Colorado's Primary Care Payment Reform Collaborative

Sixth Annual Recommendations Report

DRAFT 1 (12/6/2024)

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Acknowledgements

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The Colorado Health Institute facilitated the preparation and publication of this report.

Executive Summary

The Primary Care Payment Reform Collaborative (the Collaborative) is pleased to present this sixth annual recommendations report. Since its creation in 2019, the Collaborative has focused on the goal of strengthening primary care through increased investment and the adoption of value-based payment models, to support and promote the delivery of high-quality, person-centered care that improves health outcomes for all Coloradans. This year, the Collaborative has chosen to focus on three topics: marketplace dynamics that affect primary care practices, new technology such as artificial intelligence (AI), and health equity. Health equity is a long-standing priority for the Collaborative and marketplace dynamics and AI are two timely and influential topics affecting primary care.

Over the last six years, the Collaborative has made strides in advancing primary care investment through value-based payment in Colorado, and has typically focused its recommendations on strategies related to care delivery, including integrated care delivery,

and payment mechanisms. During that time, however, Colorado and the nation have seen some significant shifts in the primary care landscape. In this report, the Collaborative has chosen to examine two key trends - , namely marketplace dynamics and AI - that have and will continue to shape primary care, and therefore the Collaborative's work. Marketplace dynamics, including increasing consolidation and private equity investment, are having large impacts on providers, patients, and payers, prompting concerns about the sustainability of independent practices, real and potential negative impacts on patient care, and increased prices. AI is an emerging new tool that holds great promise but also raises concerns about how these technologies are developed and deployed In this report, the Collaborative identifies and discusses concerns and opportunities for both topics.

This report also revisits and expands on recommendations related to health equity, a core principle that continues to guide the Collaborative's work. This year, the Collaborative focuses on tracking the progress of value-based payments to address health disparities.

Recommendation 1: <final text here>

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

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. Colorado has been an early leader in primary care payment reform among states. When the Collaborative was established in 2019, Colorado was one of only a handful of states engaged in strategies to increase investments in primary care. Now, thirteen states are pursuing such policies.

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+).
- **Partner** with the Department of Health Care Policy and Financing to align primary care quality models with Collaborative's recommendations through the Accountable Care Collaborative and other alternative payment models
- **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 the 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 eleven meetings in 2024. 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 XXXXXXXXXX.

Introduction and Key Context

This year's report builds upon previous recommendations from the Collaborative's five existing annual reports.

Summary of Previous Annual Reports

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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.

Fifth Annual Report | 2023

Payment for behavioral health integration. Behavioral health integration should be intentionally supported as a key component of increased investment in primary care.

Workforce for behavioral health integration. Payers should support and promote care delivery strategies that incorporate no clinician providers as part of the care delivery team to holistically address whole-person and whole-family health needs.

Health-related social needs screening. Payers should support and incentivize clinician and nonclinician providers working on integrated care teams to conduct health-related social needs screening, referrals, and successful connections to needed services.

Medication-assisted treatment. Payers should support primary care providers and members of integrated care teams in offering medication-assisted treatment (MAT) services through adequate payment that reflects the additional time and training needed to address complex patient needs.

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Addressing Key Context Surrounding Primary Care

The Collaborative believes primary care is foundational to a highly functioning health care delivery system, and reaffirms its north star that increased investment in primary care is needed to improve patient outcomes, improve health equity, and reduce health care

costs. Primary care remains an area of underinvestment both at the national and state level[1]. Additional investment is needed now more than ever as primary care is experiencing workforce challenges fueled by physician burnout and challenges recruiting staff to rural areas, continued need to address equity through primary care, challenges with affordability and access to health care across Colorado heightened by the end of continuous Medicaid coverage through the Public Health Emergency, and the tenuous financial state of rural and independent practices.

Over the last six years, the Collaborative has made strides in advancing primary care investment through value-based payment in Colorado. The Collaborative's recommendations have helped shape policies within the state, such as the development of a statutory definition of primary care, and informed the development of new regulatory tools, including a primary care investment target for private payers and aligned parameters for primary care alternative payment models (APMs). Collaborative members have offered insights on the methodology for collecting and analyzing primary care and alternative payment model (APM) spending data. The Collaborative has also taken an active role in addressing emergent issues, notably the COVID-19 pandemic, issuing recommendations for the use of telehealth in primary care, a modality that remains important to ensuring access to care. The Collaborative also issued recommendations specific to the integration of behavioral health into primary care, recognizing the continuing rise of behavioral health needs, especially among children and youth, in Colorado.

The work of the Collaborative has also played an important role nationally. Colorado was one of four states selected to participate in the State Transformation Collaborative (STC), an initiative of the Health Care Payment and Learning Action Network that seeks to accelerate the shift from fee-for-service (FFS) to value-based, person-centered approaches through Medicaid and Medicare collaboration and partnership. In addition, Centers for Medicare & Medicaid Services (CMS) is partnering with Colorado to pilot Making Care Primary, a new primary care model to enhance access to and quality of primary care services. Through Making Care Primary, which launched in July 2024, Colorado has an opportunity to include Medicare in the state's ongoing multi-payer alignment efforts.

While the Collaborative's achievements to date have been laudable, additional work remains. Changes in the primary care landscape, both in Colorado and nationally, since the Collaborative's inception in 2019 will have an important influence on challenges and opportunities for primary care, and future strategies and efforts to strengthen and support primary care. The recommendations and discussion in this report focus on two features of

[1] https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

the current landscape, marketplace dynamics and artificial intelligence, and one of its continued priorities, health equity.

The focus on marketplace dynamics and artificial intelligence acknowledges that primary care is influenced by many factors outside of the doctor's office. Changing market trends have implications for the business and sustainability of primary care practices which affect patients, providers, and payers alike. In recent years, the rapid consolidation of health care practices and systems has had significant effects on independent practices and led to increased health care costs.[2] Additionally, private equity investors have taken an interest in the field and made record investments in healthcare.[3] Concerns about the effects of consolidation and private equity are numerous. The Collaborative recommends that trends in these marketplace dynamics should be monitored.

The rapid advancement of AI technology is set to be a disruption in the health care space. Initial promises about the capability of AI claim that the technology can save providers time on burdensome tasks and assist in providing quality health care. The intent of new AI tools ranges from reducing administrative burden to assisting with diagnoses. However, clinicians and staff are concerned AI could cause or exacerbate ethical or equity issues. Questions remain about how to build and maintain patient trust with the use of this new technology. The Collaborative recommends that AI should be adopted into primary care thoughtfully by addressing these questions.

Health equity is a long-standing commitment of the Collaborative. Several past recommendations by the Collaborative have focused on this subject (see Summary of Previous Annual Reports). This year, the Collaborative has turned its focus to accountability and assessing the progress that value-based payment models can make towards addressing health equity. Several state-wide efforts to promote value-based payment models are in progress in Colorado. This year the Collaborative puts forward considerations that can be used to evaluate the impact of these efforts in improving health disparities.

At the time of this report [legislation is currently being considered that would extend the Collaborative to September 2032]. Regardless of the outcome, the Collaborative strongly supports continued action to strengthen primary care. The issues and recommendations in this report provide important insights and considerations for future work.

[2] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[3] https://www.harvardmagazine.com/2024/05/right-now-private-equity-hosptials

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

- TBD pending CIVHC's presentation to the collaborative

Recommendations

The recommendations and discussion in this report focus on market dynamics, emerging artificial intelligence (AI) technology, and health equity. As the primary care landscape continues to shift, high quality health care and equitable treatment must continue to be a clear priority. Payment structures that support these goals are needed more than ever. The recommendations in this report suggest how to consider these topics thoughtfully to lay the foundation for future responsible investments.

Recommendation 1: Monitor the Landscape of Marketplace Dynamics in Colorado Primary Care

Marketplace dynamics of primary care practices, particularly consolidation and private equity investments, should be monitored in Colorado. These dynamics have a direct impact on the quality and cost of healthcare. Understanding trends in the marketplace dynamics is needed to support the primary care workforce and inform future investments in primary care infrastructure.

//BREAKOUT BOX: Types of Consolidation //

- Horizontal mergers - occur when there is consolidation between entities that offer the same or similar services, such as when a health system acquires a hospital or when two physician practices that provide overlapping services merge.
- Vertical mergers- occur when there is consolidation between entities that offer different services along the same supply chain, such as when a hospital or health plan acquires a physician practice.
- Cross-market mergers - occur when there is consolidation between two providers that operate in different geographic markets for patient care.
- "Soft" consolidation – other types of affiliations between health care entities that occur without necessarily changing ownership. Examples include accountable care organizations or joint ventures.
- Source: Definitions drawn or adapted from Kaiser Family Foundation[4]

[4] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

//END BREAKOUT BOX//

Consolidation and Private Equity. The nation is seeing an increasing amount of consolidation of health care practices. Consolidation refers to when hospitals, health systems, or other health care entities join under common ownership through either a merger or acquisition.[5] There are multiple types of consolidation, including vertical mergers, horizontal mergers, and cross-market mergers (see breakout box for definitions). There are also other types of business relationships, sometimes referred to as "soft" forms of consolidation, such as accountable care organizations and joint ventures.[6]

Private equity investments have been a major driver of consolidation in recent years. Private equity is a form of corporate ownership that often entails relying on loans to acquire a business, taking it private, and attempting to increase its value with the goal of selling it at a profit in three to seven years.[7] While not all consolidation is driven by private equity investments, consolidation of physician practices by private equity has significantly changed the health care market.

Marketplace Data and Trends. In 2012 the number of physicians working for a hospital or health system owned practices was 29%. By 2022 that number increased to 41%. Over this ten year period, large health care systems have grown and captured much of the health care practice market.[8] Now the ten largest health systems account for one in five (22%) of every nonfederal general acute care hospital beds.[9] In a parallel trend, private equity investments in health care have increased in the last decade. From 2010 to 2019, the estimated annual value of private equity deals in health care has increased from $41.5 billion a year to $119.9 billion a year.[10]

Understanding the Colorado Landscape. Tracking Colorado's marketplace landscape is difficult for two primary reasons. First, the different types of consolidation, including "soft" consolidation, paint a complicated picture of partnerships among hospitals, health

[5] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[6] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[7] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[8] KFF analysis of AHA hospital data from the AHA Annual Survey Database and the AHA Trendwatch Chartbook, 2021 and of American Medical Association (AMA) physician data from the AMA report "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022.

[9] Kaiser Family Foundation Analysis of Bed counts, ownership, and states of operation were obtained from RAND Hospital Data, 2022. Operating revenues were obtained from audited financial statements.

[10] https://www.harvardmagazine.com/2024/05/right-now-private-equity-hosptials

systems, and practices. Each type of consolidation has different benefits and drawbacks for patients and providers. For example, consolidation could help a financially struggling practice stay open by infusing the practice with financial support and resources. On the other hand, a larger health system may not be familiar or receptive to a local community's needs and may make decisions to cut needed services. The forces surrounding consolidation are often multifactorial, making it difficult to measure.

Second, business practices and decisions around consolidation are not transparent. Private equity involvement in health care is of particular concern because private equity firms operate under the public and regulatory radar. Many private equity transactions in health care are not reportable to antitrust or financial regulatory authorities. As a result, private equity investments in health care lack meaningful oversight.[11]

Negative Impacts on Payers, Providers, and Patients. Consolidation and private equity investments raise concerns about negative impacts to payers, providers, and patients given this financialization of the health care sector.[12]

Cost of Care

The rise in health care costs due to consolidation has a clear negative impact on payers, who must pay more to cover their members benefits, and ultimately patients, who share in paying this increased cost of care. Evidence shows that consolidation leads to higher prices for payers and consumers, straining payer budgets and burdening patients and families with high out of pocket costs.[13] There is clear evidence that consolidation leads to higher health care costs, particularly for horizontal consolidation.[14] Studies show prices increase anywhere from 3% to 65% as a result of hospital mergers.[15]

Quality of Care

The shift from independent physician-operated practices to corporate or consolidated practice groups has direct impacts on care delivery. Private equity owners, who do not necessarily have a clinical background, may make decisions that prioritize cost-savings or financial benefits over high quality patient care or good working conditions for health care staff. However, the evidence is mixed on how general consolidation impacts quality of

[11] https://petris.org/soaring-private-equity-investment-in-the-healthcare-sector-consolidation-accelerated-competition-undermined-and-patients-at-risk/

[12] https://www.nejm.org/doi/abs/10.1056/NEJMms2308188

[13] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[14]https://catalyst.harvard.edu/news/article/care-costs-more-in-consolidated-health-systems/

[15] https://www.rand.org/pubs/research_reports/RRA1820-1.html

care overall. One study of Medicare claims found that hospital mergers lead to no change in 30-day readmission but a decrease in patient experience measures.[16] Yet, other studies have found increased negative health outcomes following consolidations or private equity takeovers. For example, markets with increased consolidation in cardiology led to increases in negative health outcomes, with a 5-7% increase in risk-adjusted mortality. Another study of over 662,000 hospitalizations showed that private equity acquisitions resulted in an increase of 25.4% in hospital-acquired conditions, namely risk of falls and IV associated bloodstream infections.[17] Some experts in health care have written "the private equity business model is fundamentally incompatible with sound healthcare that serves patients."[18]

Provider and Practice Experience

Larger concerns exist about the extraction of wealth and resources from practices and providers because of private equity investments. Evidence shows that selling hospital assets, including real estate, buildings, and equipment is a common practice in private equity exits.[19] These decisions can ultimately leave hospitals saddled with unsustainable leases, massive debt, and a dearth of resources.

Increasing consolidation has also led to a proliferation of provider non-compete agreements. Non-compete agreements restrict employees from joining competitors or starting similar businesses within a given timeframe and geographical area after leaving their jobs.[20] These agreements have become extremely widespread in health care - estimates place the number of primary care doctors bound by a non-compete as high as 45%.[21] This restricts health care employee and provider options for independence and movement in high concentrated markets. Non-compete agreements can contribute to keep wages low[22], worsening healthcare workforce shortages. These effects are felt

[16] https://pubmed.ncbi.nlm.nih.gov/31893515/

[17] https://jamanetwork.com/journals/jama/fullarticle/2813379

[18] https://petris.org/soaring-private-equity-investment-in-the-healthcare-sector-consolidation-accelerated-competition-undermined-and-patients-at-risk/

[19] https://jamanetwork.com/journals/jama/fullarticle/2821826?guestAccessKey=00d9206e-c4e5-468b-be37-9ba2a2b551fd&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=073024

[20] https://hbhi.jhu.edu/news/impact-noncompetes-healthcare-7-expert-takeaways

[21] https://www.ama-assn.org/press-center/press-releases/ama-urge-end-noncompete-covenants-many-physician-contracts

[22] https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes#xd_co_f=YzM5MGUyYjUtYjRkOS00M2FhLWJkM2MtNzIyNDk0NThmZTA0~

acutely in rural areas. In Colorado, physicians are afforded protection from non-competes however awareness of this protection is low and there is concern among the Collaborative that non-competes are still widely used in physician contracts.[23]

Role of Value-Based Payment. Value-based payment models could mitigate negative outcomes that result from private equity investments, given their focus on balancing cost-savings with high quality primary care. The Collaborative's work focuses on developing strategies for increased investments in primary care through value-based payment models. In its first recommendations report, the Collaborative recommended an increased investment target. This target was later 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. Rapidly rising health care costs work against this type of investment target and is why the Collaborative finds it important to monitor the marketplace dynamics of consolidation and private equity investments. Directing payment reform requires examining how these dynamics both on the state and national level, impact the flow of payments.

Miscellaneous topics for PCPRC Review:

- ACOs – benchmarking, attribution, HRSN, pediatrics
- Independent primary care – additional payments, upfront capital for "low-revenue" physician led ACOs, reduce threshold of minimum covered beneficiaries
- Multiple CMMI models

Commented [2]: ALL- please add additional thoughts and comments to help elucidate these points- and/or indicate whether you think they should be included.

Recommendation 2: Ethical and Equitable Adoption of AI

New technology, including artificial intelligence (AI) tools, should be thoughtfully adopted into the primary care setting. Valid concerns about AI accuracy, impacts on practice workflow, and consent over the rapid adoption of this technology should be meaningfully addressed before the technology is standardized.

Emergence of AI. The use of AI in healthcare is not new but use has surged with recent advancements in AI models. In particular, models that take in data and inputs and generate new content, commonly known as generative AI, have become popular. The prevalence of a large, complex health care software ecosystem has facilitated the rapid

[23] C.R.S. 8-2-113

proliferation of this technology into many practices. In 2022, one fifth of hospitals in the U.S. had adopted some form of AI – the number is likely higher now.[24]

The applications of AI in primary care are numerous. AI tools can aid with everything from care delivery, such as diagnosis and counseling patients, to administrative tasks, such as managing patient panels and documentation.[25] Collaborative members have witnessed increasing use of AI across Colorado in a variety of settings. Health systems and smaller, independent practices are using or have considered using AI to help with administrative tasks. These tasks include documentation, inbox management, and other administrative duties.

Easing Administrative Burden. A recent study of primary care recommendations estimated that physicians would need 27 hours per day to provide the recommended care (preventive, chronic, and acute) to a panel of 2,500 adult patients, including administrative work, such as documentation and managing inboxes.[26] The study points to the larger problem of the high workload and administrative burden that accompanies current patient management. This workload stresses the health care workforce and leads to high levels of burnout among primary physicians.[27]

AI technology has the potential to decrease time spent on administratively burdensome tasks such as documenting patient encounters, populating visit notes, and retrieving medical records.[28] While early signs suggest AI can reduce the time to accomplish administrative tasks, Collaborative members are concerned that the addition of AI could lead to higher expectations of productivity without meaningful improvements in quality of care. For example, time and capacity gained back through AI may shift to expectations for higher patient loads. Currently, many primary care providers are overloaded with patients, with some seeing as many as 20 patients per day.[29] More research is needed to understand whether AI tools can lead to more quality time with patients or other valuable uses of provider time, rather than an increase in patient volume.

Accuracy and Bias. The Collaborative is monitoring potential concerns around accuracy, bias, and liability through the use of AI. First, users may experience "over-trust" of AI, and become lax in or stop monitoring AI output.[30] This can lead to incorrect or error-prone

[24] https://academic.oup.com/healthaffairsscholar/article/2/10/qxae123/7775605#google_vignette

[25] https://pmc.ncbi.nlm.nih.gov/articles/PMC10301994/

[26] https://link.springer.com/article/10.1007/s11606-022-07707-x

[27] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1351351

[28] https://pmc.ncbi.nlm.nih.gov/articles/PMC10301994/

[29] https://www.physicianleaders.org/articles/how-many-patients-can-primary-care-physician-treat

[30] https://pmc.ncbi.nlm.nih.gov/articles/PMC9023880/

AI outputs even with oversight, and is a risk for use of AI within primary settings if staff are not properly trained on these tools. Second, the quality of outputs produced by AI tools depends on the quality of data input into the tool. If existing patient data from patient panels or charts is inaccurate or incomplete, then its output may also be flawed, potentially leading to incorrect diagnosis or treatment suggestions. These concerns, among many others, point to the need for high levels of testing of the accuracy and appropriate use of AI in health care settings.

Finally, the Collaborative shares concerns that AI may promote or worsen biases already built into current data models. AI systems can suffer from bias if designed or trained on biased data, which compounds existing social inequities. Bias impacts underserved communities, such as communities of color, which can be subject to AI predictions that are less accurate or underestimate the need for care.[31]

Inequitable Uptake of AI Technology. The adoption of AI in primary care raises concerns about worsening disparities in access to resources between large well-resourced and small under resourced practices. Due to high overhead costs, small independent practices may lack the financial resources, technological infrastructure, and technical expertise to implement and effectively use AI tools. This could lead to widening an existing gap in access to advanced healthcare services and resources for underserved communities. Larger, resource rich practices may attract providers who have been trained in modern academic and research centers that use such tools. If new providers train on tools that are not available in rural and other underserved areas, it may serve as a deterrent for providers to seek jobs in those areas, worsening workforce disparities.

Patient Consent and Engagement. Data use and consent is a significant concern in the use of AI. Currently there is no strong federal regulation concerning AI or its use in health care. In Colorado, there have been some actions taken to protect consumers from discrimination in the use of AI algorithms (SB24-205). Additionally, Colorado law protects consumers from insurance practices that result in unfair discrimination on the basis of race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression (SB21-169). However, since regulation of discrimination in algorithm data use is still new, it is unclear how these protections will play out. This leaves many patients and other health care stakeholders wary of AI tools.

Currently, whether an AI tool is used in health care and on health records is determined by the provider or health system, notably leaving patients out of the loop. In cases where patients are authorizing consent for the use of AI tools, the consent is embedded into consents associated with using patient portals and other platforms that are necessary for communicating with their providers, leaving little choice to meaningfully decline use of AI.

[31] https://www.nature.com/articles/s41746-023-00858-z

This raises the issue of whether patients are allowed the chance to participate in informed consent of these tools.

Studies highlight patient concern over the use of AI.[32] In 2023, 60% of U.S. adults said they would be uncomfortable with their provider relying on AI for medical care, with 33% feeling like health outcomes for patients would get worse if AI were involved.[33] These concerns raise important questions about the role of AI in the provider-patient relationship. If patients do not trust AI assisted care, then AI could cheapen clinical advice, even if a physician endorses the advice. Further, if patients do not trust AI, then it may not be appropriate to use it for communication between a provider and a patient.

Answers to these important concerns should be guided by patient voice in the development and use of AI tools. This issue is complex, and not all patients experience technology and trust in the health care system the same way. A variety of patient perspectives is needed to best inform this issue, including patients from different communities, backgrounds, and age ranges. Part of addressing the issue is designing systems that empower patients to make informed decisions about their data and how it is used. As AI is continually adopted, this includes building trust and fostering a more equitable and patient-centered approach to AI in healthcare.

Payment Considerations for AI. AI tools are beginning to be used to process billing and payments. An analysis of Current Procedure Terminology (CPT) codes created explicitly for medical AI shows there is nascent but growing adoption of AI in health care. Fifty percent of CPT codes associated with AI were created in 2022 or later.[34]

Aside from direct payment for AI CPT codes, AI has the potential to support other areas of payment. First, risk adjustment is a key component of payment models to support practices that serve complex or high acuity clients. In its third recommendations report, the Collaborative encouraged the use of social data to improve risk adjustment models. AI tools can help incorporate social data and needs prediction. Second, AI tools could be used to support components of primary care delivery that are incentivized or supported through value-based payment structures. This may include supporting advanced primary care activities such as care coordination, same-day triage or patient messaging, and assuring continuity of care. Finally, AI could help support providers and payers in managing patients on their panel. AI could help sort through complex information to

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[32] https://pmc.ncbi.nlm.nih.gov/articles/PMC10198520/#:~:text=Overall%2C%20while%20some%20patients%20expressed,AI%20system%20could%20be%20fallible.

[33] https://www.pewresearch.org/science/2023/02/22/60-of-americans-would-be-uncomfortable-with-provider-relying-on-ai-in-their-own-health-care/

[34] https://ai.nejm.org/doi/full/10.1056/AIoa2300030

provide key updates to providers so they can be responsive to the population health needs of their patient panels.

The financial impacts of the adoption of AI are still unclear. It is possible the cost of the new technology could raise health care costs, but it's uncertain how it may save on costs in other areas. The effect of AI on costs to the provider, payer, and patient should be monitored as the technology is adopted.

The Collaborative believes it is too early to make a recommendation related to payment about this technology. There is tremendous potential for AI to benefit primary care by assisting providers in their critical work and reducing the amount of time spent on laborious tasks. However, given the rapid adoption of AI, it is important to be thoughtful in how AI is adopted into the health care setting. The concerns about the use of AI in primary care outlined above should be considered by policymakers and health care leaders. The Collaborative wishes to underscore the importance of thinking through how to ethically and equitably adopt use of AI. Patient and provider voice should be a key component of addressing these concerns as the adoption of AI continues to unfold.

Recommendation 3: Evaluate the Progress of Payment Models in Driving Health Equity Actions

Payment models should drive meaningful actions to address health equity. This includes incentivizing evidence-informed actions that improve the quality of care and lead to a reduction in disparate health outcomes. The extent to which payment models are successful in addressing disparities and directing quality improvements in health care should be tracked.

Focusing on Health Equity in Payment. The Collaborative has consistently elevated the importance of health equity throughout its work and in its past recommendations reports. While past reports have focused on identifying gaps and needs, the focus must now shift to taking action to address these needs.

Data Collection

Data collection to identify disparities and social needs is essential for health equity. The Collaborative has put forward recommendations supporting both types of data collection. In its second annual report the Collaborative recommended that data collection at the plan, health system, and practice level should allow for analysis of racial and ethnic disparities. In its fifth annual report the Collaborative recommended payers should support and incentivize clinician and nonclinician providers working on integrated care teams to collect health-related social needs data through screenings.

Support for Culturally Responsive Care

Throughout its recommendations, the Collaborative has promoted the importance of culturally responsive care. In its third annual report, the Collaborative suggested cultural competency training and implicit bias training as a foundational step for payers and providers to build competence in health equity. It also emphasized that future work should explore how to quantify the measurement of cultural competency. In its fifth recommendations report the Collaborative emphasized the importance of team-based care payment support in primary care. Team-based care can include nonclinical workforce, such as community health workers, who can provide culturally competent services. Additionally, team-based care can reduce workforce entry barriers by opening positions that require less credentialing and value diverse experiences.

Accountability for Health Equity. The Collaborative has previously shared three guiding principles that are essential to further efforts to improve equity:

- Elevate the voices of individuals and families alongside experts in the health care field
- Incentivize action to reduce disparities
- Focus on whole-person care

These principles remain relevant and can be used as a framework to track the progress of payment reform in driving change.

Elevate the voices of individuals and families alongside experts in the health care field

This guiding principle remains a priority for the Collaborative and for other primary care reform efforts. In 2024, the United States of Care published policy principles to engage patients in "patient-first care." In these principles, changing from fee-for-service to value-based payment is an essential part of reform.[35] Any assessment of the success of value-based payment initiatives should include patient and family voice. Meeting people where they are, and hearing patient concerns should be prioritized.

Incentivize action to reduce disparities

Payment models should continue to be evaluated for whether they are specifically incentivizing providers to take action to reduce disparities. This includes using demographic, social, and health data to understand what impact value-based payments have on disparities. In addition to tracking health trends, examining the design and implementation of these models can help identify opportunities to align best practices to address disparities.

[35] https://unitedstatesofcare.org/wp-content/uploads/2024/09/Patient-first-care-principles-usofcare.pdf

Focus on whole-person care

Payment models should support the importance of social determinants in impacting patient health. Support for clinician and nonclinician providers to conduct health-related social needs screening, referrals, and successful connections to needed services is key in this area. The extent to which screening and referring patients is successful in having their needs addressed is an important area of focus to understand progress in this area. In coming years, the implementation of the Social Health Information Exchange in Colorado will play a key role in supporting providers' abilities to address patient's social needs as well as physical.[36]

Examples of Infrastructure to Track Progress. While adequate data collection is foundational to address health equity, additional infrastructure is required to coordinate, evaluate and promote accountability for health equity. There are examples of payers in other states and at the national level that maintain collaborative initiatives to evaluate the implementation of their value-based models. This includes monitoring cost savings and health outcomes, including any reductions in health disparities.

National Example

As a result of widening disparities brought on by the COVID-19 pandemic, Aetna's Medicare Multicultural Care Management program employed care managers specifically trained in culturally competent care to work with Black and Hispanic Medicare patients. While outcomes from this initiative are not publicly available, Aetna has expressed their commitment to expand this program, suggesting positive results.[37]

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Massachusetts Example

In 2019, a rigorous evaluation of the Alternative Quality Contracts of Blue Cross Blue Shield of Massachusetts was published concluding the contracts resulted in cost savings and improved quality of care. However, this data was not disaggregated by demographic factors to assess for a reduction in disparities[38].

Michigan Example

Blue Cross Blue Shield Michigan hosts the Michigan Social Health Intervention to Eliminate Disparities (MSHIELD) Collaborative Quality Initiative to evaluate and hold accountable health equity focused initiatives in hospitals and other collaborative quality initiatives,

[36] https://oehi.colorado.gov/SHIE

[37] https://www.healthleadersmedia.com/payer/aetna-medicare-executive-healthcare-inequity-i-feel-more-hopeful

[38] https://www.nejm.org/doi/full/10.1056/NEJMsa1813621

community organizations, and payers. MSHIELD uses demographic and health data to identify quality improvement goals for health equity of outcomes. This includes developing Health Equity Dashboards to track progress in addressing health equity.

Role of the Collaborative. The Collaborative is interested in tracking and understanding the progress that value-based payment models make in addressing health disparities. Using payment as a tool to prioritize high quality patient care is an ongoing focus of the Collaborative. As highlighted above, adequate data collection is needed to understand progress. In the future, the Collaborative hopes to leverage the Colorado All Payer Claims database as a source of claims data on alternative payment models. The Collaborative also hopes to explore more examples of robust infrastructure that can support the continued evaluation of value-based payment models, such as the three examples listed above.

Conclusion and Future Work

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The recommendations in this report address the long-standing priority of health equity and two timely topics of marketplace dynamics and AI. These recommendations underscore the Collaborative's long-standing commitment to promoting high quality care for those in Colorado who need it most. At the time of this report, legislation has been introduced to continue the Collaborative's work in increasing and supporting investment in primary care. The Collaborative is looking forward to the prospect of continuing this work and has identified priorities for future work which will center around measuring investments in primary care and the impact of value-based payments on improving health outcomes.

For example, the Collaborative hopes to utilize the Colorado All Payer Claims database to better understand the state of value-based payment model reporting and impacts. An analysis of this data source and other states' efforts can help measure Colorado's progress in adopting value-based payments in the primary care setting. Additionally, the Collaborative would also like to increase data transparency by exploring the option of sharing data about value-based payment models in a public dashboard. The Collaborative will also continue to explore important topics in primary care payment reform as they arise.

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

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Appendix B: Primary Care Reform Collaborative Work and Impact Highlights to Date

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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, 202X-202X, Center for Improving Value in Health Care