Second Regular Session
Seventy-third General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 22-0020.01 Yelana Love x2295

HOUSE BILL 22-1325

HOUSE SPONSORSHIP

Kennedy and Caraveo, Bacon, Bernett, Bird, Boesenecker, Cutter, Esgar, Exum, Froelich, Gonzales-Gutierrez, Hooton, Jodeh, Kipp, Lindsay, Lontine, McCluskie, Michaelson Jenet, Ricks, Titone, Valdez A., Valdez D., Weissman, Woodrow

SENATE SPONSORSHIP

Ginal,

House Committees
Health & Insurance
Appropriations

Senate Committees
Health & Human Services
Appropriations

A BILL FOR AN ACT

CONCERNING ALTERNATIVE PAYMENT MODELS FOR PRIMARY CARE SERVICES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires the division of insurance (division) to collaborate with the department of health care policy and financing, the department of personnel, and the primary care payment reform collaborative to develop and promulgate rules for alternative payment model parameters for primary care in the commercial health insurance market.

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOUSE
3rd Reading Unamended
April 25, 2022

HOUSE
Amended 2nd Reading
April 22, 2022

For health-care plans that are issued or renewed on or after January 1, 2025, the bill requires each carrier to ensure that the carrier's alternative payment models for primary care incorporate the aligned alternative payment model parameters created by the division.

The division is also required to develop and periodically update a set of core competencies around whole-person care delivery that primary care providers must meet in order to be eligible to receive practice support provided by the division and other value-based payments provided by a carrier. In updating the core competencies, the division shall consider recommendations provided by the primary care payment reform collaborative.

Once the division has 5 years of data, the division is required to analyze the data, produce a report on the data, and present the findings to the general assembly during the department of regulatory agencies' presentation to legislative committees at hearings held pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

With regard to the primary care payment reform collaborative (collaborative), the bill:

- Requires the collaborative to annually review the alternative payment models developed by the division and provide the division with recommendations on the models;
- Requires the collaborative to provide the division with recommendations on the core competencies developed by the division; and
- Adjusts the date on which the collaborative must deliver its annual reports.

With regard to the all-payer health claims database, the bill:

- Requires the administrator to include in the primary care spending report data related to the aligned quality measure set determined by the division; and
- Adjusts the date on which the annual reports are due.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 10-16-155 as follows:

10-16-155. Alternative payment model parameters - parameters to include an aligned quality measure set - primary care providers - requirement for carriers to submit alternative payment models to the division - legislative declaration - report - rules -

definitions. (1) **Legislative declaration.** THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) FEE-FOR-SERVICE HEALTH-CARE PAYMENT MODELS HAVE LONG BEEN CRITICIZED FOR INCENTIVIZING A HIGHER VOLUME OF HEALTH-CARE SERVICES RATHER THAN A GREATER VALUE, PERPETUATING HEALTH DISPARITIES BY FAILING TO MEET THE NEEDS OF PATIENTS WITH THE HIGHEST BARRIERS TO CARE;

(b) UNDERINVESTMENT IN PRIMARY CARE HAS CREATED BARRIERS TO ACCESS THAT HAVE DETERRED PATIENTS FROM SEEKING TIMELY PREVENTATIVE CARE AND MADE IT MORE DIFFICULT FOR PROVIDERS TO EXPAND TEAM-BASED, COMPREHENSIVE CARE MODELS THAT IMPROVE HEALTH OUTCOMES AND REDUCE DOWNSTREAM COSTS;

(c) NUMEROUS EFFORTS HAVE BEEN MADE TO MOVE OUR HEALTH-CARE SYSTEM FROM A FEE-FOR-SERVICE MODEL TO A VALUE-BASED PAYMENT MODEL, INCLUDING COMPREHENSIVE PRIMARY CARE PLUS, PATIENT-CENTERED MEDICAL HOMES, THE STATE INNOVATION MODEL, THE MULTI-PAYER COLLABORATIVE, THE HEALTH-CARE PAYMENT LEARNING AND ACTION NETWORK, AND THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE;

(d) VALUE-BASED PAYMENT MODELS ALSO HAVE NOT ALWAYS RECOGNIZED THE UNIQUE NATURE OF PEDIATRICS, WHICH REQUIRES APPROACHES THAT REFLECT SPECIFIC NEEDS IN PEDIATRIC POPULATIONS;

(e) COLORADO IS PART OF THE CENTERS FOR MEDICARE AND MEDICAID INNOVATION'S STATE TRANSFORMATION COLLABORATIVE PROJECT, WHICH CREATES AN OPPORTUNITY FOR ALIGNMENT BETWEEN MEDICARE, MEDICAID, AND COMMERCIAL INSURANCE PLANS;

(f) BY ESTABLISHING ALIGNED PARAMETERS FOR PRIMARY CARE

ALTERNATIVE PAYMENT MODELS, INCLUDING QUALITY METRICS AND PROSPECTIVE PAYMENTS, IT IS THE INTENT OF THE GENERAL ASSEMBLY TO:

(I) IMPROVE HEALTH-CARE QUALITY AND OUTCOMES IN A MANNER THAT REDUCES HEALTH DISPARITIES AND ACTIVELY ADVANCES HEALTH EQUITY;

(II) INCREASE THE NUMBER OF COLORADANS WHO RECEIVE THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME AT AN AFFORDABLE COST;

(III) ENCOURAGE MORE PRIMARY CARE PRACTICES TO PARTICIPATE IN ALTERNATIVE PAYMENT MODELS; PROVIDE CONSISTENT EXPECTATIONS; REDUCE ADMINISTRATIVE BURDENS; AND HELP SMALL, RURAL, AND INDEPENDENT PRACTICES STAY INDEPENDENT;

(IV) SUPPORT COLLABORATION BETWEEN PHYSICAL AND BEHAVIORAL HEALTH-CARE SERVICES AND LOCAL PUBLIC HEALTH AGENCIES AND HUMAN SERVICES DEPARTMENTS TO IMPROVE POPULATION HEALTH; AND

(V) FACILITATE PRACTICE TRANSFORMATION TOWARD INTEGRATED, WHOLE-PERSON CARE, SO PRACTICES CAN COORDINATE CARE AND ADDRESS SOCIAL DETERMINANTS OF HEALTH SUCH AS HOUSING STABILITY, SOCIAL SUPPORT, AND FOOD INSECURITY.

(2) AS USED IN THIS SECTION:

(a) "ALIGNED QUALITY MEASURE SET" MEANS ANY SET OF NATIONALLY RECOGNIZED, EVIDENCE-BASED QUALITY MEASURES DEVELOPED FOR PRIMARY CARE PROVIDER CONTRACTS THAT INCORPORATE QUALITY MEASURES INTO THE PAYMENT TERMS.

(b) "ALTERNATIVE PAYMENT MODEL" MEANS A HEALTH-CARE PAYMENT METHOD THAT USES FINANCIAL INCENTIVES, INCLUDING

SHARED-RISK PAYMENTS, POPULATION-BASED PAYMENTS, AND OTHER PAYMENT MECHANISMS, TO REWARD PROVIDERS FOR DELIVERING HIGH-QUALITY AND HIGH-VALUE CARE.

(c) "PRIMARY CARE" OR "PRIMARY CARE SERVICES" MEANS THE PROVISION OF INTEGRATED, EQUITABLE, AND ACCESSIBLE HEALTH-CARE SERVICES BY CLINICIANS WHO ARE ACCOUNTABLE FOR ADDRESSING A LARGE MAJORITY OF PERSONAL HEALTH-CARE NEEDS, DEVELOPING A SUSTAINED PARTNERSHIP WITH PATIENTS, AND PRACTICING IN THE CONTEXT OF FAMILY AND COMMUNITY.

(d) "PRIMARY CARE PAYMENT REFORM COLLABORATIVE" MEANS THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE CONVENED PURSUANT TO SECTION 10-16-150.

(e) "PRIMARY CARE PROVIDER" OR "PROVIDER" MEANS THE FOLLOWING PROVIDERS, WHEN THE PROVIDER IS PRACTICING GENERAL PRIMARY CARE IN AN OUTPATIENT SETTING:

(I) FAMILY MEDICINE PHYSICIANS;

(II) GENERAL PEDIATRIC PHYSICIANS AND ADOLESCENT MEDICINE PHYSICIANS;

(III) GERIATRIC MEDICINE PHYSICIANS;

(IV) INTERNAL MEDICINE PHYSICIANS, EXCLUDING INTERNISTS WHO SPECIALIZE IN AREAS SUCH AS CARDIOLOGY, ONCOLOGY, AND OTHER COMMON INTERNAL MEDICINE SPECIALTIES BEYOND THE SCOPE OF GENERAL PRIMARY CARE;

(V) OBSTETRICS AND GYNECOLOGY PHYSICIANS;

(VI) ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS;

(VII) BEHAVIORAL HEALTH PROVIDERS, INCLUDING

PSYCHIATRISTS, PROVIDING MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES WHEN INTEGRATED INTO A PRIMARY CARE SETTING; AND

(VIII) OTHER PROVIDER TYPES SPECIFIED BY THE COMMISSIONER BY RULE.

(f) "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.

(g) "RISK ADJUSTMENT" MEANS AN ADJUSTMENT TO THE PAYMENT FOR PRIMARY CARE SERVICES THAT IS DETERMINED BY QUANTIFYING A PATIENT'S COMPLEXITY BASED ON OBSERVABLE DATA, ADDRESSING THE TIME AND EFFORT PRIMARY CARE PROVIDERS SPEND IN CARING FOR PATIENTS OF DIFFERENT ANTICIPATED HEALTH NEEDS, AND INCLUDING SOCIAL FACTORS SUCH AS HOUSING INSTABILITY, BEHAVIORAL HEALTH ISSUES, DISABILITY, AND NEIGHBORHOOD-LEVEL STRESSORS.

(3) (a) (I) THE DIVISION SHALL DEVELOP ALTERNATIVE PAYMENT MODEL PARAMETERS BY RULE FOR PRIMARY CARE SERVICES OFFERED THROUGH HEALTH BENEFIT PLANS.

(II) THE DIVISION SHALL DEVELOP THE PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS IN PARTNERSHIP WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, THE DEPARTMENT OF PERSONNEL, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE, AND CARRIERS

AND PROVIDERS PARTICIPATING IN ALTERNATIVE PAYMENT MODELS IN ORDER TO OPTIMIZE AND CREATE POSITIVE INCENTIVES FOR ALIGNMENT BETWEEN HEALTH BENEFIT PLANS OFFERED BY CARRIERS AND PUBLIC PAYERS AND ACHIEVE THE FOLLOWING OBJECTIVES:

(A) INCREASED ACCESS TO HIGH-QUALITY PRIMARY CARE SERVICES;

(B) IMPROVED HEALTH OUTCOMES AND REDUCED HEALTH DISPARITIES;

(C) IMPROVED PATIENT AND FAMILY ENGAGEMENT AND SATISFACTION;

(D) INCREASED PROVIDER SATISFACTION AND RETENTION; AND

(E) INCREASED PRIMARY CARE INVESTMENT THAT RESULTS IN INCREASED HEALTH-CARE VALUE.

(III) AT A MINIMUM, THE ALTERNATIVE PAYMENT MODEL PARAMETERS MUST:

(A) INCLUDE TRANSPARENT RISK ADJUSTMENT PARAMETERS THAT ENSURE THAT PRIMARY CARE PROVIDERS ARE NOT PENALIZED FOR OR DISINCENTIVIZED FROM ACCEPTING VULNERABLE, HIGH-RISK PATIENTS AND ARE REWARDED FOR CARING FOR PATIENTS WITH MORE SEVERE OR COMPLEX HEALTH CONDITIONS AND PATIENTS WHO HAVE INADEQUATE ACCESS TO AFFORDABLE HOUSING, HEALTHY FOOD, OR OTHER SOCIAL DETERMINANTS OF HEALTH;

(B) UTILIZE PATIENT ATTRIBUTION METHODOLOGIES THAT ARE TRANSPARENT AND REATTRIBUTE PATIENTS ON A REGULAR BASIS, WHICH MUST ENSURE THAT POPULATION-BASED PAYMENTS ARE MADE TO A PATIENT'S PRIMARY CARE PROVIDER RATHER THAN OTHER PROVIDERS WHO MAY ONLY OFFER SPORADIC PRIMARY CARE SERVICES TO THE PATIENT AND

INCLUDE A PROCESS FOR CORRECTING MISATTRIBUTION THAT MINIMIZES THE ADMINISTRATIVE BURDEN ON PROVIDERS AND PATIENTS;

(C) INCLUDE A SET OF CORE COMPETENCIES AROUND WHOLE-PERSON CARE DELIVERY THAT PRIMARY CARE PROVIDERS SHOULD INCORPORATE IN PRACTICE TRANSFORMATION EFFORTS TO TAKE FULL ADVANTAGE OF VARIOUS TYPES OF ALTERNATIVE PAYMENT MODELS; AND

(D) REQUIRE AN ALIGNED QUALITY MEASURE SET THAT CONSIDERS THE QUALITY MEASURES AND THE TYPES OF QUALITY REPORTING THAT CARRIERS AND PROVIDERS ARE ENGAGING IN UNDER CURRENT STATE AND FEDERAL LAW SO LONG AS THE QUALITY MEASURE SET INCLUDES QUALITY MEASURES THAT ARE PATIENT-CENTERED AND PATIENT-INFORMED AND ADDRESS: PEDIATRIC, PERINATAL, AND OTHER CRITICAL POPULATIONS; THE PREVENTION, TREATMENT, AND MANAGEMENT OF CHRONIC DISEASES; AND THE SCREENING FOR AND TREATMENT OF BEHAVIORAL HEALTH CONDITIONS.

(IV) THE DIVISION SHALL ANNUALLY CONSIDER THE RECOMMENDATIONS ON THE ALTERNATIVE PAYMENT MODEL PARAMETERS AND POSITIVE CARRIER INCENTIVE ARRANGEMENTS PROVIDED BY THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE AND BY CARRIERS AND PROVIDERS PARTICIPATING IN ALTERNATIVE PAYMENT MODELS BUT NOT PARTICIPATING IN THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE.

(V) THE ALTERNATIVE PAYMENT MODELS MUST ALSO:

(A) ENSURE THAT ANY RISK OR SHARED SAVINGS ARRANGEMENTS MINIMIZE SIGNIFICANT FINANCIAL RISK FOR PROVIDERS WHEN PATIENT COSTS EXCEED WHAT CAN BE PREDICTED;

(B) INCENTIVIZE THE INTEGRATION OF BEHAVIORAL HEALTH-CARE SERVICES THROUGH LOCAL PARTNERSHIPS OR THE HIRING OF IN-HOUSE

BEHAVIORAL HEALTH STAFF;

(C) INCLUDE PROSPECTIVE PAYMENTS TO PROVIDERS FOR HEALTH PROMOTION, CARE COORDINATION, HEALTH NAVIGATION, CARE MANAGEMENT, PATIENT EDUCATION, AND OTHER SERVICES DESIGNED TO PREVENT AND MANAGE CHRONIC CONDITIONS AND ADDRESS SOCIAL DETERMINANTS OF HEALTH;

(D) RECOGNIZE THE VARIOUS LEVELS OF ADVANCEMENT OF ALTERNATIVE PAYMENT MODELS AND PRESERVE OPTIONS FOR CARRIERS AND PROVIDERS TO NEGOTIATE MODELS SUITED TO THE COMPETENCIES OF EACH INDIVIDUAL PRIMARY CARE PRACTICE; AND

(E) SUPPORT EVIDENCE-BASED MODELS OF INTEGRATED CARE THAT FOCUS ON MEASURABLE PATIENT OUTCOMES.

(b) (I) EXCEPT AS PROVIDED IN SUBSECTION (3)(b)(II) OF THIS SECTION, FOR HEALTH BENEFIT PLANS THAT ARE ISSUED OR RENEWED ON OR AFTER JANUARY 1, 2025, A CARRIER SHALL ENSURE THAT ANY ALTERNATIVE PAYMENT MODELS FOR PRIMARY CARE INCORPORATE THE PARAMETERS ESTABLISHED IN THIS SUBSECTION (3).

(II) FOR MANAGED CARE PLANS THAT ARE ISSUED OR RENEWED ON OR AFTER JANUARY 1, 2025, AND IN WHICH SERVICES ARE PRIMARILY OFFERED THROUGH ONE MEDICAL GROUP CONTRACTED WITH A NONPROFIT HEALTH MAINTENANCE ORGANIZATION, A CARRIER SHALL ENSURE THAT ANY ALTERNATIVE PAYMENT MODELS FOR PRIMARY CARE INCORPORATE THE ALIGNED QUALITY MEASURE SET ESTABLISHED IN SUBSECTION (3)(a)(III)(D) OF THIS SECTION.

(c) BY DECEMBER 1, 2023, THE COMMISSIONER SHALL PROMULGATE RULES DETAILING THE REQUIREMENTS FOR ALTERNATIVE PAYMENT MODELS PARAMETERS ALIGNMENT. THE DIVISION SHALL ALLOW

CARRIERS THE FLEXIBILITY TO DETERMINE WHICH NETWORK PROVIDERS AND PRODUCTS ARE BEST SUITED TO ACHIEVE THE GOALS AND INCENTIVES SET BY THE DIVISION IN THIS SECTION.

(4) ONCE THE DIVISION HAS FIVE YEARS OF DATA, THE DIVISION SHALL ANALYZE THE DATA AND, SUBJECT TO AVAILABLE APPROPRIATIONS, PRODUCE A REPORT ON THE DATA THAT AGGREGATES DATA ACROSS ALL CARRIERS. THE DIVISION SHALL PRESENT THE FINDINGS TO THE GENERAL ASSEMBLY DURING THE DEPARTMENT OF REGULATORY AGENCY'S PRESENTATION TO LEGISLATIVE COMMITTEES AT HEARINGS HELD PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2 OF ARTICLE 7 OF TITLE 2.

(5) THE DIVISION SHALL RETAIN A THIRD-PARTY CONTRACTOR TO DESIGN AN EVALUATION PLAN FOR THE IMPLEMENTATION OF PRIMARY CARE ALTERNATIVE PAYMENT MODELS BY CARRIERS. THE PLAN MUST INCLUDE ALTERNATIVE PAYMENT MODELS IMPLEMENTED BY CARRIERS AND PROVIDERS PRIOR TO JANUARY 1, 2025. IN DESIGNING THE EVALUATION PLAN, THE CONTRACTOR SHALL, TO THE EXTENT PRACTICABLE:

(a) REPORT ON THE EFFECTS OF THE ALTERNATIVE PAYMENT MODELS ON POPULATIONS THAT HAVE HISTORICALLY FACED SYSTEMIC BARRIERS TO HEALTH ACCESS;

(b) REPORT ON THE EFFECTS OF THE ALTERNATIVE PAYMENT MODELS ON PRIMARY CARE PROVIDERS, PRIMARY CARE PRACTICES, AND PRIMARY CARE PRACTICES' ABILITY TO STAY INDEPENDENT, INCLUDING THE EFFECTS ON PRIMARY CARE PROVIDERS' ADMINISTRATIVE BURDENS; AND

(c) CONSIDER AND IDENTIFY ANY AVAILABLE DATA SOURCES OR DATA LIMITATIONS THAT SHOULD BE INCLUDED OR ADDRESSED IN THE EVALUATION PLAN TO ALLOW FOR MEASUREMENT AND REPORTING ON THE EFFECTS OF THE PRIMARY CARE PAYMENT MODEL PARAMETERS ON SUCH POPULATIONS, INCLUDING THE COLLECTION OR ANALYSIS OF DATA THAT IS DISAGGREGATED, AT A MINIMUM, BY RACE, ETHNICITY, SEX, GENDER, AND AGE.

(6) TO SUPPORT THE IMPLEMENTATION OF ALIGNED PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS BY CARRIERS, THE DIVISION SHALL RETAIN A THIRD-PARTY CONTRACTOR TO PROVIDE TECHNICAL ASSISTANCE TO CARRIERS. THE DIVISION SHALL WORK WITH CARRIERS TO DETERMINE THE NATURE AND SCOPE OF THE TECHNICAL ASSISTANCE AND OTHER SUPPORTS THAT WILL BEST FACILITATE THE IMPLEMENTATION OF ALIGNED PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS.

(7) THE COMMISSIONER MAY PROMULGATE RULES NECESSARY TO IMPLEMENT THIS SECTION.

(8) ANY INFORMATION SUBMITTED TO THE DIVISION IN ACCORDANCE WITH THIS SECTION IS SUBJECT TO PUBLIC INSPECTION ONLY TO THE EXTENT ALLOWED UNDER THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24. THE DIVISION SHALL NOT DISCLOSE ANY TRADE SECRET OR CONFIDENTIAL OR PROPRIETARY INFORMATION TO ANY PERSON WHO IS NOT OTHERWISE AUTHORIZED TO ACCESS THE INFORMATION, INCLUDING ANY CONTRACTUAL INFORMATION BETWEEN CARRIERS AND PROVIDERS.

SECTION 2. In Colorado Revised Statutes, 10-16-150, **amend** (1)(h), (1)(i)(IV), and (4); and **add** (1)(j) and (2.5)

10-16-150. Primary care payment reform collaborative -

created - powers and duties - report - definition - repeal. (1) The commissioner shall convene a primary care payment reform collaborative to:

(h) Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care; ~~and~~

(i) Develop and share best practices and technical assistance to health insurers and consumers, which may include:

(IV) The delivery of advanced primary care that facilitates appropriate utilization of services in appropriate settings; AND

(j) ANNUALLY REVIEW THE ALTERNATIVE PAYMENT MODELS DEVELOPED BY THE DIVISION PURSUANT TO SECTION 10-16-155 (3) AND PROVIDE THE DIVISION WITH RECOMMENDATIONS ON THE MODELS.

(2.5) IN CARRYING OUT THE DUTIES OF SUBSECTION (1)(j) OF THIS SECTION, IN ADDITION TO THE MEMBERS OF THE COLLABORATIVE DESCRIBED IN SUBSECTION (2) OF THIS SECTION, THE COMMISSIONER SHALL INCLUDE HEALTH INSURERS AND HEALTH-CARE PROVIDERS ENGAGED IN A RANGE OF ALTERNATIVE PAYMENT MODELS.

(4) By ~~December 15, 2019~~ FEBRUARY 15, 2023, and by each ~~December~~ FEBRUARY 15 thereafter, the primary care payment reform collaborative shall publish primary care payment reform recommendations, informed by the primary care spending report prepared in accordance with section 25.5-1-204 (3)(c). The collaborative shall make the report available electronically to the general public.

SECTION 3. In Colorado Revised Statutes, 25.5-1-204, **amend** (3)(c)(I) introductory portion and (3)(c)(II) as follows:

25.5-1-204. Advisory committee to oversee the all-payer health

claims database - creation - members - duties - legislative declaration - rules - report. (3) (c) (I) By ~~August 31, 2019~~ NOVEMBER 15, 2022, and by each ~~August 31~~ NOVEMBER 15 thereafter, SUBJECT TO AVAILABLE APPROPRIATIONS, the administrator shall provide a primary care spending report to the commissioner of insurance for use by the primary care payment reform collaborative established in section 10-16-150 regarding primary care spending:

(II) The report prepared in accordance with this subsection (3)(c) must include:

(A) The percentage of the medical expenses allocated to primary care;

(B) 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; AND

(C) DATA RELATED TO THE ALIGNED QUALITY MEASURE SET DETERMINED BY THE DIVISION OF INSURANCE IN ACCORDANCE WITH SECTION 10-16-155 (3).

SECTION 4. Appropriation. (1) For the 2022-23 state fiscal year, $56,328 is appropriated to the department of personnel and administration for use by the division of human resources. This appropriation is from the general fund. To implement this act, the division may use this appropriation as follows:

(a) $49,048 for personal services related to state agency services, which amount is based on an assumption that the division will require an additional 0.7 FTE; and

(b) $7,280 for operating expenses related to state agency services.

SECTION 5. Act subject to petition - effective date. This act

takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.