Colorado's Primary Care Payment Reform Collaborative

Fifth Annual Recommendations Report

February 2024

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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.

//BEGINNING OF BREAKOUT BOX: Definitions 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

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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[1] 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:

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~~at the system level~~ 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 t~~T~~hese investments through ~~must be supported by~~ prospective value based payments that adequately support team-based care delivery models ~~that involve an array of behavioral health providers, care coordination activities,~~

[1] 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 multi-payer alignment around the recommendations in this report and additional strategies to strengthen primary care.

~~and efforts to develop and connect referrals across the spectrum of integrated care delivery~~.

Recommendation 2: Payers should support and promote~~Payments for~~ team-based care ~~should support and promote~~ care delivery strategies that incorporate non-clinician 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 c~~C~~linician and non-clinician providers working on integrated care teams ~~should be supported and incentivized~~ 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 p~~P~~rimary care providers and members of integrated care teams ~~should be supported~~ 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.

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.

//BREAKOUT BOX : 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

Multi-payer alignment. Multi-payer 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.

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.

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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 an important dimension 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 these 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~~1~~ Colorado Health Access Survey, over ~~about~~ 875,000~~724,000~~ Coloradans age 18 and older reported not getting needed mental health care or counseling services and about 107,000~~80,000~~ 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). Behavioral health stigma can take many forms and is

of particular concern for Colorado's rural and underserved communities who often also face limited access to care and more difficulty seeking care confidentially due to intimate community size.

Table 1: Stigma is a common reasons for skipping needed behavioral health services		
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%**		

Source: 2023 Colorado Health Access Survey

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 various care teams informed about their care plan~~communication with various care teams~~. 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." 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.). 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. 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). 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).[2,3,4]

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

2020	2021	2022
12.0%	13.6%	15.1%

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

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.[5]

The Collaborative has also consistently supported increased proportions of prospective payments to providers/practices.[6] These payments allow for greater flexibility to provide

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

[3] 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.

[4] 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.

[5] 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.

[6] 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

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.[7]

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.

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[8], 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.

Current Payment Landscape. A variety of payers in Colorado are working to implement strategies to support behavioral health integration. Several commercial payers in Colorado

population to provide predictable revenue and flexibility to manage care within a budget to optimize patient outcomes and better manage population health.

[7] See Appendix C

[8] 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 towards less deficit-based frameworks.

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.[9]

Challenges and Opportunities. Challenges, gaps, and needs within behavioral health integration in Colorado include sustainability, support for practice integration, and unclear mandates for large employers and self-funded plans.

Despite successful examples 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, however these plans cannot be directly influenced by this report's recommendations. CIVHC estimates that self-funded plans are held by approximately half of Coloradans who have commercially insured health care plans. 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

[9] 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.

collaboration between public and private healthcare 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, 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 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, ~~possible future service additions should be taken into account~~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 clinicians and non-clinicians that 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 team-based care delivery strategies that incorporate non-clinician 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.

//BREAKOUT BOX: 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
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> //END BREAKOUT BOX

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." 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 Non-Clinician providers. In integrated care delivery settings, non-clinical 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 non-clinician workforce means not only establishing payment for current non-clinician roles, but also bolstering the overall development pipeline of this workforce. Peer support specialists, community health professionals, and non-clinical social workers are vital to ensuring whole-person health care is not only attainable, but sustainable. Additionally, ~~S~~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.

//BEGINNING OF BREAKOUT BOX: Examples of Non-Clinician Providers//

Several types of non-clinician 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[10]

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)

[10] This definition was selected to align with community health worker initiatives at the Colorado Department of Health and Environment (CDPHE) and with the Department of Health Care Policy and Financing (HCPF).

Promotores or Promotoras de Salud is a Spanish term 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 non-clinician providers, the Collaborative supports the community health initiatives underway at the Colorado Department of Public and Health Environment (CDPHE) and the Colorado Department of Health Policy and Financing (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 non-clinician roles within a care team.

//END OF BREAKOUT BOX//

Current Payment Support Landscape. Payment for community health workers and other non-clinician 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 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) authorizing 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.

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 non-clinician 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 non-clinician 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. Patient preferences must also be prioritized, with some individuals preferring in-person care over virtual consultations. Consumer advocates have heard from patients and providers that an over-reliance 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 SUDs, 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

Clinician and non-clinician providers working on integrated care teams should be supported and incentivized 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 investments must be made to support and sustain a robust network of community and social services that can address and resolve social needs.

//BREAKOUT BOX: Definitions:

> **Health-related social needs.** Health-related social needs are an individual's and family's adverse social conditions (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

//END BREAKOUT BOX//

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 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.

//BREAKOUT BOX: 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. 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. 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 service 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.

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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 non-clinician 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 widely vary 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 for 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% versus 4.4%, respectively). 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

Primary care providers and members of integrated care teams should be supported 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.

//BREAKOUT BOX: 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.

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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. The Collaborative focused much of its discussion on areas for support and investment, but less time discussing how to measure whether the outcomes for individuals are improved as a result of that investment. Given the goals of the Collaborative include ensuring payers are able to see the benefits of their investments in the form of health outcomes and member experience, future work should include ensuring providers are accountable for improving outcomes and experience for Coloradans.

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.

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.**

Multi-Payer Alignment	• **In the Second Annual Report (2020), the Collaborative highlighted the importance of multi-payer 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 multi-stakeholder 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 the Division's subsequent promulgation of Regulation 4-2-96.** • **Colorado's work around multi-payer 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