ● Practice identifies patients who need or would benefit from behavioral health services, including through universal screening for at least one priority mental health condition, one priority substance use condition, and one lifestyle behavior.	● Practice ensures positive behavioral health screens are offered treatment within the practice or referred to appropriate services outside of the practice. ● Practice assesses the impact of care gap management on outcomes and need for improvement in the process. ● Practice reassesses behavioral health symptoms, side effects, complications, and treatment adherence at regular intervals and utilizes evidence-based stepped care guidelines in adjusting treatment plans if patients are not improving as expected. Practice considers individual patient barriers to treatment.
Continuity of Care	● Practice measures and reviews continuity of care for empaneled patients by primary care providers	● Practice implements one strategy that improves continuity for practitioners and care team(s).	● Practice re-assesses continuity of care and determines if further intervention is needed to improve

	and/or care teams.		continuity while balancing the need for prompt access to care. If further interventions are needed, the practice implements at least one intervention.
Access	● Practice assesses access to primary care services for its patients through availability of appointments and through patient experience surveys.	● Practice adopts extended hours, same day appointments, patient portal, or other methods to improve access and then reassesses for any problem areas. ● Practice ensures physical spaces and services are accessible and responsive to patients' and families' disability status, sexual orientation, and gender identity, racial and ethnic backgrounds, cultural health beliefs and practices, preferred languages, and health literacy.	● Practice has both same day (or next day) access and extended hours in place.
Comprehensiveness and Care Coordination	● Practice assesses the services it provides to patients and identifies key services that could be added to improve comprehensiveness of care, including behavioral health. ● Practice provides crisis resources and referrals as indicated. ● Practice develops a vision for behavioral health integration and chooses a strategy (e.g., full integration, virtual integration, collaborative care model) to improve comprehensiveness of behavioral health services.	● The primary care provider diagnoses and offers medication management for mild to moderate behavioral health conditions and links patients to therapy and/or specialty mental health settings as indicated. ● Practice has referral pathways for patients with behavioral health conditions including potential referral sources for populations with specific needs (e.g., LGBTQIA+ friendly). ● Practice develops workflows for referrals to social service providers.	● Practice has implemented a behavioral health integration strategy to improve comprehensiveness of behavioral health services. ● Practice ensures that primary behavioral health referral sources have appointment availability and tracks completion of first appointment.
Value Based Contracting	● Practice considers mechanisms to maximize benefit of participation in	● Practice evaluates impact of value-based payment agreements	● Practice demonstrates improvement on at least one cost or

	alternative and performance payment arrangements.	on financial stability of practice, quality of care provided, and/or clinician and staff satisfaction.	utilization metric.

Appendix C: Aligned Quality Measure Sets

Adult Measure Set

Domain	Measure	Consensus-Based Entity (CBE) ID/Steward
Preventive Care	Breast Cancer Screening	2372 / NCQA
Preventive Care	Cervical Cancer Screening	0032 / NCQA
Preventive Care	Colorectal Cancer Screening	0034 / NCQA
Preventive Care	Screening for Depression and Follow-Up	0418 / CMS
Chronic Conditions	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)	0059 / NCQA
Chronic Conditions	Controlling High Blood Pressure	0018 / NCQA
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Adult Survey -OR- Person-Centered Primary Care Measure (PRO-PM)	0006 / AHRQ 3568 / American Board of Family Medicine

Pediatric Measure Set

Domain	Measure	Consensus-Based Entity (CBE) ID/Steward
Preventive Care	Child and Adolescent Well-Care Visits	1516 / NCQA
Preventive Care	Developmental Screening in the First Three Years of Life	1448 / OHSU
Preventive Care	Well-Child Visits in the First 30 Months of Life	1392 / NCQA
Preventive Care	Screening for Depression and Follow-Up	0418 / CMS
Preventive Care	Childhood Immunization Status - Combo 10	0038 / NCQA

Preventive Care	Immunizations for Adolescents - Combo 2	1407 / NCQA
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Child Survey -OR- Person-Centered Primary Care Measure PRO-PM	0006 / AHRQ 3568 / American Board of Family Medicine