Chronic Condition Episode Logic and Business Rules – Program Year 2026

The Chronic Conditions Shared Savings Program incentivizes Primary Care Medical Providers and RAEs to improve chronic care management by paying a portion (37.5% for PCMPs, 12.5% for RAEs) of their savings achieved for members with at least one of ten chronic conditions. These ten (10) chronic conditions were determined by the Department to be major cost drivers for the State, while being amenable to primary care intervention.

Qualifying Chronic Conditions

1. Arrhythmia / Heart Block
2. Asthma
3. Coronary Artery Disease
4. Chronic Obstructive Pulmonary Disease (COPD)
5. Diabetes
6. Gastro-Esophageal Reflux Disease (GERD)
7. Heart Failure
8. Hypertension
9. Low Back Pain
10. Osteoarthritis

Chronic Condition Episode Logic and Business Rules

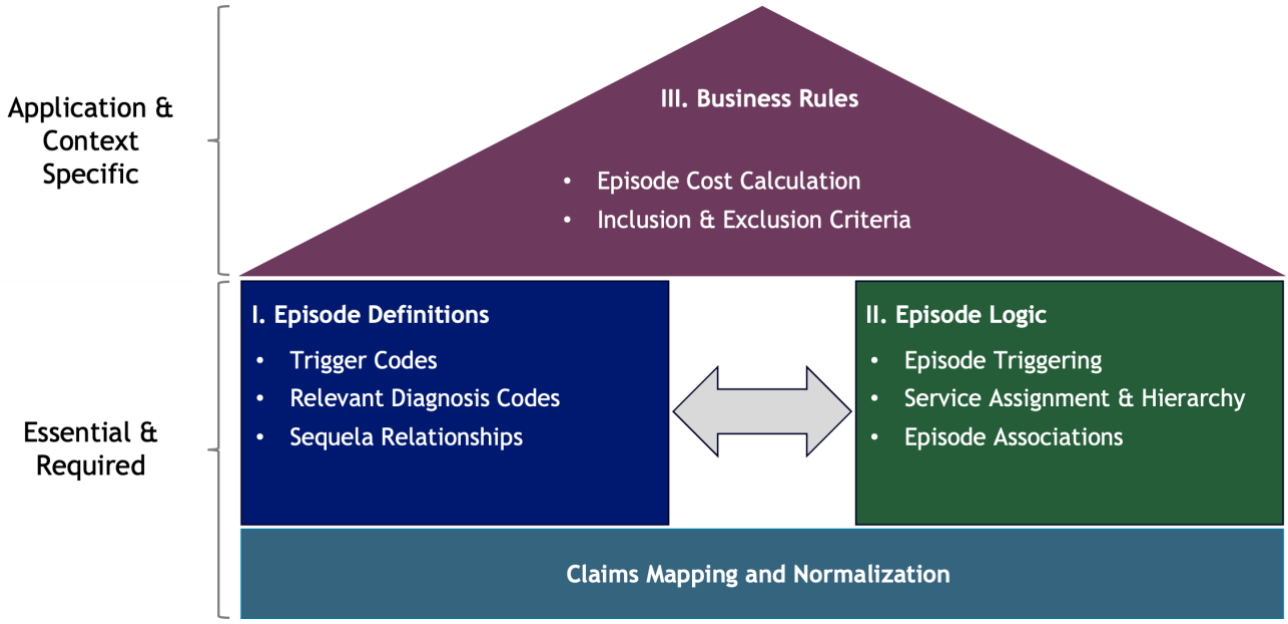
Savings in these chronic conditions are based on paid member claims across their Total Cost of Care during the Program Year (January 1 – December 31). **Total Cost of Care** consists of all the medical services a member receives, which are then adjusted by applying specific carve-outs, as identified by the Department, that a primary care provider should not be held accountable for in the context of a Primary Care Shared Savings Program.

Accounting for the resources used during an episode requires feeding all member claims into an episode grouper, that will group each claim to one or more episodes to which it is relevant. An **episode grouper** is a piece of software that operationalizes algorithms that determine when an episode should be opened and closed; identifies the healthcare services that should be assigned to one or more distinct healthcare episodes; and determines with which other episode(s) a particular episode can be associated[1].

For Program Year 2026 (January 1, 2026 – December 31, 2026), the Department is utilizing the PACES (Version 2.2) episode grouper software to administer the Chronic Conditions Shared Savings program.

An episode grouper is made up of three primary components: I. Episode Definitions, II. Episode Logic, and III. Business Rules as shown in Figure 1.

Figure 1: Episode Grouper Components



Episode Grouper Components

Regardless of the type of episode (chronic, procedural, or acute), I. Episode Definitions and II. Episode Logic must be defined and *Claims Mapping* and *Normalization* must occur. However, the III. Business Rules applied and how they are defined may vary based on the type of episode and the context in which the episode calculations are being used. For the purposes of Shared Savings, the components are consistent across all episodes since chronic episodes are the only type of episode that allows a member to be eligible and included in the program.

Claims Mapping is the process of matching field names from the raw claims to the corresponding field names required in the PACES input tables.

> **For example:** The field named "member_identifier" in the raw claims would be mapped to "member_id" in the PACES input specifications.

Normalization is the process of organizing claims into a defined set of formatting and layout specifications.

> **For example**: The PACES outputs specify that medical claims information be split between a "header" and "line" table, with distinct fields in each table. The normalization process would intake a single claims file with one row (representing a single claim line) and then split the information between the header and line-level tables.

I. Episode Definitions

Each episode is defined by a set of International Classification of Diseases, 10th Revision (ICD-10) codes, which are classified into the following categories:

- *Trigger codes*: Trigger codes are used to identify the initiation of an episode on an inpatient facility, outpatient facility, or professional claim. Trigger codes on member claims, in conjunction with the episode triggering logic (See II. Episode Logic for more information), identify the member episodes for the ten (10) chronic conditions included in the Shared Savings program. Once a chronic episode is triggered, it remains open and does not end.
    - **Example**: A member is identified as having a Diabetes episode when they have a Diabetes *trigger code* as the primary diagnosis code on their inpatient claim.
- *Relevant diagnosis codes*: Relevant diagnosis codes are used to indicate that care provided is relevant to an existing episode on an inpatient facility, outpatient facility, or professional claim. In Shared Savings, relevant diagnosis codes on a member's claim, in conjunction with the service assignment logic (See II. Episode Logic for more information), indicate that the services provided are *included* in the member's chronic episode. All trigger codes are also used as relevant diagnosis codes.
    - **Example**: Costs are assigned to a member with an existing Diabetes episode because their claim has a *relevant diagnosis code*.
- *Sequelae relationships*: Sequelae are separately defined episodes that represent complications and acute exacerbations that can occur within the context of an underlying chronic condition. In Shared Savings, sequelae relationships, in conjunction with the episode association logic (see II. Episode Logic for more information), define which acute episodes are related to the chronic episode as sequelae.
    - **Example**: Sequelae costs are assigned to a member with an existing Asthma episode because of a claim associated with respiratory failure, which has a *sequelae relationship* with Asthma.

The trigger codes, relevant diagnosis codes, and sequelae relationships for each of the ten (10) chronic conditions included in the Shared Savings Program for Program Year 2026 can be found in the *PY26 Shared Savings Chronic Condition Episode Definitions* workbook posted to the same page as this document.

II. Episode Logic

Episode logic are the rules by which new member episodes are triggered (episode triggering), member claims are assigned to already existing episodes (service assignment & hierarchy), and acute episodes are considered sequelae (episode associations). Episode logic described below are specific to the Shared Savings Program for Program Year 2026 (January 1, 2026 – December 31, 2026).

Episode Triggering

Triggering logic are the rules by which trigger codes are identified in member claims and trigger a new episode. Once a chronic episode is triggered for a condition, it remains open and does not end (e.g., the episode exists forever). In contrast, acute and procedural episodes each have

their own predetermined time period that they are active for.

Episode triggering logic varies based on claim type. Episodes are triggered for a member in accordance with the rules below:

Claim Type	Rule
Inpatient	An inpatient facility claim with a trigger code as the principal diagnosis.
Outpatient	An Evaluation and Management (E&M) claim (professional or outpatient facility) with a trigger diagnosis code in any position PLUS another E&M visit claim (professional or outpatient) with a trigger diagnosis code occurring between 30 and 450 days after.
Professional	

Service Assignment & Hierarchy

Service assignment logic are the rules that determine when services performed, identified by relevant diagnosis codes included in member claims, are attributed ("assigned") to existing episodes. When a service is "assigned" to an existing episode, it means that the utilization and cost associated with the service are attributed to the existing episode. In order for a claim to be assigned to an existing episode, the date of service on the claim must be on or after the date that the existing episode was triggered.

Service assignment rules vary based on claim type. Member claims are attributed to an existing episode in accordance with the rules below:

Claim Type	Rule
Inpatient	An inpatient facility claim with a relevant diagnosis code as the principal diagnosis.
Outpatient	A professional or outpatient facility claim with a trigger code or relevant diagnosis code in any diagnosis code position on the claim.
Professional	

Because chronic episodes remain open forever after being initially triggered, it is possible and likely for another type of episode (procedural or acute) to occur within the chronic episode window (e.g., for another episode to co-occur). As a result, a service with a relevant diagnosis code may meet the assignment criteria for two different types of episodes at the same time. In cases of overlapping episode types, PACES prioritizes assignments to procedure episodes over acute & chronic episodes and acute episodes over chronic. This means that when a chronic episode is open alongside another procedure or acute episode, a service will only be assigned to

the chronic episode if it cannot be first assigned to the other open episode types. This is referred to as the assignment hierarchy.

> **Example:** A pre-operative x-ray performed in preparation for a knee arthroplasty procedure to relieve pain resulting from osteoarthritis could be assigned to both episodes (knee arthroplasty is a procedural episode and osteoarthritis is a chronic episode). In cases like this where episodes of different types share the same service, the service assignment rules give preference to procedural and acute episodes over the chronic episode. As a result, pre-operative x-ray in the example would only be assigned to the procedural episode (knee arthroplasty).

After the application of the assignment hierarchy, any services that remain under consideration for assignment to an existing chronic episode may be shared if the member has multiple existing chronic conditions that the service is relevant to.

> **Example**: An E&M visit for a person with co-morbid diabetes and coronary artery disease will likely be assigned to both chronic episodes (diabetes and coronary artery disease). For a single service to be assigned to multiple episodes, the episodes must be of the same type (e.g., multiple chronic episodes).

Episode Associations

If an acute episode with a defined sequelae association to the chronic episode is triggered within the chronic episode window, then an association link between the acute episode and the chronic episode is established and all services assigned to the acute episode become part of the chronic episode.

> **Example**: If a member with asthma (a chronic episode) triggers acute respiratory failure (an acute episode with a defined *sequelae relationship* to asthma) during the course of their chronic episode window, then an association link is established between the episodes and all of the services assigned to the acute respiratory failure episode become part of the asthma episode.

III. Business Rules

Business rules are the criteria and specifications that determine how costs are measured and which Members with episodes are included and excluded. Business rules described below are specific to the Shared Savings Program for Program Year 2026 (January 1, 2026 – December 31, 2026).

Episode Cost Calculation

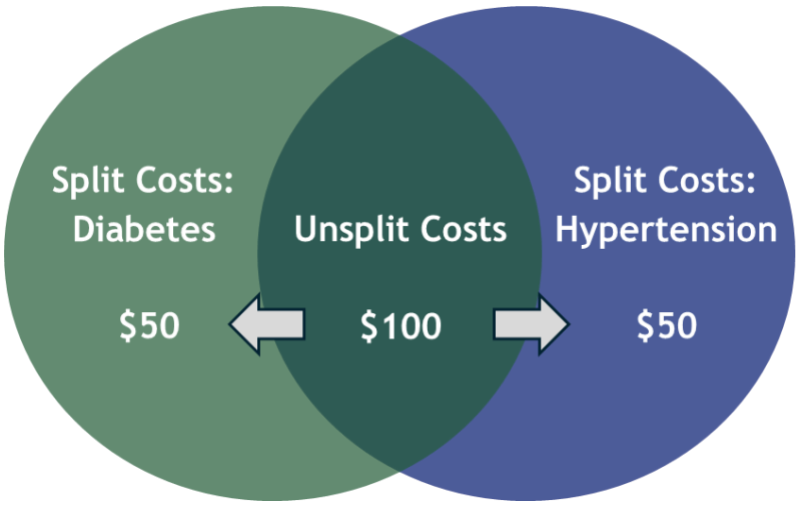
For the purposes of identifying members with one of the ten (10) chronic episodes, **these episodes must have nonzero assigned episode costs during the threshold or performance period in order to be counted**. For example, if a member has only one of the ten episodes trigger, but that episode does not have assigned cost in the threshold or performance period, then this member would not be eligible for the program. This helps to ensure that the member's chronic episode is a driver of cost for the threshold or performance period. Episode costs are calculated by summing costs from two sources within the episode:

1. *Assigned services*: Excluding dental services, prescriptions, and behavioral health services reimbursed by the RAEs, allowed amounts from all assigned medical services within the period are included in episode costs.

   To avoid double-counting of costs for the same service when it is assigned to multiple chronic episodes, the allowed amounts are split proportionally by the number of episodes to which it is assigned. Unsplit costs are not typically utilized for characterizing episode costs because of this double-counting issue.

   > **Example**: If a service with an allowed amount of $100 is assigned to two chronic episodes based on *Relevant Diagnosis Codes*, each chronic episode would each be apportioned $50 (shown by figure 3 below). Similarly, if a service with an allowed amount of $80 is assigned to four chronic episodes, each chronic episode would each be apportioned $20.

Figure 3: Example of Cost Splitting Across Comorbid Episodes (One Member)



2. *Sequelae*: Any assigned services for associated sequelae that occur within the threshold or performance period are included in the chronic episode costs. Thus, if a sequelae triggers in the threshold or performance period, but extends beyond its end, only allowed amounts for those services assigned to the sequelae that were delivered prior to the last date of the threshold or performance period are added to chronic episode costs. Sequelae costs that extend past the threshold or performance period would be captured in the subsequent program year.

Member and Service Exclusions from Chronic Conditions Shared Savings

For the purposes of identifying members and services that a provider can reasonably control Total Cost of Care for, specific filtering criteria are applied to remove members and services that the Department believes should not be included in the Primary Care Shared Savings program. Technical definitions of High-Acuity Member Carve-Outs and Service Carve-Outs are available on pages 31-34 of the Primary Care Payment Structure Provider Guide.

1. *Members Excluded from Shared Savings*

   - **Chronic Conditions:** Members must have at least one of the ten chronic conditions

trigger prior to the period or within the first six months.

- **Minimum Enrollment Period:** Members must be enrolled with Health First Colorado for at least six months during the period.
- **Minimum Attribution Period:** Members must be attributed to a PCMP for at least six months during the period.
- **Geographic Attribution:** Members cannot be geographically attributed (applicable for Calendar Year 2024 data).
- **Category of Aid:** Members cannot be enrolled in PACE, CHP+, Medicare, or a Health First Colorado MCO (Denver Health, Rocky Mountain Prime).
- **Age:** Members must be aged 19 years or older.
- **Nonzero Claims Costs:** Members must have more than $0 in claims costs during the period.
- **High-Acuity Member Carve-Outs:**
    - Members must not require lifelong specialized care (e.g., quadriplegia, ALS, comatose).
    - Members must not be actively receiving hospice or end-of-life care.
    - Members must not have received an organ transplant.
    - Members must not have ongoing treatment for malignant or metastatic cancer.

2. *Services Carved Out of Total Cost of Care*

- Maternity-related services.
- Long-term home health services.
- Services provided at long-term nursing and intermediate care facilities.
- Waiver Services - Home- and Community Based Services (HCBS).
- Non-Emergency Medical Transportation.
- Behavioral Health Secure Transportation.
- Dental services.
- Vision services.
- RAE-reimbursed Behavioral Health Services.
- Pharmacy costs.
- Services provided at Indian Health Services (IHS) PCMPs.