

Value-Based Payments Legislative Report

Pertaining to Calendar Year 2024

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Submitted to: The Joint Budget Committee and Joint Health Committees



COLORADO
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Policy & Financing

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Executive Summary

In 2024, the Department of Health Care Policy and Financing (the Department) continued to advance a clear principle: pay health care providers based on the quality and results of care, rather than the number of services delivered. Value-based payments are designed to contain costs and promote investments that deliver measurable value for Colorado Medicaid beneficiaries.

Nationally, the Centers for Medicare & Medicaid Services (CMS) has called on States to increase the share of Medicaid payments tied to value-based models¹. The Department has embraced this call², with an estimated 52% of Colorado Medicaid payments tied to value-based payment arrangements. The urgency for this work is clear, as per capita costs for Colorado Medicaid are projected to rise in the years ahead³. By continuing to advance value-based payment infrastructure, the Department remains focused on improving member health outcomes while ensuring that each dollar spent delivers maximum value.

Key Developments in 2024:

- **Primary Care Alternative Payment Model Advancements:** In Alternative Payment Model 1 (APM 1), 90% of participating primary care locations met quality goals. Alternative Payment Model 2 (APM 2) provided stable monthly payments to nearly 240 primary care organizations, serving over 520,000 members. Almost half of the provider organizations in the chronic conditions program earned shared savings by reducing costs while maintaining quality. Looking ahead to 2025, the Department is repositioning the primary care value-based Payment (VBP) framework to effectively consolidate and streamline primary care quality and payment incentives under the Accountable Care Collaborative Phase III framework (Effective 7/1/25).
- **Saving Colorado Money on Prescription Drug Costs:** Over 700 practices participated, resulting in 97% of prescriptions within the Medicaid Preferred Drug List (PDL). PDL usage improves affordability and efficacy; based on prior analysis, every 1% change in PDL usage impacts the state General Fund by \$16 million. Work is underway to improve data and expand the tool's reach, already used by over 65% of Medicaid prescribers.
- **Maternity Care:** The maternity bundled payment program completed its fourth year. A new model is in development, set to begin in 2027, with a stronger focus on access, continuity of care, and patient experience while continuously controlling cost and improving affordability.
- **Behavioral Health Safety Net Enhancements:** Essential Safety Net Providers receive targeted payments for critical services such as mobile crisis responses and opioid treatment, while Comprehensive Safety Net Providers are reimbursed through a prospective daily payment system that offers flexible and sustainable funding and ties payment to quality outcomes. Nineteen Comprehensive Safety Net Providers enrolled in the daily payment system.

¹ <https://www.cms.gov/medicare/quality/value-based-programs>

² <https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Department%20Performance%20Plan%20FY25-26.pdf>

³ <https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY%202025-26%2C%20S-1%2C%20BA-1%20MSP%2C%20rem.pdf>

- **Hospital Transparency Program (HTP):** Presented as a separate Legislative Report on the Department’s website⁴, HTP is the largest value-based payment program in Colorado, encompassing all medical hospitals across the state. The goal of the HTP is to improve the quality of hospital care provided to Health First Colorado members by tying provider fee-funded hospital payments to quality-based initiatives. By evolving quality care to Medicaid members and the related processes to achieve those results, HTP serves to improve hospital quality care for all Coloradans. The HTP completed its first performance year in September 2024. The 85 participating hospitals achieved at least a partial payment on 86% of the quality measures, indicating a high level of quality of care. Hospitals have additionally demonstrated noticeable improvement from the beginning of the program in key areas of community engagement (performing 5,204 engagement activities), screening for health-related social needs (more than 58,000 screenings performed), and screening for perinatal and postpartum depression and anxiety (more than 24,000 screenings performed).

I. Introduction

The Department continues to advance value-based payment (VBP) initiatives that reward quality and outcomes rather than service volume. VBPs serve as a mechanism to control cost growth, foster provider innovation, and provide person-centered care to Health First Colorado members.

Section 25.5-4-401.2, C.R.S. requires the Department to submit an annual report “...describing rules adopted by the state board and contract provisions approved by CMS in the preceding calendar year that authorize payments to providers based on performance.” This statute requires that the Department include:

- I. A description of performance-based payments included in state board rules, including which performance standards are targeted with each performance-based payment;
- II. A description of the goals and objectives of the performance-based payments, and how those goals and objectives align with other quality improvement initiatives;
- III. A summary of the research-based evidence for the performance-based payments, to the extent such evidence is available;
- IV. A summary of the anticipated impact and clinical and nonclinical outcomes of implementing the performance-based payments;
- V. A description of how the impact or outcomes will be evaluated;
- VI. An explanation of steps taken by the state department to limit the administrative burden on providers;
- VII. A summary of the stakeholder engagement process with respect to each performance-based payment, including major concerns raised through the stakeholder process and how those concerns were remediated;
- VIII. When available, evaluation results for performance-based payments that were implemented in prior years; and
- IX. A description of proposed modifications to current performance-based payments.

⁴ <https://hcpf.colorado.gov/sites/hcpf/files/2025%20CHASE%20Annual%20Report%20%5BFinal%5D.pdf>



The report features six value-based payment models pursuant to section 25.5-4-401.2, C.R.S. Unless otherwise specified, details of the Department’s value-based payment pertain to work completed in **Calendar Year (CY) 2024**. The six programs highlighted in this report include:

1. **Alternative Payment Model 1 (APM 1):** A primary care value-based payment model that assesses provider performance based on electronic clinical quality measures (eCQMs), as well as administrative and structural quality metrics. Providers may receive an increase to their fee schedule rates for achieving specific quality targets. Conversely, failing to meet these targets can result in payment reductions.
2. **Alternative Payment Model 2 (APM 2):** A primary care value-based payment model that offers two components: a prospective per member per month (PMPM) payment and a shared savings opportunity for effective management of 12 high-cost chronic conditions. APM 2 builds upon the quality measurement framework established in APM 1.
3. **Payment Alternative for Kids (PACK):** A value-based payment model developed to support pediatric primary care. In order to enhance the reach and impact of the program, PACK focused on consolidation efforts into the Single Comprehensive Primary Care Payment Structure embedded within the Accountable Care Collaborative (ACC) Phase III for a July 1, 2025, rollout.
4. **Prescriber Tool Alternative Payment Model:** A shared savings payment model for prescribers utilizing a Real Time Benefit Inquiry module to make prescription drugs more cost-effective.
5. **Maternity Bundled Payment:** A shared-savings payment model that covers the entire perinatal period for pregnant and birthing people.
6. **Essential and Comprehensive Safety Net Behavioral Health Provider Alternative Payment Model:** A behavioral health value-based payment model that uses quality measures for safety net provider accountability and a prospective payment system for reimbursement.

In 2024 The Department continued to advance the development of the All-Inclusive Care for the Elderly (PACE) APM and the Dental APM. As both initiatives were in the early stages of development at the time of this report, a brief overview is included to highlight progress to date. Next year’s Legislative Report will include comprehensive program operation details and results.

PACE is designed for individuals who are eligible for nursing home level of care but can live safely in the comfort of their own home, with the appropriate supports. Year 1 began SFY 2023-24, which focused on building program infrastructure and validating measures without tying payments to performance. Beginning Year 2 (SFY 2024-25), the program entered its reporting-only phase, where providers began submitting data to demonstrate performance readiness. This progress positions PACE to transition into a pay-for-performance year in SFY 2025-26, as long as program parameters and funding requirements are met.

The Dental APM⁵, developed in partnership with DentaQuest, a dental health benefits administrator, aims to improve member access and equity in oral health. It emphasizes preventive services for children, young adults, and members utilizing maternity care. In 2024, DentaQuest implemented an access study that highlighted gaps in oral health services and advanced key configuration work needed to implement the Dental Home model. This included member attribution planning, provider communication strategies, and system readiness steps in preparation for a phased go-live start date of September 1, 2025. As the Dental APM is scheduled for implementation beginning after the current CY24 reporting period, next year’s CY25

⁵ <https://hcpf.colorado.gov/dental-benefits>



Legislative Report will include comprehensive program operation details. This report does not include the Accountable Care Collaborative (ACC) pay-for-performance programs, skilled nursing facility initiatives, or the Hospital Transformation Program (HTP), which are detailed in separate legislative reports on the Department’s [website](#)⁶. Additional initiatives including Colorado Providers of Distinction and a new Maternity Alternative Payment Model (designed to replace current maternity bundled payment program). These programs will be included in future reports when they are authorized by the General Assembly and meet the reporting requirements of section 25.5-4-401.2, C.R.S.

II. Accountable Care Collaborative

In preparation for ACC Phase III launch on July 1, 2025, the Department proposed major revisions to its primary care value-based payment structure⁷. The changes consolidate the Department’s primary care APMs, including APM 1, the shared savings component of APM 2, and PACK into a single comprehensive primary care payment structure. These changes are intended to address the need for programmatic alignment and streamlined measurement and payment across existing programs, eliminating duplication and reducing administrative burden on providers.

To advance the Department’s long-term value-based payment strategy, the FY 2025-26 R-06 Budget Request “Accountable Care Collaborative” merged multiple primary care APM structures into a single comprehensive model embedded within the ACC Phase III framework. The ACC Primary Care Payment Structure offers Primary Care Medical Providers (PCMPs) different payment streams to incentivize a diverse set of goals. The payment streams include 1) quality payments to reward PCMPs that meet quality goals, 2) medical home payments for PCMPs that have advanced primary care capabilities, with additional payments for PCMPs that have highly integrated care, 3) shared savings payments to reward PCMPs that meet cost and quality targets for the management of members with a chronic condition, and 4) access stabilization payments to preserve access for small, rural, and pediatric PCMPs.

III. Primary Care Alternative Payment Models

A. Alternative Payment Model 1

APM 1⁸ is a pay-for-performance program that ties payment to performance to enhance member health outcomes. PCMPs earn points by meeting quality goals or demonstrating improvement on defined quality metrics. PCMPs who meet the established quality threshold receive an upward adjustment to their fee-for-service reimbursement rates. Enhancement funds not earned by underperforming providers are redistributed among those who meet performance criteria. The scoring methodology is based on the APM 1 Measure Set, which is categorized into structural measures, administrative measures, and electronic clinical quality measures (eCQMs).

⁶ <https://hcpf.colorado.gov/legislator>

⁷ <https://hcpf.colorado.gov/acc-phase-iii-stakeholder-engagement>

⁸ <https://hcpf.colorado.gov/alternative-payment-model-1-apm-1>

In 2024, the Department engaged stakeholders to support the redesign of Primary Care APMs and prepared for the transition to ACC Phase III. The Department hosted APM 1 “office hours” sessions to provide program updates and solicit feedback on program changes, including the upcoming quality incentive structure transition to ACC Phase III.

Key changes to APM 1 for Program Year (PY) 2025 include the alignment of the APM 1 clinical quality measure set with the ACC Phase III Quality Program measure set, increasing consistency across quality reporting efforts. The Department also maintained the Medicaid-only reporting requirement for electronic clinical quality measures (eCQMs), originally implemented in PY 2024. In addition, a denominator threshold was introduced for administrative clinical quality measures to ensure data credibility; providers must have at least 30 attributed members in the measure denominator to be eligible to score and earn points.

To address provider concerns related to meeting denominator thresholds and the Medicaid-only eCQM reporting requirement, the Department has continued its collaboration with the ACC’s Regional Accountable Entity (RAE) Practice Facilitators to support practices in meeting these expectations for PY 2025. This includes identifying solutions for reporting challenges that are outside a provider’s control. The implementation of the Medicaid-only reporting requirement has also led to an increase in providers establishing electronic connections with Health Information Exchanges (HIEs), enabling the use of supplemental data feeds. These connections enhance the Department’s ability to gain deeper insights into the quality of care delivered to the Medicaid population and also support the ACC Phase III goal of enhancing the integration and usage of HIE systems.

APM 1 Results

In 2024, PY 2023 quality score results were calculated for the 342 non-Federally Qualified Health Center (FQHC) locations and 20 FQHC locations. 307 (90%) non-FQHC locations achieved the quality score threshold. The remaining 35 practices (10%) were subject to rate decreases, averaging -0.72%, paying on average 99.28% of fee-for-service (FFS). All 20 FQHC locations achieved the quality threshold, resulting in no negative rate adjustments. PY 2023 APM 1 quality results are demonstrated in Table 1.

In PY 2024, all 20 FQHC locations again achieved the quality threshold. PY 2024 results for non-FQHCs are not yet available at the time of this report and will be included in next year’s report.

Table 1 Program Year 23 APM1 Quality Score Results

Total APM1 Participants	Number of PCMPs who achieved quality threshold	Average point score for PCMPs who achieved quality threshold	Number of PCMPs who <u>did not</u> achieve quality threshold
342	307	242	35

Between PY 2022 and 2023, APM 1 quality performance improved among participating providers. For non-FQHC practices, the percentage of locations meeting the quality score threshold increased from 87% (278 of 318) in PY22 to 90% (307 of 342) in PY23, reflecting

enhanced performance and continued provider engagement with the program. Additionally, the average negative rate adjustment for practices not meeting the threshold decreased slightly from -0.84% to -0.72%, indicating increased performance gains even among lower-performing sites. FQHC locations maintained strong performance across both years, with all 20 locations consistently meeting the quality threshold and avoiding any rate reductions.

B. Alternative Payment Model 2 and PACK

APM 2⁹ is a voluntary VBP model that enables PCMPs to replace some or all of their FFS revenue with a prospective PMPM payment and provides shared savings incentive payments for PCMPs that effectively manage members with chronic conditions. APM 2 offers providers greater revenue stability and flexibility, enabling them to better support member health, enhance care outcomes, and reduce health disparities for members.

In 2024, the Department began its redesign of APM 2 and completed 22 Design Review Team (DRT) stakeholder sessions, including 11 for APM 2, and 11 for the design and program launch of PACK. These sessions ran from February to July 2024 and included a diverse group of primary care providers, members, and advocates. Topics covered included overall program goals, quality measurement, payment structure, and performance improvement. These sessions informed the consolidation of the Department's primary care APMs, as stakeholders expressed the need for alignment of payment and quality metrics, sufficient funding to cover service delivery, and a general support of VBP initiatives.

The Department's stakeholder engagement regarding PACK revealed that many pediatric practices have been unable to participate in the Department's APMs historically. Pediatric providers indicated that the primary care APMs for which they are eligible are not particularly geared towards children, resulting in limited engagement. The simultaneous redesign of APM 2 and the planned rollout of ACC Phase III created an opportunity for the Department to align program objectives by embedding APM 2 and PACK into the ACC architecture under a Single Comprehensive Primary Care Payment Structure. The confluence of these programs in ACC Phase III would reduce the administrative burden to PCMPs by housing primary care APM initiatives under one program. This consolidation was responsive to stakeholder feedback that suggested too many of the Department's value-based programs are siloed and therefore difficult to meaningfully participate. While pediatric providers have expressed a need for a separate pediatric APM attuned to the needs of children, the maturation of a consolidated primary care APM design resulted in specific incentive pathways for pediatric practices that could effectively be merged into ACC Phase III, including an Access Stabilization payment to support continued member access to pediatric, small, and rural practices, and a quality payment to incentivize clinical quality in pediatric primary care.

Prospective Payments - Per Member Per Month (PMPM)

APM 2 supports providers by offering stable revenue in the form of Prospective Payments using a Per Member Per Month (PMPM) payment mechanism in which the provider can choose to receive either fee-for-service payments or partial capitation payments. Prospective payment rates are designed to provide steady, predictable revenue for PCMPs month over month, ensuring stability despite changes in utilization. Participating PCMPs may select to

⁹ <https://hcpf.colorado.gov/alternative-payment-model-2-apm-2>

receive a portion (0%-100%) of their FFS reimbursement for eligible services as prospective PMPM payments for qualifying attributed members. PCMPs that select a PMPM of 1-100% 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.

The Department's FY 2023-24 R-6 budget request, "Supporting PCMP Transition with Value Based Payments" included a 16% rate increase to the PMPM for participants who elect more than 25% of their revenue as a prospective PMPM. Providers that select to receive at least 25% of their primary care payments as prospective payments are eligible for a 16% rate increase. In PY 2024, a total of 239 PCMPs participated in APM 2, representing a total of 522,594 attributed members. PCMPs that select to receive any portion of their revenue as a 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 the Department 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 the Department with the necessary data to perform reconciliation and inform future rates.

In 2024, the Department reconciled PMPMs to fee-for-service for Program Year 2023 for which 21 practices took some level of PMPM. For all participating practices, the PMPM for the year was higher than the cost of shadow billed FFS claims for the relevant members and months by a total of \$3.9 million across all participants. Reconciliation showed that the prospectively set payments were higher than actual utilization, which was caused in part by a rate setting methodology which used base data from 2019 because it was the most recent available non-Public Health Emergency (PHE) data. The Department estimated that primary care utilization would return to pre-COVID levels during the PHE unwind. When it became apparent that this utilization assumption was not accurate, the Department initiated a mid-year rebase of 2024 rates. Beginning September 1, 2024, all rates were reset using a blend of 2022 and 2023 data. This resulted in an average decrease to prospective payment rates of 12.2%. The Department conducted substantial stakeholder work to educate on this rate adjustment, including the rationale and expected impact. As a result of the mid-year rate adjustment, two participants opted out of APM 2 for the remainder of 2024.

There is a distinct APM 2 program specifically for FQHCs to comply with federally mandated FQHC reimbursement requirements. Under the Benefits Improvement and Protection Act of 2000, states must set prospective payment rates and adjust them annually for inflation and changes in services. Any alternative payment models available to FQHCs must adhere to this requirement. FQHCs may still receive a PMPM, although they must participate at 100% PMPM as opposed to the non-FQHC track, which allows participants to elect any percentage between 0-100%. FQHCs may also participate in the shared savings incentive payment portion of the program.

The three FQHCs participating in APM 2 Prospective Payments completed their second year of participation in Calendar Year 2024. Because of the unique nature of FQHC rate setting, each FQHC was evaluated on a separate timeline corresponding to their fiscal year and their PPS rates. Based on the analysis conducted in 2024, none of the three participating FQHCs were underpaid relative to their PPS rate. The Department also began to evaluate the FQHC rate

methodology to ensure model sustainability and support for FQHC participants for future years.

Chronic Conditions Shared Savings Incentive Payments

APM 2 also shares financial rewards with PCMPs in the form of Chronic Condition Shared Savings Payments, which are up-side only incentive payments. Shared savings incentive payments reward providers for cost-effective chronic condition management. Savings beyond a 2% threshold of average historical cost are split evenly with providers and the Department. To be eligible to retain any shared savings providers must be enrolled in APM 1 and meet certain quality thresholds. In 2024, the Department reconciled shared savings payments for PY 2023.

40 PCMP organizations (i.e. Provider Billing ID at the tax level) participated in the chronic conditions shared savings program in PY23. Nineteen PCMP organizations achieved the minimum savings rate of 2%, earning incentive payments totaling \$845,676 (50% of the total savings), an increase in total savings compared to the previous performance year (CY22). The most significant reductions occurred within professional and outpatient claims, particularly in services such as consultations, MRIs, physical therapy, medical equipment/supplies, and home health care. The Department is completing deep dives with PCMPs who achieved Shared Savings to determine success factors in order to continue expanding cost savings in future years.

IV. Prescriber Tool Alternative Payment Model

The Prescriber Tool Alternative Payment Model (APM) launched on October 1, 2023, to include providers in the drug cost affordability solution. As prescription drug utilization remains a leading contributor to rising health care expenditures, its management is a top priority for Colorado¹⁰. The program incentivizes Preferred Drug List (PDL) compliance through use of the Prescriber Tool and is instrumental in achieving 97% Medicaid PDL compliance.

The Prescriber Tool is a versatile platform accessible to prescribers through most electronic health record (EHR) systems that consists of four modules: electronic prescribing (eRx), electronic prior authorization (ePA), real-time benefits inquiry (RTBI), and an opioid misuse risk module¹¹. With these resources, providers can make rapid and transparent decisions with ease, enabling the selection of cost-effective medications.

The Prescriber Tool APM has three main goals: expand prescription drug affordability, reduce administrative burden for prescribers, and improve patient health outcomes and experience. Operational goals for PY 2 (October 1, 2024 - June 30, 2025) sought to increase awareness and uptake of the RTBI module by rewarding providers for engaging with the Department's data validation efforts and prescribing preferred medications.

To accomplish this, the Department conducted stakeholder engagement through two webinars to educate providers on PY 2. The Department provided PDL compliance rates to providers and solicited feedback on PDL accuracy and the APM program via a survey. Completion of the

¹⁰ <https://hcpf.colorado.gov/sites/hcpf/files/Reducing%20Prescription%20Drug%20Costs%20in%20Colorado%20Second%20Edition.pdf>

¹¹ <https://hcpf.colorado.gov/prescriber-tool-alternative-payment-model>

survey was required to receive a shared savings incentive payment based on savings attributable to the usage of the Prescriber Tool. Total savings for PY 2 were \$612,665. Per the Department's State Plan Amendment, 75% of savings could be shared with practices resulting in a total of \$459,498 of distributed funds. 701 practices completed the survey and received an incentive payment. At the same time, the 97% PDL compliance accomplishment is instrumental as, based on prior analysis, each 1% PDL change represents a \$16 million impact to the state General Fund.

Survey results included feedback from providers that the prescriber tool had several key positive impacts including ease of tool use, providing pharmacy benefit information at the point of care which supports in facilitating provider/patient communication, and decreasing prior authorization times. While there were overall savings in the program and an overall increase in PDL compliance (+0.13%), continuing users did have a decrease in PDL compliance (-0.17%). This is likely due to a couple variables: 1) PDL compliance rates have plateaued and will slightly vary year to year, and 2) changes in rebates and other drug cost factors in 2023 and 2024.

The Department is in the early phases of redesigning the APM to address challenges and better align this APM with other Department initiatives, reduce administrative burden on practices, and continue to incentivize the use of the Prescriber Tool. The Department's transition to a new Pharmacy Benefits Manager in early 2026 will offer additional vendors to provide RTBI information to more EHRs. The Department anticipates that this will increase provider adoption and use of the Prescriber Tool.

V. Maternity Bundled Payment Program

Launched in 2020, the Maternity Bundled Payment (MBP) program is an episode-based payment model aimed at improving maternal care quality and control costs¹². This program is voluntary and includes only upside risk. The program covers prenatal, labor and delivery, and postpartum services. Obstetric providers who deliver babies or offer prenatal care can join as principal accountable providers (PAPs), earning incentives for improving care quality. Each PAP has a cost target based on historical claims, and performance is reviewed annually. Shared savings are awarded if quality goals are met beginning the second year of participation.

The Maternity Bundled Payment program concluded its fourth year of operation in October 2024 with nine obstetrical practices enrolled, representing approximately 33% of Health First Colorado births. Results from PY 4 will be available in late calendar year 2025. For PY 3 (November 2022 - October 2023), there were total savings of \$6,619.

Beginning in the summer of 2024, the Department began developing a new Maternity APM to better center care quality, health equity, and patient experience in the program's design. The initiative builds on ongoing stakeholder engagement, program evaluation, and lessons learned from the current model to advance the Department's goal of promoting equity, high-quality care, and a positive patient experience for birthing people in Colorado¹³.

¹² <https://hcpf.colorado.gov/bundled-payments>

¹³ <https://hcpf.colorado.gov/maternity-alternative-payment-model>

To support this work, the Department hosted a series of stakeholder engagement sessions from summer to fall of 2024 with a diverse range of stakeholders including providers, members, advocates, and policy experts. Their feedback shaped the draft model, informing key areas such as program goals, quality measures, payment methodology, performance improvement, and long-term sustainability. This input helped establish a person-centered framework aligned with the Department’s North Star vision of respectful, holistic care for all birthing individuals.

The New Maternity APM prioritizes improving health outcomes and member-centered care throughout the perinatal journey while continuously controlling cost and improving affordability. Key elements of the draft model design include:

- **Three Distinct Episodes of Care:** The perinatal period is divided into three episodes—prenatal, labor and delivery, and postpartum—each with tailored payment methodologies, provider responsibilities, and quality measures. This structure reflects stakeholder feedback emphasizing that providers should be accountable for outcomes related to the care they deliver.
- **Distinct payment mechanisms:** The program matches each episode to a payment mechanism that will drive the identified key change, such as driving increases in early prenatal intervention to improve member outcomes and reduce total episode cost by up to 48%. The model will continue to provide shared savings opportunities for providers who control cost while providing high quality delivery and newborn care.
- **Inclusion of the Newborn:** The model integrates newborn care, recognizing the interconnectedness of maternal and infant health from prenatal care onward, and promoting aligned incentives for improved outcomes across the dyad. Newborn care is also a prioritized focus and opportunity in controlling cost given the large room for cost reduction in NICU (neonatal intensive care unit).
- **Facility Participation and Team-Based Care:** Facilities are included in the model to reflect the critical role of team-based care during labor and delivery. This approach acknowledges the impact of collaborative care on birthing outcomes, newborn health, and the patient experience.
- **Postpartum Incentive Payment:** Given that maternal morbidity most frequently occurs between 42 and 365 days postpartum, the model proposes an incentive payment to increase the utilization of comprehensive postpartum visits during this period. This aims to improve maternal outcomes, enhance care continuity, and address persistent gaps in postpartum care.
- **The program is tentatively scheduled to go live on January 1, 2027, pending all necessary approvals.** The current Maternity Bundled Payment program will be sunset to enable a focused transition and onboarding of participants into the new Maternity APM.

VI. Essential and Comprehensive Safety Net Behavioral Health Provider Alternative Payment Model

Pursuant to HB 22-1278, HCPF, in collaboration with the Behavioral Health Administration (BHA), developed and implemented cost-informed APMs for Essential and Comprehensive Safety Net Behavioral Health Providers. These APMs introduce greater accountability to the

provider community to increase member access to inclusive services. The Department uses a directed payments methodology to direct RAEs to pay Safety Net Providers using the Department-developed APMs. As of July 1, 2024, RAEs were required to reimburse Essential Safety Net Providers (ESNP), at a minimum, according to a cost-informed Essential Safety Net Provider fee schedule. This fee schedule was based on historical reimbursement for services defined by the BHA as Essential Safety Net Services in program regulations at section 2 CCR 502-1-12.4. Directed payments are time-limited and based on community need and underutilized services. When ESNP payments were reviewed in April 2025, cost and utilization trends indicated that directed payments for ESNP outpatient services were no longer appropriate. Thus, ESNP-directed payments for general outpatient services were discontinued on July 1, 2025. However, directed payments for the following behavioral health services continue to be provided by ESNPs and are to remain in place as of July 1, 2025:

- Mobile Crisis Response (MCR) services
- Opioid Treatment Program (OTP) services

Services in a bedded facility provided by ESNPs will continue to receive ESNP directed payments until June 30, 2026, after which rate-setting authority returns to the RAEs, who may negotiate provider rates based on quality and network needs, in alignment with the managed care system.

As of July 1, 2024, Comprehensive Safety Net Providers (CSNP) are reimbursed by the Regional Accountable Entities (RAEs) under a prospective payment system (PPS) methodology. A PPS is a flexible, advanced reimbursement model that ties payment to daily encounters instead of to individual services. This means that a provider will receive an encounter payment for each patient they see in a day, and the payment is the same regardless of which services are provided so long as the services are covered by the PPS rate. The PPS is provider specific, as it is based on each CSNP's actual costs, including the cost of serving people who are uninsured or underinsured. The PPS provides flexible, sustainable and predictable funding. In addition to requiring RAEs to reimburse CSNPs at their PPS rate, they must also offer the CSNPs in their Region a VBP arrangement for meeting measurable outcomes that improve member access to quality care. A state PPS rate was also developed to allow new CSNP providers to begin immediately accessing the PPS reimbursement without having historical cost reports. 19 CSNPs successfully enrolled from July 1, 2025-December 31, 2025.

VII. Conclusion

Calendar Year 2024 marked steady progress in the Department's advancement of value-based payment (VBP) reform. Building on years of implementation experience, the Department focused on streamlining existing programs, engaging stakeholders, and preparing for the launch of Accountable Care Collaborative (ACC) Phase III.

Throughout the year, the Department refined its VBP models, including APM 1, APM 2, and PACK, while advancing shared savings approaches in maternity care and the Prescriber Tool. Stakeholder input played a critical role in shaping these efforts, particularly around simplifying administrative processes and supporting providers who have historically faced barriers to participating in the Department's VBPs.

This work culminated in the FY 2025-26 R-06 Budget Request “Accountable Care Collaborative,” which consolidates multiple primary care APMs into a single, comprehensive payment structure under ACC Phase III.