Colorado's Primary Care Payment Reform Collaborative

Fifth Annual Recommendations Report

FEBRUARY 2024

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Acknowledgements

Special thanks to the members of the of the Primary Care Payment Reform Collaborative who devoted many hours to developing the findings and recommendations presented in this report:

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- **Jack Teter**, Regional Director of Government Affairs, Planned Parenthood of the Rocky Mountains, Colorado, New Mexico, Southern Nevada, and Wyoming
- **Patricia A. Valverde**, PhD, MPH, Latino Research and Policy Center, Colorado School of Public Health, University of Colorado Anschutz Medical Campus
- **Peter T. Walsh**, MD, MPH, Chief Medical Officer, Colorado Department of Health Care Policy and Financing
- The **Colorado Health Institute** facilitated the preparation and publication of this report.

The recommendations in this report are a product of the Collaborative and should not be construed as recommendations or specific opinions of the Division of Insurance or Department of Regulatory Agencies.

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Executive Summary

The Primary Care Payment Reform Collaborative (the Collaborative) is pleased to present this fifth annual recommendations report. Since its creation in 2019, the Collaborative has remained focused on the goal of strengthening Colorado's primary care infrastructure and care delivery system through increased investment and the adoption of value based payment models, also known as alternative payment models (APMs), that drive value, not volume, and improve health outcomes. This year, unlike in previous reports, the Collaborative has chosen to focus on a single topic — integration of behavioral health into primary care. Behavioral health needs, especially among children and youth, continue to rise among patients being seen in primary care settings.

These recommendations reflect the importance the Collaborative places on integrated care delivery as a model for increasing access to person-centered, whole-person and whole-family care. They are offered in accordance with the Collaborative's statutory charge to develop recommendations to advance the use of APMs to increase investment in advanced primary care delivery, which the Collaborative has previously defined to include comprehensive care that focuses on behavioral health integration. In addition, the report discusses current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation, and identifies barriers and opportunities around the adoption of APMs by health insurers and providers to support integrated care delivery.

The recommendations in this report are a product of the Collaborative and should not be construed as recommendations or specific opinions of the Division of Insurance or Department of Regulatory Agencies.

This report builds upon previous recommendations and identifies opportunities to advance the integration of behavioral health services into primary care settings through the use of value based payments and other reimbursement mechanisms with the goals of ensuring: a) primary care providers are adequately and sustainably paid to deliver care that truly meets their patients' needs; b) payers* are able to see the benefits of their investments in the form of improved health outcomes and member experience; and c) patients can more easily access needed services with reduced stigma. To achieve these goals, the Collaborative makes the following recommendations:

* The term payer, as used in this report, refers primarily to health insurers regulated by the Division of Insurance. However, the Collaborative has consistently recognized the importance of private and public payer alignment to the success of APMs and continues to support and advocate for multipayer alignment around the recommendations in this report and additional strategies to strengthen primary care.

RECOMMENDATION 1:

Behavioral health integration should be intentionally supported as a key component of increased investment in primary care. Key infrastructure components that should be prioritized and adequately financed through joint, systemic efforts include investments in workforce, interoperable data, broadband access, and other tools needed to deliver high-quality, whole-person and whole-family care. Payers should reinforce and sustain these investments through prospective value based payments that adequately support team-based care delivery models.

RECOMMENDATION 2:

Payers should support and promote care delivery strategies that incorporate nonclinician providers as part of the care delivery team to holistically address whole-person and whole-family health needs. Increased payment options for team-based approaches will bolster provider capacity to offer integrated behavioral health services in the primary care setting that will improve patient health outcomes.

RECOMMENDATION 3:

Payers should support and incentivize clinician and nonclinician providers working on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services. In addition to provider payments for health-related social needs screening and referrals, system-level, cross-sector investments must be made to support and sustain a robust network of community and social services that can address and resolve social needs.

RECOMMENDATION 4:

Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment (MAT) services through adequate payment that reflects the additional time and training needed to address complex patient needs. Provider and patient education is also important to ensure stigma and other concerns related to substance use disorder treatment are considered, respected, and addressed.

Definition of Integrated Care

Integrated care is defined as the care a patient experiences as a result of a team of "primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization." —*Agency for Healthcare Research and Quality*

Colorado's Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative was established by House Bill 19-1233. It works to develop recommendations and strategies for payment system reforms to reduce health care costs by increasing the 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 by health insurers and providers and develop recommendations to address these barriers.
- Develop recommendations to increase the use of alternative payment models 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 2023. 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.

The recommendations contained within this report are a product of the Collaborative and should not be construed as recommendations or specific opinions of the DOI or Department of Regulatory Agencies (DORA).

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:

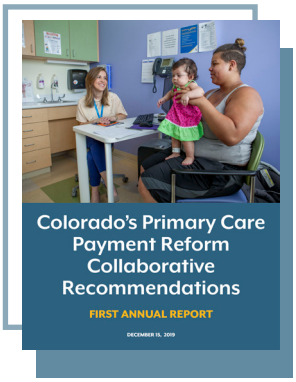
- Health care providers;
- Health care consumers;
- Health insurance carriers;
- Employers;
- U.S. Centers for Medicare and Medicaid Services (CMS);
- Experts in health insurance actuarial analysis;
- Primary Care Office, Colorado Department of Public Health and Environment (CDPHE); and
- Colorado Department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

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

Introduction and Key Context

In this fifth annual report, the Collaborative remains focused on its founding goal of supporting and strengthening the primary care infrastructure in Colorado. This year's report builds upon previous recommendations (see Previous Annual Reports) and work focusing on payment and care delivery strategies that are needed to advance the integration of behavioral health services into primary care settings.

Summary of Previous Annual Reports



First Annual Report 2019

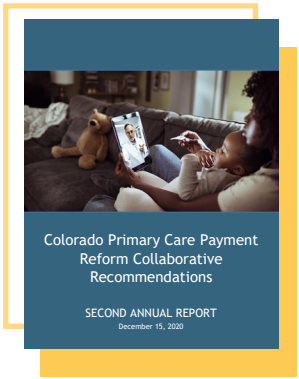
Definition of primary care. The Collaborative recommends a broad and inclusive definition of primary care, including care provided by diverse provider types under both fee-for-service and alternative payment models.

Primary care investment target. All commercial payers should be required to increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least 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 alternative payment models. Increased investments in primary care should be offered primarily through infrastructure investments and alternative payment models that offer prospective funding and incentives for improving quality.



Second Annual Report 2020

Multipayer alignment. Multipayer alignment is crucial to the success of alternative payment models, and Colorado should build upon the prior and ongoing work of payers and providers to advance high-quality, value based care. Practices need common goals and expectations across payers. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices.

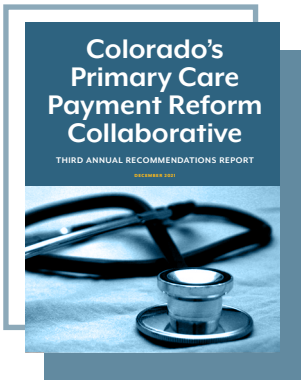
Measuring primary care capacity and performance. Measures used to evaluate primary care alternative payment models should be aligned across public and private payers and reflect a holistic evaluation of practice capacity and performance.

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

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

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

Summary of Previous Annual Reports



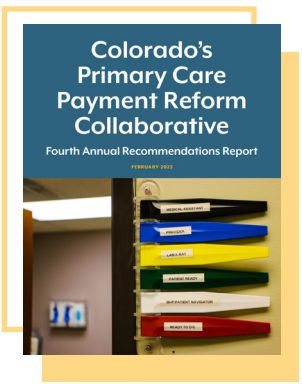
Third Annual Report 2021

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 alternative payment model. 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 alternative payment models 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.



Fourth Annual Report 2022

Aligning quality measures. Quality measures should be aligned across payers to ensure accountability, standardization, and continuous improvement of primary care alternative payment models. Aligned quality measure sets may include a menu of optional measures, reducing the administrative burden while still allowing for flexibility.

Improving patient attribution. Patient attribution methodologies for primary care alternative payment models should be patient-focused, clearly communicated to providers, and include transparent processes for assigning and adding or removing patients from a practice's patient attribution list.

Improving risk adjustment. Incorporating social factors into risk adjustment models as a tool to advance health equity is essential to ensure providers have adequate support to treat high-need populations. An evidence-based, proven social risk adjustment model is needed. Additionally, increased transparency is needed around the components of current payer-level risk adjustment models.

Focusing on Behavioral Health Integration in Primary Care

The Collaborative recognizes that behavioral health is an essential component of whole-person and whole-family health. Previous recommendations reports from the Collaborative have consistently supported integrated care delivery, which addresses physical and behavioral health needs as important dimensions of primary care. The Collaborative's definition of primary care, put forth in the first annual recommendations report, explicitly includes "behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting." The Collaborative also issued a series of care delivery and payment considerations for behavioral health in the third annual report, which recommended that "effective models for the integration and coordination of behavioral health and primary care should be encouraged and supported through alternative payment models and other strategies." As behavioral health needs in Colorado have continued to escalate, and in light of the state's efforts to reform the behavioral health system, the Collaborative is using this year's report to delve more deeply into the subject by offering insights specific to the integration of behavioral health in primary care settings.

Behavioral health integration in primary care is important for many reasons, but foremost among them is its capacity to address behavioral health stigma, which remains a significant obstacle for patients with mental health and substance use disorder needs. According to the 2023 Colorado Health Access Survey, over 875,000 Coloradans 18 and older reported not getting needed mental health care or counseling services, and about 107,000 reported not getting needed substance use services. Of the people who did not get needed services, stigma was a common reason cited for forgoing care (see Table 1).[1] Behavioral health stigma can take many forms and is of particular concern for Colorado's rural and underserved communities that often also face limited access to care and more difficulty seeking care confidentially due to intimate community size.

Behavioral health integration in primary care helps lower the barrier to entry for patients by bringing needed services to a familiar, non-stigmatized, and private setting, where patients can build on the relationship and trust with their primary care provider. Behavioral health integration can also increase access to care by reducing logistical burdens on patients, such as managing multiple appointments, disjointed medical records systems that don't communicate with one another, and keeping

Table 1: Stigma is a common reason for skipping needed behavioral health services[1]

Type of Service	Reasons why Coloradans didn't get needed behavioral health services in 2023*	
	Did not feel comfortable talking with a health professional about personal problems	Concerned about what would happen if someone found out they had a problem
Mental health or counseling services	37.6%	22.7%
Treatment or counseling for alcohol or drug use	61.7%	50.8%

*Respondents could choose multiple reasons for not seeking care, so percentages do not add up to 100.

various care teams informed about their care. This approach helps keep individuals in their primary care medical home while offering flexible and sustainable basic behavioral health services, which could lead to better health outcomes for patients.

In addition, integrated behavioral health care delivery can improve the well-being and job satisfaction of providers. A 2022 international survey of primary care providers conducted by the Commonwealth Fund showed that the majority of providers in the U.S. say they are "burned out and stressed, and many feel the pandemic has negatively impacted the quality of care they provide."[2] Addressing primary care provider burnout requires a systemic approach to bolster support that providers receive both in and out of the clinic. In its Taking Action Against Clinician Burnout report, the National Academy of Medicine emphasized the importance and benefits of implementing team-based care to reduce clinician burnout, noting that the social support provided by a team can improve clinician well-being, as well as having positive impacts on patient experience and health outcomes (through improved care coordination, increased safety, etc.).[3] As a team-based approach, behavioral health integration allows behavioral health professionals to support care and bolster professional satisfaction in primary care. This collaborative approach can better meet patient needs and ultimately improve patient outcomes.

On the payment side, behavioral health integration can improve the financial well-being of health care practices by aligning multiple payers to consistently support behavioral health integration — especially through value based payments. The use of value based payments to enhance provider capacity for integrated care is crucial for the sustainability of primary care and independent practices, particularly in the face of increasing trends like venture capital and private equity investment and consolidation. By implementing value based payments that bolster team-based care delivery, practices can improve their revenue and reduce financial strain.

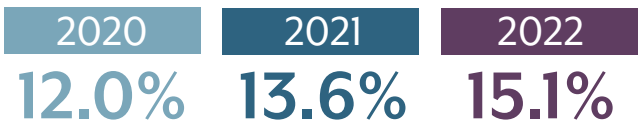
Update on Investments in Primary Care and Spending Through Alternative Payment Models

The Collaborative's recommendations have consistently focused on strengthening primary care to ensure a strong, sustainable system for integrated, whole-person care delivery. An underlying tenet of these recommendations has been that while increased investment in primary care is needed regardless of the payment type, primary care can be better supported and sustained by shifting away from fee-for-service reimbursement structures to value based payments, which use financial incentives and other payment mechanisms to reward providers for delivering high-quality and high-value care (as defined in Colorado Rev. Stat § 10-16-157 Section 2b). Additional information on how the Collaborative's past recommendations have shaped investments in primary care is available in Appendix B: Primary Care Reform Collaborative Work and Impact Highlights to Date.

To understand spending on primary care in Colorado and track changes in investment over time, the Collaborative has received annual reports on primary care spending and alternative payment model use in Colorado from the Center for Improving Value in Health Care (CIVHC).

Figure 2: Primary Care Spending as a Percentage of All Medical Spending in Colorado Across All Reported Payer Types

Excludes Pharmacy and Dental[i]



Source: Primary Care Spending and Alternative Payment Model Use in Colorado, 2020-2022 Report (Appendix C)

[i] See Appendix C for CIVHC's complete Primary Care Spending and Alternative Payment Model Use in Colorado, 2020-2022 report.

In December 2023, CIVHC presented its latest report on primary care and APM spending, based on data from the Colorado All Payer Claims Database (APCD) for calendar years 2020-2022, to the Collaborative. The key findings show that primary care spending as a percentage of total medical spending across all reporting payer types (commercial, Medicare Advantage, Medicaid, and CHP+) has increased from 12.0% in 2020 to 15.1% in 2022 (see Figure 2).[i,ii,iii]

Annual spending through alternative payment models, both as a percentage of total medical expenditures and as a percentage of primary care spending, has also been a metric of interest for the Collaborative. CIVHC reports that in 2022, value based alternative payment models (which for the purposes of this report, exclude risk-based payments and capitated payments not linked to quality) accounted for 31.0% of total medical spending and 62.4% of total primary care spending across all reported payer types.[iv]

The Collaborative has also consistently supported increased proportions of prospective payments to providers/practices.[v] These payments allow for greater flexibility to provide whole-person and whole-family care that better meets patient needs and can improve patient experience and health outcomes. In 2021, CIVHC added a data field for payers to identify prospective payments; the most recent report indicates prospective payments under APMs accounted for 34.2% of total medical and 79.2% of total primary care spending across all reported payer types in 2022.[i]

Currently, CIVHC does not collect data in a way that allows primary care and alternative payment model spending to be broken out by age group. Therefore, it is not possible to determine the amount of current spending that is allocated for children. While some pediatric practices, particularly in the Denver metro area, are actively participating in integrated care delivery models (like the Collaborative Care Model), Collaborative members have consistently raised concerns that pediatric practices have fewer opportunities to participate in alternative payment models. Engaging public and private payers in advancing alternative payment models that are designed for pediatric populations and that support and reward preventive care remains an ongoing priority.

[ii] CIVHC's analysis is based on carrier-submitted data. Payers have continually worked with CIVHC and the DOI to refine their data collection and reporting methodologies, which can result in adjustments to the figures that are reported year to year. In this year's reporting, one payer was able to include behavioral health spending occurring in an integrated primary care setting for the first time, which notably increased both the payer's and the overall percent of primary care spending.

[iii] Certain payers are excluded from the primary care investment requirements of Colorado Regulation 4-2-72, including Kaiser Permanente Colorado and Denver Health. For additional information, please see Appendix C for the full CIVHC report on primary care spending and alternative payment model use.

[iv] Value based APM arrangements, as operationalized in CIVHC's reporting methodology, do not include risk-based payments and capitation payments not linked to quality (3N and 4N HCP LAN categories respectively). Please see Appendix C for the full CIVHC report on primary care spending and alternative payment model use.

[v] As defined in Colorado Rev. Stat § 10-16-157, "prospective payment" means a payment made in advance of services that is determined using a methodology intended to facilitate care delivery transformation by paying providers according to a formula based on an attributed patient population to provide predictable revenue and flexibility to manage care within a budget to optimize patient outcomes and better manage population health.

Recommendations

The recommendations in this report focus on four key topic areas related to behavioral health integration and discuss the current payment landscape as well as associated challenges and opportunities to strengthen integrated care delivery: payment, health-related social needs,[vi] workforce, and medication-assisted treatment.

RECOMMENDATION 1:

Payment for Behavioral Health Integration

Behavioral health integration should be intentionally supported as a key component of increased investment in primary care. Key infrastructure components that should be prioritized and adequately financed through joint, systemic efforts include investments in workforce, interoperable data, broadband access, and other tools needed to deliver high-quality, whole-person and whole-family care. Payers should reinforce and sustain these investments through prospective value based payments that adequately support team-based care delivery models.

Approved by Unanimous Consensus

Current Payment Landscape. A variety of payers in Colorado are working to implement strategies to support behavioral health integration. Several commercial payers in Colorado are supporting various models such as the Collaborative Care Model and Primary Care Behavioral Health Care Model. Commercial payers are also working on expanded care management, value based purchasing, and other forms of alternative payment models.

Behavioral health integration is also a priority for public payers, including Medicare and Medicaid. Initiatives by HCPF, such as Accountable Care Collaborative Phase III as well as Alternative Payment Model 2, are among the approaches exploring behavioral health integration payment for Health First Colorado. Additionally HCPF is developing an integrated care benefit for Medicaid members and is collaborating with the Behavioral Health Administration (BHA) to support integrated care. On the Medicare front, the CMS Behavioral Health Strategy includes efforts to strengthen behavioral health services in primary care. Colorado is participating in CMS's Making Care Primary Model, which seeks to improve care management and coordination in order to form stronger partnerships between primary care providers and specialists.[vii]

Challenges and Opportunities. Challenges, gaps, and needs within behavioral health integration in Colorado include sustainability, support for practice integration, and an unclear path for engaging large employers and self-funded plans in payment alignment initiatives. Despite successful examples

[vi] For the purposes of this report, the Collaborative is using the term health-related social needs due to its wide use in the field at the time of publishing. However, the Collaborative recognizes that this is evolving terminology, and that there may be different preferences to refer to these types of needs, services, and supports, including interest in moving toward less deficit-based frameworks.

[vii] In June 2023, the Centers for Medicare & Medicaid Services (CMS) announced that Colorado will be one of several states to pilot the Making Care Primary Model. Launching July 1, 2024, the 10.5-year model will improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health needs as well as their health-related social needs (HRSNs) such as housing and nutrition.

of behavioral health integration, such as state initiatives like the State Innovation Model and other community-level successes, sustainability remains a significant challenge. Determining the necessary financial support to sustain integrated behavioral health practices over time is complex, as it varies based on factors like practice size, location, care delivery model, and patient population. This lack of a single, straightforward answer or strategy poses challenges to calculating the amount of resources required at both a practice and system level in Colorado. However, understanding how much funding is needed to sustain such care delivery over the long term is important for planning and resource allocation.

Large employers that offer self-funded insurance plans represent a significant portion of the health care marketplace in Colorado. Overall, self-funded plans, in which employer pay for their employee health claims directly, are estimated to comprise around 50% of what most Coloradans think of as the "insurance market" (coverage that is not obtained through a public source such as Medicaid, Medicare, or the Veterans Administration). Self-funded plans are not subject to state regulation and, therefore, fall outside the scope of some policy and regulatory mechanisms available to the Collaborative and DOI. Nevertheless, engaging with large employers in voluntary discussions regarding primary care investment, integration, and value based payments can facilitate alignment and collaboration between public and private health care sectors, ultimately benefiting patients and health care delivery in the state.

Supporting Team-Based Care. The implementation of successful behavioral health integration requires adequate payment for team-based care, including team-based care delivery models that involve an array of behavioral health providers, care coordination activities, and support for developing and sustaining referrals across a spectrum of integrated care delivery. This approach prioritizes improving patient health outcomes and reducing health care silos. A successful example of integrated behavioral health care in primary care is Kaiser Permanente's Primary Care Behavioral Health Model and Collaborative Care approach,[viii] which have demonstrated a significant 6:1 return on investment by treating depression in primary care. Kaiser Permanente's Collaborative Care approach is a team-based, patient-centered model of care that has shown to be effective in supporting individuals with a diagnosis of depression and/or anxiety within the primary care setting. Collaborative care uses a registry to identify and outreach patients who are not improving or have disengaged from treatment. Team members include the patient, primary care provider, a care manager working closely with the patient for follow up, and a psychiatric consultant. Kaiser's billing model and best practices emphasize the importance of critically examining whether service offerings are contributing to patient health improvement when designing incentives.

While increased payment may flow through various mechanisms, shifting from fee-for-service to prospective value-based payments for services can increase the sustainability of integrated behavioral health care models and primary care. Successful implementation of prospective payments relies on payments that match the demand and are flexible enough to allow service offerings to increase when demand increases. Designing prospective payments that allow for new integrated services to be offered in practices requires care. For example, if prospective payments are based on the status quo, but a practice is in the middle of implementing new care team models and services, prospective payments may lock providers into an underpayment scenario. For value based payments to support improvements in primary care, careful consideration should be paid to how payments are structured in advance of services being added.

Prospective payments for pediatric practices require additional considerations. The pediatric setting offers opportunities to provide preventive and whole-family care that addresses the behavioral health needs not only of infants, children, and adolescents, but also the parents. Such care can best be delivered when care teams include both early infant mental health providers as well as

[viii] Kaiser Permanente's Collaborative Care approach is a team-based, patient-centered model of care that has shown to be effective in supporting individuals with a diagnosis of depression and/or anxiety within the primary care setting. Collaborative care uses a registry to identify and reach out to patients who are not improving or have disengaged from treatment. Team members include the patient, primary care provider, a care manager working closely with the patient for follow up, and a psychiatric consultant.

clinicians and nonclinicians who can address adult needs and family-related matters. Prospective payments can be challenging in supporting such teams, due to fluctuations in patient populations — a payment may be adequate to support a certain number of patients, but the constant addition of new patients (i.e., through births of new babies) may result in inadequate support. Prospective payments for pediatrics should account for changes in patient population and be inclusive of whole family needs and supports.

Keeping Track of Billing Codes and Investments. Billing codes, including Psychiatric Collaborative Care Model and Health Behavior Assessment and Intervention codes, are essential to ensuring that providers are appropriately reimbursed for their behavioral health integration services. These codes are already being used by multiple commercial payers, and CMS has taken action to increase their use in the 2024 Physician Fee Schedule. They play a significant role in supporting current and future behavioral health integration efforts. The Collaborative has emphasized the importance of payer alignment in relation to APM structures, but alignment around billing codes is also an important mechanism for both reducing administrative burden on practices and improving the state's capacity to measure primary care investments. As behavioral health integration codes are further adopted, alignment of these codes across payers should be considered and pursued when feasible.

The Collaborative reiterates its previous recommendation that payers should report their investments in behavioral health integration to DOI. This reporting will help track and evaluate the progress and impact of behavioral health integration initiatives. The Collaborative recognizes that payers currently report on certain behavioral health measures through mechanisms including the Healthcare Effective Data and Information Set, and existing reporting should be leveraged whenever possible to minimize administrative burden. To better inform strategies to increase investment in behavioral health integration and to identify opportunities for payer alignment, limited additional reporting on the types of integrated behavioral health programs payers currently have in place, as well as the percentage of members eligible to participate in such programs and/or the percentage of members served, will also be valuable. For example, the alignment of behavioral health codes among payers will allow for better tracking of investments in integration and reduce administrative burden for providers and care teams.

Collaborating With Other Behavioral Health Efforts. Ongoing collaboration with the BHA and participation in statewide efforts is essential, particularly for aligning efforts across various forms of care delivery. Building and maintaining the necessary infrastructure, such as telehealth capabilities and integrated health information systems, to support behavioral health integration is crucial for the success and sustainability of these initiatives. Such investments can significantly improve the coordination and delivery of behavioral health services within the broader health care ecosystem.

RECOMMENDATION 2:

Workforce for Behavioral Health Integration

Payers should support and promote care delivery strategies that incorporate nonclinician providers as part of the care delivery team to holistically address whole-person and whole-family health needs. Increased payment options for team-based approaches will bolster provider capacity to offer integrated behavioral health services in the primary care setting that will improve patient health outcomes.

Approved by Unanimous Consensus

Definitions

Team-based care. "Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care." — *National Academy of Medicine*

Whole-person care and whole-family care. Whole person-care and whole-family care [is] the coordination of health, behavioral health, and social services in a patient- and family-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. — *adapted from JSI*

About Team-Based Care. Team-based care delivery is a foundational component of advanced primary care and integrated care delivery models. As highlighted in the 2021 National Academies Implementing High-Quality Primary Care report, the integration of team-based methods into primary care can increase the impact and capacity of primary care to "comprehensively address a broader range of whole-person health needs, and establish effective, shared linkages with families, community organizations, and specialist resources over time."[4] Team-based care delivery can also reduce provider burnout and increase job satisfaction by creating an environment in which team members can perform work best suited to their abilities.

Primary care has increasingly become a central location for addressing behavioral health issues. The capacity of primary care providers to meet the physical and behavioral health needs of patients and families can be greatly enhanced through an expanded care team that can effectively coordinate care. Due to the variety of care delivery models and patients served, the exact team composition will vary according to the type of practice. Payment flexibility is needed to support practices in creating and sustaining care teams to deliver appropriate whole-person and whole-family care.

Colorado, like many other states, faces behavioral health workforce challenges, including provider shortages and a lack of providers that accept commercial insurance. The Collaborative supports efforts by the BHA and other state agencies to address these systemic issues.

Community Health Workers and Other Nonclinician providers. In integrated care delivery settings, nonclinical providers, including community health workers, play a crucial role in connecting patients with behavioral health and social services. Community health workers can help patients access care, improve their experience of care, and advance health equity. Social and behavioral health needs are often intertwined, and community health workers are uniquely situated to play a role in addressing both.

Supporting a strong nonclinician workforce means not only establishing payment for current nonclinician roles, but also bolstering the overall development pipeline of this workforce. Peer support specialists, community health workers, and non-clinical social workers are vital to ensuring whole-person health care is not only attainable but sustainable. Additionally, systemic investments in recruitment and training programs — such as the behavioral health micro-credentialing work currently underway at the BHA and the creation of new roles like the qualified behavioral health assistant role — are needed to enhance the workforce in this field.

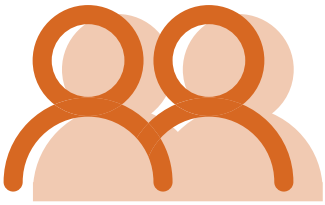
Current Payment Support Landscape. Payment for community health workers and other nonclinician providers varies among public and private payers. In the 2024 Physician Fee Schedule, CMS included coding and payment changes to support multidisciplinary teams of clinical staff and other auxiliary personnel in furnishing patient-centered care. CMS will

Examples of Nonclinician Providers

Several types of nonclinician providers can support team-based behavioral health integration. Depending on the context, a behavioral health integration team composition can vary in order to meet the needs of patients. In order to meet the specific needs of patient populations, practices/providers must be afforded a level of flexibility to determine the types of professionals or positions on their team.

Community Health Worker

"A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." – *American Public Health Association*[viii]



Peer Support Workers

"Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse." – *Substance Abuse and Mental Health Services Administration (SAMSHA)*

Promotores or Promotoras de Salud

Promotores or Promotoras de Salud are Spanish terms "used to describe trusted individuals who empower their peers through education and connections to health and social resources in Spanish-speaking communities." – *MHP Salud*

Note: While these terms describe the roles of various nonclinician providers, the Collaborative supports the community health initiatives underway at CDPHE and HCPF. These agencies are aligned around a definition of community health worker that is based on the American Public Health definition (above), but are using "community health worker" as an umbrella term for individuals who may go by many names, such as: health promoters; community outreach workers; promotores de salud; health navigators; patient navigators. The Collaborative appreciates and reinforces the use of "community health worker" as an inclusive term to refer to additional, related nonclinician roles within a care team.

[viii] This definition was selected to align with community health worker initiatives at CDPHE and with HCPF.

now pay health care support staff, including community health workers, care navigators, and peer support specialists, for providing medically necessary community health integration, social determinants of health risk assessment, and principal illness navigation services. Previously, such staff were able to serve as auxiliary personnel in the performance of services "incident to the services of a Medicare-enrolled billing physician or practitioner." The updates to the fee schedule are an important step forward as these codes will directly support services performed by community health workers, care navigators, and peer support specialists.

Legislation recently passed in Colorado (Senate Bill 23-002) authorizes HCPF to seek federal authorization to provide Medicaid reimbursement for community health worker services, starting July 1, 2024. HCPF is seeking stakeholder input on the development of these services and is working closely with the BHA on the development of the new qualified behavioral health assistant role. In the BHA's report Strengthening the Behavioral Health Workforce in Colorado: An Approach to Community Partnership, the BHA notes that behavioral health aides will be able to participate on Medicaid reimbursable teams.[5]

The payment landscape for community health worker services for private payers varies, but in many instances commercial insurers do not reimburse community health workers or other nonclinician staff. This represents an area of opportunity for improvement. The evidence of the effectiveness of community health workers continues to grow, which generates an increasingly strong case for reimbursement across all payer types. Formal payment structures for community health workers across all payers is necessary for long-term support and financial sustainability of these services.

Provider training. Training for all providers within a practice, including clinician and nonclinician staff, is essential to the integration of behavioral health in primary care settings. The adoption of team-based care delivery often necessitates significant restructuring of practice staff roles, responsibilities, workflows, and even physical space. Integrating behavioral health in a practice also introduces new dynamics that demand additional support and investments, both internally and externally. For example, successful behavioral health integration services require ongoing communication and relationship-building among staff members and between staff, patients, and their families. Providers typically lack training for collaborative work within integrated care settings, where medical and behavioral health services closely intertwine, so training is needed in this area. Preparing providers to function effectively within this integrated model is pivotal to the success of behavioral health integration.

Fortunately, there are numerous opportunities for provider training within the health care landscape. Initiatives such as House Bill 22-1302 grants and Making Care Primary offer resources and support for learning, equipping providers with the skills and knowledge required to thrive in integrated care settings. Additionally, Colorado boasts a multitude of successful behavioral health integration efforts, which can serve as models to support additional adoption. For example, Federally Qualified Health Centers (FQHCs) across the state have implemented a range of integrated care delivery models and offer a variety of best practices that can inform other integration efforts. Future work is needed to explore the scalability of these models and to inform training programs that comprehensively address both medical and behavioral health needs.

The Role of Telehealth. Telehealth can play an important part in behavioral health integration by offering greater access to services and increased flexibility for both patients and providers. Telehealth has been highlighted as an important modality for behavioral health services for several reasons. First, telehealth serves as a crucial tool for providing care in specific regions of the state with low access to care. Many rural and underserved regions of the state face workforce shortages that hinder physical access to care. In these regions, integrated behavioral

health care is more difficult to achieve. Telehealth enables patients to access care remotely, bridging geographical gaps and ensuring they receive the medical attention they require. Second, telehealth is an essential option for providing health care, particularly in times of crisis. The COVID-19 pandemic prompted a dramatic surge in the use of telehealth services, encompassing both physical and behavioral health needs. Since the onset of the pandemic, telehealth has remained a significant tool in the health care system and its continued integration is important to expanding access to care and increasing care quality. Several commercial payers in Colorado are continuing to look for ways to promote telehealth utilization among their members, as a way to make care more accessible.

Telehealth presents certain challenges, including inequitable access. It can be particularly challenging to access care via telehealth in areas that lack adequate technological infrastructure, such as rural and frontier communities (often referred to as "tech deserts"). Patients may also deal with physical infrastructure issues, such as lacking a room in a home or workplace where they can meet confidentially with a provider. Consumer advocates have heard from patients and providers that an overreliance on telehealth can have adverse impacts for clients in mental and behavioral health care crises. On-the-ground resources must be available for the most vulnerable patients to access in-person care for conditions such as substance use disorders, eating disorders, and other matters. Patients should be able to make informed decisions with their providers about which option (telehealth, in-person, or a combination) works best to address their needs.

Lessons drawn from the rapid adoption of telehealth during the pandemic can continue to inform future strategies. As telehealth continues to adopt and evolve, in the context of integrated care delivery and in particular with regard to substance use disorder and opioid use disorder, it will be important to educate providers and patients so both are well-informed and comfortable with telehealth technology and processes.

RECOMMENDATION 3:

Health-Related Social Needs

Payers should support and incentivize clinician and nonclinician providers working on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services. In addition to provider payments for health-related social needs screening and referrals, system-level, cross-sector investments must be made to support and sustain a robust network of community and social services that can address and resolve social needs.

Approved by Unanimous Consensus

Definitions:

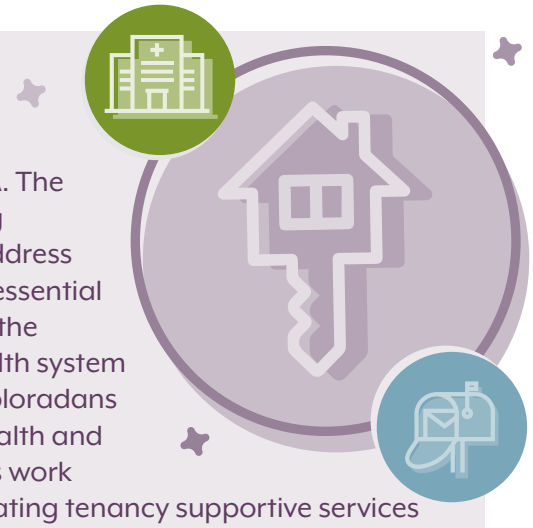
Health-related social needs. Health-related social needs are an individual's and family's adverse social conditions (e.g. housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age). – *Adapted from Kaiser Family Foundation*

Health-related social needs screening and referral. A health-related social needs screening tool is a set of questions, typically evidence-based, that can be asked by a physician, nurse, social worker, or other health care personnel to determine whether a patient has certain unmet social needs. Patients with identified social needs can then be referred to community resources. – *Adapted from Center for Consumer Engagement in Health Innovation*

Health-related social needs are an important component of whole-person and whole-family care and have a profound influence on health outcomes. The Collaborative has previously recognized the need for care delivery and payment approaches that support providers in addressing both the health and social needs of patients, and these recommendations are particularly salient in the context of integrated care delivery models. The integration of behavioral health care in primary care settings will further increase the capacity of primary care to address physical, behavioral, and social needs of Coloradans, improving not just health outcomes but overall well-being.

Health-Related Social Needs Payment Support Landscape. The current payment landscape to support social needs screening and referral in

Spotlight on Housing



While too many Coloradans experience challenges with multiple social needs, including food insecurity, transportation challenges, and personal safety issues, housing has consistently emerged as a top concern across Colorado. In the 2023 Colorado Health Access Survey, 7.1% of Coloradans said they weren't sure if they would have stable housing in the next two months.[1] When individuals and families are housing insecure, their capacity to prioritize or address their health needs (physical and behavioral) is greatly diminished. Factors contributing to the housing crisis are multifaceted and complex, and the solutions to these challenges require work through primary care and beyond. At a provider level, utilization of the Homelessness Management Information System (HMIS) to identify individuals experiencing homelessness or housing insecurity can help coordinate referrals to and provision of housing resources across clinical and service providers. Additionally, provider offices can participate in their region's Continuum of Care (CoC) Coordinated Entry System (CES) to communicate their patients' needs, including medication distribution and patient adherence. Finally, providers can participate in co-responder or street medicine and outreach teams to provide direct care to patients in the field.

At a state level, housing is being incorporated as a fundamental component of the behavioral health system reform efforts spearheaded by Colorado's BHA. The BHA is pursuing strategies to address housing as an essential support within the behavioral health system to ensure all Coloradans can achieve health and well-being. This work includes integrating tenancy supportive services as an option into BHA's new contracting model for behavioral health safety net delivery, the Behavioral Health Administration Service Organizations (BHASOs). Tenancy supportive services provide an array of services to Department of Local Affairs voucher clients, individuals and families who are at risk of homelessness, and others. Tenancy supportive services can include landlord mediation, tenant-based training, employment and vocational training support, and clinical assessments and support for behavioral health needs. The BHA has also developed a Care Coordination Team to support hospital and psychiatric institution alternative placements for individuals who would otherwise become displaced or unhoused upon discharge.

The Collaborative embraces and applauds these efforts and hopes that the recommendations in this report, which seek to advance the integration of behavioral health into primary care, can be part of the solution.

Colorado involves various billing codes and payment models across different sectors of health care, including Medicare, Medicaid, and commercial payers.

In Medicare, the 2024 Physician Fee Schedule now includes billing codes for community health integration, social determinant of health risk assessment, and principal illness navigation. Initiatives like Making Care Primary aim to promote universal health-related social needs screenings and referrals. In Colorado, Medicaid adopts a medical home model with primary care medical providers and standardized care coordination and case management tiers. Legislative efforts like House Bill 23-1300 and Senate Bill 23-174 are also aimed at advancing health-related social needs support by providing continued Medicaid coverage or coverage for certain mental health services to vulnerable Medicaid populations. In particular, Senate Bill 23-174 promotes preventive mental health care for these vulnerable populations by providing certain supportive services (like family therapy, case management, and treatment planning) to people under the age of 21 without first requiring a diagnosis.

Many commercial payers, including Medicare Advantage, use Z codes to support health-related social needs screening and referral. The private insurance landscape related to the use of Z codes varies, but in general commercial payers have lagged behind their public payer counterparts in their adoption and use of Z codes. Outside of Z codes, multiple payers in Colorado have activities and programs in place to screen members for health-related social needs to help navigate members with identified needs to available community resources. Many are also actively considering the use of Z codes as a component of or complement to existing efforts.

Challenges and Opportunities. The use of health-related social needs screening and referrals in primary care has steadily increased, and is now being supported across various payers. Administering health-related social needs screening and referrals requires resources, including practice transformation support, to develop office workflows and roles and responsibilities within expanded care teams.

Additionally, patient education around the purpose and use of screening for health-related social needs is necessary to ensure patients understand and are receptive to screening. Patients have varying perspectives on being screened for social needs in health care settings, with many expressing concerns related to stigma and other types of discrimination, including race and class status. In some instances, those with social needs have been the most hesitant about screening. Patient education about screening, including why and how the results will and will not be used, can help address concerns and is valuable in building overall trust, communication, and transparency between providers and patients. In this context, it's also important to consider engaging families in the screening process. Families can be important for gaining a better understanding of an individual's social needs. They can provide insights into the patient's home environment and daily routine and can participate in supporting patients through their treatment plans. To fully engage families, specific, tailored education about the purpose and process of screening is also needed. Provider education around stigma and bias is equally important to confront and reduce the structural and social barriers often experienced by those with social and behavioral health needs.

While health-related social needs screening and referrals have been increasingly adopted in primary care settings, the process of actually connecting patients to resources and the availability of resources in the community remain significant obstacles. Providers may face difficulties in identifying and establishing relationships with resources and organizations in their communities, and challenges remain around establishing "closed-loop" referral systems that allow providers to track whether patients are following through on referrals. From a patient perspective, navigating across multiple

systems (health care, social services, housing, food banks) can be challenging, and even if successful connections are made, community organizations may lack the resources to meet the identified need. The challenge of referrals for resources that don't actually exist within a community is often called the "bridge-to-nowhere" and is a major problem in addressing health-related social needs.

Supporting a Robust Social Support System. In order to address important social needs, the Collaborative recommends that health-related social needs screening, referral, and connections be supported and incentivized in integrated care settings. This should be true for all levels of providers, including clinician and nonclinician staff. This recommendation is made with the acknowledgement and important qualification that such efforts must be complemented with other actions to support and sustain a strong social services delivery network in Colorado. The success of health-related social needs supportive services hinges on system-level investments made in these services. Social needs are complex and vary widely among different populations, so a healthy ecosystem of social support is necessary to address long-standing systemic issues.

Connecting with Solutions Outside of the Clinic. Community care hubs are emerging as a potential solution to serving people with high levels of social need, with some commercial engagement in this area. These care hubs can lower the barrier to access many types of social needs-related care and can host a variety of resources in a centralized space. The Collaborative supports the creation of community care hubs in Colorado, which can facilitate and potentially streamline connections between payers and provider and resource networks. For example, a payer or practice could contract directly with a care hub to refer and connect patients with multiple needs (e.g., food insecurity, housing insecurity, transportation) and develop a standard set of policies and procedures related to closed-loop referrals.

Collaboration with partners in other realms, such as school districts, is also important to support whole-person and whole-family care for pediatric populations. The Collaborative supports ongoing state efforts to strengthen connections across sectors, including the systemic work underway at the BHA. Legislation developed by the Behavioral Health Task Force highlights the opportunity to increase access to behavioral health services through partnerships between school-based providers or health centers, health care providers in the community, and other community-based services. Additional efforts to integrate resources, such as incorporating programs like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) within primary care offices, should also be supported to improve access to resources and improve health outcomes for both children and parents.

Health-Related Social Needs Data Considerations. Collecting social needs data brings challenges related to how the data is collected and used. In many communities, high levels of stigma remain around social needs, and many patients may not be willing to disclose that information. Additionally, patients may be sensitive to certain terms or questions commonly used in the health care field to describe social needs due to past negative experiences in the health care system. In the 2023 Colorado Health Access Survey, people of color were more likely than white Coloradans to report being treated disrespectfully when getting care (7.7% vs. 4.4%, respectively).[1] This context is important to consider when implementing health-related social needs screening and referral into practice workflows. To address these issues surrounding social need data, further exploration should be conducted on best practices for data sensitivity and cultural competency to ensure patients are not deterred from seeking help due to increased health-related social needs screening and care offerings. This would include a better understanding of how discrimination based on factors like income and race influence screening rates and access to community resources.

RECOMMENDATION 4:

Medication-Assisted Treatment

Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment (MAT) services through adequate payment that reflects the additional time and training needed to address complex patient needs. Provider and patient education is also important to ensure stigma and other concerns related to substance use disorder treatment are considered, respected, and addressed.

Approved by Unanimous Consensus

Definition

Medication-assisted treatment (MAT). MAT involves the use of medications, such as buprenorphine and methadone, in combination with counseling and behavioral therapies to address substance use disorder. Food and Drug Administration-approved medication-assisted treatments for substance use disorders cover the following diagnoses: nicotine dependence, alcohol use disorder, and opioid use disorder. MAT may also include opioid overdose reversal agents. – *Adapted from SAMSHA*

Current MAT Payment Support Landscape. The delivery of MAT in integrated primary care settings can improve care delivery and health outcomes for patients with mental health and substance use disorder needs. The landscape of payment to support MAT for substance use disorder is multifaceted, involving various federal and state regulations and payment policies. At the federal level, Medicare covers reasonable and necessary services provided by Medicare-enrolled health care practitioners for treating substance use disorders, such as alcohol use disorder and other substance abuse. The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which went into effect in January 2020, added a benefit for treating opioid use disorder that includes comprehensive MAT services provided in approximately 1,700 Substance Abuse Mental Health Services Administration-certified Opioid Treatment Programs. The services provided in these programs include management, care coordination, psychotherapy, counseling, telehealth services, and dispensing and administration of MAT drugs.

At the state level, Health First Colorado covers the substance use disorder treatment care continuum, including medication-assisted treatment. State regulations also set coverage and reimbursement requirements for commercial insurance plans regulated by the DOI.

Challenges and Opportunities. While MAT services are covered by both private and public insurers, uncertainty over billing practices can sometimes serve as a barrier to MAT delivery in primary care. Providers can struggle to understand what is acceptable to bill and who can do the billing, leading some to avoid offering services. A lack of clarity surrounding licensing requirements for MAT administration in different settings (e.g., FQHCs) can further compound provider uncertainty and hesitancy.

Many of the primary care providers who are offering MAT are currently using evaluation and management codes for billing, which may or may not provide adequate reimbursement or tracking. The use of value based payments to support MAT

delivery is an evolving area. Several national models, including the Patient-Centered Opioid Treatment (P-COAT) Alternative Payment Model, seek to integrate medical and behavioral health services payment and increase the use of office-based opioid treatments. The P-COAT emphasizes a patient-centered approach to opioid treatment, aligning care with individual needs and preferences. The adoption of this and other value based payments in Colorado is not well-known. A better understanding of if and how payers are using alternative payment models to reimburse for MAT services — and what that reimbursement looks like in the context of team-based primary care — would help to inform efforts to bolster investment in MAT services.

While the provision of MAT in primary care can improve access to needed services, the time associated with providing this care is an important consideration and potential barrier for integrated care teams. Primary care providers face increased pressures on their time in the clinic, and creating enough time to fully address the needs of individuals who are often dealing with both addiction and other behavioral health concerns can be a challenge. Creating payment approaches and systems that take into account the additional time and effort that goes into managing this population is an important part of the solution.

Supporting Appropriate Training for MAT. Health care providers must undergo specialized training to administer MAT effectively. While such training is available in Colorado, it often requires uncompensated time away from the clinic, which can impact practice revenue, particularly for small practices. In addition, implementing MAT within primary care practices requires adjustments to workflow and protocols. The identification and adoption of best practices and ongoing support for practice transformation are crucial for the successful implementation of MAT. Therefore, primary care providers and practices must be supported by adequate payment for additional time and training needed to address MAT patients.

Many primary care providers are not familiar or comfortable managing patients who need MAT, so financial support for comprehensive training on treatment and patient counseling is needed to support providers who wish to integrate MAT. Additionally, stigma for mental health care is a significant barrier to care for many patients and communities, so provider training on how to respectfully address patients' concerns in this area is important.

The Collaborative wishes to highlight the importance of appropriate MAT patient counseling training for two specific patient populations: adolescents and pregnant people. Opioid use among adolescents and teenagers continues to rise, reaching alarming levels in Colorado and nationwide. Communicating with adolescents can be challenging, and providers must be equipped with the right tools to know how to ask teenagers about substance use. Another issue is that providers say they are often not comfortable prescribing MAT for pediatric patients. This is an area that is a particular challenge in the pediatric space and an area where additional support and training is needed. It can also be difficult to address substance use in populations of pregnant patients. Some patients are unwilling to disclose their opioid use status because of the potential for the involvement of the Department of Human Services. In these cases, initiating treatment is difficult. Additionally, MAT adherence requirements are high and can be difficult to meet with this population. An exploration of how adherence requirements could be made flexible to provide some level of treatment to this population at crucial weeks of development would be better than nothing.

Connecting to MAT Resources. Not all primary care providers will choose to offer MAT services. Some may not see enough demand for MAT services, while others may not see it as part of their focus. In cases where providers have decided not to directly administer MAT treatment, it is essential that providers know where they can send patients to receive those services. Education and resources about where to refer patients and how to answer patients' questions about what they can expect at the first steps of the referral process should be available to providers. Providing clarity regarding how to find a licensed MAT provider may help make the referral process easier.

Conclusion

The recommendations in this report build upon the last four years of recommendations from previous efforts and offer additional guidance on the integration of behavioral health services into the primary care setting. While this report primarily focuses on identifying needed infrastructure and payment supports to advance integrated care delivery, the Collaborative acknowledges the importance of ensuring such investments and payments have the desired impacts on health outcomes and on patient, family, and provider experience. Measurement and accountability for such outcomes is complex, as broader market and system-level dynamics interact with and influence providers' ability to achieve improved outcomes. The Collaborative therefore emphasizes the need for future discussions to not only clarify and define appropriate provider accountability in this context, but also to establish measures of success at the patient, family, provider, and system level.

As an area for future work, the Collaborative looks forward to exploring continued efforts to expand coverage and payment for integrated behavioral health services under alternative payment models. The Collaborative will also continue to explore and assess the scalability and success of current models and programs to bolster health-related social needs support, including housing, the primary care workforce, and increase access to MAT.

Endnotes

[1] Colorado Health Institute. 2023 Colorado Health Access Survey. (2023) https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2023

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[5] Behavioral Health Administration. Strengthening the Behavioral Health Workforce in Colorado: An Approach to Community Partnership. (September 2022) https://bha.colorado.gov/sites/bha/files/documents/BHA_Workforce_Report_2022.pdf

Appendix A:

Primary Care Payment Reform Collaborative Standard Operating Procedures and Rules of Order

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 Reform Collaborative Work and Impact Highlights to Date

Figure 1: Primary Care Payment Reform Collaborative Work and Impact Highlights To Date

Since 2019, the Collaborative has made yearly recommendations on how to develop strategies for increased investments in primary care that deliver the right care, in the right place, at the right time. A high-level summary of this work and its impacts to date follows.

Definition of Primary Care	• In the first annual report (2019), the Collaborative recommended a comprehensive definition of primary care to direct future investments in primary care. • The Collaborative's definition now serves as the basis for the collection of primary care and alternative payment model (APM) spending data, which the Center for Improving Value in Health Care (CIVHC) provides to the Collaborative on an annual basis to inform future priorities and recommendations. • The definition was leveraged by the DOI to implement Regulation 4-2-72: Concerning Strategies to Increase Health Insurance Affordability, which establishes a primary care investment target for health insurance companies regulated by the DOI. • The definition also shaped legislative efforts to advance the adoption of APMs, culminating in the passage of House Bill 22-1325 and the DOI's subsequent promulgation of Regulation 4-2-96.
Primary Care Investment Target	• In the first annual report, the Collaborative recommended commercial payers increase the percentage of total medical expenditures (excluding pharmacy) spent on primary care by at least 1 percentage point annually through 2022. • This recommended target was implemented by the DOI in Regulation 4-2-72, which requires carriers to increase the proportion of total medical expenditures in Colorado allocated to primary care by 1 percentage point annually in calendar years 2022 and 2023. Regulation 4-2-72 also requires carriers to report certain data on alternative payment model expenditures to DOI.

Investing in Advanced Primary Care Models	• In the first annual report, the Collaborative highlighted elements of advanced primary care delivery models that should be supported through increased investment, which included comprehensive care, integrated behavioral health, and team-based care. • This recommendation has been expanded upon in subsequent reports, which have highlighted the various components of practice transformation that are needed to support providers in offering whole-person and whole-family care. • The DOI utilized this work to inform the development of the Primary Care Implementation Plan reporting requirements established in Regulation 4-2-72. More recently, the DOI used the Collaborative's work in this space to help structure the core competencies included in Regulation 4-2-96.
Increased Investment Through Alternative Payment Models	• In the first annual report, the Collaborative recommended that increased investments in primary care should be offered primarily through infrastructure payments and APMs that offer prospective funding and incentives for improving quality. The recommendation was reiterated in the third annual report (2021), which offered additional strategies for meeting this goal. • In putting forth a definition of primary care, the Collaborative also recommended that the definition be applied to care and payments provided under both fee-for-service reimbursement and APMs. Based on this recommendation, CIVHC developed a method to include information on APM expenditures, as a percentage of both total medical spending and primary care spending, as part of its annual Primary Care and APM Model Use report. The DOI also implemented a requirement for health insurance carriers to annually report information on their use of APMs, through the APM Implementation Plan included in Regulation 4-2-72.
Advancing Equity	• Every year, the Collaborative has centered health equity in its work and recommendations. This includes issuing recommendations for data collection frameworks to support health equity and equity-driven care delivery and payment methodologies. • The Collaborative has sought to recruit members from a variety of backgrounds who can speak to the needs of Colorado's diverse primary care practices and patient populations.
Multipayer Alignment	• In the Second Annual Report (2020), the Collaborative highlighted the importance of multipayer alignment to the success of APMs and recommended building on the ongoing work of payers and providers to advance high-quality, value based care. • This recommendation led to the Colorado APM Alignment Initiative, a multistakeholder engagement effort led by the Office of Saving People Money on Health Care, the Department of Health Care Policy and Financing (HCPF), the Division of Insurance (DOI), and the Department of Personnel and Administration (DPA) to discuss and develop recommendations for Colorado-specific, consensus-based APMs that could be used to advance alignment of value based payment approaches within the public and commercial markets. • The recommendations issued by the Collaborative in the Fourth Annual Report (2023) and the Colorado APM Alignment Initiative informed the development of House Bill 22-1325 and DOI's subsequent promulgation of Regulation 4-2-96. • Colorado's work around multipayer alignment has garnered national attention and contributed to the state's selection to participate in the Health Care Payment and Learning Action Network's State Transformation Collaborative and the new Centers for Medicare and Medicaid's new Making Care Primary model.

Appendix C:

Primary Care Spending and Alternative Payment Model Use in Colorado, 2020-2022, Center for Improving Value in Health Care

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

PRIMARY CARE SPENDING AND ALTERNATIVE PAYMENT MODEL USE IN COLORADO, 2020-2022

Submitted November 2023

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

NAVIGATION

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

BACKGROUND

The Center for Improving Value in Health Care (CIVHC) provides this report of primary care and alternative payment models (APM) spending (2020-2022) 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 2022 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: 2020, 2021, and 2022. Primary care and APM spending for 2022, 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*.

Additionally, CIVHC collects Medicaid-adjacent data from multiple organizations, including MCO/HMOs and Regional Accountable Entities (RAEs). As of 2023, CIVHC included a section detailing Medicaid payers by RAE region in Table 2 of the accompanying Excel file, which was initially aggregated at just the line of business and payer name.

FINDINGS

Key observations include highlights from the report of primary care spending for 2020-2022 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 2022.

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 2022, primary care spending as a percentage of ***all medical spending*** (excluding pharmacy and dental) in Colorado across all reported payer types was 15.2%. Primary care spending accounted for 13.9% of total medical spending in 2021 and 12.9% of total medical spending in 2020.

- The percentage of primary care spending in Colorado, excluding Kaiser Permanente and Denver Health payments[1], is 15.1% in 2022, 13.6% in 2021 and 12.0% in 2020.

- Primary care spending as a percentage of ***all medical spending*** varies by payer type. In 2022, primary care accounted for 8.5% of commercial medical spending, 17.7% of Medicare Advantage medical spending, 19.1% of Medicaid medical spending, and 14.7% of CHP+ medical spending.

    - The percentage of primary care spending in Colorado in 2022, excluding Kaiser Permanente and Denver Health payments, is 5.0% of commercial medical spending, 19.7% of Medicare Advantage medical spending, 19.1% of Medicaid medical spending, and 11.7% of CHP+ spending.

APM Spending

- In 2022, 36.1% of ***all medical spending*** across all reported lines of business was paid through value-based APM arrangements[2]. This also varies by payer type – 24.1% of commercial, 47.8% of Medicare Advantage, 40.1% of Medicaid, and 7.3% 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 21.0% of ***all medical spending***.

    - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 15.1% of ***all medical spending*** in 2022.

    - Excluding Kaiser Permanente and Denver Health, 31.0% of ***all medical spending*** was paid through value-based APM arrangements in 2022. 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 9.7% of commercial, 35.1% of Medicare Advantage, 41.2% of Medicaid, and 0.0% of CHP+ in 2022.

- Of ***all primary care spending*** in 2022, APMs, including non-value-based and value-based arrangements, accounted for 82.7% of spending. The remaining 17.3% of primary care spending occurred through traditional FFS payment arrangements. Of primary care

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[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.*

[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).*

spending made through APMs, the highest percentage flowed through Pay for Performance (category 2C).

- Value-based APM arrangements built on a FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 14.7% of ***all primary care spending*** in 2022.
- Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 53.1% of ***all primary care spending*** in 2022.

Additional Metrics[3]:

Spending Per Member Per Month:

- In 2022 and across all lines of business, ***total medical*** spending per member per month (PMPM) was $322.21. ***Primary care*** spending PMPM was $48.83.
    - ***Total medical expenditures*** expressed as spending PMPM vary by payer type. In 2022, total medical expenditures PMPM were $472.13 for commercial, $689.38 for Medicare Advantage, $220.06 for Medicaid, and $162.53 for CHP+.
    - Similar to total medical expenditures, ***primary care expenditures*** expressed as spending per member per month vary also by payer type. In 2022, primary care expenditures PMPM were $40.03 for Commercial, $121.90 for Medicare Advantage, $41.93 for Medicaid, and $23.83 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, 22.3% of ***all medical spending*** in 2022 was paid on a prospective basis.
    - Excluding FFS, 54.2% of ***all medical spending through an alternative payment model*** was paid on a prospective basis in 2022.
    - 99.3% of Category 4 payments, 14.5% of Category 3, and 14.5% of Category 2 payments were made prospectively.
    - Excluding Kaiser Permanente and Denver Health, 13.2% of ***all medical spending*** and 27.6% 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

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

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 2022, 20.8% of commercial, 35.5% of Medicare Advantage, 17.7% of Medicaid, and 7.3% of CHP+ was paid prospectively.
- Of ***all spending through an alternative payment model***, 76.5% of commercial, 56.8% of Medicare Advantage, 41.8% of Medicaid, and 98.4% of CHP+ was paid prospectively.

Member Cost Sharing:

- Across all lines of business, payer organizations covered 94.0% of ***all medical spending*** in 2022; members were responsible for 6.0% of the costs. Excluding Medicaid and CHP+, which has minimal member liability, payer organizations covered 89.0% 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 93.1% of ***all primary care spending*** in 2022. Payer investment in primary care has been steady for the past three years; health plans covered 93.3% of primary care expenditures in 2020 and 93.3% in 2021.
- In commercial lines of business only, payer organizations covered 85.7% of ***all medical spending*** in 2022; members were responsible[3] for 14.3% of the costs.
    - Payer investment in primary care for commercially insured members slightly decreased in 2022 compared to 2020; payer organizations covered 88.7% of primary care expenditures in 2020, 86.4% in 2021, and 86.1% in 2022.

[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 from 12% in 2020 to 15% in 2022.

Figure 1: Percent of Primary Care Spending by Payer Over Time, 2020-2022

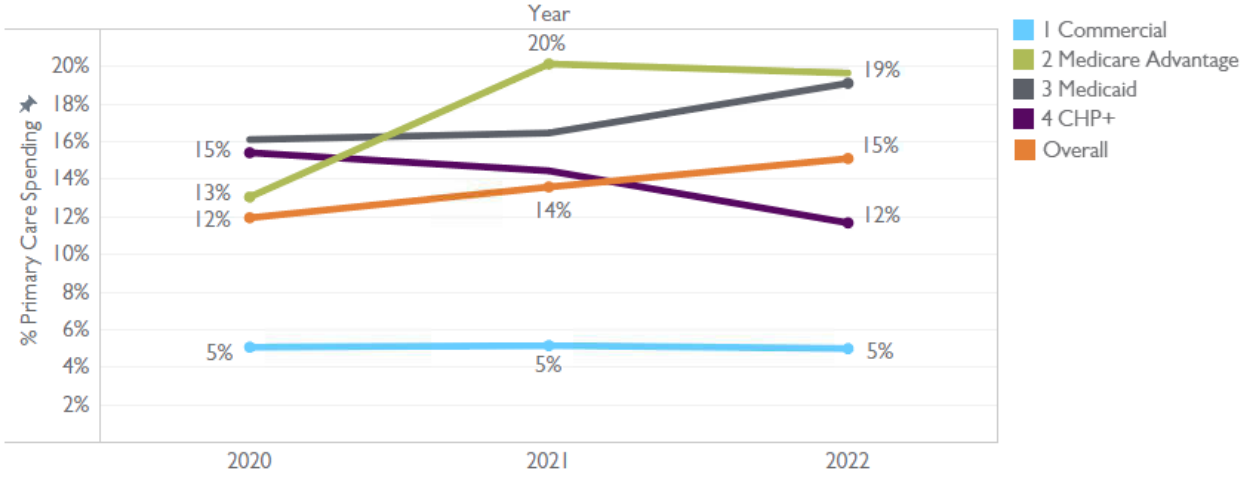


Figure 2: Share of Primary Care Spending, 2022.

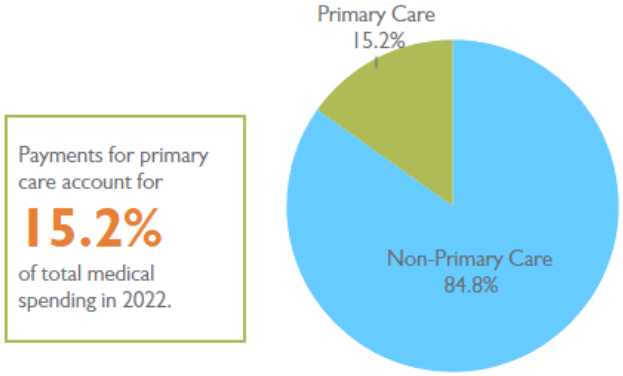
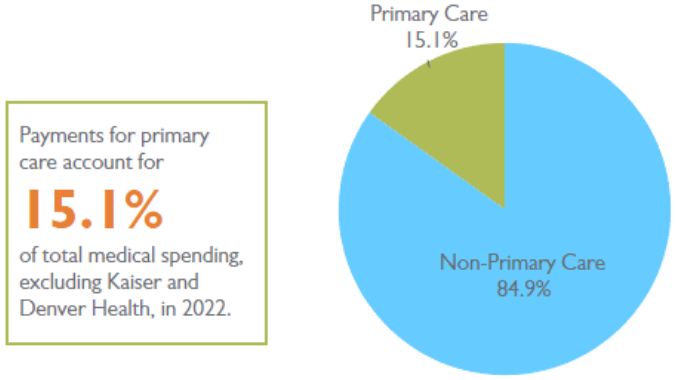


Figure 3: Share of Primary Care Spending, excluding Kaiser and Denver Health, 2022.



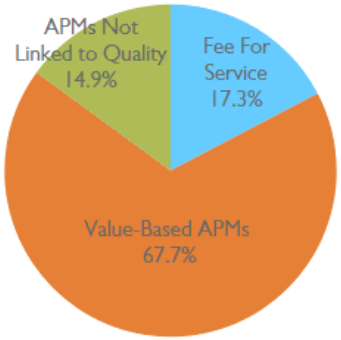
Note: The denominator (total medical spending) does not include pharmacy expenditures.

Figures 4: Share of Primary Care Spending by APM Category, 2022.

Payments under value-based alternative payment models account for

67.7%

of total **primary care spending** in 2022.



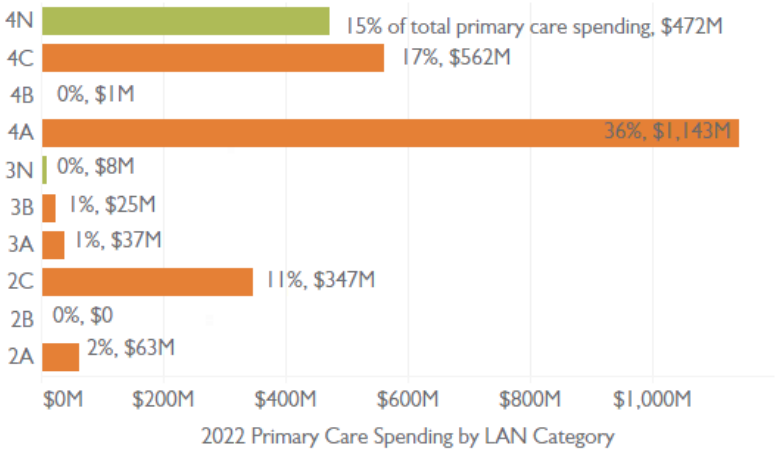
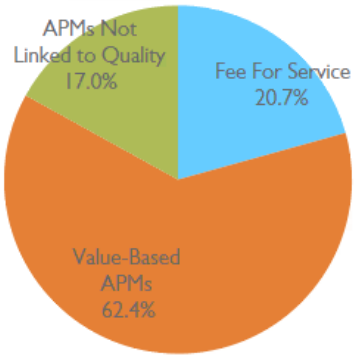


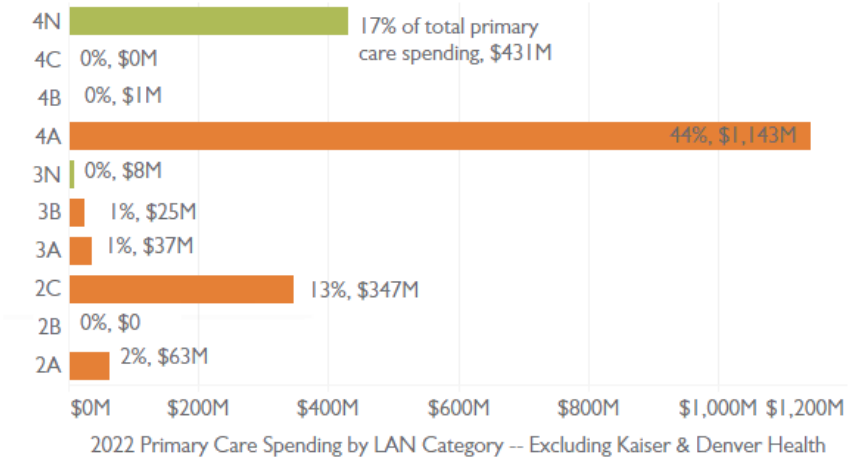
Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser and Denver Health, 2022.

Payments under value-based alternative payment models account for

62.4%

of total **primary care spending**, excluding Kaiser and Denver Health, in 2022.





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, 2022.

Payments under value-based alternative payment models account for **36.1%** of **total medical spending** in 2022.

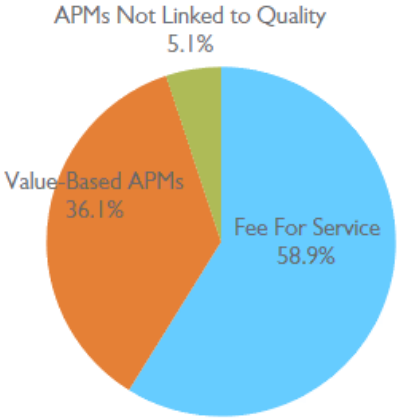
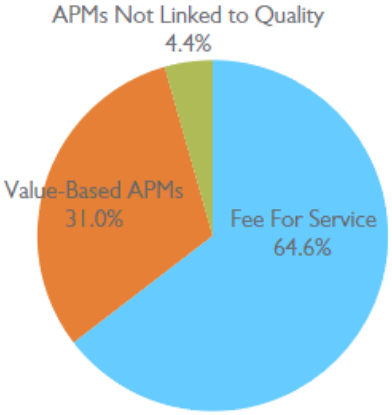


Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser and Denver Health, 2022.

Payments under value-based alternative payment models account for **31.0%** of **total medical spending**, excluding Kaiser and Denver Health, in 2022.



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, 2020-2022.

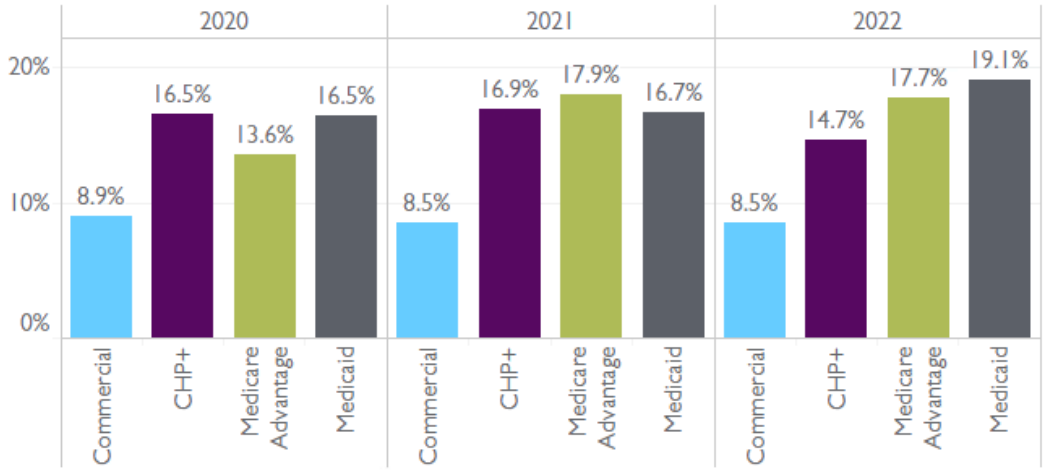


Figure 9: Primary Care Spending by Member Months by Payer, 2020-2022.

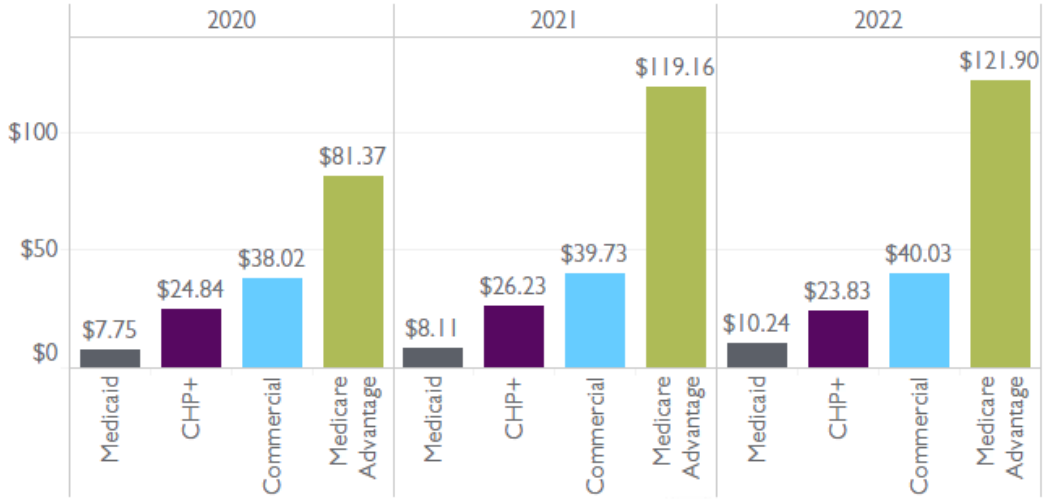


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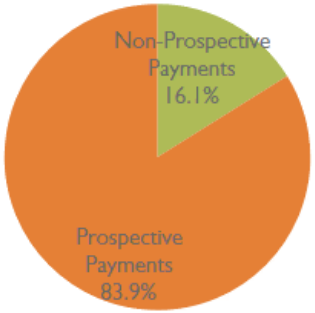
Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2022.

Prospective payments under alternative payment models account for

83.9%

of total **primary care spending** in 2022.



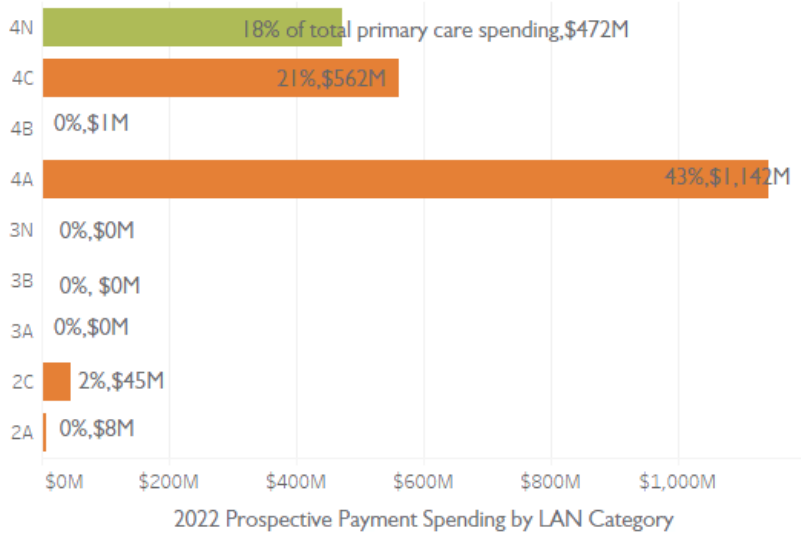
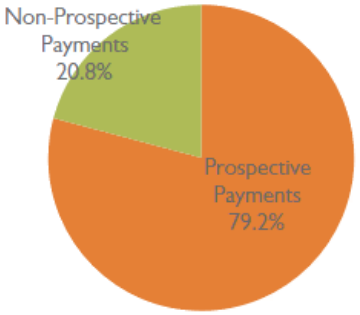


Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser and Denver Health, 2022.

Prospective payments under alternative payment models account for

79.2%

of total **primary care spending**, excluding Kaiser and Denver Health, in 2022.



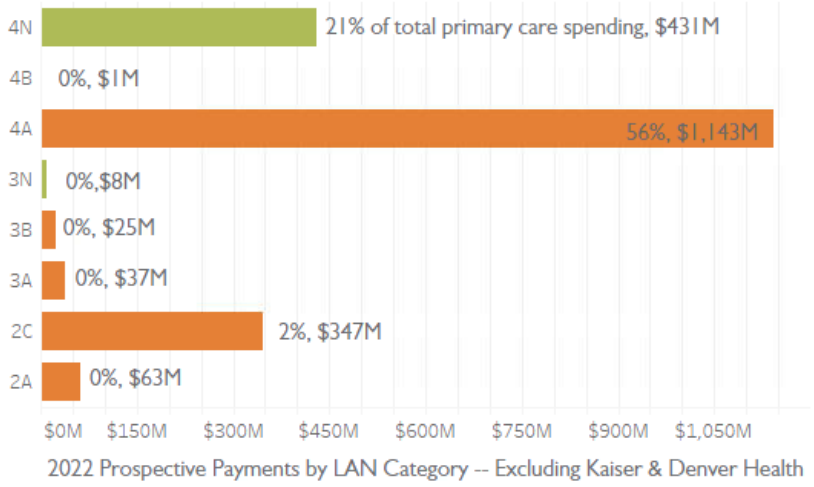


Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2022.

Prospective payments under alternative payment models account for

54.2%

of **total medical spending** in 2022.

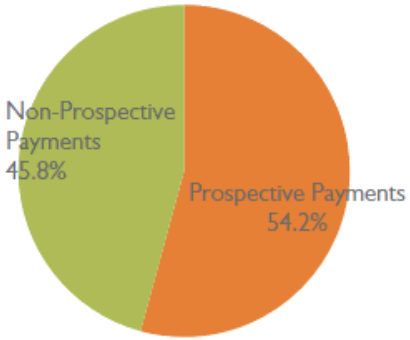
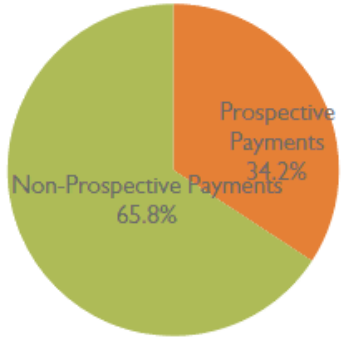


Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser and Denver Health, 2022.

Prospective payments under alternative payment models account for

34.2%

of **total medical spending**, excluding Kaiser and Denver Health, in 2022.



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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:

At time of submission of the November 22nd, 2023 report, CIVHC received APM submissions from 16 payers in 2023, all of which have signed attestation.

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 16 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.

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RESULTS

TABLE 1: TOTAL MEDICAL AND PRIMARY CARE SPENDING BY PAYMENT MODEL AND PAYER TYPE (2022)

Results for 2020-2022 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	2022	Total Medical Spending	$ 21,208,576,785	$ 12,483,591,877	$ 103,157,652	$ -	$ 3,463,441,394	$ 308,296,972	$ 576,312,065	$ 182,456,770	$ 1,313,884,093	$ 860,882	$ 1,880,067,765	$ 896,507,316
		Primary Care Spending	$ 3,214,107,994	$ 556,450,674	$ 63,073,174	$ -	$ 346,548,720	$ 37,371,708	$ 24,677,343	$ 8,496,987	$ 1,142,754,489	$ 745,981	$ 562,050,432	$ 471,938,485
		% Primary Care Spending	15.2%	4.5%	61.1%	0.0%	10.0%	12.1%	4.3%	4.7%	87.0%	86.7%	29.9%	52.6%
COMMERCIAL	2022	Total Medical Spending	$ 7,231,176,533	$ 5,262,904,803	$ 15,972,789	$ -	$ 364,251,976	$ 282,633,592	$ 50,925,720	$ -	$ 130,853	$ 746,144	$ 1,026,409,578	$ 227,201,080
		Primary Care Spending	$ 613,109,426	$ 212,180,736	$ 7,818,715	$ -	$ 745,380	$ 34,409,789	$ 4,318,374	$ -	$ 5,128	$ 745,981	$ 352,757,164	$ 128,159
		% Primary Care Spending	8.5%	4.0%	49.0%	0.0%	0.2%	12.2%	8.5%	0.0%	3.9%	100.0%	34.4%	0.1%
MEDICARE ADVANTAGE	2022	Total Medical Spending	$ 4,258,169,719	$ 1,595,373,102	$ 318,728	$ -	$ 800,022,446	$ 17,536,478	$ 370,632,562	$ 178,504,791	$ -	$ 114,738	$ 847,496,587	$ 448,170,286
		Primary Care Spending	$ 752,967,655	$ 51,720,900	$ -	$ -	$ 34,137,870	$ 1,908,790	$ 20,358,969	$ 8,496,914	$ -	$ -	$ 205,748,752	$ 430,595,460
		% Primary Care Spending	17.7%	3.2%	0.0%	0.0%	4.3%	10.9%	5.5%	4.8%	0.0%	0.0%	24.3%	96.1%
MEDICAID	2022	Total Medical Spending	$ 9,622,942,338	$ 5,536,211,108	$ 86,866,136	$ -	$ 2,298,327,749	$ 8,121,684	$ 154,753,783	$ 3,951,979	$ 1,313,689,280	$ -	$ -	$ 221,020,619
		Primary Care Spending	$ 1,833,910,504	$ 282,131,654	$ 55,254,458	$ -	$ 311,665,469	$ 1,047,913	$ -	$ 73	$ 1,142,685,401	$ -	$ -	$ 41,125,535
		% Primary Care Spending	19.1%	5.1%	63.6%	0.0%	13.6%	12.9%	0.0%	0.0%	87.0%	0.0%	0.0%	18.6%
CHP+	2022	Total Medical Spending	$ 96,288,195	$ 89,102,863	$ -	$ -	$ 839,224	$ 5,218	$ -	$ -	$ 63,959	$ -	$ 6,161,601	$ 115,331
		Primary Care Spending	$ 14,120,410	$ 10,417,384	$ -	$ -	$ -	$ 5,218	$ -	$ -	$ 63,959	$ -	$ 3,544,517	$ 89,331
		% Primary Care Spending	14.7%	11.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	57.5%	77.5%

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

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

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TABLE 1a: ALTERNATIVE PAYMENT MODELS AS A PERCENTAGE OF PRIMARY CARE SPENDING, BY PAYER TYPE (2022)

Results for 2020-2022 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	2022	Primary Care Spending	$ 3,214,107,994	$ 556,450,674	$ 63,073,174	$ -	$ 346,548,720	$ 37,371,708	$ 24,677,343	$ 8,496,987	$ 1,142,754,489	$ 745,981	$ 562,050,432	$ 471,938,485
		% of Total Primary Care Spending	100.0%	17.3%	2.0%	0.0%	10.8%	1.2%	0.8%	0.3%	35.6%	0.0%	17.5%	14.7%
COMMERCIAL	2022	Primary Care Spending	$ 613,109,426	$ 212,180,736	$ 7,818,715	$ -	$ 745,380	$ 34,409,789	$ 4,318,374	$ -	$ 5,128	$ 745,981	$ 352,757,164	$ 128,159
		% of Total Primary Care Spending	100.0%	34.6%	1.3%	0.0%	0.1%	5.6%	0.7%	0.0%	0.0%	0.1%	57.5%	0.0%
MEDICARE ADVANTAGE	2022	Primary Care Spending	$ 752,967,655	$ 51,720,900	$ -	$ -	$ 34,137,870	$ 1,908,790	$ 20,358,969	$ 8,496,914	$ -	$ -	$ 205,748,752	$ 430,595,460
		% of Total Primary Care Spending	100.0%	6.9%	0.0%	0.0%	4.5%	0.3%	2.7%	1.1%	0.0%	0.0%	27.3%	57.2%
MEDICAID	2022	Primary Care Spending	$ 1,833,910,504	$ 282,131,654	$ 55,254,458	$ -	$ 311,665,469	$ 1,047,913	$ -	$ 73	$ 1,142,685,401	$ -	$ -	$ 41,125,535
		% of Total Primary Care Spending	100.0%	15.4%	3.0%	0.0%	17.0%	0.1%	0.0%	0.0%	62.3%	0.0%	0.0%	2.2%
CHP+	2022	Primary Care Spending	$ 14,120,410	$ 10,417,384	$ -	$ -	$ -	$ 5,218	$ -	$ -	$ 63,959	$ -	$ 3,544,517	$ 89,331
		% of Total Primary Care Spending	100.0%	73.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	25.1%	0.6%

Notes:

Total medical expenditures do not include pharmacy spending.

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

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TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022)

The following tables report medical expenditures stratified by both named payer for 2022.
Payers with multiple lines of business appear more than once.

COMMERCIAL 2022							
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	5.9%	28.0%	$ 32,652,351	$ 154,848,944	$ 553,902,872	$ 1,602,072	0.3%
Anthem	5.2%	30.2%	$ 52,272,892	$ 306,122,143	$ 1,013,366,056	$ 10,448,402	1.0%
Blue Cross Blue Shield of Illinois	3.0%	10.6%	$ 274,180	$ 986,221	$ 9,284,809	$ -	0.0%
Cigna	3.0%	0.0%	$ 29,011,615	$ 24,267	$ 973,089,083	$ 43,737,955	4.5%
Denver Health	0.7%	0.0%	$ 1,764,025	$ -	$ 250,275,534	$ 183,484,965	73.3%
Humana	7.4%	0.0%	$ 1,985,487	$ -	$ 26,693,810	$ -	0.0%
Kaiser Permanente	17.8%	61.3%	$ 365,354,157	$ 1,259,282,571	$ 2,054,453,227	$ 1,259,282,570	61.3%
Rocky Mountain Health Plan	3.4%	0.2%	$ 4,849,432	$ 301,921	$ 143,387,590	$ 19,690	0.0%
UnitedHealthcare**	6.0%	1.4%	$ 86,700,972	$ 19,504,584	$ 1,444,667,987	$ 7,712,896	0.5%
Allegiance Benefit Plan Management*	5.1%	0.0%	$ 1,730,746	$ -	$ 33,993,230	$ -	0.0%
Ameriben*	4.9%	0.0%	$ 1,772,710	$ -	$ 35,962,718	$ -	0.0%
American Enterprise*	0.0%	0.0%	$ -	$ -	$ 782,870	$ -	0.0%
Employee Benefit Management Services Inc.*	3.3%	0.0%	$ 2,071,065	$ -	$ 62,262,398	$ -	0.0%
Friday Health Plans*	5.6%	0.0%	$ 5,658,654	$ -	$ 100,746,894	$ -	0.0%
Harrington Kaiser Permanente*	5.2%	0.0%	$ 685,519	$ -	$ 13,213,514	$ -	0.0%
HealthSmart*	3.1%	0.0%	$ 18,726	$ -	$ 603,338	$ -	0.0%
Meritain Health*	4.1%	0.0%	$ 2,200,656	$ -	$ 53,911,635	$ -	0.0%
UCHealth Plan*	8.8%	0.0%	$ 885,047	$ -	$ 10,012,339	$ -	0.0%
UMR*	5.2%	0.0%	$ 23,197,179	$ -	$ 442,645,985	$ -	0.0%
USHEALTH Group*	0.3%	0.0%	$ 24,011	$ -	$ 7,920,643	$ -	0.0%

MEDICARE ADVANTAGE 2022							
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%	2.4%	$ 7,941,809	$ 4,159,330	$ 172,456,219	$ -	0.0%
Anthem	4.3%	20.2%	$ 3,157,774	$ 14,782,059	$ 73,182,073	$ 420,666	0.6%
Blue Cross Blue Shield of Illinois	21.7%	0.0%	$ 930	$ -	$ 4,288	$ -	0.0%
Denver Health	0.9%	0.0%	$ 631,829	$ -	$ 69,296,692	$ -	0.0%
Kaiser Permanente	14.7%	74.9%	$ 208,316,377	$ 1,064,415,656	$ 1,421,707,265	$ 1,064,415,656	74.9%
UnitedHealthcare**	22.8%	42.1%	$ 516,937,609	$ 952,764,494	$ 2,265,257,120	$ 448,183,086	19.8%
Humana*	6.2%	0.0%	$ 15,981,326	$ -	$ 256,266,062	$ -	0.0%

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TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022) – Continued

MEDICAID‡ 2022							
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	20.0%	40.6%	$ 1,660,669,515	$ 3,362,087,002	$ 8,285,717,562	$ 1,136,973,635	13.7%
Rocky Mountain Health Plans: RAE 1, MCO	8.8%	37.0%	$ 24,415,634	$ 102,531,579	$ 276,803,715	$ 88,805,256	32.1%
Carelon: RAEs 2 & 4 (Submitting on behalf of NHP and HCI)	22.2%	22.2%	$ 34,146,745	$ 34,146,745	$ 153,815,008	$ 59,603,350	38.8%
Colorado Access: RAEs 3 & 5	8.9%	58.7%	$ 36,207,667	$ 237,996,259	$ 405,450,408	$ 154,753,783	38.2%
Colorado Community Health Alliance: RAEs 6 & 7	14.3%	51.2%	$ 34,948,114	$ 124,997,049	$ 244,157,138	$ 124,997,048	51.2%
Denver Health: MCO	16.9%	0.0%	$ 43,522,829	$ -	$ 256,998,508	$ 141,657,344	55.1%

MEDICAID‡ by RAE 2022							
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: RAE 1	100.0%	100.0%	$ 165,283,461	$ 165,283,461	$ 165,283,461	$ 165,283,461	100.0%
Rocky Mountain Health Plan: RAE 1	8.8%	37.0%	$ 24,415,634	$ 102,531,579	$ 276,803,715	$ 88,805,256	32.1%
HCPF: RAE 2	100.0%	100.0%	$ 67,373,392	$ 67,373,392	$ 67,373,392	$ 67,373,392	100.0%
Carelon: RAE 2	37.8%	37.8%	$ 13,245,216	$ 13,245,216	$ 34,996,896	$ -	0.0%
HCPF: RAE 3	100.0%	100.0%	$ 237,768,109	$ 237,768,109	$ 237,768,109	$ 237,768,109	100.0%
Colorado Access: RAE 3	14.7%	60.3%	$ 32,844,098	$ 134,549,173	$ 223,104,610	$ 76,599,314	34.3%
HCPF: RAE 4	100.0%	100.0%	$ 118,015,276	$ 118,015,276	$ 118,015,276	$ 118,015,276	100.0%
Carelon: RAE 4	17.6%	17.6%	$ 20,901,529	$ 20,901,529	$ 118,818,112	$ 59,603,350	50.2%
HCPF: RAE 5	100.0%	100.0%	$ 143,750,299	$ 143,750,299	$ 143,750,299	$ 143,750,299	100.0%
Colorado Access: RAE 5	1.9%	54.1%	$ 2,350,381	$ 68,054,635	$ 125,685,653	$ 50,137,386	39.9%
HCPF: RAE 6	100.0%	100.0%	$ 160,713,869	$ 160,713,869	$ 160,713,869	$ 160,713,869	100.0%
Colorado Community Health Alliance: RAE 6	12.6%	55.5%	$ 16,826,175	$ 73,964,063	$ 133,353,522	$ 73,964,063	55.5%
HCPF: RAE 7	100.0%	100.0%	$ 139,511,698	$ 139,511,698	$ 139,511,698	$ 139,511,698	100.0%
Colorado Community Health Alliance: RAE 7	16.4%	45.9%	$ 18,121,939	$ 50,781,528	$ 110,552,158	$ 50,781,528	45.9%

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TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022) – Continued

CHP+ 2022							
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	12.0%	0.0%	$ 7,413,716	$ -	$ 61,740,212	$ -	0.0%
Denver Health	28.4%	0.0%	$ 1,465,224	$ -	$ 5,168,058	$ -	0.0%
Kaiser Permanente	26.0%	49.7%	$ 3,652,990	$ 7,000,824	$ 14,075,688	$ 7,000,824	49.7%
Rocky Mountain Health Plan	10.5%	0.5%	$ 1,400,334	$ 69,177	$ 13,344,311	$ 69,177	0.5%
Friday Health Plans*	9.6%	0.0%	$ 188,145	$ -	$ 1,959,926	$ -	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 is sourced from the CO ACPD.

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

Additional Notes:
Total medical expenditures do not include pharmacy.
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 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 (AM012 and AM016) 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 (AM014 and AM018) 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 not included 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

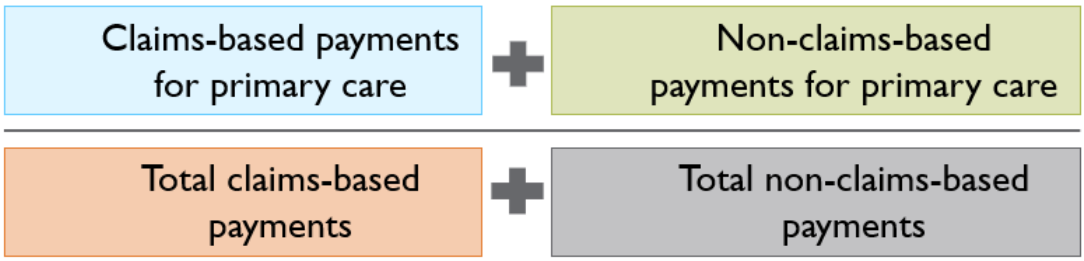
AmeriBen/IEC Group	FFS only
American Enterprise	FFS only
Employee Benefits Management Services Inc	FFS only
Friday Health Plans	FFS only
Harrington Kaiser Permanente	FFS only
HealthScope Benefits	FFS only
HealthSmart Benefit Solutions	FFS only
Humana*	FFS only
Meritain Health	FFS only
UCHealth Plan Administrators	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 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:



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

Taxonomy Code	Description	Taxonomy Type
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
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

Taxonomy Code	Description	Taxonomy Type
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

Taxonomy Code	Description	Taxonomy Type
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
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

Taxonomy Code	Description	Taxonomy Type
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
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/<

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
99412	PREVENTIVE COUNSELING GROUP
99420	Administration and interpretation of health risk assessments

Procedure Code	Description
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

Procedure Code	Description
3353F	MILD-MOD DEP SYMP BY DEPTOOL
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

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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).

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

Category Code	Value	Definition/Example
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).
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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