COLORADO
Department of Health Care Policy & Financing

Primary Care Workgroup Feedback Sessions
Shared Savings Session 2
Meeting Minutes

Date: June 25, 2025
Time: 12:00 PM to 1:00 PM
Session Topic: Proposed Updates to Primary Care Shared Savings

Agenda

1. Welcome and Recap of Last Session
2. Eligibility and Threshold Goals
3. Funds Flow

Meeting Minutes:

1. Welcome and Recap of Last Session

Lauren Bell welcomed the group and reviewed logistics for the workgroup. Workgroup members introduced themselves through the chat. Lauren reviewed the feedback from the previous session which included support for the new Total Cost of Care (TCOC) model. She shared that stakeholders had concerns about the split of funds between Regional Accountable Entities (RAEs), HCPF, and Primary Care Medical Providers (PCMPs). Stakeholders suggested that PCMPs should retain a higher level of savings percentage than HCPF and RAEs since they provide direct care to members.

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

Other attendees included Araceli Santistevan (HCPF), Devin Kepler (HCPF), Madisen Frederick (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 Samantha Block (Support Team).

2. Eligibility and Threshold Goals

Madisen Frederick introduced herself and explained how provider eligibility and thresholds will change for Program Year (PY) 2026. One goal is to expand member reach so that more chronic members are captured. In the current state, provider eligibility is based on total member attribution at the PCMP level. After a few years in the program, HCPF has recognized that the current state has resulted in some providers working harder than others to achieve Shared Savings, due to differences in their attributed member size. Madisen shared that in PY 26, large providers (defined as 700 or more attributed members) will receive their own Tax Identification Number (TIN) level threshold. To increase data credibility and to track costs

appropriately, providers who are closer to 700 chronic members will have a higher minimum savings rate (MSR) to ensure that their savings are not due to random variation. She shared that as member size increases, the MSR decreases to account for the increase in data credibility from that member size.

Madisen explained that Shared Savings will focus on attributed members only. RAEs will earn Shared Savings through a RAE-specific threshold which will include PCMP attributed members within each RAE. Each RAE will also need to demonstrate how they have worked with PCMPs to achieve Shared Savings to be eligible for payment, if savings are earned in their region, as well as meet certain quality metrics.

Madisen shared that PCMPs who meet the credibility threshold will be assigned a TIN-specific Shared Savings threshold. If they meet this threshold, they will earn Shared Savings. PCMPs who do not meet the credibility threshold will be pooled together for a small provider pool. She explained that HCPF is seeking feedback on whether the small provider pool should be opt-in or have mandatory enrollment.

Madisen then discussed the pros and cons of the two options.

- Option 1- Opt-In: This option allows the choice for those who are actively invested and interested in achieving Shared Savings to participate, yet the risk is that the pool could be too small, creating a lesser chance of achieving Shared Savings.

- Option 2- Mandatory: This will increase the pool to be large enough while maintaining no downside risk. However, more engaged providers may unfairly carry the burden of achieving Shared Savings compared to those who are less engaged.

Lauren opened discussion for initial reactions to the threshold changes and any reactions to the small provider options. The majority of participants selected option 1 over option 2.

Discussion:

- A participant shared that their small practice has not experienced difficulty achieving Shared Savings to this point in the program so the small provider pool does not make it easier. They echoed the concern about potentially carrying the weight of responsibility for managing the costs of chronic conditions compared to others in a small provider pool and felt that a high-achieving practice should not be held accountable to other PCMPs that may not be as engaged.

- A participant asked how the credibility threshold of 700 was selected when other practices have achieved Shared Savings with less attributed members.

    - Araceli added context that, previously, Shared Savings eligibility was determined by Alternative Payment Model (APM 1) eligibility. In APM 1, the credibility threshold was 500 attributed members, which resulted in issues with

small denominators, which creates difficulty in digging into the data and understanding the why around achievement. With APM 1 sunsetting, HCPF needed to determine new eligibility criteria, but also wanted to continue to include small providers.

- Araceli added that the 700 attributed members are active patients with a chronic condition from the list.

Madisen then explained upcoming changes for PY 26 related to eligibility and minimum savings rate (MSR). Provider eligibility will be based on credible minimum volume threshold which means that it requires 700 or more attributed members with chronic conditions at the TIN level. She shared that a variable MSR will be introduced in PY 26, which scales incrementally based on the size of the provider. Larger providers will have lower savings targets to reduce the chance of random variation and fluctuation within a smaller dataset.

Madisen shared how the variable MSR tiers will work. She explained that for a provider with 700 members, any outliers in a small sample size would skew the data more significantly than a provider with 4,700 members. Using a variable MSR that is scalable to the size of the population controls how outliers may skew data. She explained that smaller providers will have a 5.0% MSR to reduce the chance of random variation, but larger practices will have a 2.0% MSR since the data is more credible.

Madisen added clarification that the variable MSR would be the same mechanism in the small provider pool. Araceli added that they expect that since there will be pooling within a RAE region, the pool will be large enough to have a lower MSR.

Lauren opened the discussion for reactions to the changes in provider thresholds and variable MSR.

- A participant pointed out that there may be some unintended consequences if providers on the cusp of the credibility threshold limit their attribution to instead be put in a small provider pool and have a smaller MSR.
    - Araceli appreciated this comment as a potential perverse incentive that may be created in setting eligibility.

3. Funds Flow

Araceli Santistevan introduced herself and reminded the group that in 2026, Shared Savings will be split between HCPF (50%), RAEs (12.5%) and PCMPs (37.5%). She shared that feedback is especially important on this as policy decisions about how payments will happen are still being decided.

Araceli shared that HCPF would like incentive payments to flow through the RAEs just like the Quality Payments or Medical Home Payments but service payments like fee for service or

Primary Care Prospective Payments will come from the Department. However, there is added complication for Shared Savings because 40% of TINs span multiple RAEs. Because of this there are two funding mechanisms based on the thresholds. TIN-level payments will be made by HCPF directly to the TIN-level PCMP, while the small provider pool will be paid by the RAEs.

Araceli explained that for the small provider pool, HCPF would calculate the total savings for each regional pool and then the RAEs would pass the funds to providers within that pool based on the percentage of chronic members within that pool.

For TIN-level PCMPs, like the current state of Shared Savings, HCPF will disperse the total payment directly to the organization as one lump sum and then the organization would decide how it is distributed to their locations but neither HCPF nor the RAEs will dictate this.

Lauren asked participants for feedback on the funds flow and how RAEs can best support PCMPs in chronic disease management.

Discussion:

- One participant offered that RAEs could support by working with local non-profits or by assisting with breaking down barriers for patients to access specialists or other care that cannot be provided in a primary care setting. Though there is concern with cutting Shared Savings dollars from PCMPs to share with RAEs, there is an opportunity for RAEs to use the funds for specialists, since there are so few that currently take Medicaid patients. It was mentioned that RAEs can support with reducing emergency room visits and inpatient admissions through their care coordination efforts.

- Araceli provided confirmation that providers are automatically enrolled if they have 700 members attributed.

Lauren closed the meeting by reminding participants to share any other last feedback by email. She also previewed upcoming stakeholder engagement opportunities which include a Data and Technology Testing Team in the Fall as well as an updated education session for updates to Prospective Payment and Shared Savings.