COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care and APM Implementation Plan Guidance and FAQ

*** * * Revised June 20, 2024 * * ***

Colorado Regulation 4-2-72

1. When are annual Primary Care and AMP Implementation Plans due?

Primary Care and APM Implementation Plans (IPs) must be submitted to the Division **no later than July 31, 2024**. All required components of the Primary Care and APM IPs should be emailed directly to Tara Smith, Primary Care and Affordability Director, at tara.smith@state.co.us.

2. What timeframe should be covered by the Primary Care and AMP Implementation Plans?

The Primary Care and APM IPs are structured to capture a carrier's current and future plans for primary care and APM expenditures. They are intentionally "forward-looking" documents and should be completed as such.

For the **Primary Care IP** submission due on July 31, 2024, carriers should submit a written narrative that includes a description of the carrier's current and future plans to address each of the required elements in Section 1 of Appendix B (see regulation 4-2-72). For Section 2 of Appendix B, carriers should submit a primary care budget template that includes expected or projected spending for calendar years 2024, 2025, 2026.

For the **APM IP** submission due on July 31, 2024, carriers should submit a written narrative that includes a description of the carrier's current and future plans to address each of the required elements in Section 1 of Appendix C (see Regulation 4-2-72). For Section 2, carriers should submit an APM expenditure worksheet that indicates spending by LAN category (as both a dollar amount and a percentage of total annual spending) expected or projected to occur in calendar year 2025.

3. How is the Division defining primary care and APMs?

For the purposes of Primary Care and APM IP reporting, carriers should use the following definitions, as contained in Section 4 of Regulation 4-2-72:

- "Alternative Payment Model" or "APM" means, for the purposes of this regulation, health care payment methods that use financial incentives to promote greater value - including higher quality care at lower costs - for patients, purchasers, and providers. Unlike traditional fee for service payments, APMs utilize cost and quality control strategies that benefit consumers by increasing the value of care delivered and, ultimately, the affordability of care.

- "APM framework" means, for the purposes of this regulation, the APM Framework published by the Health Care Payment Learning and Action Network.
- "Primary care" means, for the purposes of this regulation, 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.

4. Which payments (claims-based and otherwise) should carriers include in the primary care and APM numerators?

All claims and non-claims-based payments for primary care should be included in the primary care expenditures numerator. Likewise, all claims and non-claims-based payments that a carrier considers part of APMs should be included in the APM expenditures numerator. This includes payments for shared savings, as well as all payments in the Health Care Payment Learning and Action Network (LAN) Framework Category 2 and higher.

5. What baseline will be used to calculate the 1% point annual increases in primary care spending in 2022 and 2023?

The Division will use a carrier's percentage of total medical expenditures allocated to primary care for the calendar year 2021 as the baseline for calculating the 1% point annual increase in 2022 and 2023.

The Division will use health care expenditure data from the entire 2022 year and the entire 2023 year to determine whether the annual 1% point increase has been met. For example, a carrier will have met the 1% point increase if the percentage of total medical expenditures for all of 2022 is 1% point higher than the percentage of total medical expenditures that were allocated to primary care in 2021.

NOTE: Compliance with the 1% point annual increase will be determined based on the data carriers annually submit to the Colorado All-Payer Claims Database (APCD) regarding primary care and total medical expenditures made through paid claim amounts and non-claims payments. Additional information about the required data submission is available on CIVHC's Submitter Resources webpage (see specifically the CIVHC Data Submission Guide and APM Data Submission Manual).

6. **How will the Division address confidential or proprietary information contained in the Primary Care or AMP Implementation Plans?**

In addition to the complete (unredacted) information that carriers must submit, the Division will allow carriers to submit abbreviated "public" versions of the Primary Care or APM IPs with

confidential information redacted. The public version of the documents must be submitted IN ADDITION TO, not in lieu of, the carriers' more detailed filing with the Division.

Carriers are not required to submit a second, public version of the documents, but if they choose to do so the public version must contain the following information:

Primary Care Implementation Plan:

Section 1

- The written narrative submitted for Section 1 of Appendix B must contain a description of the carrier's strategies for each of the required elements in subsections a, b, and c. Programs or initiatives should be described in sufficient detail to provide a clear understanding of the components and/or anticipated impacts.

  Participation or enrollment numbers, for providers or members, and/or specific contractual arrangements with providers may be redacted from the public version.

Section 2

- Carriers may provide an overall percentage of the amount of primary care expenditures made through Fee-for-Services payments and the percentage of primary care expenditures may through Non-Claims Based Payments or APMs;

- For carriers that choose to report percentage amounts, the following modifications will be allowed on the public version of the Primary Care Expenditures Budget Template:

  - "Number of Primary Care Visits" - this line item may be redacted;

  - "Fee-for-Service Payments"- the percentage of expenditures made through FFS payments may be included on the TOTAL line item, in lieu of a dollar amount; the line items for "Increase in E&M codes" and/or "Other" may be redacted;

  - "Other Expenditures" - the percentage of expenditures made through non-claims-based expenditures or APMs may be included on the TOTAL line item, in lieu of a dollar figure; carriers must still indicate the categories or types of activities that are currently or will be supported through non-claims-based payments or APMs, which can be expressed as a percentage.

APM Implementation Plan:

Section 1

- The written narrative submitted for Section 1 of Appendix C must contain a description of the carrier's strategies for each of the required elements in subsections A through F. Programs or initiatives should be described in sufficient detail to provide a clear understanding of the components and/or anticipated impacts.

Participation or enrollment numbers, for providers or members, and/or contractual arrangements with specific providers may be redacted from the public version.

Section 2

- Carriers may provide the percentage of annual total spending that is expected to occur in each category of spending for the APM framework only; dollar figures may be redacted from the public version.