COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2024 Sunset Review

Primary Care Payment Reform Collaborative

October 15, 2024

COLORADO
Department of Regulatory Agencies
Executive Director's Office

October 15, 2024

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Pursuant to section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) at the Department of Regulatory Agencies (DORA) undertakes a robust review process culminating in the release of multiple reports each year on October 15.

A national leader in regulatory reform, COPRRR takes the vision of their office, DORA and more broadly of our state government seriously. Specifically, COPRRR contributes to the strong economic landscape in Colorado by ensuring that we have thoughtful, efficient, and inclusive regulations that reduce barriers to entry into various professions and that open doors of opportunity for all Coloradans.

As part of this year's review, COPRRR has completed an evaluation of the Primary Care Payment Reform Collaborative. I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2025 legislative committee of reference.

The report discusses the question of whether there is a need for the program created under Section 150 of Article 16 of Title 10, C.R.S. The report also discusses the effectiveness of the Commissioner of Insurance in carrying out the intent of the statutes and makes recommendations for statutory changes for the review and discussion of the General Assembly.

To learn more about the sunset review process, among COPRRR's other functions, visit coprrr.colorado.gov.

Sincerely,

Patty Salazar
Executive Director

October 15, 2024

FACT SHEET

Primary Care Payment Reform Collaborative

Background

What is the Primary Care Payment Reform Collaborative?

The Primary Care Payment Reform Collaborative was created in 2019 within the Department of Regulatory Agencies' Division of Insurance. The Commissioner of Insurance is directed by statute to invite members from a variety of sectors to participate in the Collaborative, including, but not limited to, health care providers, health care consumers, and health insurers.

Why was it established?

The Collaborative was established to, among other things, advise in the development of affordability standards and targets for carrier investments in primary care, to identify any barriers to the adoption of alternative payment models by health care providers and insurers, and to develop recommendations to address any barriers.

What work does the Collaborative perform?

The Collaborative develops recommendations relating to alternative payment models and the ways in which they may be utilized in Colorado to further communication and value among payers, health care providers, and patients.

What has the Collaborative accomplished?

The Collaborative has developed a variety of recommendations during calendar years 2019 through 2023. These recommendations include the development of a broad, inclusive definition of primary care, as well as a recommendation that all commercial payers increase the percentage of total medical expenditures spent on primary care by at least one percentage point each year through 2022.

What does it cost?

In fiscal year 22-23, the total expenditures of the Collaborative were $49,999 and 0.3 full-time equivalent employees were allocated to the Collaborative.

Key Recommendation

- **Continue the Collaborative for seven years, until 2032, and schedule the next sunset review to take place pursuant to section 2-3-1203, Colorado Revised Statutes.**

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Background

Sunset Criteria

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are guided by statutory criteria and sunset reports are organized so that a reader may consider these criteria while reading. While not all criteria are applicable to all sunset reviews, the various sections of a sunset report generally call attention to the relevant criteria. For example,

- In order to address the first criterion and determine whether the program under review is necessary to protect the public, it is necessary to understand the details of the profession or industry at issue. The Profile section of a sunset report typically describes the profession or industry at issue and addresses the current environment, which may include economic data, to aid in this analysis.
- To address the second sunset criterion--whether conditions that led to the initial creation of the program have changed--the History of Regulation section of a sunset report explores any relevant changes that have occurred over time in the regulatory environment. The remainder of the Legal Framework section addresses the fifth sunset criterion by summarizing the organic statute and rules of the program, as well as relevant federal, state, and local laws to aid in the exploration of whether the program's operations are impeded or enhanced by existing statutes or rules.
- The Program Description section of a sunset report addresses several of the sunset criteria, including those inquiring whether the agency operates in the public interest and whether its operations are impeded or enhanced by existing statutes, rules, procedures, and practices; whether the agency or the agency's board performs efficiently and effectively and whether the board, if applicable, represents the public interest.
- The Analysis and Recommendations section of a sunset report, while generally applying multiple criteria, is specifically designed in response to the fourteenth criterion, which asks whether administrative or statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

These are but a few examples of how the various sections of a sunset report provide the information and, where appropriate, analysis required by the sunset criteria. Just as not all criteria are applicable to every sunset review, not all criteria are specifically highlighted as they are applied throughout a sunset review. While not necessarily exhaustive, the table below indicates where these criteria are applied in this sunset report.

Table 1
Application of Sunset Criteria

Sunset Criteria	Where Applied
(I) Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare.	• Profile of the Industry • History of Regulation • Recommendation 1
(II) Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less, or the same degree of governmental oversight.	• History of Regulation
(III) If the program is necessary, whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms.	• Legal Summary
(IV) If the program is necessary, whether agency rules enhance the public interest and are within the scope of legislative intent.	• Legal Summary
(V) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters.	• Legal Summary • Program Description and Administration
(VI) Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively.	• Program Description and Administration
(VII) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.	• Legal Summary • Program Description and Administration
(VIII) Whether regulatory oversight can be achieved through a director model.	• Not applicable
(IX) The economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition.	• Profile of the Industry

Sunset Criteria	Where Applied
(X) If reviewing a regulatory program, whether complaint, investigation, and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.	• Not applicable
(XI) If reviewing a regulatory program, whether the scope of practice of the regulated occupation contributes to the optimum use of personnel.	• Not applicable
(XII) Whether entry requirements encourage equity, diversity, and inclusivity.	• Not applicable
(XIII) If reviewing a regulatory program, whether the agency, through its licensing, certification, or registration process, imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subsection (5)(a) of this section must include data on the number of licenses, certifications, or registrations that the agency denied based on the applicant's criminal history, the number of conditional licenses, certifications, or registrations issued based upon the applicant's criminal history, and the number of licenses, certifications, or registrations revoked or suspended based on an individual's criminal conduct. For each set of data, the analysis must include the criminal offenses that led to the sanction or disqualification.	• Not applicable
(XIV) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.	• Recommendation 1

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at coprrr.colorado.gov.

The functions of the Primary Care Payment Reform Collaborative and the Commissioner of Insurance (Collaborative and Commissioner, respectively), as enumerated in Section 150 of Article 16 of Title 10, Colorado Revised Statutes (C.R.S.), shall terminate on September 1, 2025, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of the Collaborative pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed program should be continued and to evaluate the performance of the Collaborative and the Commissioner. During this review, the Commissioner must demonstrate that the program serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, COPRRR staff interviewed Division of Insurance staff, members of the collaborative, practitioners, payers, and officials with state and national professional associations; and reviewed Colorado statutes and rules, and the laws of other states.

The major contacts made during this review include, but are not limited to:

- American Academy of Pediatrics, Colorado Chapter;
- Colorado Academy of Family Physicians;
- Colorado Community Health Network;
- Colorado Consumer Health Initiative;
- Colorado Department of Regulatory Agencies, Division of Insurance;
- Colorado Department of Public Health and Environment;
- Eugene S. Farley Jr. Health Policy Center, University of Colorado;
- Kaiser Permanente; and
- United Healthcare.

Profile of the Industry

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), C.R.S. The first criterion asks whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare.

To understand the need for the program, it is first necessary to recognize what the primary care industry does, the work that they perform, and who they serve.

High quality primary care is an important component of a high functioning health care system and plays a crucial role in improving patient outcomes and experience, controlling health care costs, and addressing health inequities. However, the United States has historically underinvested in primary care, and visits related specifically to primary care physicians continue to decline. Additionally, the primary care workforce is continuing to shrink, and clinicians are frequently leaving primary care to specialize in other, more lucrative fields in health care.[2]

Primary care in the United States is traditionally paid for utilizing what is commonly referred to as a "fee-for-service" approach. Essentially, when a patient needs to see their primary health care provider due to a health care issue, the health care provider offers services to the patient, and then typically bills either the patient, or a third-party payer, such as an insurance company, Medicaid, or Medicare, for each type of service provided.

However, the fee-for-service approach is widely perceived as containing challenges to providing quality care due to gaps in the types and amounts of fees covered by many payers, including, but not limited to:[3]

- Authorized fee amounts may be less than the cost of providing quality care,
- Fees may not be established for some types of services,
- Health care providers may be paid more to treat a health care issue than to provide preventative care services,
- Quality assurance regarding the appropriateness of services provided is not monitored, and
- Comparison regarding health care providers is not feasible due to a lack of ability to assess what types of services will be utilized in advance of the treatment.

[2] National Academies of Sciences, Engineering, and Medicine, *Implementing high-quality primary care: Rebuilding the foundation of health care*. National Academies Press (2021), p. 3.
[3] Center for Health Care Quality and Payment Reform. *Barriers to Affordable, High Quality Care: The Real Problems with Fee for Service*. Retrieved July 2, 2024, from chqpr.org/Care_Barriers.html

Additionally, fee-for-service models are typically perceived as rewarding health care providers for the number of tests and procedures performed, rather than rewarding them for keeping their patients healthy.[4]

As a result, many payers and providers are expressing the desire to shift to more value-based payment systems that focus on comprehensive care and prevention.[5]

These value-based payment systems are commonly referred to as alternative payment models, and they utilize innovative approaches to provide other payment options beyond the fee-for-service system.[6]

Payment model types that are widely utilized include:[7]

- Fee-for-service models (with no link to quality and value) – This payment model type uses traditional methods of payment for health care services on a per service basis, and no adjustments are taken into account for provider reporting on data, provider performance related to costs of services, or infrastructure investments.
- Fee-for-service models (linked to quality and value) – This payment model type uses traditional methods of payment for health care services on a per service basis but includes at least some additional payments based on the quality or efficiency of care delivery. For example, health care payments made using this model may be adjusted for infrastructure investments to help improve health care or clinical services, whether quality data is provided by health care providers, or how well health care providers perform related to quality and cost metrics.
- Alternative payment models built on fee-for-service – This payment model type is based on cost performance, regardless of how a financial or utilization benchmark might be established or adjusted. Payments made under this type of alternative payment model are structured in a way that encourages health care providers to deliver services that are effective and efficient.
- Population-based payment models – This payment model type includes population-based payments that are not directly triggered by service delivery. It encourages health care providers to provide holistic, person-centered care which can be used to provide a variety of services, including care coordination, wellness services, as well as a large variety of preventative health care services.

[4] Colorado Department of Health Care Policy and Financing, *Affordability Toolkit: Alternative Payment Models (APM),* April 2021.
[5] Colorado Department of Health Care Policy and Financing, *Affordability Toolkit: Alternative Payment Models (APM),* April 2021.
[6] Colorado Department of Health Care Policy and Financing, *Affordability Toolkit: Alternative Payment Models (APM),* April 2021.
[7] Health Care Payment Learning and Action Network, *Alternative Payment Model: APM Framework*, (2017), pp. 24–27.

The Primary Care Payment Reform Collaborative develops recommendations relating to alternative payment models and the ways in which they may be utilized in Colorado to further communication and value among payers, health care providers, and patients.

The ninth sunset criterion questions the economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition.

According to national scorecard data, as a percentage of overall health care spending, primary health care spending in the United States has continued to shrink, demonstrated by a reduction from 6.2 percent in 2013 to 4.6 percent in 2020. Additionally, the primary care workforce is shrinking. Although one out of three doctors in the United States are currently primary care physicians, only one out of five physicians who have completed their residency have been reported to be working in the field of primary care two years later, between the years of 2012 and 2020.[8]

In Colorado, primary care spending has remained reasonably consistent in recent years. In 2018, primary care spending was 9.5 percent of the total medical spending in the state, with only a slight decrease to 9.2 percent in 2019, and in 2020, primary care spending witnessed a slight increase to 9.4 percent.[9]

[8] American Academy of Family Physicians. *New Scorecard Finds Primary Care Funding and Physician Workforce are Shrinking.* Retrieved July 30, 2024, from aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html
[9] Center for Improving Value in Health Care, *Report of Colorado Primary Care Spending and Alternative Payment Model Use: 2018 – 2020,* November 2021, p.4.

Legal Framework

History of Regulation

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The first and second sunset criteria question:

> Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare; and
>
> Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less or the same degree of governmental oversight.

One way that COPRRR addresses this is by examining why the program was established and how it has evolved over time.

In 2019, the Primary Care Payment Reform Collaborative (Collaborative) was created through the passage of House Bill 19-1233. The Collaborative was established to, among other things, advise in the development of affordability standards and targets for carrier investments in primary care, to identify any barriers to the adoption of alternative payment models by health care providers and insurers, and to develop recommendations to address any barriers.

House Bill 22-1325 directed that, in addition to the work assigned to the Collaborative in 2019, the Division of Insurance is required to develop primary care alternative payment models in partnership with the Department of Health Care Policy and Financing (HCPF), the Department of Public Health and Environment (CDPHE), and the Department of Personnel and Administration (DPA), as well as carriers and providers who work with alternative payment models to work in conjunction with the Collaborative to optimize and create incentives for the alignment of health benefit plans and public payers.

Legal Summary

The third, fourth, fifth and seventh sunset criteria question:

> Whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms;
>
> Whether agency rules enhance the public interest and are within the scope of legislative intent;

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters; and
>
> Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

A summary of the current statutes and rules is necessary to understand whether the program is set at the appropriate level and whether the current laws are impeding or enhancing the agency's ability to operate in the public interest.

The Commissioner of Insurance at the Division of Insurance (Commissioner and Division, respectively) located within the Department of Regulatory Agencies (DORA), is directed by section 10-16-150, C.R.S, to convene the Collaborative.

The Collaborative was established to, among other things:[10]

- Consult with DPA, the Executive Director of HCPF, and the Administrator at the Colorado All-payer Claims Database;
- Advise in the development of affordability standards and targets related to carrier investments in primary care;
- Analyze the percentage of medical expenses allocated to primary care in coordination with the Administrator of the All-payer Claims Database;
- Develop a recommendation regarding the definition of primary care directed to the Commissioner;
- Identify any barriers related to the adoption of alternative payment models by health insurers and providers and develop recommendations that address these barriers;
- Develop recommendations regarding increasing the use of alternative payment models that are not paid on a fee-for-service or per-claim basis;
- 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 as well as technical assistance with consumers and insurers; and
- Annually review the Division's alternative payment models and provide recommendations regarding the models.

Additionally, section 10-16-150(2), C.R.S., requires that the Commissioner request participation in the work of the Collaborative from representatives of the following groups:

[10] § 10-16-150(1), C.R.S.

- Health care providers, including primary care providers;
- Health care consumers;
- Health insurers, including those that contract with HCPF;
- Employers that purchase health insurance for their employees, as well as employers that offer self-insured health benefit plans;
- Representatives from the federal Centers for Medicare and Medicaid Services;
- Representatives from the Primary Care Office located in CDPHE;
- The Executive Director of HCPF; and
- Experts in health insurance actuarial analysis.

Further, the Collaborative is required by statute to publish primary care payment reform recommendations, which consider the Primary Care Spending Report.[11]

[11] § 10-16-150(4), C.R.S.

Program Description and Administration

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The fifth, sixth and seventh sunset criteria question:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters;
>
> Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively; and
>
> Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

In part, COPRRR utilizes this section of the report to evaluate the agency according to these criteria.

The Commissioner of Insurance at the Division of Insurance (Commissioner and Division, respectively) located within the Department of Regulatory Agencies (DORA), is directed by section 10-16-150, C.R.S, to convene the Primary Care Payment Reform Collaborative (Collaborative). The Collaborative was established in 2019 to, among other things, advise in the development of affordability standards and targets for carrier investments in primary care, to identify any barriers to the adoption of alternative payment models by health care providers and insurers, and to develop recommendations to address any barriers.

Table 2 outlines the total expenditures as well as the total number of full-time equivalent (FTE) employees dedicated to the Collaborative for fiscal years 19-20 through 22-23.

Table 2
Collaborative Expenditures and FTE

Fiscal Year	Total Expenditures	FTE
19-20	$70,150	0.4
20-21	$25,000	0.3
21-22	$49,999	0.3
22-23	$49,999	0.3

The Collaborative's work has been directly supported through various contracts. For example, the Director has worked closely with the Center for Improving Value in Health Care (CIVHC) to develop an annual Primary Care Spending Report for use by the Collaborative. The Division supports CIVHC in the collecting and reporting this data through a multi-year contract ($25,000 per year). In addition, the Division also retained the Colorado Health Institute (CHI) to assist with the production (design, copy editing, formatting, etc.) of the Collaborative's Annual Recommendations Reports in fiscal years 2019-20, 2021-22, and 2022-23.

The Collaborative was established in fiscal year 19-20, and revenue sources for fiscal years 19-20 through 22-23 include a contract with the Center for Improving Value in Health Care to provide an annual primary care and alternative payment model spending report to the Division, for use by the Collaborative, as well as a contract with the Colorado Health Institute to support the technical production, including the design and layout, of the Collaborative's annual recommendation report. Total revenue sources for each fiscal year include:

Fiscal Year 19-20
- Contract with the Center for Improving Value in Health Care ($25,000)[12]
- Contract with the Colorado Health Institute ($45,150)[13]

Fiscal Year 20-21
- Contract with the Center for Improving Value in Health Care ($25,000)

Fiscal Year 21-22
- Contract with the Center for Improving Value in Health Care ($25,000)
- Contract with the Colorado Health Institute ($24,999)

Fiscal Year 22-23
- Contract with the Center for Improving Value in Health Care ($25,000)
- Contract with the Colorado Health Institute ($24,999)

Additionally, the Division hired the Primary Care and Affordability Director (Director) in October 2019 to facilitate Collaborative meetings and to ensure that the Collaborative meets statutory objectives.

Further, the Director oversees the development of the annual recommendations reports of the Collaborative and assists with the development of the annual Primary Care Spending Report. The number of FTE included in the table above refers specifically to this position.

[12] Annual contract to provide an annual primary care and alternative payment model spending report to the Division, for use by the Collaborative.
[13] Contract to support the technical production (design, layout) of the Collaborative's annual recommendation report.

The Commissioner is directed by statute to invite members from a variety of sectors to participate in the Collaborative, including:[14]

- Representatives who are health care providers, including primary care providers;
- Representatives who are health care consumers;
- Representatives who are health insurers, including those that contract with the Colorado Department of Health Care Policy and Financing (HCPF) as a managed care entity;
- Representatives who are employers that purchase health care insurance for employees;
- Representatives from the federal Centers for Medicare and Medicaid Services;
- Representatives from the Primary Care Office within the Colorado Department of Public Health and Environment;
- Representatives who are experts in the field of health insurance actuarial analysis; and
- The Executive Director of HCPF.

The Collaborative meets on a monthly basis. Meetings are conducted in a virtual format and are open to the public.

Proposals of the Collaborative

The Collaborative has developed a variety of recommendations during calendar years 2019 through 2023. The following information provides recommendations relayed each calendar year and known outcomes for each recommendation are included as well.

On December 15, 2019, the Collaborative released its first annual report which outlined recommendations related to equitable access to health care and the role of payment reform. These recommendations included: [15]

- Recommendation 1 – A broad, inclusive definition of primary care was developed to include care providers by diverse provider types for both fee-for-service and other alternative payment models. This definition was utilized as the basis for the collection of alternative payment model and primary care spending data which helps to inform the work of the Collaborative. Further, the definition was utilized in the development of the Division's Regulations 4-2-72 (entitled, "Concerning Strategies to Enhance Health Insurance Affordability"), and 4-2-96 (entitled, "Concerning Primary Care Alternative Model Parameters"), as well as House Bill 22-1325 (entitled, "Primary Care Alternative Payment Models");
- Recommendation 2 – All commercial payers should be required to increase the percentage of total medical expenditures (except for pharmacy) spent on primary care by at least one percentage point each year through 2022. This

[14] § 10-16-150(2), C.R.S.
[15] Colorado Primary Care Payment Reform Collaborative, *Colorado's Primary Care Payment Reform Collaborative Recommendations: First Annual Report*, December 2019, p. 3.

recommendation was implemented by the Division with the promulgation of Regulation 4-2-72, which required carriers to increase the proportion of total medical expenditures allocated for primary care by one percent annually for calendar years 2022 and 2023;
- Recommendation 3 – Short, medium, and long-term metrics which are expected to be improved by increased investment in primary care should be tracked and identified by the State;
- Recommendation 4 – Increased investment in primary care should work to support the adoption of advanced primary care models by providers that build core competencies for whole-person care; and
- Recommendation 5 – Increased investments in primary care should be offered through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality in primary care. The Division utilized this recommendation in the development of Regulation 4-2-72 and to assist in the structuring of core competencies included in Regulation 4-2-96.

In July 2020, due to the COVID-19 pandemic and the reduced ability to provide medical services on an in-person basis, the Collaborative formulated a variety of emergency recommendations related to telehealth options:[16]

- Recommendation 1 - Continue the expansion of access to telehealth services, including audio-only encounters, for COVID-19 and non-COVID-19 related care. This recommendation was addressed in Section 5.C of Emergency Regulation 20-E-05, which prohibited carriers from imposing limitations on audio only or live video technologies;
- Recommendation 2 – Continue to reimburse providers for telehealth services such as diagnostics, consultations, and treatment services in the same manner that the providers would have received if the services were provided on an in-person basis for both COVID-19 and non-COVID-19 related care;
- Recommendation 3 – Maintain availability for in-person office visits when needed or preferable, since Colorado Revised Statutes require commercial insurance carriers to provide an adequate network of providers within a community for in-person health care;
- Recommendation 4 – Allow the decision to utilize telehealth in the care of a patient to be made jointly by the patient and the health care provider;
- Recommendation 5 – Continue to cover appropriate child-care and adult wellness visits in telehealth services;
- Recommendation 6 – Standardize billing requirements for telehealth services across carriers;
- Recommendation 7 – Provide patients and providers with clear information by both private and public payers to ensure that up-to-date information on telehealth services is easily accessible, and understandable;

[16] Colorado Primary Care Payment Reform Collaborative, *Recommendations Regarding the Use of Telehealth to Support Primary Care Delivery during the COVID-19 Pandemic and Beyond*, July 2020, pp. 2 - 6.

- Recommendation 8 - Extend the expansion of telehealth coverage, with ongoing evaluation of the impacts regarding cost and utilization to inform state and federal policy; and
- Recommendation 9 – Provide additional educational resources for providers regarding the acquisition of any hardware and technology needed for telehealth services, as well as the continued expansion of broadband access in rural areas.

Additionally, several of the Division's emergency regulations were subsequently codified in state law through the passage of Senate Bill 20-212.

On December 15, 2020, the Collaborative released its second annual report which outlined recommendations including:[17]

- Recommendation 1 - Colorado should build upon the prior and ongoing work of payers and health care providers to advance high quality, value-based care to align multi-payers in order to shift from fee-for-service towards a system of value-based payment systems. This recommendation led to the development of the Colorado Alternative Payment Model Alignment Initiative, which develops recommendations regarding consensus-based alternative payment models that are specific to Colorado and can be used to increase alignment in public and commercial markets;
- Recommendation 2 – Primary care capacity and performance should be measured on both the micro and macro levels to evaluate primary care alternative payment models, and should be aligned across private and public payers in order to elicit improvements;
- Recommendation 3 – Measures regarding whether increased use of alternative payment models and increased investment in primary care are achieving desired outcomes in the health care system, and whether aspects of value and care should also be examined;
- Recommendation 4 – Colorado's diverse population should be reflected in initiatives to enhance and support primary care services; and
- Recommendation 5 – Data collection regarding health equity should consider the analysis of racial and ethnic disparities.

In December of 2021, the Collaborative released its third annual report which outlined recommendations including:[18]

- Recommendation 1 - Increase investments in primary care through value-based payments and infrastructure investments;

[17] Colorado Primary Care Payment Reform Collaborative, *Colorado Primary Care Payment Reform Collaborative Recommendations: Second Annual Report*, December 2020, p. 4.
[18] Colorado Primary Care Payment Reform Collaborative, *Colorado's Primary Care Payment Reform Collaborative: Third Annual Recommendations Report*, December 2021, p. 6.

- Recommendation 2 – Increase inclusion and diversity in future health care initiatives by making health equity a central consideration in the design of any alternative payment model;
- Recommendation 3 – Encourage and support a variety of effective models through alternative payment models and other strategies that help to integrate and coordinate behavioral health and primary care; and
- Recommendation 4 - Increased investments in primary care should support collaboration with public health agencies to advance prevention and health promotion to improve population health.

In February of 2023, the Collaborative released its fourth annual report which outlined recommendations including:[19]

- Recommendation 1 - Quality measures should be aligned across payers to ensure accountability, standardization, and continuous improvement of primary care alternative payment models. The Division utilized this recommendation to assist in the structuring of the aligned adult and pediatric quality measure sets included in Regulation 4-2-96;
- Recommendation 2 - Patient attribution methodologies for primary care alternative payment models should be patient-focused, clearly communicated to providers, and include transparent processes for assigning and adjusting patient attribution lists (i.e., adding or removing patients). The Division utilized this recommendation to assist in the structuring of the aligned patient attribution requirements included in Regulation 4-2-96; and
- Recommendation 3 - Incorporate social factors into risk adjustment models as a tool to advance health equity by ensuring providers have adequate support to treat high-need populations. Further, the Collaborative recommended ongoing exploration of existing and emerging risk adjustment models for primary care that include inputs related to both medical and social needs, and increased transparency around the components of current payer-level risk adjustment models to improve provider understanding of risk adjustment and identify areas for potential payer alignment. The Division utilized this recommendation to assist in the structuring of the aligned risk adjustment requirements included in Regulation 4-2-96.

In February of 2024, the Collaborative released its fifth annual report which outlined recommendations including:[20]

[19] Colorado Primary Care Payment Reform Collaborative, *Colorado's Primary Care Payment Reform Collaborative: Fourth Annual Recommendations Report,* February 2023, p. 3.
[20] Colorado Primary Care Payment Reform Collaborative, *Colorado's Primary Care Payment Reform Collaborative: Fifth Annual Recommendations Report*, February 2024, p. 5.

- Recommendation 1 - Behavioral health integration should be intentionally supported as a key component of increased investment in primary care;
- Recommendation 2 - Payers should support and promote care delivery strategies that incorporate non-clinician health care providers as part of the care delivery team to holistically address whole-person and whole-family health needs;
- Recommendation 3 - Clinician and non-clinician health care providers should be incentivized to work on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services; and
- Recommendation 4 - Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment services that reflects the additional time and training needed to address complex patient needs through adequate payment.

In sum, over the course of six years, the Collaborative made 29 recommendations, some of which are known to have been implemented. Some recommendations call for or require broader cross-agency or cross-sector collaboration, which currently lack a mechanism to track implementation status or outcomes.

Analysis and Recommendations

The final sunset criterion questions whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest. The recommendation that follows is offered in consideration of this criterion, in general, and any criteria specifically referenced in that recommendation.

Recommendation 1 — Continue the Primary Care Payment Reform Collaborative for seven years, until 2032, and schedule the next sunset review to take place pursuant to section 2-3-1203, Colorado Revised Statutes.

The primary care workforce is proportionately declining in the United States. Utilization of what is commonly referred to as a "fee-for-service" approach has contributed to this decline, since it is widely perceived as containing challenges to providing quality care due to gaps in the types and amounts of fees covered by many payers.

Essentially, when a patient needs to see their primary health care provider due to a health care issue, the health care provider offers services to the patient, and then typically bills either the patient, or a third-party payer, such as an insurance company, Medicaid, or Medicare, for each type of service provided.

These perceived challenges may include, but are not limited to:[21]

- Authorized fee amounts may be less than the cost of providing quality care,
- Fees may not be established for some types of services,
- Health care providers may be paid more to treat a health care issue than to provide preventative care services,
- Quality assurance regarding the appropriateness of services provided is not monitored, and
- Comparison regarding health care providers is not feasible due to a lack of ability to assess what types of services will be utilized in advance of the treatment.

To address these concerns, a variety of alternative payment models are being developed to provide alternatives to the standard "fee-for-service" model.

The Commissioner of Insurance at the Division of Insurance (Commissioner and Division, respectively) located within the Department of Regulatory Agencies (DORA), is directed by section 10-16-150, Colorado Revised Statutes (C.R.S.), to convene the Primary Care Payment Reform Collaborative (Collaborative).

[21] Center for Health Care Quality and Payment Reform. *Barriers to Affordable, High Quality Care: The Real Problems with Fee for Service*. Retrieved July 2,2024, from chqpr.org/Care_Barriers.html

The Collaborative was established to, among other things:[22]

- Consult with the Colorado Department of Personnel and Administration, the Executive Director of the Colorado Department of Health Care Policy and Financing, and the Administrator at the Colorado All-payer Claims Database;
- Advise in the development of affordability standards and targets related to carrier investments in primary care;
- Analyze the percentage of medical expenses allocated to primary care in coordination with the Administrator of the All-payer Claims Database;
- Develop a recommendation regarding the definition of primary care directed to the Commissioner;
- Identify any barriers related to the adoption of alternative payment models by health insurers and providers and develop recommendations that address these barriers;
- Develop recommendations regarding increasing the use of alternative payment models that are not paid on a fee-for-service or per-claim basis;
- 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 as well as technical assistance with consumers and insurers; and
- Annually review the Division's alternative payment models and provide recommendations regarding the models.

Towards this end, the Collaborative has put forward 29 recommendations since its creation in 2019.

The Collaborative is comprised of members from state and federal entities, insurance providers, health care providers, and consumers to strengthen the variety and accessibility of alternative payment models through a comprehensive approach.

The Collaborative addresses a range of complex issues and is unique in its ability to bring together a wide variety of stakeholders to address increasing demands on Colorado's primary care network.

The first sunset criterion asks if the program under review is necessary to protect the public health, safety, and welfare. Through the application of the regulatory framework established in statute, the Collaborative fulfills an essential role through the recommendations it provides and the relationships it develops to help ensure the functionality and accessibility of primary care in the state. Therefore, the General Assembly should continue the Collaborative.

However, the Collaborative is an advisory committee, and as such, does not provide regulatory oversight in the same manner as programs that are typically scheduled under Title 24, C.R.S., for sunset review.

[22] § 10-16-150(1), C.R.S.

Since the primary purpose of the Collaborative is to provide recommendations to the Division and the General Assembly, a Title 2 sunset review structure would more aptly address any further sunset reviews since these types of reviews are tailored to advisory committees.

Given the dynamic nature of ever-evolving alternative payment models and the advisory committee functions performed by the Collaborative, the General Assembly should continue the Collaborative for seven years, until 2032, and schedule the next sunset review to take place pursuant to section 2-3-1203, C.R.S.