Primary Care Payment Structure

Prospective Payment and Shared Savings Programs

Program Year 2026

COLORADO
Department of Health Care Policy & Financing

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.
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Introduction

The mission of the Department of Health Care Policy and Financing (HCPF) is to improve healthcare equity, access, and outcomes for the people served while saving Coloradans money on health care and driving value for Colorado. Health First Colorado (Colorado's Medicaid program) currently serves more than one million Coloradans, many of whom have complex health needs due to life circumstances and disability. To address the unique needs of members, the Accountable Care Collaborative (ACC) was created in 2011 as the primary delivery system for Health First Colorado. Regional Accountable Entities (RAEs) are responsible for promoting member health and well-being by administering the capitated behavioral health benefit, establishing and supporting networks of providers, and coordinating medical and community-based services for members in their region. New contracts for ACC Phase III became effective on July 1, 2025. This guide provides programmatic and eligibility details on the Prospective Payments and Shared Savings under the Primary Care Payment Structure, as part of the ACC Phase III, which will go live on January 1, 2026.

Key Definitions

- **Accountable Care Collaborative (ACC):** The primary delivery system for Health First Colorado. It refers to administrative and financial arrangements between Regional Accountable Entities (RAEs, defined below) and HCPF.
- **Alternative Payment Model (APM):** A method of paying for health care services that directly links to performance on cost, quality, and the patient's care experience.
- **Regional Accountable Entities (RAEs):** Managed care entities that are a central component of the ACC. HCPF contracts with the RAEs to promote and provide physical and behavioral health care services for Health First Colorado members.
- **Billing Entity:** A group of PCMPs that share a single Tax ID.
- **Fee-for-Service (FFS)**: A payment system in which a payer reimburses providers for each service rendered based on a predetermined rate for each service.
- **Primary Care Medical Provider (PCMP):** Providers enrolled with Health First Colorado that meet certain licensing requirements and contract with the RAE covering the region in which their practice is located. PCMPs serve as the focal point of care for members attributed to them and partner with their RAE to coordinate the health needs of their members.
- **Prospective Payment:** A method of reimbursement in which healthcare providers are paid a predetermined, fixed amount in advance for a specified set of services.
- **Shared Savings:** Incentivizes providers to effectively manage members with chronic conditions by paying providers a portion of the savings achieved.

Primary Care Payment Structure Design

The purpose of the Primary Care Payment Structure is to improve member outcomes and reduce health disparities by creating stable investments in PCMPs across the state. This model was designed with input from Health First Colorado members, advocates, and providers.

From 2021 to 2023, the Department collaborated with primary care providers across Colorado to develop the Alternative Payment Model 2 (APM 2) program, which remained in effect through Program Year 2025. This development was carried out through a continuous feedback process with providers, ensuring that the initial implementation of the APM 2 program was inclusive and aligned with the priorities of Colorado providers. Stakeholder engagement meetings continued throughout 2024. Members, providers, and other community stakeholders participated to provide feedback that will inform the future model design.

The Primary Care Payment Structure is a continuation of the programs established in APM 2, implementing refined methodologies in Program Year 2026 that offer incentive opportunities for PCMPs and better align with Department goals. The programs that were previously administered under APM 2, Prospective Payments and Shared Savings, will be folded into the broader Primary Care Payment Structure that captures additional funding streams. Providers will also gain access to new dashboards offering actionable, timely data insights that enable PCMPs to track performance against targets and identify specific care gaps.

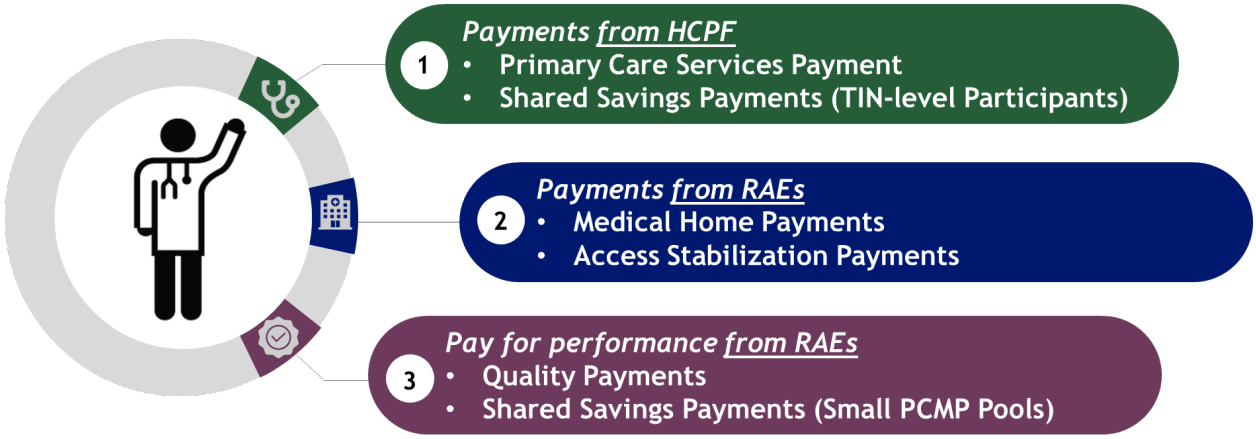
Primary Care Payment Structure program goals established through the stakeholder process include:

1. Improve outcomes for members with chronic conditions.
2. Improve outcomes for child and adolescent members.
3. Increase access to primary care services for all members across the state.
4. Reduce the total cost of care while keeping primary care costs stable or higher.
5. Provide stabilized revenue for PCMPs.
6. Reduce administrative burden of program participation.

Primary Care Payment Structure Incentives

ACC Phase III introduces an improved Primary Care Payment Structure for all Primary Care Medical Providers (PCMPs). This model combines design elements from multiple Alternative Payment Model (APM) programs from the RAEs and HCPF, and includes pediatric considerations to create a singular, comprehensive payment structure. All programs under the Primary Care Payment Structure **operate on a calendar year basis (January 1 through December 31)** with the exception of Access Stabilization payments, which operate on a **State Fiscal Year basis (July 1 through June 30)**. More information on Access Stabilization Payments can be found on the ACC Provider and Stakeholder Resource Center webpage. PCMP payments through HCPF and the RAEs come in three distinct payment streams found in Figure 1 below:

Figure 1: Primary Care Payment Structure



1. Payments from HCPF (Primary Care Services): PCMPs will continue to receive payment for providing Primary Care Services from HCPF. PCMPs may choose to take this **Primary Care Services Payment** as a fee-for-service payment or a prospective payment.

For Billing Entities that are eligible for a provider-specific threshold for **Shared Savings Payments**, HCPF will make savings payments directly to the Billing Entity given that larger networks tend to span multiple RAEs. This payment incentivizes PCMPs to reduce the Total Cost of Care (TCOC) relative to their own historical average TCOC for adult members with a chronic condition.

2. Payments from RAEs (Medical Home and Access Stabilization): PCMPs will receive per-member-per month (PMPM) **Medical Home Payments** from RAEs to support their role as a focal point of care for Health First Colorado members. This payment focuses on building and maintaining advanced primary care activities such as care coordination, integrated behavioral health services, and population health management.

RAEs will also provide **Access Stabilization Payments,** a dedicated pool of funds aimed at

preserving access to care for Health First Colorado members. These payments are directed to specific types of PCMPs that do not receive cost-based reimbursement.

3. Pay for Performance from RAEs (Quality and Shared Savings): Eligible PCMPs can earn a **Quality Incentive Payment** based on performance toward adult and pediatric quality measures. PCMPs that have too few patients to be assessed fairly on quality metrics will have an opportunity to earn these payments through quality improvement activities.

PCMPs eligible for the PY2026 Quality Performance Track will be assessed on a minimum of four (4) and a maximum of six (6) measures. The Department will establish measure-specific thresholds at three payment tiers: Basecamp Thresholds, Treeline Thresholds, and Summit Thresholds. For more information about the quality measures and threshold methodology, see HCPF's Quality Operations Guide.

The quality gate (e.g., the minimum necessary quality performance to benefit from program participation) for Prospective Payments and Shared Savings will align closely with the PY2026 PCMP Quality Performance Track administered under the Accountable Care Collaborative (ACC). Further details on program-specific quality gates are available in the Prospective Payment and Shared Savings sections below.

PCMPs that do not fall under a Billing Entity with a provider-specific **Shared Savings Payment** threshold may elect to participate in the Small PCMP Pool under their assigned RAE. PCMPs who opt into each pool will be measured on their collective performance in reducing Total Cost of Care (TCOC) from the baseline period to the performance period.

See HCPF's ACC Phase III webpage for more information about the program changes as they become available.

Prospective Per Member Per Month (PMPM) Payment

Advantages of Participation

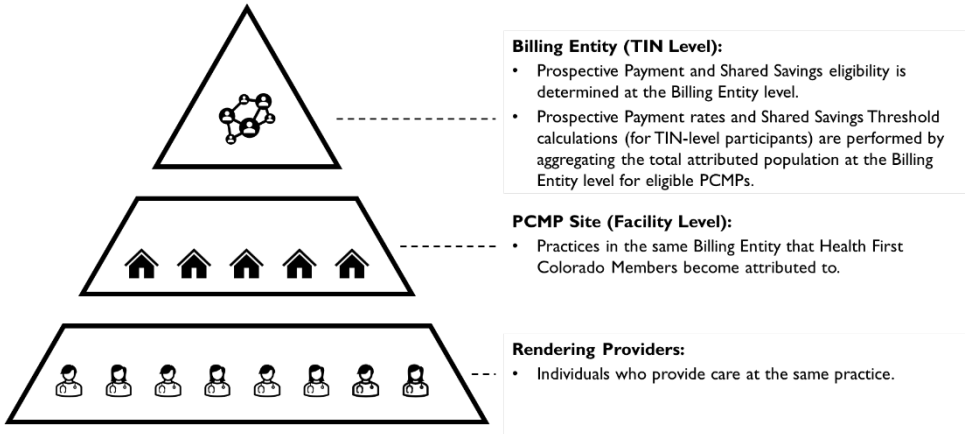
Prospective payment rates are designed to provide steady, predictable revenue for PCMPs month over month, ensuring stability despite changes in utilization.

Eligible Services and Rendering Providers

Eligible services reimbursed under the Primary Care Payment Structure are those included in the **Modified APM Code Set**, which is identical to the APM Code Set historically utilized in APM 1 and APM 2. The Modified APM Code Set can be found in the Appendix.

The relationship between the billing entity, PCMP, and rendering provider is shown below in Figure 3. Individual providers' primary care provider taxonomy codes are used to identify primary care providers within each PCMP. Historical claims are limited to those rendered by providers with primary care provider taxonomy codes included in the list of **Primary Care Prospective Payment Taxonomy Codes**. Rendering providers are rolled up to their PCMPs. Program eligibility and prospective payment rates are determined at the Billing Entity level. All PCMPs are rolled up to their billing entity (e.g., Tax Identification Number or TIN).

Figure 3: Billing Entity to Rendering Physician Hierarchy



The Primary Care Prospective Payment Taxonomy Codes can be found in the Appendix as well as HCPF's Primary Care Payment Structure webpage, under the Program Resources section.

Program Eligibility

Billing entities are eligible to enroll in the Prospective Payment program for PY2026 if they meet both of the following criteria:

- **Quality Tie:** At least one PCMP is eligible for the PY2026 Quality Performance Track.
- **Minimum Attribution:** The billing entity must have at least an average of 500 qualifying attributed members across Calendar Year 2024. Qualifying attributed members are members that are not:
  - Geographically attributed
  - Enrolled in PACE
  - Enrolled in CHP+
  - Dual Eligible, or
  - Enrolled in a Health First Colorado MCO (Denver Health, Rocky Mountain Prime).

The 500-member threshold is established using a credibility threshold that aligns with standard credibility formulas utilized by CMS programs.

PMPM Selection

Prospective Payments are advance payments that are reimbursed on a per-member, per-month (PMPM) basis. Participating PCMPs may select to receive a portion (1-100%) of their expected fee-for-service (FFS) reimbursement for **eligible services** as prospective PMPM payments for qualifying attributed members. PCMPs that select a PMPM of 1-99% will receive the remaining percentage as reduced rate FFS claims payment. A PCMP's prospective payment percentage is selected at the billing entity level and uniformly applied to all practices under the billing entity.

Prospective Payment Rate-Setting Process (Non-FQHCs)

PMPM payment rates are based on the PCMP's qualifying attributed member population's historical claims ("base data") for **eligible services** ("Prospective Payment eligible services") that are performed by providers with a **primary care provider taxonomy code**.

The methodology described below does not apply to PCMPs that are Federally Qualified Health Centers (FQHCs). Services rendered at FQHCs are reimbursed on an encounter rate basis rather than the HCPF fee schedule, requiring a different methodology to develop a PMPM Prospective Payment Rate. The Department is in the process of designing an FQHC-specific methodology and discussing with stakeholders. More information will be available in the Program Year 2027 Primary Care Payment Structure Guide.

The following steps give an overview of the actuarial process used to calculate each PCMP's prospective PMPM rate. Each interested PCMP receives more detailed data specific to their practice prior to enrolling in the program.

1. **Category of Aid (COA):** Base data is broken out by COA. Each calculation step is applied at the COA level:
   - Infant (I) – Members aged less than twelve (12) months
   - Toddler (T) – Members aged one (1) to three (3) years
   - Healthy Child (C) – Members aged four (4) to eighteen (18) years
   - Child with a Behavioral Health Condition (CBH)
   - Healthy Adult (A) – Members aged nineteen (19) or more years
   - Adult with a Behavioral Health Condition (ABH)
   - Adult with a Chronic Condition (ACC)
   - Adult with Behavioral Health and Chronic Conditions (ABHCC)

   These are used to calculate a singular PMPM rate that accurately reflects the services provided to each PCMP's specific member population.

   A member is identified as having a Chronic Condition if they have one of ten (10) conditions that are addressed in the Shared Savings program. See the "Shared Savings for Members with Chronic Conditions" section for more information.

   A member is identified as having a Behavioral Health Condition if they have one of 20 chronic episodes that Patient-Centered Episode System (PACES), a software algorithm that identifies chronic, procedural, and acute episodes, groups into the "Behavioral and Mental Health" clinical chapter. These conditions include, but are not limited to anxiety, major depression, bipolar disorder, and obsessive compulsive disorder (OCD). See the PACES Episodes by clinical chapter for the full list of episodes.
2. **Repricing:** Base data is repriced to the most recent fee schedule. For Program Year 2026 (PY2026) the fee schedule as of October 1, 2025 as applied to base data.
3. **Incurred But Not Reported (IBNR) Adjustment:** IBNR adjustment accounts for claims that were incurred but may not be accurately reflected in the data for various reasons, such as outstanding payments and adjudication.
4. **Leakage Removal:** Claims for members that were identified as leakage are removed from the base data. Leakage is defined as Prospective Payment eligible services performed by a different billing entity (other than the member's attributed billing entity).
5. **Credibility Weighting:** PMPM rate projections for PCMPs with fewer attributed members are much more volatile. As a result, if a PCMP has fewer attributed members than the standard credibility threshold as defined by the Department, their base data is blended with the corresponding statewide COA-specific PMPM rates to increase credibility.
6. **Retrospective Program Changes:** Base data is adjusted for policy and program changes that occurred between the base data period and the Program Year.

7. **Prospective Program Changes:** Base data is adjusted for known policy and program changes that will take effect in the Program Year and were not effective during the base years.
8. **Membership Mix Update:** Changes in a PCMP's attributed membership are accounted for by utilizing PCMP's actual attributed member months by COA as of Quarter 1 of 2025 (January 1, 2025 through March 30, 2025) to project member mix and arrive at PCMP's final PMPM rate.

If a provider is a newly participating PCMP and has no claims experience for their attributed population, the collective experience of the other PCMPs under their billing entity is used. If there are no other PCMPs under their billing entity, the new PCMP would be ineligible for the program as claims history is required to be eligible for the Quality Performance Track. The rate calculated by the Department is effective for the rate effective period and is agreed to by the PCMP via their annual Notification Letter. See the Notification Letter section in the Appendix for more information.

Prospective Payment Reconciliation

PCMPs that select to receive any portion of their revenue as prospective PMPM payment are still required to submit claims for all services provided, even though the service billed may not generate payment. This billing practice is known as shadow billing, which enables HCPF to "shadow price" the amount that the PCMP would have been paid under FFS. Shadow billing is a requirement of prospective PMPM payment participation. Shadow billing provides HCPF with the necessary data to perform reconciliation and inform future rates. Inaccurate or inconsistent shadow billing can negatively impact a PCMP's future rates and reconciliation results.

After the conclusion of each Performance Year, the Department must allow a six-month runout period before conducting the reconciliation process.

Note: While Federally Qualified Health Centers (FQHCs) are required to shadow bill and go through a reconciliation process, federal law requires that HCPF reimburse all FQHCs for no less than what they would have received under the federal PPS encounter rate.

Quality Standards for Prospective Payment Retention

Participation in prospective payments is risk-free for the first year of enrollment. In subsequent years of participation, reconciliation is tied to a billing entity's ability to meet a minimum quality threshold. This requires each billing entity to meet a minimum of two (2) Basecamp thresholds per PCMP site that is eligible for the Performance Track (e.g., if four (4) PCMP sites under a large billing entity are eligible for the Performance Track, then the billing entity must achieve a collective eight (8) Basecamp Thresholds for their assigned Quality Measures).

In the **first year of prospective payment participation**:

- If the PMPM amount paid is less than the shadow priced FFS amount, HCPF will pay the difference to the billing entity.
- If the PMPM amount paid is more than the shadow priced FFS amount, the billing entity may keep the difference.

In the **second year and subsequent years of prospective program participation**:

- If the PMPM amount paid is less than the shadow priced FFS amount, HCPF will pay the difference to the billing entity only if the billing entity has met the quality threshold of two (2) Basecamp Quality Thresholds per eligible Performance Track site.
    - If a billing entity **does not meet** the required quality threshold, they do not receive any additional payment that would make them whole to the shadow priced FFS amount.
- If the PMPM amount paid is more than the shadow priced FFS amount, the billing entity may keep the difference only if the billing entity has met the quality threshold of two (2) Basecamp Quality Thresholds per eligible Performance Track site.

Quality Tie – Prospective Payment Program: If a billing entity **does not meet** the required quality threshold, they will be required to remit no more than 4% (overpayment return ceiling) of the total prospective PMPM payment they received that year. This approach is new for Program Year 2026. The Department aims to create a predictable maximum limit with the new overpayment return ceiling, so providers can anticipate the potential financial impact. Therefore, the overpayment return ceiling is based on the prospective PMPM provided at the start of the performance period. In contrast, during Program Year 2025, providers had to remit any amount received through the prospective PMPM payment that exceeded the shadow priced FFS amount, without a ceiling.

Opting Out of Prospective Payments

If at any point during the Program Year the billing entity chooses to opt out of participating in the Prospective Payment Program, they must contact the Department at HCPF_primarycarepaymentreform@state.co.us. The billing entity's enrollment will be terminated on the first of the month following 30 days of notice.

Shared Savings for Members with Chronic Conditions

The Department continues to support Colorado's shift to value-based care through a shared savings program that rewards PCMPs for effective management of Total Cost of Care (TCOC) for their attributed members with chronic conditions.

Shared savings payments are upside-only (e.g., PCMPs can earn additional revenue if they reduce chronic condition costs but are not penalized if they do not). This incentivizes practices to improve the management of chronic conditions while maintaining quality of care. The shared savings payment rewards PCMPs and RAEs with 37.5% and 12.5%, respectively, of the total savings achieved across costs associated with members having at least one of the ten chronic conditions listed in Figure 4 below. For more information on how to utilize RAE resources to support Shared Savings performance, please refer to the FAQs in the Appendix. For more information on how the PACES grouper identifies members with chronic conditions, please refer to the Episode Logic and Business Rules document on the HCPF website.

Figure 4: List of Qualifying Conditions

Qualifying Chronic Conditions

These conditions were determined to be **major cost drivers** for the State and are considered amenable to primary care intervention. Members must have **one or more** of the following conditions to be evaluated under the shared savings program:

- Asthma
- Coronary Artery Disease
- Diabetes
- Gastro-Esophageal Reflux Disease (GERD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Lower Back Pain
- Osteoarthritis
- Heart Failure
- Arrhythmia / Heart Block

Shift to Total Cost of Care

In Program Year 2026, the Shared Savings Program transitioned from an episode-based model to a Total Cost of Care (TCOC) model. Members with chronic conditions remain the focus of the shared savings program, but PCMPs and RAEs are better incentivized to treat and otherwise address common comorbidities. Total spending on all healthcare costs for chronic members will be calculated annually. The TCOC model is designed to reward providers and RAEs for maintaining high-quality care while concurrently reducing overall healthcare costs. The shift to TCOC allows for greater PCMP opportunity to generate savings across all levels of care for members with chronic conditions, not just the costs assigned to each specific chronic episode. Certain member and service exclusions will be applied so that costs included in the program will only include what providers can reasonably influence and be held accountable for throughout care delivery.

The following **member filters** are applied to both periods, once in the calculation of Shared Savings thresholds using Calendar Year 2024 data, and again to performance calculations based on Calendar Year 2026 data. These filters are applied to ensure that participating PCMPs can reasonably identify and manage costs for their attributed population:

- **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 6 months during the period.
- **Minimum Attribution Period:** Members must be attributed to a PCMP for at least 6 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.

  Technical definitions of member carve-outs can be found in the "Shared Savings Member and Service Carve-Out Definitions" section of the Appendix.

The following **healthcare service cost carve-outs** are applied to the calculation of Shared Savings thresholds (CY2024 data) and performance (CY2026 data) to ensure that participating

PCMPs are not incentivized or penalized for services for which clinical need should be prioritized. Other exclusions are applied if they are not reimbursed via traditional FFS or FQHC encounter payments:

- **Service Carve-Outs:**
  - 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.

Technical definitions of service carve-outs can be found in the "Shared Savings Member and Service Carve-Out Definitions" section of the Appendix.

Eligibility

Providers may be eligible to participate under two separate pathways: Provider-specific Thresholds (TIN-level participation), or a Small PCMP Pool under each RAE.

TIN-Level Participation: A minimum attribution requirement of 1,000 members with a chronic condition was determined using a credibility formula, which establishes a minimum level of statistical confidence for calculating savings. For Program Year 2026, if a billing entity has 1,000 attributed members with a chronic condition in the threshold period (Calendar Year 2024), then they are automatically enrolled as a TIN-level participant and will be evaluated against a provider-specific threshold. TIN-level participation is mandatory for all billing entities that are eligible for a provider-specific threshold.

Small PCMP Pool Participation: Remaining PCMPs (e.g., Providers not automatically enrolled as TIN-level participants) who are eligible for the Performance Year 2026 Quality Performance Track are eligible to opt into the Small PCMP Pool. RAEs will solicit participation for their Small PCMP Pools at least three months before each Program Year begins. For Program Year 2026, the recruitment process occurred over a 4-week period from mid-September to mid-October.

TCOC Thresholds

TCOC thresholds are the cost targets established in advance of the performance period using Calendar Year 2024 data. Thresholds are specific to each participant, meaning that TIN-

level participants, RAEs, and Small PCMP Pools are only measured against their own historical performance. This is a change from the Performance Year 2025 Shared Savings program, in which participants were measured against thresholds based on statewide benchmarks. **Threshold calculations for each participant follow the steps outlined below:**

1. **Member Aggregation:** Determine the sum of attributed member years for each participant after applying the necessary member carve-outs.

   Member years account for partial-year enrollment or chronic conditions that are only active for a portion of the threshold period (minimum of 6 months for each member).

2. **Cost Aggregation:** Determine the Total Cost of Care for the participant's attributed population after applying the necessary service carve-outs as outlined above and defined in the appendix.

3. **Per-Member Per-Year Costs:** Divide aggregate costs by aggregate member years to arrive at per-member, per-year (PMPY) costs for the threshold period.

4. **Minimum Savings Rate:** Compare aggregate member years to the Minimum Savings Rate tiers outlined in Figure 5 below and determine the applicable savings rate for each participant. Note that the effective Minimum Savings Rate (MSR) will be re-evaluated using performance period data since member attribution may fluctuate between MSR tiers.

5. **Base Year Threshold**: Multiply the PMPY cost by one minus the MSR percentage to arrive at the Base Year threshold to be communicated to each participant prior to the start of the performance year.

   Note that the Base Year Threshold will be risk-adjusted and trended during savings calculations for Performance Year 2026, resulting in the final Commendable Threshold (defined below) that PY2026 performance will be measured against. This allows for an apples-to-apples comparison between the Baseline and Performance period data, accounting for changes in risk, price of services, policy changes, etc.

Figure 5: Minimum Savings Rate Tiers

Larger populations have a lower MSR because cost averages are more stable and statistically credible.

Smaller populations have a higher MSR because cost data is more volatile.

Minimum Chronic Members Attributed	Minimum Savings Rate (MSR)
6,300	2.0%
4,000	2.5%
2,800	3.0%
2,000	3.5%
1,500	4.0%
1,200	4.5%
1,000	5.0%

Example: A practice with 4,000 Chronic members at TIN-level has an MSR of 2.5%

Shared Savings Reconciliation and Payment Conditions

Following the end of a Performance Year, participants will have their Base Year Thresholds adjusted to account for change in member risk (Risk Adjustment), change in price of services (Trend Adjustment), and the change in statewide utilization (Trend Adjustment). After determining a participant's final MSR and adjusting for risk and trend, the Commendable Threshold is established. Actual PMPY costs from Performance Year 2026 are reconciled against the Commendable Threshold to determine if a participant achieved Year-over-Year (YoY) savings (e.g., reduced costs in CY2026 relative to CY2024).

The following factors will be applied to the Base Year Threshold to arrive at the Commendable Threshold:

1. Participant's change in the Chronic Illness and Disability Payment System (CDPS) risk score from the threshold period (Calendar Year 2024) to the performance period (Calendar Year 2026). More information about CDPS risk scores can be found in the appendix.
2. Any Centers for Medicare and Medicaid Services (CMS) approved policy changes (i.e. program updates).
3. A statewide trend that encapsulates changes in HCPF fee schedule increases or decreases, and changes in member utilization and service mix after accounting for differences in member severity between the performance and threshold periods.

Quality Tie - Shared Savings Program: Providers will only be eligible to receive shared savings payments if the participant met the Basecamp Quality Threshold for at least two Adult quality measures per Performance Track PCMP (e.g., if four (4) PCMP sites under a large billing entity are eligible for the Performance Track, then the billing entity must achieve a collective eight (8) Basecamp Thresholds for their Adult Quality Measures). Adult Quality Measures consist of the following Performance Track Measures:

- Depression Screening and Follow-up (Adults).
- Cervical Cancer Screening.
- Colorectal Cancer Screening.
- Glycemic Status Assessment.
- Controlling High Blood Pressure.
- Chlamydia Screening.
- Breast Cancer Screening.

PCMPs will be eligible to receive 37.5% of the savings between the Commendable Threshold and actual PMPY cost achieved in Performance Year 2026. If PMPY costs

are **higher** than the Commendable Threshold, participants will not receive any shared savings. However, there will be no adverse consequences for the provider, as this is an upside risk program.

If the participant has not met two (2) Basecamp Quality Thresholds for adult measures per Performance Track PCMP, they will not receive any shared savings.

Appendix

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Attribution Methodology

Attribution is the process by which members are assigned to a participating PCMP that serves as a focal point of care. Accurate determination of the relationship between a member and PCMP is critical to APMs to ensure that the correct PCMP is credited and reimbursed appropriately for a member's improved outcomes and costs. Unattributed members and excluded members will continue to receive 100% of the Health First Colorado Fee Schedule regardless of PMPM selection.

All members are initially attributed to a PCMP in the following order:

1. **Member Choice**: Every member has the option of changing their PCMP at any time by contacting their Health First Colorado enrollment broker. Member choice is prioritized above other types of attribution.
2. Based on **Utilization:** If a member has a predominant claims history with a PCMP over the last 18 months, and the PCMP is contracted with the ACC as a PCMP, the member is attributed to that PCMP.

Reattribution is the process by which members are reassigned to a different PCMP based on the most recent claims history. Reattribution occurs every month for members 0 to 2 years old and every three months for all members older than 2.

The Department generates monthly PCMP attribution lists that are available to PCMPs. Prospective payments to PCMPs will change based on the number of monthly attributed members.

Under prospective payment methodology, the following members are **excluded** from prospective PMPM payment and shared savings payment calculations:

- Members who are geographically attributed to a participating provider (applicable for dates of service through 6/30/2025).
- Members who are dually enrolled in Medicare and Medicaid.
- Members enrolled in the Program for All-Inclusive Care for the Elderly (PACE).
- Members enrolled in Child Health Plan *Plus* (CHP+)
- Members enrolled in managed care plans through Denver Health or Rocky Mountain Health Plans - PRIME.

Note: A member is only attributed to one PCMP at a time. This eliminates the possibility of

duplicating payments to multiple PCMPs for the same member. If a member is reattributed, payments will only be made to the PCMP for dates of service within the attribution period. If a member is reattributed to a PCMP that does not participate, no payment will be made for that member.

Provider Notification Letter and Response

Notification Letter

Billing entities that are eligible and elect to participate in Prospective Payments or Shared Savings will receive a Notification Letter from the Department of Health Care Policy and Financing (HCPF) prior to the start of the Program Year, which runs from January 1 – December 31, which states the specific qualifications for that PCMP's participation.

For Prospective Payments, the Notification Letter contains the following information:

- *Rate Effective Date*: The rate effective start and end date for program participation (enrollment is annually on a calendar year).
- *Fee-for-Service (FFS) Percentage*: The percentage reduction in FFS reimbursement to the Health First Colorado fee schedule proposed by the participating PCMP.
- *Per-Member-Per-Month (PMPM) Rate*: The Prospective Payment to PCMPs based on historical data from their qualifying members.

For Shared Savings, the Notification Letter contains the following information:

- *Attributed Chronic Member Years*: Total member years accounted for in the Base Year Threshold calculation.
- *Attributed Chronic Member TCOC*: Total member costs accounted for in the Base Year Threshold calculation.
- *Base Year Threshold:* Average per-member, per-year (PMPY) costs for their base period attribution. Note that Base Year Thresholds will be risk-adjusted and trended when performance period data becomes available.

Please note Provider Notification Letters for the Prospective Payments and Shared Savings Payments will be sent separately.

Response Letter

A written response letter is required for Prospective Payment participants in order to sign off on PMPM rates. The written response letter is a signed copy of the Notification Letter from a billing entity affirming that all ACC-contracted PCMPs will receive payment pursuant to the established calculations. The Department will only make payments as outlined in this guide if the Department receives a signed agreement from the PCMP through this Response Letter.

A Notification Letter Response must be signed by a representative of the billing entity to finalize enrollment into Prospective Payments. The Response Letter memorializes the billing entity's agreement with the terms of the Notification Letter.

Modified APM Code Set

Code	Procedure	Code	Procedure
36415	ROUTINE VENIPUNCTURE	99304	NURSING FACILITY CARE INIT
36416	CAPILLARY BLOOD DRAW	99305	NURSING FACILITY CARE INIT
90460	IM ADMIN 1ST/ONLY COMPONENT	99306	NURSING FACILITY CARE INIT
90471	IMMUNIZATION ADMIN	99307	NURSING FAC CARE SUBSEQ
90472	IMMUNIZATION ADMIN EACH ADD	99308	NURSING FAC CARE SUBSEQ
90473	IMMUNE ADMIN ORAL/NASAL	99309	NURSING FAC CARE SUBSEQ
90474	IMMUNE ADMIN ORAL/NASAL ADDL	99310	NURSING FAC CARE SUBSEQ
99201	OFFICE/OUTPATIENT VISIT NEW	99315	NURSING FAC DISCHARGE DAY
99202	OFFICE/OUTPATIENT VISIT NEW	99316	NURSING FAC DISCHARGE DAY
99203	OFFICE/OUTPATIENT VISIT NEW	99318	ANNUAL NURSING FAC ASSESSMNT
99204	OFFICE/OUTPATIENT VISIT NEW	99324	DOMICIL/R-HOME VISIT NEW PAT
99205	OFFICE/OUTPATIENT VISIT NEW	99325	DOMICIL/R-HOME VISIT NEW PAT
99211	OFFICE/OUTPATIENT VISIT EST	99326	DOMICIL/R-HOME VISIT NEW PAT
99212	OFFICE/OUTPATIENT VISIT EST	99327	DOMICIL/R-HOME VISIT NEW PAT
99213	OFFICE/OUTPATIENT VISIT EST	99328	DOMICIL/R-HOME VISIT NEW PAT
99214	OFFICE/OUTPATIENT VISIT EST	99334	DOMICIL/R-HOME VISIT EST PAT
99215	OFFICE/OUTPATIENT VISIT EST	99335	DOMICIL/R-HOME VISIT EST PAT

Modified APM Code Set

99336	DOMICIL/R-HOME VISIT EST PAT	99386	PREV VISIT NEW AGE 40-64
99337	DOMICIL/R-HOME VISIT EST PAT	99387	INIT PM E/M NEW PAT 65+ YRS
99341	HOME VISIT NEW PATIENT	99391	PER PM REEVAL EST PAT INFANT
99342	HOME VISIT NEW PATIENT	99392	PREV VISIT EST AGE 1-4
99343	HOME VISIT NEW PATIENT	99393	PREV VISIT EST AGE 5-11
99344	HOME VISIT NEW PATIENT	99394	PREV VISIT EST AGE 12-17
99345	HOME VISIT NEW PATIENT	99395	PREV VISIT EST AGE 18-39
99347	HOME VISIT EST PATIENT	99396	PREV VISIT EST AGE 40-64
99348	HOME VISIT EST PATIENT	99397	PER PM REEVAL EST PAT 65+ YR
99349	HOME VISIT EST PATIENT	99401	PREVENTIVE COUNSELING INDIV
99350	HOME VISIT EST PATIENT	99402	PREVENTIVE COUNSELING INDIV
99381	INIT PM E/M NEW PAT INFANT	99403	PREVENTIVE COUNSELING INDIV
99382	INIT PM E/M NEW PAT 1-4 YRS	99404	PREVENTIVE COUNSELING INDIV
99383	PREV VISIT NEW AGE 5-11	99406	BEHAV CHNG SMOKING 3-10 MIN
99384	PREV VISIT NEW AGE 12-17	99407	BEHAV CHNG SMOKING > 10 MIN
99385	PREV VISIT NEW AGE 18-39	99408	AUDIT/DAST 15-30 MIN

Modified APM Code Set

99409	AUDIT/DAST OVER 30 MIN		
99411	PREVENTIVE COUNSELING GROUP		
99412	PREVENTIVE COUNSELING GROUP		
99415	PROLONG CLINCL STAFF SVC		
99416	PROLONG CLINCL STAFF SVC ADD		
G0101	CA SCREEN; PELVIC/BREAST EXAM		
G0124	SCREEN C/V THIN LAYER BY MD		
G8431	POS CLIN DEPRES SCRN F/U DOC		
G8510	SCR DEP NEG, NO PLAN REQD		
Q0091	OBTAINING SCREEN PAP SMEAR		

Note: Prospective Payments exclude Long-Acting Reversible Contraceptive codes from the calculated rates to ensure that Members have free choice of all qualified and willing providers of those Long-Acting Reversible Contraceptive services.

Primary Care Provider Taxonomy Codes

Service	Code	Service	Code
Clinical Nurse Specialist - Acute Care	364SA2100X	Clinical Nurse Specialist -Community Health/Public Health	364SC1501X
General Practice	208D00000X	Clinical Nurse Specialist - Family Health	364SF0001X
Internal Medicine - Hospice and Palliative Medicine	207RH0002X	Clinical Nurse Specialist – Gerontology	364SG0600X
Physical Medicine Rehabilitation - Hospice and Palliative Medicine	2081H0002X	Clinical Nurse Specialist – Women's Health	364SW0102X
Advanced Practice Midwife	367A00000X	Family Medicine	207Q00000X
Clinic/Center - Family Planning, Non-Surgical	261QF0050X	Family Medicine - Addiction Medicine	207QA0401X
Clinic/Center - Federally Qualified Health Center (FQHC)	261QF0400X	Family Medicine - Adolescent Medicine	207QA0000X
Clinic/Center - Health Service	261QH0100X	Family Medicine - Adult Medicine	207QA0505X
Clinic/Center - Primary Care	261QP2300X	Family Medicine - Bariatric Medicine	207QB0002X
Clinic/Center - Rural Health	261QR1300X	Family Medicine - Geriatric Medicine	207QG0300X
Clinical Nurse Specialist - Adult Health	364SA2200X	Family Medicine - Hospice and Palliative Medicine	207QH0002X
Clinical Nurse Specialist - Chronic Care	364SC2300X	Internal Medicine	207R00000X

Primary Care Provider Taxonomy Codes

Internal Medicine - Geriatric Medicine	207RG0300X	Nurse Practitioner – Perinatal	363LP1700X
Midwife	176B00000X	Nurse Practitioner - Primary Care	363LP2300X
Military Health Care Provider	171000000X	Nurse Practitioner – School	363LS0200X
Nurse Practitioner	363L00000X	Nurse Practitioner – Women's Health	363LW0102X
Nurse Practitioner - Acute Care	363LA2100X	Obstetrics Gynecology	207V00000X
Nurse Practitioner - Adult Health	363LA2200X	Obstetrics Gynecology - Critical Care Medicine	207VC0200X
Nurse Practitioner - Community Health	363LC1500X	Obstetrics Gynecology – Gynecology	207VG0400X
Nurse Practitioner - Family	363LF0000X	Obstetrics Gynecology - Maternal Fetal Medicine	207VM0101X
Nurse Practitioner - Gerontology	363LG0600X	Obstetrics Gynecology – Obstetrics	207VX0000X
Nurse Practitioner - Neonatal	363LN0000X	Obstetrics Gynecology - Reproductive Endocrinology	207VE0102X
Nurse Practitioner - Obstetrics Gynecology	363LX0001X	Pediatrics	208000000X
Nurse Practitioner - Pediatrics	363LP0200X	Pediatrics - Adolescent Medicine	2080A0000X
Nurse Practitioner - Pediatrics - Critical Care	363LP0222X	Pediatrics - Child Abuse Pediatrics	2080C0008X

Primary Care Provider Taxonomy Codes

Pediatrics - Neonatal- Perinatal Medicine	2080N0001X		
Physician Assistant	363A00000X		
Physician Assistant - Medical	363AM0700X		
Preventive Medicine - Occupational Medicine	2083X0100X		
Preventive Medicine - Preventive Medicine/Occupational Environmental Medicine	2083P0500X		
Preventive Medicine - Public Health General Preventive Medicine	2083P0901X		
Registered Nurse	163W00000X		
Registered Nurse - Case Management	163WC0400X		
Registered Nurse - Community Health	163WC1500X		
Registered Nurse - General Practice	163WG0000X		

Year-over-Year (YoY) Application of CDPS

For Program Year 2026, the Department will utilize the Chronic Illness and Disability Payment System (CDPS) to better align with other HCPF payment programs and more than 30 other state Medicaid agencies.

CDPS categorizes individuals based on their medical diagnoses and the expected cost of care, helping states and MCOs adjust payments based on the health status and anticipated healthcare needs of enrollees. Weights are fixed across all states and time periods unless UC San Diego publishes a new version of the CDPS model. HCPF utilizes the most recent version of CDPS (Version 7.2 – Updated 2024).

For Shared Savings, HCPF utilizes the Prospective model for assigning risk scores to members, meaning that the preceding 12 months of utilization is used to predict the following 12 months of utilization (and therefore, cost). For example: A member's risk score for the CY2024 threshold period (1/1/2024 - 12/31/2024) would be determined using claims with dates of service from CY2023 (1/1/2023 - 12/31/2023). Prospective risk models are consistent with those utilized in other CMS programs.

For Shared Savings, members are assigned into the SSI (disabled) or TANF Adult CDPS model based on their assigned category of aid. Weights are applied based on member demographics (age, sex) and diagnosis code from each claim in the prospective period (e.g., utilization for dates of service from 1/1/2023 – 12/31/2023 to predict CY2024 risk). Figure 6 below shows an example member risk score with the buildup of individual CDPS weights.

Figure 6: Example CDPS Member Risk Calculation

Flag (Severity)	Weight
Female Age 25	0.052
Gastro (Low)	0.249
Diabetes (Type 1)	2.195
Cancer (Low)	0.658
Total Risk Score	3.154

Participant-specific risk (billing entity, Small PCMP Pool or RAE) is aggregated by summing the risk scores for the total attributed population and dividing by the sum of attributed member years. This is performed separately for the threshold period and the performance period. Once performance year data becomes available, each participant's Base Year Threshold is risk adjusted by applying the percentage change in participant-specific risk from the threshold period to the performance period.

Shared Savings Program
Member and Service Carve-Out Definitions

Member Carve-Outs

Category	Technical Definition
Members must not require lifelong specialized care (e.g., quadriplegia, ALS, comatose).	• Members who have one of the following chronic episodes active as of the end of the period (e.g., 12/31/2024 for PY2026 thresholds): ○ ALS ○ Brain Injury / Coma ○ Cerebral Palsy ○ Chronic Kidney Disease ○ Cystic Fibrosis
Members must not be actively receiving hospice or end-of-life care.	• Members who have a claim during the period with a Hospice revenue code, as defined by the HCPF Hospice Billing Manual.
Members must not have received an organ transplant.	Members who have one of the following procedural or acute episodes within the past four years: • Kidney Transplant (Procedural) • Liver Transplant (Procedural) • Transplant Nos Complication (Acute) • Intestinal Transplant Complications (Acute) • Liver Transplant Complications (Acute) • Pancreas Transplant Complications (Acute) • Bone Marrow Transplant Complication (Acute) • Kidney Transplant Complication (Acute) • Heart Transplant Complications (Acute)
Members must not have ongoing treatment for malignant or metastatic cancer.	• Members who have one of the following chronic episodes active at the end of the period (e.g., 12/31/2024 for PY2026 thresholds) AND at least $500 in episode

	costs for these episodes: ○ kaposi's sarcoma nos ○ colorectal neoplasm malignant ○ esophagus neoplasm malignant ○ hepatobiliary neoplasm malignant ○ metastatic neoplasm to gi organs ○ malignant neoplsm spleen ○ other gi neopasm malignant ○ pancreatic neoplasm malignant ○ small bowel neoplasm malignant ○ stomach neoplasm malignant ○ lymphoma other non-Hodgkin ○ lymphoma Hodgkin ○ metastatic neoplasm to lymph nodes ○ kaposi's sarcoma lymph nodes ○ male breast neoplasm malignant ○ scrotum/contents neoplasm malignant ○ penis neoplasm malignant ○ prostate neoplasm malignant ○ msk nos neoplasm malignant ○ cns nos neoplasm malignant ○ meningial neoplasm malignant ○ bladder neoplasm malignant ○ kidney neoplasm malignant ○ gyn nos neoplasm malignant ○ leukemia chronic

Service Carve-Outs

Category	Technical Definition
Maternity-related services	• Claims related to one of the following procedural or acute episodes active during the period (e.g., CY2024 for PY2026 thresholds): ○ Pregnancy Delivery/Trigger ○ C-Section ○ Vaginal Delivery ○ Obstetric Trauma Maternal ○ Malignant Neoplasm Placenta

	○ Neoplasm Uncertain Behavior Placenta ○ Abortion Spontaneous/Induced ○ Ectopic Pregnancy/Related ○ OB/LandD Complications ○ Other Obstetric Disease ○ Prenatal Maternal Complications ○ Soft Tissue Nos - Pregnancy Related ○ Newborn
Long-term home health services.	• Provider Type = Home Health (10); *AND* • Claim Type = Crossover (C) OR Long-Term Care (L); *AND* • Revenue Code = any of (421, 431, 441, 551, 571, 579, 590, 599, 780)
Services provided at long-term nursing and intermediate care facilities	• Provider Type = Nursing Facility (20 OR 21); *AND* • Claim Type = Long-Term Care (L)
Waiver Services - Home- and Community Based Services (HCBS)	• Provider Type = HCBS (36); *AND* • Member Health Program Code = any of (BI, CCTBI, CCTCM, CCTDD, CCTEB, CCTSL, CES, CHCBS, CHRP, CLLI, CMHS, CWA, DD, EBD, SCI, SLS)
Non-Emergency Medical Transportation	• Place of Service Code = Land Transport (41) OR Air Transport (42); *AND* • Diagnosis Code = Other General Signs / Symptoms (R68.89); *OR* • Procedure Code = one of the following: ○ A0110 ○ A0080 ○ A0090 ○ A0120 ○ A0425 ○ A0130 ○ S0209 ○ T2001 ○ A0210 ○ A0210 ○ T2005 ○ T2049 ○ A0428

	○ A0426 ○ A0433 ○ A0425 ○ A0434 ○ A0190 ○ A0021 ○ A0422 ○ A0430 ○ A0431 ○ A0140 ○ A0180 ○ A0200 ○ A0100
Behavioral Health Secure Transportation	• Procedure Code = A0999 with Modifier ET; *OR* • Procedure Code = A0425 with Modifier ET
Dental services	• Claim Subtype = Dental
Vision services	• Claim Subtype = Vision
RAE-reimbursed Behavioral Health Services	• Dataset specific to RAE BH services
Pharmacy costs	• Dataset specific to pharmacy claims
Services provided at Indian Health Services (IHS) PCMPs	• Provider type code = 61

Primary Care Payment Structure Frequently Asked Questions

Below are some frequently asked questions to help providers better understand the transition to the ACC Phase III Primary Care Payment Structure. Providers can reach out to Department staff to receive free access to data analysis specific to their practice or system's situation or fill out a brief survey to learn more.

General

1. Will primary care medical providers be able to see or track their performance?
    a. Yes. The Department is developing quarterly reports that will drill down to the member- and claim- level to assist program participants with tracking performance and managing their attributed population.

2. How often will member reattribution take place?
    a. Reattribution is the process by which members are reassigned to a different PCMP based on their most recent claims history. Reattribution occurs every month for members 0 to 2 years old and every three months for all members older than 2. Please see the Attribution Methodology section of the guide for additional details.

3. When can a provider join Shared Savings or Prospective Payments?
    a. Prospective Payments: Interested providers can enroll on an annual basis. The Department will need at least two months to develop per-member, per-month rates for providers who choose to enroll outside of the annual Program Year cycle (e.g., selecting a rate effective date other than January 1).
    b. Shared Savings: Eligibility will be determined on an annual basis. For billing entities with more than 1,000 attributed members with one of the ten program chronic conditions, enrollment is automatic and mandatory. For PCMPs not automatically enrolled, RAEs will conduct an annual recruitment process starting in September of each year for their Small PCMP Pool, as outlined in the Eligibility section.

4. Can a participant withdraw during the middle of a Program Year?
    a. Prospective Payments: Yes. A billing entity can decide to withdraw from Prospective Payment participation in the middle of a Program Year with proper notification. If the billing entity chooses to stop participating on the first day of the month, their withdrawal will be effective starting the first day of the following month. If they decide to withdraw in the middle of a month, their withdrawal will be effective on the first day

of the second month after their decision (i.e. if the withdrawal decision is submitted March 15th, the withdrawal is effective on May 1st).

b. Shared Savings: Given that Shared Savings is upside-only, there is no option available for a PCMP or billing entity to withdraw from the program mid-year.

Prospective Payments

5. What Evaluation and Management codes will be a part of the per member, per month payment?

   a. Please see the Modified APM Code Set in the Appendix for additional details.

6. How often will the enrolled providers receive Prospective Payments?

   a. The per member, per month payment will be paid on a monthly basis for qualifying attributed members.

7. If 100% of a PCMP's revenue for primary care services is reimbursed via Prospective Payments, why does a PCMP need to submit Shadow Billed claims?

   a. Shadow Billing is crucial for HCPF for two reasons: 1) for reconciliation at the end of the performance period, and 2) for accurate data in future rate-setting. For reconciliation, once the Program Year is complete, HCPF determines if additional payments or recoupments need to be made to correct for significant differences between the Shadow Billed FFS amount and PMPM payments made. For future rate-setting periods, maintaining accurate claims data for participants ensures that the Department can continue to track primary care utilization across all PCMPs, which is especially important to capture in future rate-setting periods should the participant continue to enroll in Prospective Payments.

Shared Savings

8. How often will Shared Savings payments be made?

   a. Incentive payments will be paid annually. Payments will be made nine to ten months after the end of the Program Year, which allows sufficient time for claims runout and reconciliation of participant performance against their thresholds.

9. Why does the Minimum Savings Rate (MSR) change based on the number of attributed members with a chronic condition?

   a. The variable MSR tiers were established for two reasons. One reason is to reduce the probability of savings being driven by random fluctuation in cost / utilization. As sample size increases, the MSR decreases. The second reason was to allow for a greater number of participants at the TIN level. If the MSR can scale above 2.0%, then the

minimum number of attributed members with a chronic condition can be lowered from 6,300 members.

10. Why is the Shared Savings Program Year 2026 threshold based on a participants own historical cost as opposed to risk-adjusted statewide average in Program Year 2025?

    a. The purpose of this change is to realign the program incentive to reward year-over-year (YoY) reductions in cost for each participant. Thresholds are now tailored to each TIN's, RAE's, or Small PCMP Pool's attributed member population for those with a chronic condition. This is a significant change from Program Year 2025 since those thresholds were set using a statewide FQHC or Non-FQHC average. Historically, participants who were consistently more cost-efficient than the statewide average would achieve savings payments, even if their average cost per episode increased from the threshold period to the performance period.

11. How should PCMPs utilize their RAEs to improve Shared Savings performance and better manage their attributed member population?

    a. Before the start of each Program Year, RAEs are required to develop a strategic plan to help their constituent PCMPs achieve Shared Savings and reduce costs for their attributed members with chronic conditions. Participating PCMPs should reach out to their respective RAEs to learn more about their strategy and leverage their assistance wherever possible. For more information, please reference the ACC Phase III Provider and Stakeholder Resource Center.

12. Are Shared Savings calculated for all members with the ten chronic conditions listed?

    a. Yes, Shared Savings calculations capture total medical spend for attributed members that have one of the ten chronic conditions, as long as they meet the member filter requirements listed in the Shift to Total Cost of Care section.

13. Where can I find more information about members captured in the Shared Savings Program?

    a. Alongside the workbook that outlines each participant's TIN-specific or Small PCMP Pool-specific Base Year Threshold for Program Year 2026, HCPF will provide member-level detail that helps each participant identify A) all members that are accounted for in their CY2024 cost threshold, and B) which of the ten chronic conditions are present for each member. Participants will continue to receive updated data throughout Program Year 2026 that aligns with their performance period attribution. Participants will also have the opportunity to provide feedback on how future iterations could better assist them in improving Shared Savings program performance.

For more information contact

hcpf_primarycarepaymentreform@state.co.us

or use the Department's QandA / Feedback Form for the Primary Care Payment Structure