



COLORADO

Department of Health Care
Policy & Financing

Prospective Payments Part 2

Primary Care Workgroup Sessions

June 11, 2025

Today's Agenda:

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

Recap of Last Session

- Proposed changes for PY 26:
 - Updating Member Mix
 - Support for including behavioral health and chronic conditions
 - Future member mixes should consider high costs associated with health related social needs
 - PMPM Rebasing
 - Support for utilizing rebasing for improved accuracy

Proposed PY26 Member Mix Updates



PY 26

HCPF is proposing to update the four rates* for member mix:

Infant
(<12 months)

Toddler
(1-3 years old)

Adult
(19+ years old)

Child
(4-18 years old)

- Child - Healthy (C)
- Child - Behavioral Health (CBH)

- Adult - Healthy (A)
- Adult - Behavioral Health (ABH)
- Adult - Chronic Condition (ACC)
- Adult - Behavioral Health and Chronic Condition (ABHCC)

Rationale:

Behavioral health and chronic condition status offers more predictive advantage over disability status and sex

Proposed PY 26 PMPM Rebasing Process



HCPF

Calculates PMPM rate based on historical utilization

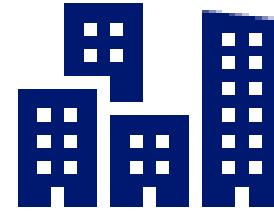
Jan 1
2026



PCMP

PCMP provides services

Dec 31
2026



HCPF

PMPM rebasing occurs to identify actual member mix

Claims Run Out
(Jan 2027 - June 2027)



PCMP

Reconciliation of shadow billed FFS and rebased PMPM



Updating Reconciliation Processes - Risk Corridor



Mitigating Reconciliation Pain Points: Risk Corridor



Current State

Second year and subsequent years of APM 2 program participation:

- If $PMPM < \text{Shadow Billed FFS}$, HCPF will pay the difference to PCMP
- If $PMPM > \text{Shadow Billed FFS}$, PCMP may keep the difference if APM 1 Quality Threshold met. If not met, PCMP is required to remit any amount above



Proposed Reconciliation Updates: Risk Corridors

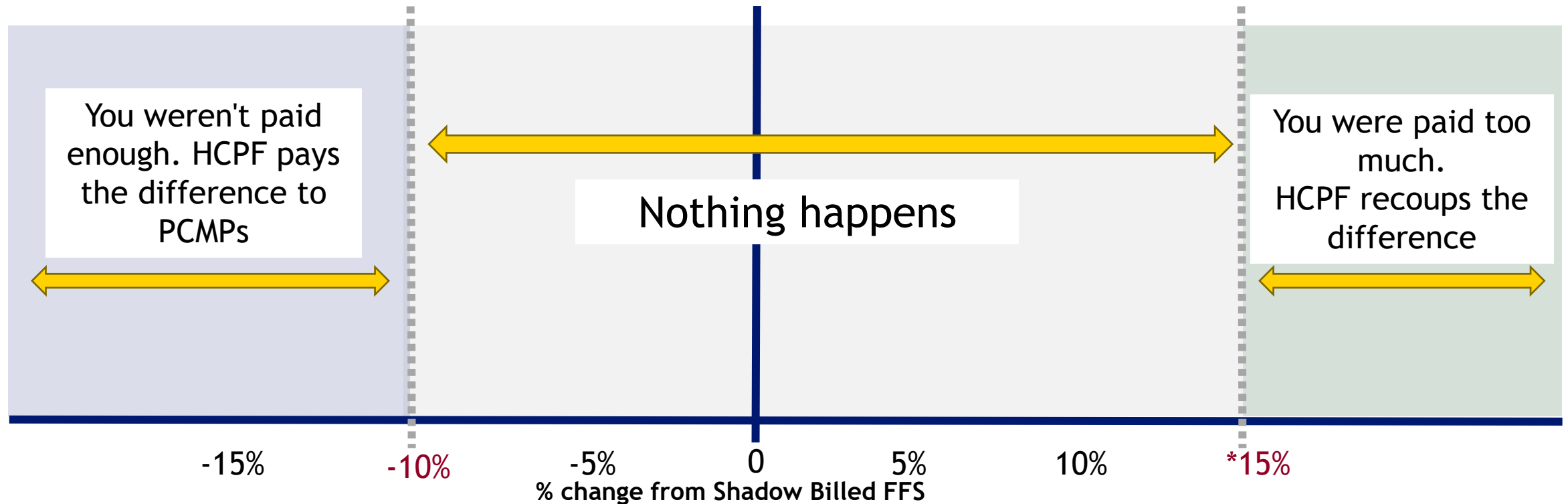


PY 26

All PCMPs who take prospective payment:

Rebased PMPM less than
Shadowed Billed FFS

Rebased PMPM greater than
Shadow Billed FFS



Rebasing Scenario 1:

Member Mix increases fixed payment because of more children with behavioral health needs.

1

PMPM Rebasing for 10,000 child member months

	PMPM	Annual Payment
Initial Child Payment Rate	\$31.00	\$31,000
Rebased with Actual Child Member Mix	\$35.00	\$35,000
Rebased Impact to Initial Child PMPM Rates	\$4,000	

Rebasing

Initial Member Mix		%
Child - Healthy		75%
Child - Behavioral Health		25%

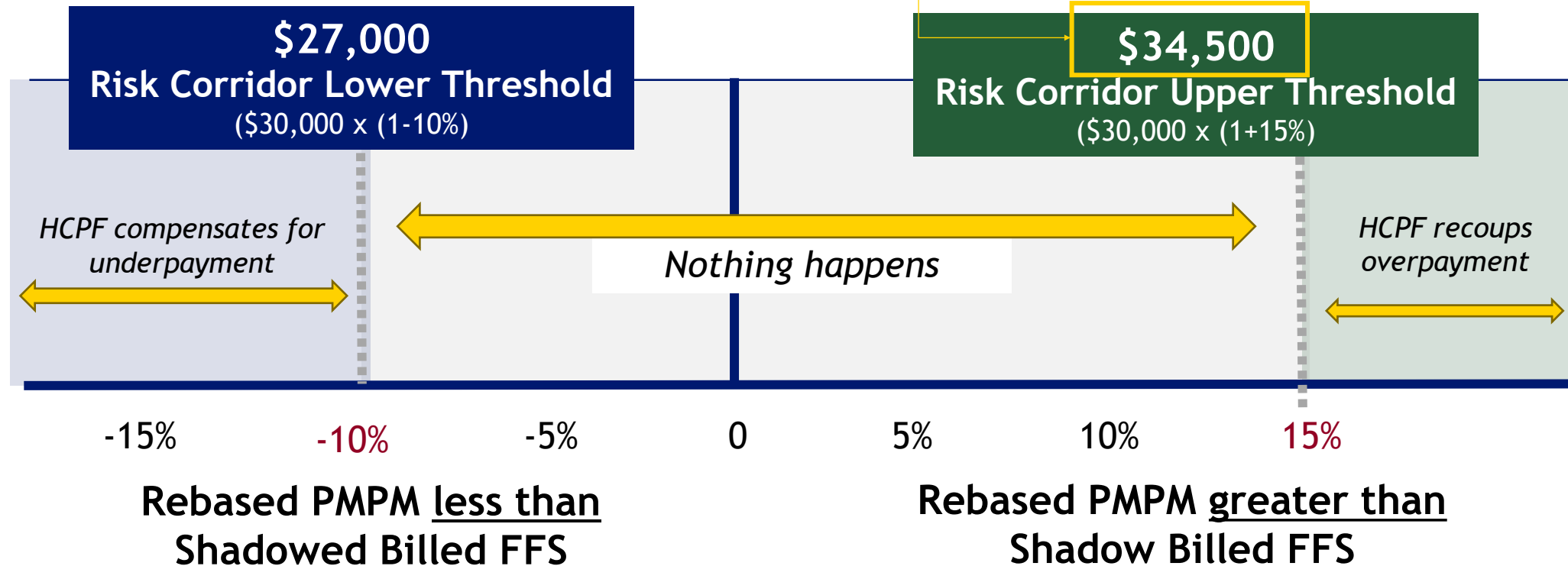
Actual Member Mix		%
Child - Healthy		▼ 40%
Child - Behavioral Health		▲ 60%

Risk Corridor Scenario 1:

Member Mix increases fixed payment because of more children with behavioral health needs.

Rebased PMPM with Actual Member Mix **\$35,000**

Total Shadow Billed Payments: **\$30,000**



Rebased PMPM subject to risk corridor: **\$500**

Scenario 1: Member Mix **increases** fixed payment because of more children with behavioral health needs.

1 PMPM Rebasing

	PMPM	Annual Payment
Initial Payment Rate	\$31.00	\$31,000
Rebased with Actual Member Mix	\$35.00	\$35,000
Rebased Impact to Initial Payment Rates	\$4,000	

2 Risk Corridor Payment

Risk Corridor Payment	\$500
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3 Total Reconciliation Payment

Rebased Impact to Initial PMPM Rates	\$4,000
Risk Corridor Payment	-\$500
Total Reconciliation Payment (-) is to HCPF/ (+) is from HCPF	\$3,500

Pros and Cons to the Proposed Reconciliation

Pros:

- For Providers: reduces risk of loss if FFS far exceeds PMPM (regardless of meeting quality)
- Limits HCPF overspending if FFS is below PMPM

Cons:

- Added methodology complexity
- Providers may not know final rate until the end of the year
- May not provide strong incentive to change behaviors toward value based care



What else?



Is the added complexity worth the extra security?



Discussion:

- What are your initial reactions to the PMPM rebasing and risk corridor?
- Will this help mitigate pain points of reconciliation?
- What are potential unintended consequences?



Vision and Goals of Prospective Payment

Theory of Change

Problem

Traditional payment models that rely on encounter-based FFS revenue rewards providers for quantity over quality.



Strategy: Prospective Payment

- Cultivates flexibility in how PCMPs care for Medicaid members, focusing on non-visit-based activities (EHR messages, phone calls, etc.)

Problem

- No way to measure if there has been behavior change for providing care
- Reconciliation is administratively burdensome

Theory of Change

Problem

- No way to measure if there has been behavior change for providing care
- Reconciliation is administratively burdensome

What are the strategies?



Potential Future State

A blended payment model that includes partial FFS and capitated payments, which allows for innovation in how PCMPs provide primary care to their patients.



Discussion:

- How does this future state resonate with you? What gives you pause?
- Are there any potential unintended consequences?
- What additional steps can be taken to achieve this future state?
- What outcomes should this model be designed to achieve - for patients and providers?