Value-Based Payment in Colorado Against the National Evidence

Briefing for the Colorado Commission on Medicaid · November 2026

Why the Commission asked

On November 10th, the Commission adopted docket line 108 without objection. As adopted, it calls for exploring where value-based payment is working in Colorado, including PRIME on the Western Slope, against the national evidence, and how to extend it where it achieves lower cost or better outcomes. It starts with a Department plan that names the programs, measures, and timeline.

In the discussion, Director Hammer noted that the national evidence has not demonstrated that value-based payments reliably reduce cost. Additionally, providers must agree to take on risk and there is not always an appetite for that. Members had asked earlier for more detail on how paying for outcomes would work. This briefing sets out what Colorado does now, what PRIME has and has not shown, and what the national evidence says about when value-based payment saves money, so the Department plan can aim at the designs most likely to work.

Bottom line

- **The national evidence supports the caution members heard.** Most federal value-based models have not saved money. An April 2025 review of 18 Medicare Innovation Center models found one-third saved substantially, one-third lost substantially, and one-third had little effect, for a net increase in federal spending of $7.7 billion. Medicaid accountable care organizations reliably increase primary care use and often reduce hospital use, but results on total cost are mixed.
- **Design is what separates the winners.** The models that save money share four features. First, they put a defined population's total cost of care – hospital, specialist, pharmacy, and behavioral health, not just primary care – under one budget, so savings anywhere count; state total-cost models, led by Maryland's, produced the largest savings among the federal models reviewed. Second, they carry real downside risk: providers repay part of any overspending rather than only sharing in savings, and one-sided shared savings has produced little net savings. Third, they cover enough members that results are not down to chance and one costly patient does not swing the budget. Fourth, their benchmarks do not punish past success: when targets reset to each provider's own recent spending, the most efficient providers have the least room to save and the most reason to leave, so regional or statewide benchmarks work better. Small bonuses on top of fee-for-service leave the incentive to bill for more services in place; in Colorado, the primary care practices that missed the 2023 quality threshold saw rate cuts averaging 0.72%. PRIME is the Colorado model closest to this design: a fixed budget for the total cost of care of a defined Western Slope population, with full risk held by Rocky Mountain Health Plans.
- **Colorado reports that about 52% of Medicaid payments are "value-based," but most of that carries little financial risk.** Most of it is pay-for-performance or prospective payment layered on fee-for-service, where reported savings are small: for example, $845,676 in primary care shared savings in 2024, and prospective primary care payments that ran $3.9 million above what fee-for-service would have paid.

- **PRIME is Colorado's one full-risk, total-cost model, and its results look favorable but have not been independently tested.** Its capitation is set at or below 98% of the fee-for-service equivalent, it reported coming in $18 million under budget in its first year, and its members rate their care well above the Medicaid average. There is no rigorous comparison group, and the Grand Junction area had a long history of low-cost, collaborative care before PRIME. SHG did not have time to talk with Rocky Mountain Health Plans and HCPF about PRIME or to research it more thoroughly, so that analysis has yet to be completed.
- **Extending it means answering three questions first:** where enough providers are organized and willing to take risk, how benchmarks will be set, and how results will be measured against a fair comparison.

How value-based payment works in Colorado today

HCPF's latest legislative report (calendar year 2024, issued November 2025) estimates that 52% of Medicaid payments are tied to value-based arrangements. That figure counts several very different kinds of payment, from small quality adjustments to full capitation.

Program	How it pays	What has been reported
RMHP PRIME (Western Slope)	Full-risk capitation to Rocky Mountain Health Plans for physical health (and behavioral health through the same organization); practices can join Prime Global Pay, a risk-adjusted capitation with year-end shared savings based on quality and total cost	See the next section
Primary care APM 1	Pay-for-performance: fee-for-service rates adjusted up or down on quality measures	307 of 342 non-FQHC locations met the quality threshold for 2023; the 35 that did not saw rate cuts averaging 0.72%
Primary care APM 2 (now folded into the ACC Phase III primary care payment structure)	Prospective per-member payments plus shared savings on chronic conditions	239 practices and 522,594 attributed members in 2024; 19 of 40 organizations earned shared savings totaling $845,676; prospective payments exceeded fee-for-service equivalents by $3.9 million, and rates were rebased down 12.2% mid-year
Maternity bundled payment	One episode payment for prenatal care through delivery	Nine practices covering about a third of births; $6,619 in savings in program year 3; a redesigned maternity model is planned for 2027
Prescriber tool	Shared savings for following the preferred drug list	97% compliance; $612,665 in savings, most of it paid to 701 practices
Hospital Transformation Program	Provider-fee-funded hospital payments at risk on quality and utilization measures	85 hospitals earned at least partial payment on 86% of measures in the first performance year; the five-year program ends in 2026
RAE incentive payments	Bonuses to RAEs and practices for quality and performance measures	$411.8 million paid over seven years, about half of what was available

Only PRIME and Denver Health's capitated plan put a whole population's total cost of care at risk. The rest pay mainly fee-for-service with adjustments, which is the category the national evidence finds least likely to change spending.

What PRIME has shown

What it is. PRIME (Payment Reform Initiative for Medicaid Enrollees) began in 2014 under HB 12-1281, the Medicaid payment reform pilot law. Rocky Mountain Health Plans receives a fixed monthly payment per member and is responsible for physical health; PRIME members also get behavioral health through the same organization. Adults and children with disabilities in nine Western Slope counties, including Mesa, Delta, Garfield, Gunnison, and Montrose, are passively enrolled up to a cap. PRIME continued into ACC Phase III in July 2025. Average enrollment was about 55,800 in FY 2022-23.

Results reported:

- **Cost.** By contract, PRIME's capitation must be at or below 98% of what the same members would cost in fee-for-service, so the state's savings are built into the rate. RMHP reports that PRIME came in $18 million under budget in its first year, kept $5 million in shared savings (90% of it passed to providers), and returned the rest to the state, and that the state cut PRIME's budget by 4% and then 7% at successive renewals. In FY 2022-23 PRIME cost $621 per member per month, reflecting a population weighted toward adults with disabilities and people also on Medicare.
- **Quality.** In FY 2024-25, HCPF reports PRIME met its goals on all four contract quality measures (substance use treatment initiation and engagement, prenatal and postpartum care, depression screening and follow-up, and diabetes control). In FY 2022-23, emergency visits fell from 686 to 594 per 1,000 members, but claims-based prenatal and postpartum rates were well below the Medicaid average.
- **Member experience.** In FY 2022-23, PRIME members rated their health plan favorably at 70.5%, compared with 53.8% across Health First Colorado, and reported getting care when needed at higher rates.

Limits of the evidence:

- No independent evaluation compares PRIME members with a matched group in fee-for-service, so the size of any savings beyond the 2% built into the rate is not established.
- HCPF's own reports say the quality figures are not risk-adjusted and that the Medicaid average is context, not a benchmark.
- The Grand Junction area had a long history of provider collaboration and low health care costs before PRIME. That may be why PRIME works there, and it may not carry over to regions without that history.
- Most of the savings figures come from RMHP itself.
- **The analysis of PRIME has yet to be completed.** SHG did not have time to talk with Rocky Mountain Health Plans, HCPF, or participating providers, or to review PRIME's contract and rate documents in depth. That work would test PRIME against the four design features in the Bottom line, including whether the 4% and 7% budget cuts at successive renewals reset its benchmark in a way that can punish past success.

The national evidence

Medicare Innovation Center models. The Center's own 2022 report to Congress said only a few of its many models had clearly reduced costs and improved outcomes; six had statistically significant net savings. An April 2025 Avalere review of 18 models found one-third yielded substantial net savings, one-third substantial net losses, and one-third had little effect, adding $7.7 billion to federal spending overall before counting providers' own costs of taking part. Primary care models (Comprehensive Primary Care Plus and Primary Care First) were among the largest losers. State and community models, led by Maryland's all-payer and total cost of care models, produced the largest savings.

Medicaid accountable care organizations. A 2024 review of 32 studies (2012–2023) found Medicaid ACOs often increase primary care visits and reduce hospital admissions, with mixed results on quality, outcomes, and cost. Under the federal State Innovation Models evaluation, Vermont's Medicaid ACO saved Medicaid about $97 million, and ACOs in Maine, Minnesota, and Vermont reduced emergency visits by 3% to 7%. Minnesota's Integrated Health Partnerships reported $10.5 million in first-year savings. Oregon credits its regional coordinated care organizations, which hold global budgets, with substantial savings, though whether it has held its growth target depends on the measure (see the regional structures briefing).

What the successful models have in common:

- **A whole population and its total cost of care under one budget,** not a bonus on top of fee-for-service.
- **Real downside risk,** which, as members heard, providers must agree to take. One-sided shared savings has produced little net savings.
- **Enough scale** to make results statistically meaningful and to spread risk.
- **Fair, stable benchmarks.** Models that reset targets against each provider's own past performance squeeze out savings over time and discourage participation; models with selection bias or unpredictable payments lost money.
- **Good, timely data.** Colorado hospitals have told the Colorado Hospital Association that the Hospital Transformation Program could not prepare them for value-based payment without reliable, timely claims data.

In short, value-based payment can lower cost, but most designs in use do not. The models with the strongest results look more like PRIME (a fixed budget for a defined population) than like the pay-for-performance programs that make up most of Colorado's 52%.

What it would take to extend it

1. **Test PRIME properly before scaling it.** Commission an independent comparison of PRIME members with similar members elsewhere, adjusted for risk, covering total cost, quality, and experience. That would answer the question members asked and give the Department plan a baseline.
2. **Go where providers are organized and willing.** Full-risk models depend on provider groups able to take risk. Identify regions or systems (health systems, FQHC networks, independent practice groups) that would volunteer, rather than mandating risk statewide.

3. **Shift dollars from small bonuses toward total-cost budgets.** Pay-for-performance adjustments of under 1% carry little incentive. The plan could set a target for the share of payment under total-cost or episode budgets with downside risk, not just the share labeled value-based.
4. **Get benchmarks right.** Use regional or statewide benchmarks rather than each provider's own history, and let providers keep a fair share of savings, which stakeholders raised in public comment.
5. **Fix the data.** Monthly claims data to participating providers is a precondition, especially for hospitals as the Hospital Transformation Program ends in 2026 and its successor is designed.
6. **Count savings honestly.** Report net savings after incentive payments and administration, against a comparison group, as line 14's reconciliation of fiscal-note savings already contemplates.

Questions for the Department plan: Which programs would move to total-cost or episode budgets, and in what order? What share of payment would carry downside risk by when? How would PRIME be evaluated, and what result would justify extending it? What would replace the Hospital Transformation Program? How will net savings be reported to the Joint Budget Committee?

Sources

- Commission record of decisions, November 10, 2026 (line 108); Docket v4.2 (lines 15 and 108)
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- HCPF, Medicaid Payment Reform and Innovation Pilot Program Report FY 2022-23 and FY 2024-25 ACC Legislative Report
- HCPF, ACC Phase III, Phase III draft contract FAQ, attribution fact sheet, and RAEs and MCOs presentation (September 2025)
- HCPF, Hospital Transformation Program; Colorado Hospital Association, HTP overview and member survey results
- HSAG for HCPF, 2015 review of the RMHP payment reform pilot
- UnitedHealthcare / RMHP, PRIME: value-based care in Colorado (plan's own account); Fierce Healthcare, Colorado's Medicaid Prime a model; Colorado Public Radio, Grand Junction and Medicaid costs
- HFMA, Avalere analysis of CMMI models (April 2025); Healthcare Dive, Many CMMI models don't generate savings; TechTarget, Only a third of CMMI models yield net savings; BenefitsPRO, CMMI 2022 report to Congress
- CHCS, Medicaid ACO scoping review, 2012–2023; Milbank Memorial Fund, States tackling health care system transformation; Milbank Quarterly, Medicaid ACOs in four SIM states; CHCS, Medicaid ACO progress in leading-edge states; Fierce Healthcare, early Medicaid ACO results