HB1325_L.001

HOUSE COMMITTEE OF REFERENCE AMENDMENT

Committee on Health & Insurance.

HB22-1325 be amended as follows:

Amend printed bill, page 4, line 22, after "OF" insert "NATIONALLY RECOGNIZED, EVIDENCE-BASED".

Page 4, strike line 27.

Page 5, strike lines 1 through 4 and substitute "BETTER PATIENT OUTCOMES AND GREATER VALUE.".

Page 5, line 13, strike "10-16-150 (1)." and substitute "10-16-150.".

Page 5, line 27, strike "AND"

Page 6, line 3, strike "SETTING." and substitute "SETTING; AND

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

Page 6, strike lines 15 and 16 and substitute "PATIENTS OF DIFFERENT ANTICIPATED HEALTH NEEDS, AND INCLUDING SOCIAL FACTORS SUCH AS HOUSING INSTABILITY, BEHAVIORAL".

Page 6, strike lines 18 through 27.

Strike pages 7 through 9 and substitute:

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

(II) THE DIVISION SHALL DEVELOP THE PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS IN PARTNERSHIP WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, THE DEPARTMENT OF PERSONNEL, AND THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE IN ORDER TO OPTIMIZE ALIGNMENT BETWEEN HEALTH BENEFIT PLANS OFFERED BY CARRIERS AND PUBLIC PAYERS AND ACHIEVE THE FOLLOWING OBJECTIVES:

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

(B) IMPROVED HEALTH OUTCOMES AND REDUCED HEALTH DISPARITIES;

(C) IMPROVED PATIENT AND FAMILY ENGAGEMENT AND SATISFACTION;

(D) INCREASED PROVIDER SATISFACTION AND RETENTION; AND

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

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

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

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

(C) INCLUDE A SET OF CORE COMPETENCIES AROUND WHOLE-PERSON CARE DELIVERY THAT PRIMARY CARE PROVIDERS MUST MEET IN ORDER TO TAKE FULL ADVANTAGE OF VARIOUS TYPES OF ALTERNATIVE PAYMENT MODELS; AND

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

(IV) THE DIVISION SHALL ANNUALLY CONSIDER THE RECOMMENDATIONS ON THE ALTERNATIVE PAYMENT MODEL PARAMETERS PROVIDED BY THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE.

(IV) THE ALTERNATIVE PAYMENT MODELS MUST ALSO:

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

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

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

AND

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

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

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

Renumber succeeding subsections accordingly.

Page 10, line 12, strike "IN THE COMMERCIAL MARKET." and substitute "BY CARRIERS.".

Page 10, strike lines 17 and 18 and substitute "BARRIERS TO HEALTH ACCESS;

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

(c) CONSIDER AND IDENTIFY ANY AVAILABLE DATA SOURCES OR".

Page 10, line 26 and 27, strike "IN THE COMMERCIAL MARKET," and substitute "BY CARRIERS,".

Page 11, line 6, strike "DIVISION" and substitute "COMMISSIONER".

Page 11, strike line 9 and substitute "(1)(h), (1)(i)(IV), and (4); and **add** (1)(j) and (2.5)".

Page 11, strike lines 17 through 21 and substitute:

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

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

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

(2.5) IN CARRYING OUT THE DUTIES OF SUBSECTION (1)(j) OF THIS

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

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