

Second Regular Session  
Seventy-third General Assembly  
STATE OF COLORADO

**PREAMENDED**

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

LLS NO. 22-0020.01 Yelana Love x2295

**HOUSE BILL 22-1325**

**HOUSE SPONSORSHIP**

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

**SENATE SPONSORSHIP**

**Ginal**,

**House Committees**

Health & Insurance  
Appropriations

**Senate Committees**

Health & Human Services  
Appropriations

**A BILL FOR AN ACT**

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

**Bill Summary**

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

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

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

HOUSE  
3rd Reading Unamended  
April 25, 2022

HOUSE  
Amended 2nd Reading  
April 22, 2022

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

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

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

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

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

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

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

---

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

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

4 **10-16-155. Alternative payment model parameters -**  
5 **parameters to include an aligned quality measure set - primary care**  
6 **providers - requirement for carriers to submit alternative payment**  
7 **models to the division - legislative declaration - report - rules -**

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

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

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

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

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

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

27 (f) BY ESTABLISHING ALIGNED PARAMETERS FOR PRIMARY CARE

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

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

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

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

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

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

21 (2) AS USED IN THIS SECTION:

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

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

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

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

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

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

16 (I) FAMILY MEDICINE PHYSICIANS;

17 (II) GENERAL PEDIATRIC PHYSICIANS AND ADOLESCENT MEDICINE  
18 PHYSICIANS;

19 (III) GERIATRIC MEDICINE PHYSICIANS;

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

24 (V) OBSTETRICS AND GYNECOLOGY PHYSICIANS;

25 (VI) ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN  
26 ASSISTANTS; ■

27 (VII) BEHAVIORAL HEALTH PROVIDERS, INCLUDING

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

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

6 (f) "PROSPECTIVE PAYMENT" MEANS A PAYMENT MADE IN  
7 ADVANCE OF SERVICES THAT IS DETERMINED USING A METHODOLOGY  
8 INTENDED TO FACILITATE CARE DELIVERY TRANSFORMATION BY PAYING  
9 PROVIDERS ACCORDING TO A FORMULA BASED ON AN ATTRIBUTED PATIENT  
10 POPULATION TO PROVIDE PREDICTABLE REVENUE AND FLEXIBILITY TO  
11 MANAGE CARE WITHIN A BUDGET TO OPTIMIZE PATIENT OUTCOMES AND  
12 BETTER MANAGE POPULATION HEALTH.

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

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

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

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

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

7 (B) IMPROVED HEALTH OUTCOMES AND REDUCED HEALTH  
8 DISPARITIES;

9 (C) IMPROVED PATIENT AND FAMILY ENGAGEMENT AND  
10 SATISFACTION;

11 (D) INCREASED PROVIDER SATISFACTION AND RETENTION; AND

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

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

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

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

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

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

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

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

22 (V) THE ALTERNATIVE PAYMENT MODELS MUST ALSO:

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

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



1 BEHAVIORAL HEALTH STAFF;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 **10-16-150. Primary care payment reform collaborative -**

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

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

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

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

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

14 (2.5) IN CARRYING OUT THE DUTIES OF SUBSECTION (1)(j) OF THIS  
15 SECTION, IN ADDITION TO THE MEMBERS OF THE COLLABORATIVE  
16 DESCRIBED IN SUBSECTION (2) OF THIS SECTION, THE COMMISSIONER SHALL  
17 INCLUDE HEALTH INSURERS AND HEALTH-CARE PROVIDERS ENGAGED IN A  
18 RANGE OF ALTERNATIVE PAYMENT MODELS.

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

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

27 **25.5-1-204. Advisory committee to oversee the all-payer health**

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

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

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

12 (B) The share of payments that are made through nationally  
13 recognized alternative payment models and the share of payments that are  
14 not paid on a fee-for-service or per-claim basis; AND

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

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

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

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

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

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