COLORADO
Department of Health Care Policy & Financing

Primary Care Workgroup Feedback Sessions
Shared Savings Session 1
Meeting Minutes

Date: June 18, 2025
Time: 12:00 PM to 1:00 PM
Session Topic: Proposed Updates to Primary Care Shared Savings

Agenda

1. Welcome and Introductions
2. Current State: Chronic Condition Shared Savings
3. Transition to a Total Cost of Care Model
4. Member and Service Exclusions

1. Welcome and Introductions

Lauren Bell welcomed the group and reviewed logistics for the workgroup. Workgroup members introduced themselves through the chat.

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), Britta Fuglevand (HCPF), Suman Mathur (Stakeholder Engagement Team), Taylor Kelley (Stakeholder Engagement Team), Lauren Bell (Stakeholder Engagement Team), Puja Patel (Support Team), Cally Prutting (Support Team), Samantha Block (Support Team) and Drew Lane (Support Team).

2. Current State: Chronic Condition Shared Savings

Araceli Santistevan introduced herself and reminded workgroup members of how the current Chronic Condition Shared Savings program is administered through the Alternative Payment Model (APM) 2 program. She shared that the payment is upside only meaning there is no risk to participation and is meant to incentivize practices to improve the management of adult chronic conditions. Primary Care Medical Providers (PCMPs) are eligible to receive 50% of the achieved savings for improving costs of 12 chronic conditions. In the current state, thresholds are set at a statewide baseline which is then risk adjusted for provider-specific thresholds, and targeting a 2% savings rate. She emphasized that in this current model, HCPF is specifically looking at costs associated with an episode of care, not all costs driven by that member. She also explained that thresholds are set using a statewide baseline of what it costs to care for members with one or more of the qualifying chronic conditions, and all program participants aim for a 2% savings rate, which becomes what is known as a commendable threshold.

Araceli reviewed stakeholder feedback related to the program since it has been operational for a few years. Stakeholders have reported that managing costs for chronic conditions continues to increase, the current program does not include "whole-person" centered care approach, and that the methodology has been overly complex or administratively burdensome.

Lauren opened the discussion up to the group to add any other feedback.

- A participant shared that having sufficient data in a timely manner to know when patients are getting care outside of the PCMP's office has been a challenge.

3. Transition to a Total Cost of Care (TCOC) Model

Madisen Frederick introduced herself and explained that HCPF has been thinking about how to expand to the whole person and the costs of care associated since the current model disregards the realities of what it means to live with a chronic condition. She shared that the TCOC model is becoming more of an industry standard as it creates more opportunities to better influence cost and spending in health care.

Madisen shared that TCOC includes the costs associated with a population and their specific conditions over a defined period of time. It typically excludes certain factors that may be out of a provider's control. She explained that a TCOC model allows for a macro-level intervention lens to incentivize and reward providers for improving health related outcomes.

Madisen continued that in Program Year (PY) 2026, they are moving away from an episodic-based model to reviewing TCOC of members who have at least one of ten eligible chronic conditions. The current model asks that providers manage members who meet the eligibility of one or more of the 12 defined chronic conditions. The key change is that HCPF will be looking at the total costs associated with a member who has at least one of the 10 eligible chronic condition episodes.

Madisen shared that the program will remain upside-only and will focus on managing costs of members with chronic conditions. In 2026, the savings will be split between HCPF (50%), RAEs (12.5%) and PCMPs (37.5%). The thresholds for RAEs and PCMPs will be focused on RAE and provider specific data rather than a statewide benchmark. Madisen explained that this change allows HCPF to set thresholds based on an individual provider's experience and data. The last main change is the removal of Crohn's Disease and Ulcerative Colitis as qualifying chronic conditions.

Madisen shared a summary of why these changes are being made in PY 2026, using these three guiding principles in decision-making:

- PCMP Accountability: The model should include what a PCMP can reasonably influence and be held accountable for. For example, Crohn's Disease and Ulcerative Colitis were

removed because managing these conditions tend to require more attention that extend beyond what a PCMP can reasonably influence.

- RAE Accountability: RAES should be held accountable for chronic condition members within their purview, including unattributed members. They can also assist PCMPs in achieving shared savings by promoting collaboration with PCMPs.

- Maximizing Participation: This program should maximize provider-level participation to encompass as many members as possible.

Discussion:

- Participants asked about the rationale for taking the 12.5% from PCMPS rather than from HCPF.

    - Araceli responded that RAEs are now eligible for a share of the split to offer them an opportunity and incentive to be more involved in this process. There are elements to managing chronic conditions with things like care coordination from a regional lens which RAEs can support. She shared that the split happened because they wanted RAEs to be engaged and have a sense of shared responsibility to achieve shared savings. Araceli added that HCPF must maintain budget neutral shared savings so these are truly savings that are getting paid out.

- A participant asked if HCPF considered only giving payments to RAEs for unattributed members.

    - Araceli explained that unattributed members will not be included in shared savings for at least 2026. The focus is meant for members who are already engaged with primary care providers. The percentage was determined as a simple, clear method for calculating payments.

- Participants questioned what incentivizes the RAEs to take on a more hands-on approach to managing chronic conditions rather than guiding the PCMPs to do it.

    - Britta Fuglevand responded that the RAEs have several contractual requirements that they must meet to receive any shared savings as part of ACC Phase III. They must provide certain levels of support to PCMPs and are required to create a regional plan to support shared savings. Regardless of how much savings are available in a region, if the RAE does not demonstrate successfully implementing related activities, they will not receive a shared savings payment.

    - Participants followed up to ask where the money would go instead in that scenario.

  - Britta answered that they have not yet discussed where the funding will go in those scenarios and said that the Department will need to discuss and then communicate the decision at the start of PY 26.

- Britta then probed the group if there was other feedback related to the new funding split between HCPF, the RAEs and PCMPs.
  - Participants did not like that providers are losing out on a portion of the savings, while HCPF continues to keep their 50% of the share. If it is mandatory to share with the RAEs, it would be more logical that it is a more even split and that HCPF takes more of a cut as well. Participants believed that the providers working hard to achieve savings should keep the funds over HCPF and the RAEs.
  - A participant added that they are a practice that does their own care coordination, in place of the RAE doing care coordination. They are providing office visits and chronic care management outside of the visit as well. If PCMPs are doing that work, it does not make sense that RAEs get a portion and PCMPs take a hit versus HCPF.

4. Member and Service Exclusions

Araceli explained that there are two categories for exclusions: members and services. For member exclusions, exclusions include members with life-long health care needs (e.g. quadriplegia, ALS, coma), members receiving hospice/end-of-life care, receiving an organ transplant, or being treated for malignant and metastatic cancers. This is to ensure that members receive the care they need and PCMPs working with those members are not being penalized for high-cost services.

Araceli shared that certain services will be carved out from the shared savings payment. Some have been excluded since other payment initiatives are tied to them like maternity related services and prescriptions. Other services like non-emergency medical transportation, dental, and vision, fall into a bucket of care where it may not be appropriate to ask a primary care provider to try to influence these services and they want to make sure that a penalty is not created. Additional service exclusions include long-term home health, long-term nursing and intermediate facilities, Home and Community-Based waiver services, behavioral health secure transportation, and behavioral health services reimbursed by the RAEs. Araceli also noted that Indian Health Service (IHS) providers are excluded because of a difference in reimbursement methodology.

Lauren opened the discussion related to Total Cost of Care.

Discussion:

- Participants asked if Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) are also excluded.

  - Araceli responded that FQHCs can participate. She shared that IHS has different cost data methodology that make the Shared Savings cost data elements look different.

- A participant shared that the Perform Plus platform will provide more robust data and emphasized that timely data is more critical for TCOC.
  - Araceli explained that Perform Plus is a new, improved data solution that will be helpful for tracking costs related to chronic conditions.

- Britta asked the group if there were any service exclusions that were an incorrect assumption or if there was anything missing from the lists.
  - Participants agreed that the lists look reasonable.

- A participant asked if the Cover All Coloradans population will be included in shared savings calculations.
  - Britta shared that they are not including this population until they have some more data. Right now, there is limited utilization history, so it is difficult to set accurate targets and cost estimates. For 2026, they will not be added.

Lauren closed the meeting by reminding participants of the last session occurring on June 25th from 12pm-1pm.