COLORADO
Department of Health Care Policy & Financing

Primary Care Workgroup Feedback Sessions
Prospective Payments Session 2
Meeting Minutes

Date: June 11, 2025
Time: 12:00 PM to 1:00 PM
Session Topic: Proposed Updates to Primary Care Prospective Payments

Agenda

1. Recap of Last Session
2. Updating Reconciliation Processes – Risk Corridor
3. Vision and Goals of Prospective Payment

1. Recap of Last Session

Taylor Kelley opened the meeting by sharing the agenda and summarizing last week's discussion around updating the member mix and using a rebasing methodology to adjust PMPM rates.

Workgroup members were representatives of providers and Regional Accountable Entities (RAEs).

Other attendees included Araceli Santistevan (HCPF), Devin Kepler (HCPF), Dawson LaRance (HCPF), Madisen Frederick (HCPF), Katie Price (HCPF), Suman Mathur (Stakeholder Engagement Team), Taylor Kelley (Stakeholder Engagement Team), Lauren Bell (Stakeholder Engagement Team), Puja Patel (Support Team), Cally Prutting (Support Team), and Allon Pevzer (Support Team).

Devin Kepler then introduced himself and recapped the changes to member mix in Program Year (PY) 2026, which includes updating the four rates used for member mix by stratifying them by age and incorporating behavioral health episodes and chronic conditions into the rates. He noted it's important that these rates are accurate and a true reflection of member mix for HCPF to move towards true capitation. He explained that member mix would influence the initial rates, and then these would be rebased. Then, reconciliation would occur, which involves comparing the shadow billed Fee for Service (FFS) claims to the rebased per member per month (PMPM). This reconciliation process is similar to the current process, except for the rebasing.

2. Updating Reconciliation Processes – Risk Corridor

Devin shared the proposed change for PY 26 which introduces a risk corridor and acknowledged this would be a change compared to the current state. He noted reconciliation is currently a pain point and described how reconciliation currently works. Currently, if the PMPM is less than the shadow billed FFS, HCPF pays the difference to a Primary Care Medical Provider (PCMP). However, if the PMPM is greater than the shadow billed FFS, PCMPs may

keep the difference only if the Alternative Payment Model (APM) 1 quality threshold is met. Otherwise, the PCMP is required to remit the full payment (as described on slide 7).

HCPF is proposing the introduction of risk corridors, which limits the financial risk for HCPF and PCMPs. If a PCMP's rebased PMPM rate is less than their shadow billed FFS rate, HCPF pays the difference, up to 10% of the difference from shadow-billed FFS claims, meaning that a PCMP cannot lose more than 10%. If a PCMP's rebased PMPM is greater than their shadow billed FFS, HCPF then recoups up to 15% of the shadow-billed FFS amount, meaning that a PCMP may keep any overage up to 15%.

Devin then walked through a scenario in which a practice's PMPM is rebased for 10,000 child member months. Upon rebasing, the practice's member mix increased their PMPM because they ended up with a greater proportion of children with behavioral health needs than originally calculated. The initial annual payment was calculated to be $31,000 using a PMPM rate of $31. The rebased payment is $35,000 using a rebased PMPM of $35. This resulted in the PCMP being underpaid by $4,000 based on member mix alone.

Next, Devin walked through the application of the risk corridor. In this same scenario, the PCMP's rebased PMPM with actual member mix was $35,000; however, the PCMP only shadow billed for $30,000. The upper threshold of the risk corridor is $34,500 (115% of the $30,000 shadow billed FFS) and the lower threshold of the risk corridor is $27,000 (90% of the $30,000 shadow billed FFS). Because the rebased PMPM is only $500 over the upper threshold, only $500 is at risk for HCPF to recoup.

Finally, the reconciliation happens, which combines the two prior calculations at once – the $4,000 owed to the PCMP due to rebasing is summed with the $500 overpayment due to HCPF from the risk corridor overpayment, resulting in a net positive payment of $3,500 paid to the PCMP from HCPF.

Devin also proposed another example where the rebased per member per month was $25,000 because the PCMPs member mix was healthier than expected, but they still shadow billed $30,000. That would fall under the lower threshold of the risk corridor of $27,000, so HCPF would owe $2,000 to the PCMP due to underpaying below the risk corridor.

Devin briefly reviewed some pros and cons of this approach. Pros include that the risk corridor reduces risk of loss if their FFS exceeds PMPM, regardless of meeting quality measures and, from HCPF's perspective, limits overspending and reduces exposure if FFS is below the PMPM. The cons include that PCMPs will not know their rates until the end of the year leading into the following program year and adding additional complexity to the overall methodology. He also acknowledged that this change does not really move much away from the FFS paradigm.

Discussion:

- Participants noted that for PCMPs, the financial risk is scenarios where member mix is healthier than expected or if the PMPM is higher than shadow billing.
    - Devin replied that regarding member mix, that is correct, that may represent less, but in the second situation (higher PMPM), the practice would just be reconciled up to 15%.
- A participant asked for clarity on how the quality model will be included in the reconciliation process.
    - Devin explained that previously, a practice had to meet a score of 200 on APM 1 to qualify to earn money back. In the new model, a PCMP will have to meet the minimum acceptable threshold on at least two measures as part of the quality program's Performance Track.
- A participant asked for clarification on the two-measure minimum acceptable threshold standard Devin noted.
    - Devin replied that to retain any overage, a practice would have to meet the minimum acceptable threshold for two measures. HCPF analyzed how many PCMPs were meeting at least minimum acceptable threshold for two measures, and it was close to 98%.
- Participants noted that people have a perception that the prospective payment is an opportunity to earn more money, whereas actuarily it is designed to be fairly neutral, and the benefit is predictability and the ability to provide services without the constraint of coding, though with the current practice of shadow billing, that is not the case.
    - Devin agreed and noted that HCPF has not been clear in messaging to providers on what prospective payment is or is not, and the goals of prospective payment.
    - A participant noted that PCMPs are in a resource constrained environment already, and that the financial pressure on them creates that expectation. In the evolution of APM 1, which was a consequence of the Affordable Care Act's (ACA) Section 1302 rate adjustment percentage expiring, Colorado state legislature created the APM program to compensate for the loss of the "rate bump" created by the ACA adjustment. Providers were starting from a position of loss and saw this as an opportunity to achieve quality measures and fill in the gap to compensate for the rate bump loss. The participant emphasized that it is important to remember that practices feel they are doing uncompensated

work for Medicaid patients, including addressing health related social needs (HRSNs).

- Participants mentioned that practices struggle with paying back funds to HCPF and asked if there was an opportunity for a monthly payment plan, since some practices may not have that money available or have credit lines to do so. It was suggested that moving to a risk-based model would require acknowledging the very thin margins practices are dealing with or giving practices an opportunity to negotiate these payments on a case-by-case basis.

Taylor then raised the question of whether the additional complexity is worth the extra security.

- Participants noted that the greatest con is that this may or may not change care delivery behavior due to the tie to FFS. It may change behavior for providers that have already embraced non-code based care, but not the masses, since there is still reconciliation.
    - Devin agreed and noted that in the past, the rate setting has not been accurate, so to loosen the tether to FFS in the future, the rate setting needs to be more accurate.
- A participant asked at what point during the fiscal year providers would know where they stand in the risk corridor. They mentioned that more frequent transparency reduces some of the consequences of risk.
    - Devin noted this timeline would require the same claims run out of 6 months, so we are still constrained to the lag in shadow billed claims data.
    - The participant asked if there could be predictive modeling or a tool that could help a practice get some clarity around what may happen and run some different scenarios, as practices feel in the dark, but this is new to them to and do not necessarily have staff to support this.
        - Devin acknowledged these challenges and this suggestion.
- Participants appreciated the effort of reducing risk to providers by making the quality bar easier to clear and implementing the risk corridor to protect providers.
- Participants were also concerned that the complexity will be difficult to get through to small, independent practices, as large systems will navigate it quickly.
    - Devin noted this also begs the question of what the minimum attribution floor should be as a small practice, as it would be difficult for a small practice to engage in a risk-based model as a small practice. As of now, HCPF is continuing with a 500 member floor.

- A participant noted that as a smaller practice the complexity can be challenging, but what is most challenging is the unpredictability since a practice is unsure of what their enrollment will be. In APM 2, practices selected the proportion of PMPM to FFS to receive, and this was complex to figure out. Colorado Access provided a workbook to model a practice's PMPM based on their number of attributed patients, but the workbook did not consider impacts to FFS. They explained that it is difficult for a practice to decide on what proportion to take. So, while this model is complex, it is not putting more administrative complexity on the providers since they are not being asked to document more quality measures or do anything additional or different. The complexity is understanding the impact, not in doing the work. For a small safety net clinic, most reimbursement comes through Medicaid, so anything that may impact Medicaid income is 70-75% of their reimbursement. The participant then asked whether in this model practices would still be electing a proportion of PMPM and FFS.
    - Devin replied that the program would remain optional, and a practice will still choose between 0% to 100% PMPM.
        - Participants shared that the complexity comes from trying to predict impacts to PMPM and FFS, and without having data available relatively quickly, it is a difficult decision to make.

3. Vision and Goals of Prospective Payment

Devin noted that while accuracy is important to determine in the short term, he wanted to talk about bigger picture goals of prospective payment. He walked through a theory of change, which is a framework that explains how certain interventions or initiatives lead to certain outcomes or impacts.

First, he explained the problem of traditional payment models that rely on encounter based FFS revenue rewards providers for quantity over quality and noted HCPF's desire to resolve this. Prospective payments are a potential solution to this problem, creating flexibility in how PCMPs care for Medicaid members by focusing on non-billable activities. This reduces a PCMP's reliance on visit based encounters and allows providers to implement practices like team-based care.

However, he noted this has resulted in a few ongoing issues, such as having no way to really assess whether there have been desired behavior changes in providing care and continued challenges with reconciliation as noted before. He emphasized HCPF's desire to address these challenges and also acknowledged the constraints of needing to reconcile, preventing true capitation. He also noted that it is important that for some activities, such as pediatric wellness visits and vaccinations, higher volumes are, in fact, considered better, and should be monitored. He asked the group for their thoughts on strategies to address these challenges, while striking the right balance of a blended payment model.

Discussion:

- Participants supported moving to a fully capitated model. They noted that changing a behavior isn't what matters, cost and quality outcomes matter. Payers often want to see a change before they pay, but a provider needs payment first to make a change. Allyson noted HCPF has taken the lead in being the primary risk taker for creating the prospective payment model to motivate these changes. However, with the constrained budget, HCPF may not be able to absorb as much risk to pay out a true capitated payment and see if quality is maintained and cost is reduced, or if cost is reduced and quality is improved. She shared that maintaining quality while seeing a cost reduction should be considered a win.

- A participant shared that considerations around private equity are top of mind – some providers must sell out to private equity to stay open. Changing the behavior of providers with a FFS mindset is missing some of the points around major financial constraints and administrative burden. Research suggests that small practices sell to private equity to support administrative work. The participant suggested that the payment model should address the pain points associated with HRSNs, health costs of poverty, and the specter of financialization, and prospective payment does not address these issues.

- A participant shared that it can be difficult as a small practice to really understand the financial implications around a PMPM model. It would require really sitting down to walk through each practice's specific circumstance.

Taylor posed how a capitated PMPM can address pain points like HRSN:

- A participant noted that there is benefit, but folks don't feel confident that the amount in the PMPM covers their ability to effectively address HRSNs, especially since there are not codes to demonstrate this work. Providers do not want to commit to a PMPM and are hesitant to risk either underpayment or overpayment to pay back. It's important to keep discussing how a PMPM can address HRSN, but people feel unsure of where this sits right now within the current context. If HRSN codes are not available, perhaps incentive dollars could be used to support this work, so there is some sort of revenue generation around HRSN work.

- Participants added that the payment model (FFS or capitation) is not as relevant as how much funding is available in the models.

- A participant shared that demonstrating quality outcomes can be burdensome. Many of the measures currently reported are just process measures rather than outcomes, so they are not truly giving providers credit for the actual work they are doing to improve care.

Taylor asked what outcomes would be most relevant to acknowledge the actual work being performed by PCMPs.

- Participants suggested that patient reported outcomes are ideal (e.g. improvement in patient functional, school outcomes). The focus should be on whether the patient is thriving, not just the absence of disease.
    - A participant specifically noted that outcomes are difficult to measure but should be worked towards. There are some structural outcomes at the practice level that could indicate the sustainability and thriving of providers.
- A participant suggested adding an outcome around PCMP improvement on quality measures.

Taylor closed the session by reminding the workgroup that the next two sessions will focus on shared savings.