APM 2

Investments in Primary Care

FY 2024 – FY 2025

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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Introduction

The mission of the Department of Health Care Policy and Financing (HCPF) is 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 over 1.75 million Coloradans[1], 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 innovation to improve access, healthcare quality, and the health of its members. 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 PCMPs include individual providers 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 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.
- **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.
- **Federally Qualified Health Centers (FQHC)**: A type of 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 provider 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.
- **Shared Savings**: Savings shared with providers for effectively managing chronic conditions.

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 primary care. This model was designed with input from Health First Colorado members, advocates, and providers.

Beginning in 2021, the Department created the APM 2 program using an iterative stakeholder feedback process to ensure an inclusive model. These meetings informed the model design, including the conditions of focus and the program goals. Since the initial implementation of APM 2, stakeholder engagement has continued to simplify the program and maximize HCPF's investments in primary care. An updated version of the payment model will be introduced as Colorado moves into ACC Phase III. Future model design also includes plans to improve data accessibility and updated dashboards with actionable, timely data insights that enable PCMPs to track performance against targets and identify specific gaps. See HCPF's *ACC Phase III* webpage for more information.

Eligibility Criteria

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

- Practices with more than 500 attributed Health First Colorado members. Note: Practices 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. See HCPF's *FQHC* webpage for more information.

Under APM 2, PCMPs are identified as individual practice locations that participate in the ACC program. Performance on APM 1 measures is determined at the PCMP practice level. A billing entity consists of all providers that share a single Tax ID.

APM 2 Model Design

The APM 2 model is designed to support providers by offering additional financial investment, stable revenue, and a continuation of the goals of the APM 1 model through **Prospective Payments** (Per Member Per Month Payments) and **Chronic Condition Shared Savings Payments.**

PCMP APM 2 Revenue

Prospective Payments

Objective

Provide **stable, predictable revenue** for practices and allow investments in medical home enhancements, including Department-supported technologies, care coordination resources, etc.

Chronic Condition Shared Savings Payments

Objective

Allow PCMPs to share **the cost savings** derived from **enhanced chronic care management.**

Prospective Per Member Per Month (PMPM) Payment and Fee-For-Service (FFS) Payment

Prospective payments are advance payments that are reimbursed on a per-member, per-month (PMPM) basis, the amount of which is based on historical costs of care for a provider's member population. The payment rate is prospectively calculated by the Department's actuaries using historical claims data, which is limited to providers with a primary care taxonomy and that deliver all services included in the Modified APM Code Set (see the Primary Care APM 2 Modified APM Code Set & Taxonomy List located in the Appendix).

The payment rate will reflect expected utilization differences between the historical data period and the rate effective period. A statewide average will be used if a provider is a newly participating PCMP. The rate calculated by the Department is effective for the rate effective period and is agreed to by the PCMP in the Notification Letter (see the Notification Letter section located in the Appendix) response.

Participating PCMPs may elect to receive a portion (0%-100%) of their expected FFS reimbursement as prospective PMPM payment for qualifying patients. PCMPs that elect a PMPM of 1-99% will receive the remaining percentage as reduced rate FFS claims payment for services included in the Modified APM code set. If a PCMP elects a PMPM of 25% or more, they will be eligible for a 16% rate increase. PCMPs may elect 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 percentages.

Table 1. Prospective PMPM Payment Reimbursement Percentage Examples

	Prospective PMPM Payment Election (%)			
	0.0%	**12.5%**	**50.0%**	**100.0%**
PMPM (a)	$20.00	$20.00	$20.00	$20.00
% Fee For Service (b)	100%	87.5%	50%	0%
% PMPM (c = 100%-b)	**0.0%**	**12.5%**	**50.0%**	**100.0%**
Incentive Increase (d = if(c≥25%, 16%, otherwise (c/25%)*16%)	0.00%	8.00%	16.00%	16.00%
Beginning PMPM Amount (e = a*c)	$0.00	$2.50	$10.00	$20.00
Additional PMPM (f = d*e)	$0.00	$0.20	$1.60	$3.20
Adjusted PMPM Amount (g = e+f)	$0.00	$2.70	$11.60	$23.20
Estimated Monthly Attribution (SFY Member Months/12) (h)	500	500	500	500
Estimated Monthly Revenue Through PMPM (i = g*h)	**$0**	**$1,350**	**$5,800**	**$11,600**
Estimated Monthly Revenue Through FFS (j= a*b*h)	**$10,000**	**$8,750**	**$5,000**	**$0**
Estimated Total Monthly Revenue (k = i+j)	**$10,000**	**$10,100**	**$10,800**	**$11,600**

PCMPs who elect a PMPM of 0% will not receive a prospective payment and will continue to receive FFS payments at 100% of the fee schedule rate. 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.

A PCMP's elected prospective payment percentage is decided at the billing entity level and uniformly applied to all practices under the billing entity.

Shadow Billing Reconciliation

PCMPs that elect 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 for the services under the Modified APM code set. Shadow billing is a requirement of prospective PMPM payment participation, as it provides HCPF with the necessary data to perform accurate reconciliation and inform future rates. Inaccurate or inconsistent shadow billing can cause significant implications to a PCMPs 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. HCPF reconciles the shadow-priced FFS amount and the actual amount prospectively paid PMPM for the Performance Year.

In the first year of APM 2 program participation:

- 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 only if they have met the APM 1 Quality Threshold (200 points or greater on APM 1 Quality Measures). See HCPF's *APM 1 webpage* for more information.

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.
- If a PCMP does not meet the required APM 1 Quality Threshold, they will be required to remit any amount received through the prospective PMPM payment that is above the shadow-priced FFS amount. See the *APM 1 Guidebook* for additional information.

Chronic Condition Shared Savings Payment

The Department aims to support Colorado's shift to value-based models by creating a shared savings program that holds practices accountable for the cost and quality of care rendered. **Shared savings payments** are upside-only and incentivize practices to improve chronic care management by rewarding practices with 50% of their savings achieved in 12 chronic conditions. The 12 chronic conditions shown in Figure 1 were determined by the Department to be major cost drivers for the State and are considered to be amenable to primary care intervention.

Figure 1: List of Qualifying Conditions

Qualifying Chronic Conditions

These conditions were determined to be **major cost drivers** for the State and are considered to be 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

Shared Savings Based on Episodes of Care

An **episode of care** refers to all the healthcare services a patient receives to address a specific health condition within a Program Year. The episode occurs if a member: 1) Is admitted to the hospital for reasons related to the condition, 2) Has multiple office visits to a physician for the condition at least 30 days apart, or 3) Has an office visit and fills a prescription for the condition 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 on the claims. Member episodes with total costs below the 5th percentile and above the 95th percentile are excluded from all calculations to remove high- and low-cost outliers. See HCPF's *Chronic Condition Episode Logic and Business Rules* for more information.

Thresholds

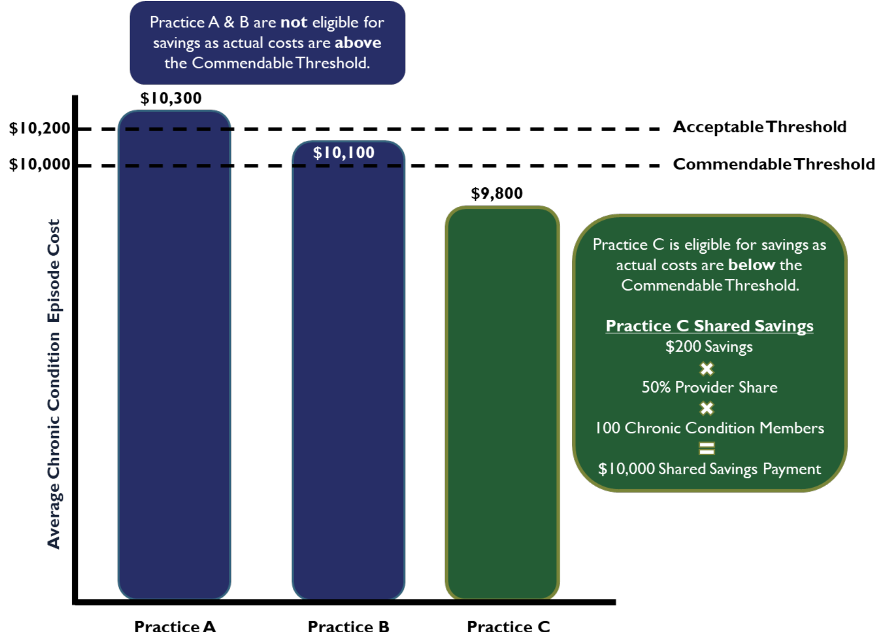
Thresholds are the prospectively set cost targets for the episodes of care. The Department's actuary uses the previous 12 months of historical claims data to determine episode performance. To arrive at the PCMP-specific threshold, the following steps are performed:

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

   PCMP's chronic condition episodes will be risk-adjusted from a statewide baseline to reflect the risk of each PCMP's qualifying patients. 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 Risk Adjustment* methodology for more information.
3. **Acceptable Threshold:** Aggregate an overall risk-adjusted average episode cost for the practice across all 12 episodes by weighting PCMP'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 PCMPs are lowering costs from the baseline period and improving the quality of care delivered.

Figure 2: Example Chronic Condition Shared Savings Payment Calculation



Chronic Condition Thresholds Reconciliation

Following the end of a Performance Year, practices will have their risk-adjusted Commendable Thresholds reconciled to their actual episode costs to determine whether any savings will be paid out. Member episodes and episode costs for the Performance Year will be determined based on the methods described above.

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

1. PCMP's mix and severity of episodes are attributed to the Performance Year.
2. Any Centers for Medicare and Medicaid Services (CMS) approved policy changes that are effective during the performance period but not included in the baseline period.

PCMPs will be eligible to receive 50% of the savings between the actual average episode cost across the 12 episodes, which is determined by weighting the PCMP'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 (200 points or greater on APM 1 Quality Measures).

If the average episode reimbursement is **higher** than the Commendable Threshold, the PCMP 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. See HCPF's *APM 1 webpage* for more information.

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 PCMPs are held responsible and reimbursed appropriately for a member's outcomes and costs. 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, 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 it 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.

Under APM 2 payment methodology, the following members are excluded from rate setting and 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).

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 non-participating PCMP, no payment will be made for that member.

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.

Modified APM Code Set

The APM 2 program uses a Modified APM Code Set for rate setting and the codes that are subject to potentially reduced FFS rates if the PCMP elects for a non-zero PMPM percentage. The Modified APM Code Set is identical to the APM Code Set for the APM 1 program, excluding 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.

The Modified APM Code Set is listed on the following pages.

APM 2 Primary Care Taxonomy

The APM 2 Primary Care Taxonomy codes play a significant role in determining FFS/prospective PMPM rates and payments. The primary care taxonomy codes are used to identify primary care providers within each billing entity. FFS/prospective PMPM rates and payments are adjusted depending on whether the rendering providers within a billing entity have primary care taxonomies. For example, if a clinic consists mostly of primary care providers (according to the taxonomy codes), this could lead to an increase in the PMPM payment rate, considering the preventative care and continuous healthcare services they provide. Similarly, if the clinic has fewer primary care providers, the payment rate may decrease.

The APM 2 Primary Care Taxonomy codes are listed on the pages following the Modified APM Code Set and can also be found on HCPF's *APM 2 webpage* under Program Resources.

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		

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
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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
99336	DOMICIL/R-HOME VISIT EST PAT	99386	PREV VISIT NEW AGE 40-64

APM 2 Primary Care Taxonomy

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

APM 2 Primary Care Taxonomy

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 Taxonomy

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		

PCMPs that elect 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, that states the specific qualifications for that PCMP's participation. The Notification Letter contains the following:

- *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 practices 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.

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. The Response Letter memorializes the PCMP's agreement with the terms of the Notification Letter.

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 and the PCMP's enrollment will be terminated on the first of the month following 30 days of the notice. The Chronic Condition Payment will be prorated to reflect the months of participation.