APM 2

Investments in Primary Care

Program Year 2025

COLORADO
Department of Health Care Policy & Financing

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.
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Table of Contents

Introduction

The mission of the Department of Health Care Policy and Financing (HCPF) is to partner with primary care providers to improve healthcare equity, access, and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado. Health First Colorado (Colorado's Medicaid program) currently serves more than one million Coloradans, many of whom have complex health needs due to life circumstances or disability. To meet the unique needs of those we serve, HCPF has a long history of innovative value-based care partnerships with primary care providers. This guidebook focuses on the Alternative Payment Model 2 (APM 2) for Primary Care and is intended to help Accountable Care Collaborative (ACC) Primary Care Medical Providers (PCMPs) and their staff successfully implement the APM in their practices. The ACC PCMP network includes individual practice sites that focus on primary care, internal medicine, family medicine, pediatrics, geriatrics, or obstetrics and gynecology.

Key Definitions

- **Alternative Payment Model (APM):** A method of paying for health care services that directly links to performance on cost, quality, and the patient's care experience.
- **Accountable Care Collaborative (ACC):** A care program that pays providers for delivering more value and improving care coordination for members.
- **Billing Entity:** A group of PCMPs that share a single Tax ID.
- **Episode of Care:** An episode of care refers to all the healthcare services a patient receives to address a specific health condition within a designated timeframe.
- **Fee-for-Service (FFS)**: A payment system in which a payer reimburses providers for each service rendered based on a predetermined rate for each service.
- **Federally Qualified Health Centers (FQHC)**: A community-based, safety net healthcare provider that receives funds from the U.S. federal government to provide primary care services in underserved areas.
- **Primary Care Medical Provider (PCMP)**: A healthcare practice site who serves as the first point of contact for patients and delivers person-focused, comprehensive care.
- **Prospective Payment**: A method of reimbursement in which healthcare providers are paid a predetermined, fixed amount in advance for a specified set of services.
- **Qualifying Members**: Health First Colorado members, excluding dual-eligible members and members enrolled in PACE, CHP+, or MCOs (Denver Health, and Rocky Mountain Health Plans - PRIME).
- **Shadow Billing**: PCMPs are required to submit claims for all services provided, even though the service billed may not generate payment, for reconciliation purposes.
- **Shared Savings:** Incentive payments for providers who effectively manage the cost of chronic episodes for their attributed population.

Developing the Alternative Payment Model

The purpose of the APM 2 program is to improve member outcomes and reduce health disparities by creating stable investments in PCMPs across the state. This model was designed with input from Health First Colorado members, advocates, and providers.

From 2021 to 2023, the Department collaborated with primary care providers across Colorado to develop the APM 2 program. This development was carried out through a continuous feedback process with providers, ensuring that the initial implementation of the APM 2 program was inclusive and aligned with the priorities of Colorado providers.

Stakeholder engagement meetings continued throughout 2024. Members, providers, and other community stakeholders participated to provide feedback that will inform the future model design. This feedback, although not included in the current version of the provider guidebook, helps to simplify the program and maximize HCPF's investments in primary care.

The future model design includes plans for additional reimbursement opportunities. Providers will also gain access to new dashboards offering actionable, timely data insights that enable PCMPs to track performance against targets and identify specific care gaps. See HCPF's ACC Phase III webpage for more information about the program changes as they become available.

APM 2 program goals established through the stakeholder process include:

1. Improve clinical outcomes for members with chronic conditions.
2. Improve medical outcomes for child and adolescent members.
3. Increase access to primary care services for all members across the state.
4. Reduce the total cost of care while keeping primary care costs stable or higher.
5. Provide stabilized revenue for PCMPs.
6. Reduce administrative burden of program participation.

APM 2 Program Participant Eligibility

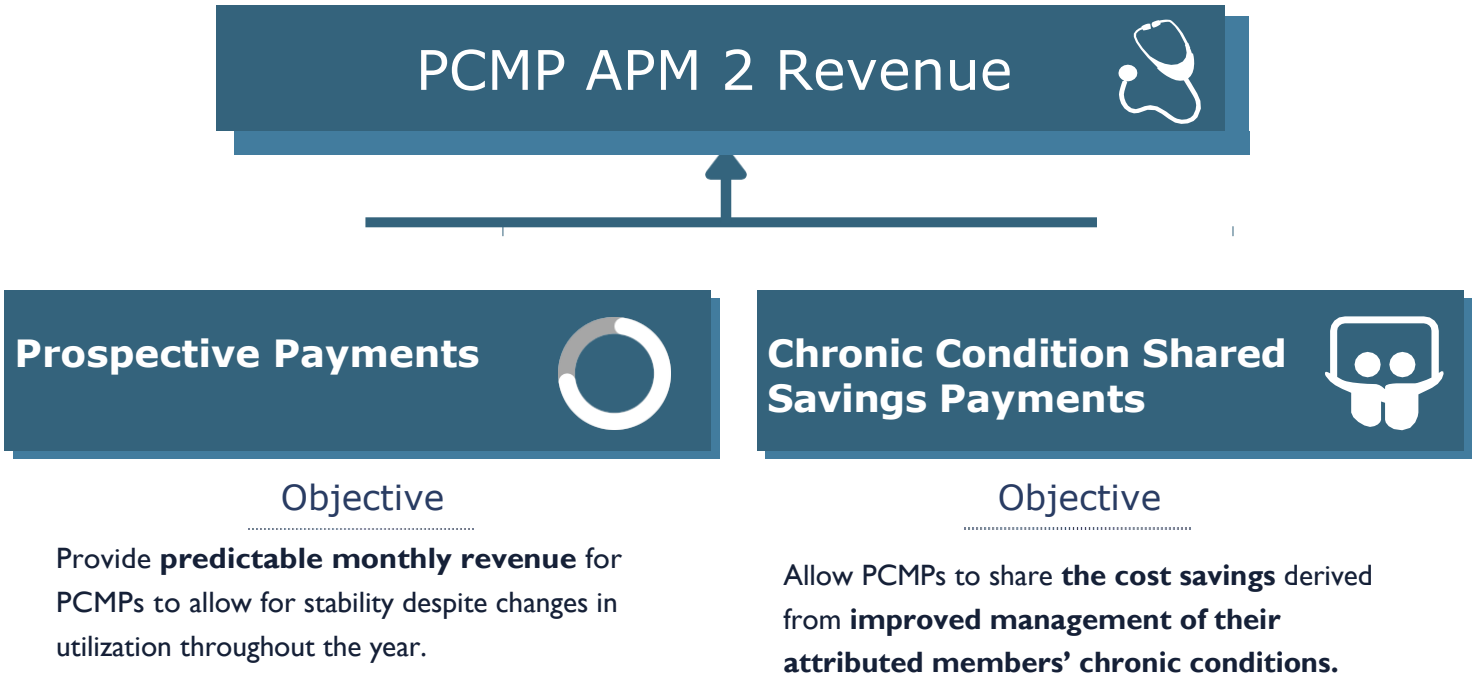
APM 2 is a voluntary program that runs on a Program Year spanning from January 1 to December 31. All APM 1 enrolled PCMPs are eligible to participate in APM 2, including:

- PCMPs with 500 or more attributed Health First Colorado members.
    - Note: PCMPs with less than 500 attributed Health First Colorado members may request to participate.
- Federally Qualified Health Centers (FQHCs) may sign up for their own track of APM 2 and FQHCs have their own set eligibility criteria. See HCPF's FQHC webpage for more information.

APM 2 Model Design

The APM 2 model design (as shown in Figure 1) supports providers by offering stable revenue in the form of **Prospective Payments** ("Per Member Per Month Payments"). The model also shares financial rewards with PCMPs in the form of **Chronic Condition Shared Savings Payments** ("Shared Savings Payments")**.** The shared savings payments are triggered annually when PCMPs achieve reductions in chronic condition health care costs for their attributed members through improved management of prevalent chronic conditions.

Figure 1: APM 2 Model Design



Prospective Per Member Per Month (PMPM) Payment

Advantages of Participation

1. Prospective payment rates are designed to provide steady, predictable revenue for PCMPs month over month, ensuring stability despite changes in utilization.

2. Providers that select to receive at least 25% of their primary care payments as prospective payments are eligible for a 16% rate increase above the Health First Colorado fee schedule.

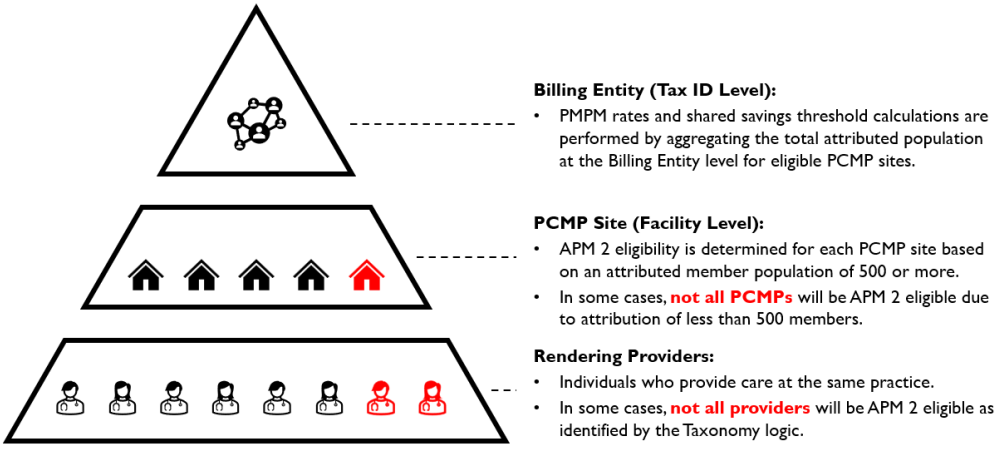
Note: As of 2025, the Department has requested legislative changes to the 16% rate increase. More details will be communicated after the 2025 legislative session is finalized.

Eligible Services and Rendering Providers

Eligible services reimbursed under the APM 2 program are those included in the **Modified APM Code Set**, which is identical to the APM 1 program's APM Code Set, excluding family planning services. The Modified APM Code Set can be found in the Appendix.

The relationship between the billing entity, PCMP, and rendering provider is shown below in Figure 2. Individual providers' primary care provider taxonomy codes are used to identify primary care providers within each PCMP. Historical claims are limited to those rendered by providers with primary care provider taxonomy codes included in the list of **APM 2 Primary Care Taxonomy Codes**. Rendering providers are rolled up to their PCMPs. Program eligibility is determined at the PCMP level. All PCMPs are rolled up to their billing entity. A PCMP's prospective payment rate is calculated at the billing entity level (e.g., tax ID).

Figure 2: Billing Entity to Rendering Physician Hierarchy



The APM 2 Primary Care Taxonomy Codes can be found in the Appendix as well as HCPF's APM 2 webpage, under the Program Resources section.

PMPM Selection

Prospective Payments are advance payments that are reimbursed on a per-member, per- month (PMPM) basis. Participating PCMPs may select to receive a portion (0%-100%) of their expected fee-for-service (FFS) reimbursement for **eligible services** as prospective PMPM payments for qualifying attributed members. PCMPs that select a PMPM of 1-99% 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.

If a PCMP wants to participate in the Chronic Conditions Shared Savings Program only, the PCMP may select a PMPM of 0%. In this case, the PCMP will not receive a prospective payment and will continue to receive FFS payments at 100% of the fee schedule rate. Despite not participating in the prospective payment portion of APM 2, the PCMP would still be eligible to earn a Chronic Conditions Shared Savings Payment, as described in the Chronic Condition Shared Savings Payment section of the guidebook.

16% Rate Increase

If a PCMP selects a PMPM of 25% or more, they will be eligible for a 16% rate increase. PCMPs may select a PMPM of less than 25%, but the 16% rate increase will be scaled down proportionate to the 25% threshold. The following table illustrates the impact of the 16% increase on varying prospective PMPM payment selections.

Table 1. Prospective PMPM Payment Reimbursement Percentage Examples

	Prospective PMPM Payment Selection (%)			
	0.0%	**12.5%**	**50.0%**	**100.0%**
A. PMPM	$20.00	$20.00	$20.00	$20.00
B. % Fee For Service	100%	87.5%	50%	0%
C. % PMPM (C = 100%- B)	**0.0%**	**12.5%**	**50.0%**	**100.0%**
D. Incentive Increase (D = if(C≥25%, 16%, otherwise (C/25%)*16%)	0.00%	8.00%	16.00%	16.00%
E. Beginning PMPM Amount (E = A*C)	$0.00	$2.50	$10.00	$20.00
F. Additional PMPM (F = D*E)	$0.00	$0.20	$1.60	$3.20
G. Adjusted PMPM Amount (G = E+F)	$0.00	$2.70	$11.60	$23.20
H. Estimated Monthly Attribution (SFY Member Months/12)	500	500	500	500
I. Estimated Monthly Revenue Through PMPM (I = G*H)	**$0**	**$1,350**	**$5,800**	**$11,600**
J. Estimated Monthly Revenue Through FFS (J = A*B*H)	**$10,000**	**$8,750**	**$5,000**	**$0**
K. Estimated Total Monthly Revenue (K = I+J)	**$10,000**	**$10,100**	**$10,800**	**$11,600**

Note: As of 2025, the Department has requested legislative changes to the 16% rate increase. More details will be communicated after the 2025 legislative session is finalized.

Prospective Payment Rate Setting Process

PMPM payment rates are based on the PCMP's qualifying attributed member population's historical claims ("base data") for **eligible services** ("APM 2 services") that are performed by providers with a **primary care provider taxonomy code**.

The following steps give an overview of the actuarial process used to calculated each PCMP's prospective PMPM rate. Each interested PCMP receives more detailed data specific to their practice prior to enrolling in the program.

1. **Category of Aid (COA):** Base data is broken out by COA. Each calculation step is applied at the COA level (Abled Adult - Male (AA-M), Abled Adult - Female (AA-F), Disabled Adult - Male (DA-M), Disabled Adult - Female (DA-F), Abled Child (AC), Disabled Child (DC)) to calculate a PMPM rate that accurately reflects the services provided to each PCMP's specific member population.
2. **Repricing:** Base data is repriced to the most recent fee schedule. For Program Year 2025 (PY2025) the fee schedule as of January 1, 2025 was applied to base data.
3. **Incurred But Not Reported (IBNR) Adjustment:** IBNR adjustment accounts for claims that were incurred but may not be accurately reflected in the data for various reasons, such as outstanding payments and adjudication.
4. **Leakage Removal:** Claims for members that were identified as leakage are removed from the base data. Leakage is defined as APM 2 services performed by a different billing entity other than the member's attributed billing entity.
5. **Credibility Weighting:** PMPM rate projections for PCMPs with fewer attributed members are much more volatile. As a result, if a PCMP has fewer attributed members than the standard credibility threshold as defined by the Department, their base data is blended with the corresponding statewide COA-specific PMPM rates to increase credibility.
6. **Retrospective Program Changes:** Base data is adjusted for policy and program changes that occurred between the base data period and the Program Year.
7. **Prospective Program Changes:** Base data is adjusted for known policy and program changes that will take effect in the Program Year and were not effective during the base years.
8. **Membership Mix Update:** Changes in a PCMP's attributed membership are accounted for by utilizing PCMP's actual attributed member months to adjust member mix and arrive at PCMP's final PMPM rate.

If a provider is a newly participating PCMP and has no claims experience for an attributed population, a statewide average is used. The rate calculated by the Department is effective for the rate effective period and is agreed to by the PCMP via their annual Notification Letter. See the Notification Letter section in the Appendix for more information.

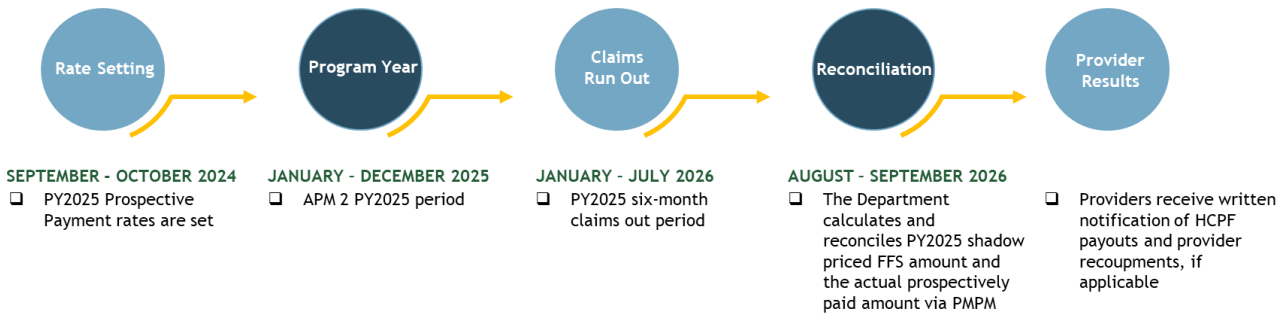
Prospective Payment Reconciliation

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 HCPF 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 HCPF with the necessary data to perform reconciliation and inform future rates. Inaccurate or inconsistent shadow billing can negatively impact a PCMP's future rates and reconciliation results.

After the conclusion of each Performance Year, the Department must allow a six-month run out period before conducting the reconciliation process as shown in Figure 3. HCPF reconciles the shadow priced FFS amount and the actual amount prospectively paid PMPM for the Performance Year.

Note: While FQHCs are required to shadow bill and go through a reconciliation process, federal law requires that HCPF reimburse all FQHCs for no less than what they would have received under the federal PPS encounter rate.

Figure 3: PY2025 Prospective Payment Rate Setting and Reconciliation Timeline



Quality Standards for Prospective Payment Retention

Participation in the prospective payment portion of APM 2 is risk-free for the first year of enrollment. In subsequent years of participation, reconciliation is tied to a PCMP billing entity's ability to meet a minimum APM 1 quality score. When evaluating a PCMP's APM 1 quality performance, HCPF takes an average of the total scores earned across all PCMP sites associated with a billing entity. For more information about the APM 1 quality measures and scoring methodology, see HCPF's APM 1 webpage.

In the **first year of APM 2 program participation**:

- The first year of APM 2 program participation is risk free.
- If the actual PMPM amount paid is less than the shadow priced FFS amount, HCPF will pay the difference to the PCMP.
- If the actual PMPM amount paid is more than the shadow priced FFS amount, the PCMP may keep the difference.

In the **second year and subsequent years of APM 2 program participation**:

- If the actual PMPM amount paid is less than the shadow priced FFS amount, HCPF will not pay the difference to the PCMP.
- If the actual PMPM amount paid is more than the shadow priced FFS amount, the PCMP may keep the difference only if the PCMP has met the APM 1 Quality Threshold, which is an average of 200 points, calculated across all PCMP practices associated with the billing entity.
- If a PCMP billing entity **does not meet** the required APM 1 Quality Threshold, an average of 200 points calculated across all of the PCMP practices associated with the billing entity, the PCMP will be required to remit any amount received through the prospective PMPM payment that is above the shadow priced FFS amount.

Opting Out of Prospective Payments

If at any point during the Program Year the PCMP chooses to opt out of participating in the APM 2 Program, they must contact the Department at HCPF_primarycarepaymentreform@state.co.us. The PCMP's enrollment will be terminated on the first of the month following 30 days of notice.

Chronic Condition Shared Savings Payment

The Department aims to support Colorado's shift to value-based care models by creating a shared savings program that rewards PCMPs for effective management of their attributed members' chronic conditions.

Shared savings payments are upside-only (e.g., PCMPs can earn additional revenue if they reduce chronic condition costs but are not penalized if they do not). This incentivizes practices to improve the management of chronic conditions while maintaining quality of care. The shared savings payment rewards practices with 50% of the savings achieved across costs associated with 12 chronic conditions. The 12 chronic conditions as shown in Figure 4 were determined by the Department to be major cost drivers for the State and are considered amenable to primary care intervention.

Figure 4: List of Qualifying Conditions

Qualifying Chronic Conditions

These conditions were determined to be **major cost drivers** for the State and are considered amenable to primary care intervention. Members must have **one or more** of the following conditions to be evaluated under the shared savings arrangement:

- Asthma
- Coronary Artery Disease
- Hypertension
- Gastro-Esophageal Reflux Disease (GERD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Crohn's Disease
- Ulcerative Colitis
- Lower Back Pain
- Osteoarthritis
- Diabetes
- Heart Failure
- Arrhythmia / Heart Block

Episodes of Care

An **episode of care** refers to all the healthcare services a member receives to address a specific chronic health condition within a program year. A member's chronic condition episode is triggered if a member: 1) is admitted to the hospital with a principal diagnosis associated with one of the 12 chronic conditions, or 2) has more than one office visit to treat the condition and the visits occur at least 30 days apart.

Although an episode may involve multiple providers or practices, it is limited to include only the healthcare costs and services relevant to that episode based on ICD-10 diagnostic and CPT codes included on the claims. Member episode costs are winsorized to address outlier episodes. Winsorization is a statistical technique used to limit extreme values in data by transforming outlier episode costs to a certain set limit. In this case, values below the 5th percentile are made equal to the 5th percentile, and values above the 95th percentile are made equal to the 95th percentile. See HCPF's *Chronic Condition Episode Logic and Business Rules* for more information.

Chronic Condition Cost Thresholds

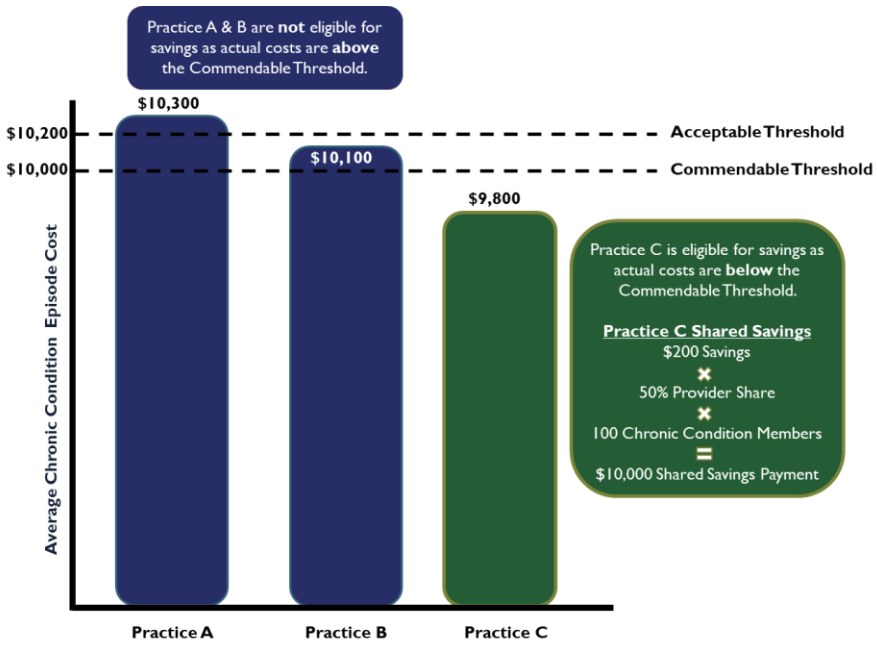
Chronic condition cost thresholds are the prospectively set cost targets for the episodes of care. Thresholds are calculated using the previous 12 months of historical claims data to determine total episode costs. To arrive at the billing entity specific threshold, the following steps are performed:

1. **Baseline Threshold:** For each episode, calculate the statewide average episode cost for qualifying attributed members.
2. **Billing Entity Specific Risk Adjusted Episode Cost:** Risk adjust the statewide average episode cost.

   Billing entity's chronic condition episodes are risk-adjusted from a statewide baseline to reflect the risk of each billing entity's qualifying attributed members, who are age 19 or older, that are Health First Colorado members for at least 6 months. The risk adjustment methodology produces an estimate of an episode's risk by considering the member's category of aid, gender, number of comorbid chronic conditions, and the number of and presence of behavioral health conditions. See HCPF's APM 2 Chronic Condition Shared Savings Program Risk Adjustment Methodology in the Appendix for more information.
3. **Acceptable Threshold:** Aggregate an overall risk-adjusted average episode cost for the billing entity across all 12 episodes by weighing the billing entity's mix of episodes in the baseline period.
4. **Commendable Threshold**: Reduce the Acceptable Threshold by the 2% minimum savings rate (MSR). The Commendable Threshold is utilized to determine shared savings.

The Commendable Threshold ensures that billing entities are lowering costs from the baseline period and improving the quality of care delivered.

Figure 5: Example Chronic Condition Shared Savings Payment Calculation



Shared Savings Reconciliation and Payment Conditions

Following the end of a Performance Year, billing entities will have their risk-adjusted Commendable Thresholds reconciled to their actual episode costs to determine whether any savings will be paid out. Providers will only be eligible to receive shared savings if the provider's average quality score for APM 1 metrics meets a minimum average of 200 points across all PCMP sites associated with the billing entity. Member episodes and episode costs for the Performance Year will be determined based on the methods described above.

For the purposes of reconciliation, the Commendable Threshold will be revised to reflect the following:

1. Billing entity's mix and severity of episodes attributed to the Performance Year.
2. Any Centers for Medicare and Medicaid Services (CMS) approved policy changes (i.e. program updates) made to the threshold methodology after the program year started but before reconciliation occurs.

PCMPs will be eligible to receive 50% of the savings between the Commendable Threshold and actual average episode cost across the 12 episodes. Savings are determined by weighting the billing entity's mix of episodes and the Commendable Threshold if the following conditions are met:

1. Actual cost is less than the Commendable Threshold, and

2. PCMP has met the APM 1 Quality Threshold (an average of 200 points or greater on APM 1 Quality Measures across all PCMPs associated with a billing entity).

If the average episode reimbursement is **higher** than the Commendable Threshold, the billing entity will **not** receive any shared savings. However, there will be no adverse consequences for the provider, as this is an upside risk program.

If the billing entity has not met the APM 1 Quality Threshold of 200 points across all PCMP sites, the billing entity will **not** receive any shared savings.

Note: Data used for reconciliation will be actual member attribution data and claims data for services rendered to attributed members for the Program Year being reconciled.

Opting Out of the Chronic Condition Shared Savings Program

If at any point during the Program Year the PCMP chooses to opt out of participating in the APM 2 Program, they must contact the Department at HCPF_primarycarepaymentreform@state.co.us. PCMP's enrollment will be terminated on the first of the month following 30 days of the notice, and the Chronic Condition Shared Savings Payment will be prorated to reflect the months of participation.

Appendix

Attribution Methodology

Attribution is the process by which members are assigned to a participating PCMP that serves as a focal point of care. Accurate determination of the relationship between a member and PCMP is critical to APMs to ensure that the correct PCMP is credited and reimbursed appropriately for a member's improved outcomes and costs.

Note: Attribution and reattribution methodologies will change on July 1, 2025 with the launch of ACC Phase III. Unattributed members and excluded members will continue to receive 100% of the Health First Colorado Fee Schedule regardless of PMPM selection.

All members are initially attributed to a PCMP in the following order:

1. **Member Choice**: Every member has the option of changing their PCMP at any time by contacting their Health First Colorado enrollment broker. Member choice is prioritized above other types of attribution.
2. Based on **Utilization:** If a member has a predominant claims history with a PCMP over the last 18 months, and the PCMP is contracted with the ACC as a PCMP, the member is attributed to that PCMP.
3. Based on **Family Connection:** If a member has no claims history with a contracted PCMP, then family relationship is used to connect a member to a contracted PCMP. More information on family connection attribution can be found here.

   Note: This method of attribution will no longer be used beginning July 1, 2025.
4. Based on **Geography:** If a member has no claims history with a contracted PCMP and cannot be attributed through a family connection, the system determines the closest appropriate PCMP within the member's region and attributes them to that location.

   Note: This method of attribution will no longer be used beginning July 1, 2025.

Reattribution is the process by which members are reassigned to a different PCMP based on the most recent claims history. Reattribution occurs every month for members 0 to 2 years old and every six months for all members older than 2.

Note: Reattribution will occur every month for members 0 to 2 years old and every three months for all members older than 2 beginning July 1, 2025.

The Department generates monthly PCMP attribution lists that are available to PCMPs. APM 2 payments to PCMPs will change based on the number of monthly attributed members.

Under APM 2 payment methodology, the following members are **excluded** from

prospective PMPM payment and shared savings payment calculations:

- Members who are geographically attributed to a participating provider.
- Members who are dually enrolled in Medicare and Medicaid.
- Members enrolled in the Program for All-Inclusive Care for the Elderly (PACE).
- Members enrolled in Child Health Plan *Plus* (CHP+)
- Members enrolled in managed care plans through Denver Health or Rocky Mountain Health Plans - PRIME.

Note: A member is only attributed to one PCMP at a time. This eliminates the possibility of duplicating payments to multiple PCMPs for the same member. If a member is reattributed, payments will only be made to the PCMP for dates of service within the attribution period. If a member is reattributed to a PCMP that does not participate in APM 2, no payment will be made for that member.

Provider Notification Letter and Response

Notification Letter

PCMPs that select to participate in APM 2 will receive a Notification Letter from the Department of Health Care Policy & Financing (HCPF) prior to the start of the Program Year, which runs from January 1 – December 31, which states the specific qualifications for that PCMP's participation. The Notification Letter contains the following information:

- *Rate Effective Date*: The rate effective start and end date for program participation (enrollment is quarterly on a calendar year).
- *Fee-for-Service (FFS) Percentage*: The percentage reduction in FFS) reimbursement to the Health First Colorado fee schedule proposed by the participating PCMP.
- *Per-Member-Per-Month (PMPM) Rate*: The Prospective Payment to PCMPs based on historical data from their qualifying members.
- *Chronic Condition Payment Acceptable Threshold*: Estimated costs of delivering chronic care management, calculated using historical data.
- *Chronic Condition Payment Commendable Threshold*: The Chronic Condition Payment Acceptable Threshold minus the minimum savings rate of 2%. This is the target rate for shared savings.

Please note Provider Notification Letters for the two APM 2 payment tracks (Prospective PMPM Payments and Chronic Condition Shared Savings Payments) may be sent separately.

Response Letter

A written response letter is required for each portion of the APM 2 program that the PCMP wishes to participate in. The written response letter is a signed copy of the Notification Letter from a PCMP affirming the Participating Physician(s) that will receive payment pursuant to the established calculations. The Department will only make payments as outlined in this guidebook if the Department receives a signed agreement from the PCMP through this Response Letter.

A Notification Letter Response must be signed by a representative of the PCMP to qualify for APM 2 payments. The Response Letter memorializes the PCMP's agreement with the terms of the Notification Letter.

Modified APM Code Set

36415	ROUTINE VENIPUNCTURE	99304	NURSING FACILITY CARE INIT
36416	CAPILLARY BLOOD DRAW	99305	NURSING FACILITY CARE INIT
90460	IM ADMIN 1ST/ONLY COMPONENT	99306	NURSING FACILITY CARE INIT
90471	IMMUNIZATION ADMIN	99307	NURSING FAC CARE SUBSEQ
90472	IMMUNIZATION ADMIN EACH ADD	99308	NURSING FAC CARE SUBSEQ
90473	IMMUNE ADMIN ORAL/NASAL	99309	NURSING FAC CARE SUBSEQ
90474	IMMUNE ADMIN ORAL/NASAL ADDL	99310	NURSING FAC CARE SUBSEQ
99201	OFFICE/OUTPATIENT VISIT NEW	99315	NURSING FAC DISCHARGE DAY
99202	OFFICE/OUTPATIENT VISIT NEW	99316	NURSING FAC DISCHARGE DAY
99203	OFFICE/OUTPATIENT VISIT NEW	99318	ANNUAL NURSING FAC ASSESSMNT
99204	OFFICE/OUTPATIENT VISIT NEW	99324	DOMICIL/R-HOME VISIT NEW PAT
99205	OFFICE/OUTPATIENT VISIT NEW	99325	DOMICIL/R-HOME VISIT NEW PAT
99211	OFFICE/OUTPATIENT VISIT EST	99326	DOMICIL/R-HOME VISIT NEW PAT
99212	OFFICE/OUTPATIENT VISIT EST	99327	DOMICIL/R-HOME VISIT NEW PAT
99213	OFFICE/OUTPATIENT VISIT EST	99328	DOMICIL/R-HOME VISIT NEW PAT
99214	OFFICE/OUTPATIENT VISIT EST	99334	DOMICIL/R-HOME VISIT EST PAT
99215	OFFICE/OUTPATIENT VISIT EST	99335	DOMICIL/R-HOME VISIT EST PAT

Modified APM Code Set

99336	DOMICIL/R-HOME VISIT EST PAT	99386	PREV VISIT NEW AGE 40-64
99337	DOMICIL/R-HOME VISIT EST PAT	99387	INIT PM E/M NEW PAT 65+ YRS
99341	HOME VISIT NEW PATIENT	99391	PER PM REEVAL EST PAT INFANT
99342	HOME VISIT NEW PATIENT	99392	PREV VISIT EST AGE 1-4
99343	HOME VISIT NEW PATIENT	99393	PREV VISIT EST AGE 5-11
99344	HOME VISIT NEW PATIENT	99394	PREV VISIT EST AGE 12-17
99345	HOME VISIT NEW PATIENT	99395	PREV VISIT EST AGE 18-39
99347	HOME VISIT EST PATIENT	99396	PREV VISIT EST AGE 40-64
99348	HOME VISIT EST PATIENT	99397	PER PM REEVAL EST PAT 65+ YR
99349	HOME VISIT EST PATIENT	99401	PREVENTIVE COUNSELING INDIV
99350	HOME VISIT EST PATIENT	99402	PREVENTIVE COUNSELING INDIV
99381	INIT PM E/M NEW PAT INFANT	99403	PREVENTIVE COUNSELING INDIV
99382	INIT PM E/M NEW PAT 1-4 YRS	99404	PREVENTIVE COUNSELING INDIV
99383	PREV VISIT NEW AGE 5-11	99406	BEHAV CHNG SMOKING 3-10 MIN
99384	PREV VISIT NEW AGE 12-17	99407	BEHAV CHNG SMOKING > 10 MIN
99385	PREV VISIT NEW AGE 18-39	99408	AUDIT/DAST 15-30 MIN

Modified APM Code Set

99409	AUDIT/DAST OVER 30 MIN		
99411	PREVENTIVE COUNSELING GROUP		
99412	PREVENTIVE COUNSELING GROUP		
99415	PROLONG CLINCL STAFF SVC		
99416	PROLONG CLINCL STAFF SVC ADD		
G0101	CA SCREEN; PELVIC/BREAST EXAM		
G0124	SCREEN C/V THIN LAYER BY MD		
G8431	POS CLIN DEPRES SCRN F/U DOC		
G8510	SCR DEP NEG, NO PLAN REQD		
Q0091	OBTAINING SCREEN PAP SMEAR		

Note: The Modified APM Code Set is identical to the APM Code Set for the APM 1 program with the exception of family planning services. APM 2 excludes Long-Acting Reversible Contraceptive codes from the Prospective Payment calculation to ensure that Members have free choice of all qualified and willing providers of those Long-Acting Reversible Contraceptive services.

APM 2 Primary Care Provider Taxonomy Codes

Clinical Nurse Specialist - Acute Care	364SA2100X	Clinical Nurse Specialist -Community Health/Public Health	364SC1501X
General Practice	208D00000X	Clinical Nurse Specialist - Family Health	364SF0001X
Internal Medicine - Hospice and Palliative Medicine	207RH0002X	Clinical Nurse Specialist – Gerontology	364SG0600X
Physical Medicine Rehabilitation - Hospice and Palliative Medicine	2081H0002X	Clinical Nurse Specialist – Women's Health	364SW0102X
Advanced Practice Midwife	367A00000X	Family Medicine	207Q00000X
Clinic/Center - Family Planning, Non-Surgical	261QF0050X	Family Medicine - Addiction Medicine	207QA0401X
Clinic/Center - Federally Qualified Health Center (FQHC)	261QF0400X	Family Medicine - Adolescent Medicine	207QA0000X
Clinic/Center - Health Service	261QH0100X	Family Medicine - Adult Medicine	207QA0505X
Clinic/Center - Primary Care	261QP2300X	Family Medicine - Bariatric Medicine	207QB0002X
Clinic/Center - Rural Health	261QR1300X	Family Medicine - Geriatric Medicine	207QG0300X
Clinical Nurse Specialist - Adult Health	364SA2200X	Family Medicine - Hospice and Palliative Medicine	207QH0002X
Clinical Nurse Specialist - Chronic Care	364SC2300X	Internal Medicine	207R00000X

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Internal Medicine - Geriatric Medicine	207RG0300X	Nurse Practitioner – Perinatal	363LP1700X
Midwife	176B00000X	Nurse Practitioner - Primary Care	363LP2300X
Military Health Care Provider	171000000X	Nurse Practitioner – School	363LS0200X
Nurse Practitioner	363L00000X	Nurse Practitioner – Women's Health	363LW0102X
Nurse Practitioner - Acute Care	363LA2100X	Obstetrics Gynecology	207V00000X
Nurse Practitioner - Adult Health	363LA2200X	Obstetrics Gynecology - Critical Care Medicine	207VC0200X
Nurse Practitioner - Community Health	363LC1500X	Obstetrics Gynecology – Gynecology	207VG0400X
Nurse Practitioner - Family	363LF0000X	Obstetrics Gynecology - Maternal Fetal Medicine	207VM0101X
Nurse Practitioner - Gerontology	363LG0600X	Obstetrics Gynecology – Obstetrics	207VX0000X
Nurse Practitioner - Neonatal	363LN0000X	Obstetrics Gynecology - Reproductive Endocrinology	207VE0102X
Nurse Practitioner - Obstetrics Gynecology	363LX0001X	Pediatrics	208000000X
Nurse Practitioner - Pediatrics	363LP0200X	Pediatrics - Adolescent Medicine	2080A0000X
Nurse Practitioner - Pediatrics - Critical Care	363LP0222X	Pediatrics - Child Abuse Pediatrics	2080C0008X

APM 2 Primary Care Provider Taxonomy Codes

Pediatrics - Neonatal- Perinatal Medicine	2080N0001X		
Physician Assistant	363A00000X		
Physician Assistant - Medical	363AM0700X		
Preventive Medicine - Occupational Medicine	2083X0100X		
Preventive Medicine - Preventive Medicine/Occupational Environmental Medicine	2083P0500X		
Preventive Medicine - Public Health General Preventive Medicine	2083P0901X		
Registered Nurse	163W00000X		
Registered Nurse - Case Management	163WC0400X		
Registered Nurse - Community Health	163WC1500X		
Registered Nurse - General Practice	163WG0000X		

Each participating provider receives a risk adjusted Acceptable and Commendable Threshold, which are based on the statewide baseline chronic episode costs and risk adjusted to align with the demographic profile and level of acuity/comorbidities for their attributed membership prior to the start of the performance period.

The Department develops a risk adjustment model to predict total episode costs for the 12 chronic conditions included in the program. The model is based on an ordinary least squares regression (OLS) that predicts total episode costs for the 12 chronic condition episodes in the APM 2 program based on factors that explain observed variation. To satisfy the normality requirements of OLS, total episode costs are logged. The risk factors included in the model are:

- *Member disability status (Yes/No)*: Identified through the member's Category of Aid (COA).
- *FQHC attribution (Yes/No)*: Whether the member was attributed to a FQHC.
- *Chronic episode (Yes/No)*: Indicators for each individual episode in the APM 2 program, including Arrythmia/Heart Block, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, Crohn's Disease, Diabetes, Gastro-Esophageal Reflux Disease (GERD), Heart Failure, Hypertension, Lower Back Pain, Osteoarthritis, Ulcerative Colitis.
- *Full year enrollment (Yes/No)*: Whether the member was enrolled through the 12-month period used to measure costs.
- *Age and Sex grouping*: Members are spilt into groups based on age and sex and include males, 19-24; males, 25-44; males, 45-64; males, 65 and up; females, 19-24; females, 25-44; females, 45-64; females, 64 and up.
- *Number of behavioral health conditions*: A continuous variable of the number of behavioral health conditions the member has during the Performance Year.
- *Number of chronic conditions*: Members are split into groups based on the number of chronic conditions they have (1, 2-3, 4-5, 6-9, 10+) in the Performance Year. These groupings have been found to be better predictors than a continuous variable.

The final model is selected to maximize predictive power. By iterating multiple model specifications, the final model is selected based on highest performance (lowest root mean squared error [RMSE], highest variance explained [R^2], and lowest information criteria statistics [AIC/BIC]). To test for potential overfitting, the model is assessed by performing a 10-fold cross-validation, where the mean RMSE is consistent with the RMSE obtained from the full data set. Additionally, out-of-sample performance is assessed by measuring the RMSE on episodes from a different year. No significant losses in performance are observed.

The predicted episode costs of the model are then used to calculate billing entity episode-specific risk scores. This is done by averaging the predicted costs for all episodes attributed to a billing entity and then dividing by the overall state-wide average episodes predicted costs. Risk scores are then multiplied by the state average episode costs to determine the providers' Acceptable and Commendable Thresholds.

APM 2 Program Frequently Asked Questions

Below are some frequently asked questions to help providers better understand a transition to APM 2. Providers can reach out to Department staff to receive free access to data analysis specific to their practice or system's situation or fill out a brief survey to learn more.

1. We have a good system we've used for many years to manage Medicaid billing and payments. If we make the transition, will our administrative burden increase?

    a. A full conversion to value-based payments is the future of Health First Colorado. Enrolling now will allow providers to get greater support during the transition. In addition, while APM 2 was developed with the help of providers, the Department continues to be open to refining the system to make it work even better. Joining now will help ensure that feedback on the model is collected and used to improve program operations.

    Providers already participating in Alternative Payment Model One (APM 1) will find that joining APM 2 involves meeting the same quality standards. However, maintaining consistent high-quality scores enable PCMPs to retain prospective PMPM payments that exceed actual utilization and provide additional stability to practice revenue streams. The APM 2 program also offers potential additional revenue through shared cost savings that result from better primary care management of chronic conditions.

2. Is the incentive payment calculated on all members with the chronic conditions listed?

    a. The chronic condition incentive payment is calculated based on all members attributed to a primary care medical provider that are identified as having one or more of the twelve chronic condition episodes.

3. I'm not ready to make the leap to this payment structure. What should I do?

    a. Providers have the flexibility to choose to receive a portion or all of their revenue as a per member per month payment, creating a reliable revenue stream that can weather tough challenges like the pandemic and more normal fluctuations like utilization seasonality. Providers can select the way they want to receive their payments, giving them an on-ramp to participation.

    All participants can decide how far and how fast they join the program and have the option to change their level of participation over time.

4. What are the episode definitions for the chronic conditions?

- Asthma
- Coronary Artery Disease
- Hypertension
- Gastro-Esophageal Reflux Disease (GERD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Crohn's Disease
- Ulcerative Colitis
- Lower Back Pain
- Osteoarthritis
- Diabetes
- Heart Failure
- Arrhythmia / Heart Block

5. Will primary care medical providers be able to see or track their costs?
    a. Yes. The State is developing robust data-sharing dashboards for program participants. Each participating primary care medical provider will eventually have a dashboard to see their patients' costs and trends over time.

6. What Evaluation and Management codes will be a part of the per member per month?
    a. The code set is the same as used in the APM 1 Code Set, excluding Family Planning codes. Please see the Modified APM Code Set in the Appendix for additional details.

7. When can a provider join the program?
    a. Providers can join on a quarterly basis. Potential program effective dates are January 1st, April 1st, July 1st, and October 1st. PMPM payments will begin after the effective date selected by the provider. Gainsharing payments will be prorated for the amount of time a provider participates in a program year.

8. How often will member reattribution take place?
    a. Reattribution is the process by which members are reassigned to a different PCMP based on their most recent claims history. Reattribution occurs every month for members 0 to 2 years old and every six months for all members older than 2. Note this methodology will change on July 1, 2025. Please see the Attribution Methodology section of the guidebook for additional details.

9. How often will the per member per month be paid?
    a. The per member per month payment will be paid monthly for qualifying attributed members.

10. Can a primary care medical provider withdraw during the middle of a program year?
    a. Yes. A primary care medical provider can decide to withdraw from participation in the middle of a program year with proper notification. If a primary care medical provider chooses to stop participating on the first day of the month, their withdrawal will be effective starting the first day of the following month. If they decide to withdraw in the middle of a month, their withdrawal will be effective on the first day of the second month after their decision (i.e. if the withdrawal decision is submitted March 15th, the withdrawal is effective on May 1st).

11. Does a provider need to participate in APM 1 in order to join APM 2?
    a. Yes. A provider must already be participating in APM 1 to be eligible for APM 2. This is due to the use of APM 1 quality measures in both programs, and to ensure there is sufficient data to calculate the PMPM and gainsharing thresholds.

12. What are the quality measures a primary care medical provider can choose from?
    a. A primary care medical provider will pick from the same set of quality measures as they would in the APM 1 program. The quality model is the same for both programs.

13. How often will incentive payments be paid?

    a. Incentive payments will be paid annually, and any achieved shared savings will be split fifty-fifty with the state, if the APM 1 quality threshold of 200 points is met.

14. How will incentive payments be calculated for providers who join mid-year (i.e. Q2, Q3, Q4)?

    a. For providers who join after the start of the program year, the incentive payment calculations will be prorated to account for the shorter performance period. Only the quarters that a provider is enrolled in the program will be included in the annual shared savings payment calculation.

15. Can pediatricians join APM 2?

    a. The State recognizes the difference between adult and pediatric primary care and is working to create a program that is more relevant for pediatricians. In the interim, pediatricians are welcome to participate in APM 2.

For more information contact

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