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,

SENATE SPONSORSHIP

(None),

House Committees
Health & Insurance
Appropriations

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING ALTERNATIVE PAYMENT MODELS FOR PRIMARY CARE**
102 **SERVICES.**

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.

For health-care plans that are issued or renewed on or after January

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.

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.

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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, AND THE PRIMARY CARE PAYMENT REFORM
27 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 TRANSPARENT 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;

1 (C) INCLUDE A SET OF CORE COMPETENCIES AROUND
2 WHOLE-PERSON CARE DELIVERY THAT PRIMARY CARE PROVIDERS SHOULD
3 INCORPORATE IN PRACTICE TRANSFORMATION EFFORTS TO TAKE FULL
4 ADVANTAGE OF VARIOUS TYPES OF ALTERNATIVE PAYMENT MODELS; AND
5 (D) ESTABLISH AN ALIGNED QUALITY MEASURE SET THAT
6 CONSIDERS THE QUALITY MEASURES AND THE TYPES OF QUALITY
7 REPORTING THAT CARRIERS AND PROVIDERS ARE ENGAGING IN UNDER
8 CURRENT STATE AND FEDERAL LAW AND ENSURE THAT THE RULES
9 INCLUDE QUALITY MEASURES THAT ARE PATIENT-CENTERED AND
10 PATIENT-INFORMED AND ADDRESS: PEDIATRIC, PERINATAL, AND OTHER
11 CRITICAL POPULATIONS; THE PREVENTION, TREATMENT, AND
12 MANAGEMENT OF CHRONIC DISEASES; AND THE SCREENING FOR AND
13 TREATMENT OF BEHAVIORAL HEALTH CONDITIONS.
14 (IV) THE DIVISION SHALL ANNUALLY CONSIDER THE
15 RECOMMENDATIONS ON THE ALTERNATIVE PAYMENT MODEL PARAMETERS
16 PROVIDED BY THE PRIMARY CARE PAYMENT REFORM COLLABORATIVE.
17 (V) THE ALTERNATIVE PAYMENT MODELS MUST ALSO:
18 (A) ENSURE THAT ANY RISK OR SHARED SAVINGS ARRANGEMENTS
19 MINIMIZE SIGNIFICANT FINANCIAL RISK FOR PROVIDERS WHEN PATIENT
20 COSTS EXCEED WHAT CAN BE PREDICTED;
21 (B) INCENTIVIZE THE INTEGRATION OF BEHAVIORAL HEALTH-CARE
22 SERVICES THROUGH LOCAL PARTNERSHIPS OR THE HIRING OF IN-HOUSE
23 BEHAVIORAL HEALTH STAFF;
24 (C) INCLUDE PROSPECTIVE PAYMENTS TO PROVIDERS FOR HEALTH
25 PROMOTION, CARE COORDINATION, CARE MANAGEMENT, PATIENT
26 EDUCATION, AND OTHER SERVICES DESIGNED TO PREVENT AND MANAGE
27 CHRONIC CONDITIONS AND ADDRESS SOCIAL DETERMINANTS OF HEALTH;

1 (D) RECOGNIZE THE VARIOUS LEVELS OF ADVANCEMENT OF
2 ALTERNATIVE PAYMENT MODELS AND PRESERVE OPTIONS FOR CARRIERS
3 AND PROVIDERS TO NEGOTIATE MODELS SUITED TO THE COMPETENCIES OF
4 EACH INDIVIDUAL PRIMARY CARE PRACTICE; AND
5 (E) SUPPORT EVIDENCE-BASED MODELS OF INTEGRATED CARE
6 THAT FOCUS ON MEASURABLE PATIENT OUTCOMES.
7 (b) FOR HEALTH BENEFIT PLANS THAT ARE ISSUED OR RENEWED ON
8 OR AFTER JANUARY 1, 2025, A CARRIER SHALL ENSURE THAT ANY
9 ALTERNATIVE PAYMENT MODELS FOR PRIMARY CARE INCORPORATE THE
10 PARAMETERS ESTABLISHED IN THIS SUBSECTION (3).
11 (c) BY DECEMBER 1, 2023, THE COMMISSIONER SHALL
12 PROMULGATE RULES DETAILING THE REQUIREMENTS FOR ALTERNATIVE
13 PAYMENT MODELS PARAMETERS ALIGNMENT.
14 (4) ONCE THE DIVISION HAS FIVE YEARS OF DATA, THE DIVISION
15 SHALL ANALYZE THE DATA AND, SUBJECT TO AVAILABLE APPROPRIATIONS,
16 PRODUCE A REPORT ON THE DATA THAT AGGREGATES DATA ACROSS ALL
17 CARRIERS. THE DIVISION SHALL PRESENT THE FINDINGS TO THE GENERAL
18 ASSEMBLY DURING THE DEPARTMENT OF REGULATORY AGENCY'S
19 PRESENTATION TO LEGISLATIVE COMMITTEES AT HEARINGS HELD
20 PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,
21 RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2
22 OF ARTICLE 7 OF TITLE 2.
23 (5) THE DIVISION SHALL RETAIN A THIRD-PARTY CONTRACTOR TO
24 DESIGN AN EVALUATION PLAN FOR THE IMPLEMENTATION OF PRIMARY
25 CARE ALTERNATIVE PAYMENT MODELS BY CARRIERS. IN DESIGNING THE
26 EVALUATION PLAN, THE CONTRACTOR SHALL, TO THE EXTENT
27 PRACTICABLE:

1 (a) REPORT ON THE EFFECTS OF THE ALTERNATIVE PAYMENT
2 MODELS ON POPULATIONS THAT HAVE HISTORICALLY FACED SYSTEMIC
3 BARRIERS TO HEALTH ACCESS;
4 (b) REPORT ON THE EFFECTS OF THE ALTERNATIVE PAYMENT
5 MODELS ON PRIMARY CARE PROVIDERS, PRIMARY CARE PRACTICES, AND
6 PRIMARY CARE PRACTICES' ABILITY TO STAY INDEPENDENT, INCLUDING
7 THE EFFECTS ON PRIMARY CARE PROVIDERS' ADMINISTRATIVE BURDENS;
8 AND
9 (c) CONSIDER AND IDENTIFY ANY AVAILABLE DATA SOURCES OR
10 DATA LIMITATIONS THAT SHOULD BE INCLUDED OR ADDRESSED IN THE
11 EVALUATION PLAN TO ALLOW FOR MEASUREMENT AND REPORTING ON THE
12 EFFECTS OF THE PRIMARY CARE PAYMENT MODEL PARAMETERS ON SUCH
13 POPULATIONS, INCLUDING THE COLLECTION OR ANALYSIS OF DATA THAT
14 IS DISAGGREGATED, AT A MINIMUM, BY RACE, ETHNICITY, SEX, GENDER,
15 AND AGE.
16 (6) TO SUPPORT THE IMPLEMENTATION OF ALIGNED PRIMARY CARE
17 ALTERNATIVE PAYMENT MODEL PARAMETERS BY CARRIERS, THE DIVISION
18 SHALL RETAIN A THIRD-PARTY CONTRACTOR TO PROVIDE TECHNICAL
19 ASSISTANCE TO CARRIERS. THE DIVISION SHALL WORK WITH CARRIERS TO
20 DETERMINE THE NATURE AND SCOPE OF THE TECHNICAL ASSISTANCE AND
21 OTHER SUPPORTS THAT WILL BEST FACILITATE THE IMPLEMENTATION OF
22 ALIGNED PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS.
23 (7) THE COMMISSIONER MAY PROMULGATE RULES NECESSARY TO
24 IMPLEMENT THIS SECTION.
25 (8) IF A CARRIER CLAIMS THAT INFORMATION SUBMITTED
26 PURSUANT TO THIS SECTION IS CONFIDENTIAL OR PROPRIETARY, THE
27 COMMISSIONER SHALL REVIEW THE INFORMATION AND REDACT SPECIFIC

1 ITEMS THAT THE CARRIER DEMONSTRATES TO BE CONFIDENTIAL OR
2 PROPRIETARY. THE COMMISSIONER SHALL NOT DISCLOSE REDACTED ITEMS
3 TO ANY PERSON; EXCEPT THAT THE COMMISSIONER MAY DISCLOSE
4 REDACTED ITEMS:
5 (a) AS MAY BE REQUIRED PURSUANT TO THE "COLORADO OPEN
6 RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24; AND
7 (b) TO EMPLOYEES OF THE DIVISION, AS NECESSARY.
8 **SECTION 2.** In Colorado Revised Statutes, 10-16-150, **amend**
9 (1)(h), (1)(i)(IV), and (4); and **add** (1)(j) and (2.5)
10 **10-16-150. Primary care payment reform collaborative -**
11 **created - powers and duties - report - definition - repeal.** (1) The
12 commissioner shall convene a primary care payment reform collaborative
13 to:
14 (h) Consider how to increase investment in advanced primary care
15 without increasing costs to consumers or increasing the total cost of
16 health care; ~~and~~
17 (i) Develop and share best practices and technical assistance to
18 health insurers and consumers, which may include:
19 (IV) The delivery of advanced primary care that facilitates
20 appropriate utilization of services in appropriate settings; AND
21 (j) ANNUALLY REVIEW THE ALTERNATIVE PAYMENT MODELS
22 DEVELOPED BY THE DIVISION PURSUANT TO SECTION 10-16-155 (3) AND
23 PROVIDE THE DIVISION WITH RECOMMENDATIONS ON THE MODELS.
24 (2.5) IN CARRYING OUT THE DUTIES OF SUBSECTION (1)(j) OF THIS
25 SECTION, IN ADDITION TO THE MEMBERS OF THE COLLABORATIVE
26 DESCRIBED IN SUBSECTION (2) OF THIS SECTION, THE COMMISSIONER SHALL
27 INCLUDE HEALTH INSURERS AND HEALTH-CARE PROVIDERS ENGAGED IN A

RANGE OF ALTERNATIVE PAYMENT MODELS.

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

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

25.5-1-204. Advisory committee to oversee the all-payer health claims database - creation - members - duties - legislative declaration - rules - report. (3) (c) (I) By ~~August 31, 2019~~ NOVEMBER 15, 2022, and by each ~~August 31~~ NOVEMBER 15 thereafter, SUBJECT TO AVAILABLE APPROPRIATIONS, the administrator shall provide a primary care spending report to the commissioner of insurance for use by the primary care payment reform collaborative established in section 10-16-150 regarding primary care spending:

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

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

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

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

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