APM 2

Investments in Primary Care

OCT 2022

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.
www.colorado.gov/hcpf

Introduction

The Department of Health Care Policy and Financing's (HCPF) mission is to improve health care 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 1.5 million Coloradans, many of whom have complex health needs either because of life circumstances or disability. To meet the unique needs of those we serve, HCPF has a long history of innovation to improve access, health care 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 and other groups with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

This model is designed 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.

Developing the Alternative Payment Model

The Department developed a goal of shifting health care service reimbursement from volume-based payments to value-based payments, and the original APM program was the first step towards realizing this goal. APM 2 seeks to continue those efforts and expand their scope to realize the biggest impact possible from these value-based payment models. This furthers the core goals outlined in the ACC of improving health outcomes for Health First Colorado members, as well as saving money. As the ACC moves into the next phase, this new payment model will help maintain that forward momentum and continue the progress made with the existing value-based payment models.

Beginning in 2021, the Department created this 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. Engagement sessions included listening sessions with providers, advocates, and Health First Colorado members, as well as seven model design team meetings over which the model was developed and refined.

Eligibility Criteria

APM 2 is a voluntary program for PCMPs who meet the eligibility criteria below:

- All PCMPs who currently qualify for participation under the APM 1 program qualify for participation in APM 2. PCMPs are identified as a billing entity that participates within the Accountable Care Collaborative program in Colorado. PCMPs must have 500 or more attributed Health First Colorado ACC enrollees.
- PCMPs interested in APM 2 with less than 500 enrollees may still be able to join but must opt-in to the APM 1 program for the quality measures.
- A group of PCMPs sharing a tax ID are eligible to participate as a collective if the grouping pool supports improved data quality or statistical credibility.

Additionally, practices must continuously meet the quality thresholds as laid out in their **Notification Letter** (see below). These measures are designed to ensure that members continue to receive effective and necessary care. These quality thresholds are determined by the same metrics and through the same process that exists for APM 1.

Please see the APM 1 Webpage for more information.

PCMPs and practices that elect to participate will receive a Notification Letter from the Department of Health Care Policy & Financing that states the specific qualifications for that practice'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 Percentage*: the percentage reduction in FFS reimbursement to the Health First Colorado fee schedule, proposed by the participating PCMP.
- *Per Member Per Month Fee*: The Partial Prospective Payment to practices based on historical data from their qualifying members.
- *Incentive Payment Acceptable Threshold*: Estimated costs of delivering chronic care management, calculated using historical data.
- *Incentive Payment Commendable Threshold*: The Incentive Payment Acceptable Threshold minus the minimum savings rate of 2%. This is the target rate for shared savings.
- *Quality Measures*: Must achieve 200 points or greater on quality measures to be eligible for any incentive payments.

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 affirmation from the PCMP through this Response Letter.

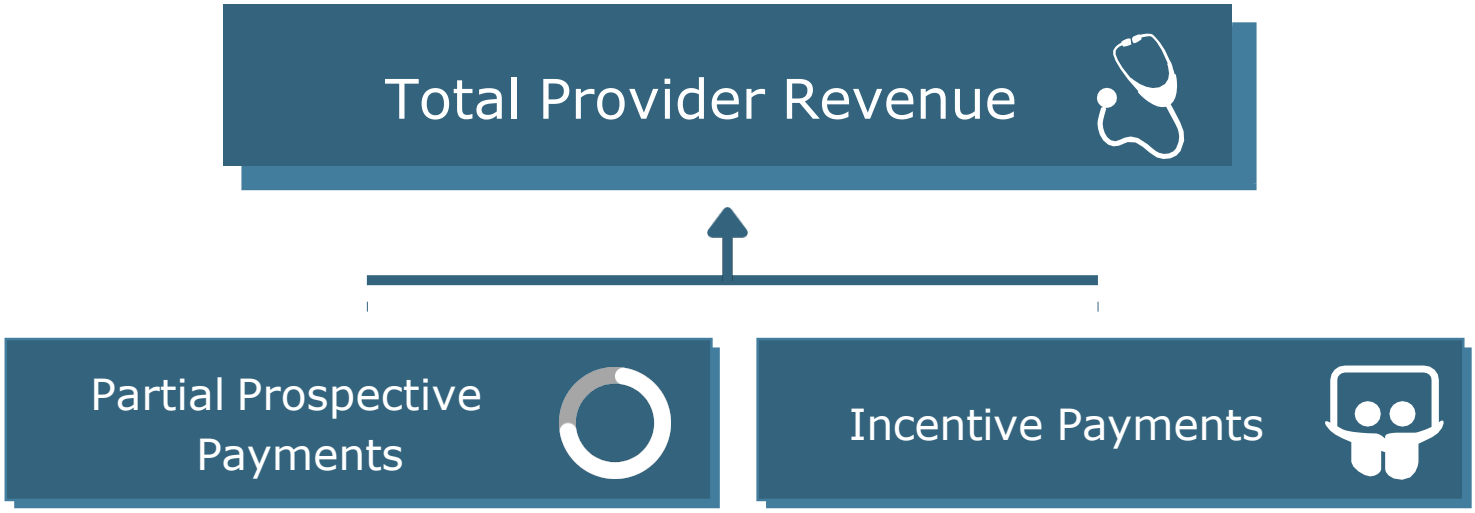
A Notification Letter Response must be signed by a representative of the PCMP to qualify. The Response Letter memorializes the PCMP's agreement with the terms of the Notification Letter.

Value-Based Payments for Primary Care and Chronic Care Management

Model Design

This model is designed 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.**

The APM 2 model is designed with two main components to support providers by offering additional financial investment, stable revenue, and a continuation of the goals of the APM 1 model. The two components are the **Partial Prospective Payment** (Per Member Per Month Payment) and the **Incentive Payments.**



Objective

Provide **stable revenue** for practices and allow investments in means of care that are not currently being rewarded (i.e., outreach and care coordination). **Continued fee-for-service payments** reflect actual visit volumes.

Objective

Allow for practices to **share in the cost savings** deriving from **enhanced chronic care management.**

Partial Prospective Payment (Per Member Per Month Fee) and Fee-For-Services Payments

Partial Prospective Payments are advance payments for some or all of the fee-for-service (FFS) revenue that a PCMP would have received due to the reduction in payment due to the acceptance of a FFS percentage. The rate of payment is prospectively calculated by the Department's actuaries using historical claims data and the PCMP's qualifying patients during the historical data period. The calculation includes all services included in the Modified APM Code Set for all physician services where the billing provider shares a tax ID where the rendering provider has a primary care taxonomy (see the Primary Care APM 2 Taxonomy located in the appendix). This rate of payment will reflect an aggregate rate that is appropriate for the PCMP's qualifying patients, indicative of the PCMP's population mix and the expected utilization differences between the historical data period and the rate effective period. The rate calculated by the Department is effective for the rate effective period and is agreed to by the PCMP in the notification letter response.

Participating practices may select between 0 - 100% of their revenue to be received as Per Member Per Month (PMPM), a partial prospective payment reflecting attributed members each month. The remainder will be billed as fee-for-service for a modified APM code set. Payment benchmarks are based on 8 quarters practices' historical claims. Risk adjustment is unnecessary because rates are set using provider-specific data, and therefore account for variation of risk among providers. A statewide average will be used if a provider is not currently a PCMP.

Example: If PCMP chooses a FFS percentage of 50%, a PCMP takes 50% of their calculated Partial Prospective Payment.

PCMP Selects 50% Fee-For-Service

To compensate for the reduction in payment for the Modified APM Code set as provided for in the Partial Prospective Payment, the PCMP will receive a monthly payment for each of the PCMP's qualifying patients.

Payment is prospectively calculated to be an equitable replacement to the forgone revenue of the PCMP due to accepting the Partial fee-for-service payment.

Partial Prospective Payment (Per Member Per Month Fee) and Fee-For-Services Payments

Choosing a Fee for Service Percentage of 0% would mean that the PCMP will receive the full Partial Prospective Payment for their Qualifying Patients and must shadow bill through the Department's MMIS to provide for the necessary data to perform the Reconciliation, as described in the shadow billing section below.

Choosing 100% would mean that the PCMP will not receive a Partial Prospective Payment at the beginning of the month and therefore the PCMP's Participating Physicians will continue to receive fee for service payments as provided for otherwise in this Guidebook. However, in that case the PCMP would still be eligible for an Incentive Payment, as described in the Incentive Payment section of the Guidebook.

Shadow Billing Reconciliation

Practices who elect to earn any part of their monthly revenue as the prospective Per Member Per Month payments must shadow bill to ensure service delivery.

Shadowing billed claims will be used to set future rates as well as reconcile payments made relative to fee for service.

- After the rate effective period ends, a comparison will be performed on the amount paid for Partial Prospective Payment (PMPM) as compared to what would have been paid under Partial FFS Payment, based on the Fee for Service Percentage selected to receive during the year.
- The total payment revenue from the Partial Prospective Payment (PMPM) will be reconciled with the total claims from the same period. Reconciliation will be ongoing on an annual basis.
- Providers will still be required to submit claims for all services provided, regardless of level of Partial Prospective Payment (PMPM) that they select. This allows an initial "shadow pricing" of the amount that would have been paid for those services. The shadow pricing methodology will reflect the Medicaid fee schedule in effect on the date of service for the services provided on the claims submitted and will reflect the amount that would have been paid in the absence of the Partial Prospective Payment (PMPM).

Partial Prospective Payment (Per Member Per Month Fee) and Fee-For-Services Payments

First Year of Program Participation

In a provider's first year of participation, they will only be accepting upside risk on the Partial Prospective Payment (PMPM). This means that if the above reconciliation comparison indicates that the Partial Prospective Payment (PMPM) and Partial Fee For Service payment was below the shadow priced FFS amount, the provider will receive additional payments to match the shadow priced fee for service amount. The provider will not be at risk for repaying the State if the Partial Prospective Payment (PMPM) is above the FFS shadow priced amount.

Second Year of Program Participation

In the second year of participation and later years, providers will be accepting upside and downside risk for the Partial Prospective Payments (PMPM) that they receive for the Modified APM Code Set. This means that the provider will only be receiving the Partial Prospective Payments (PMPM) and Partial Fee For Service Payments, and will not receive additional funding if the shadow priced Fee for Service amount is above the Partial Prospective Payment (PMPM) amount. Providers will be eligible to keep any advanced payments that exceed the shadow billed amounts if they meet the Quality Threshold (200 pts or greater on quality measures). More information on quality measures can be found at https://hcpf.colorado.gov/alternative-payment- model-1-apm-1.

If a provider does not meet the required Quality Threshold in their second year of performance and subsequent years of participation, they will be required to remit to any amount received through the Partial Prospective Payment (PMPM) that is above the shadow priced FFS amount for that same performance period. Please see the APM 1 Guidebook for additional information on the quality threshold calculation process.

Incentive Payments Based Upon Episodes

The Department aims to support Colorado's shift to value-based purchasing by rewarding high quality care and outcomes, encouraging clinical effectiveness, encouraging delivering high-quality care, using episode-based data to evaluate the costs and quality of care delivered and applying incentive payments, and establishing a PCMP for Chronic Condition Episodes of Care. **Incentive payment** is an upside only payment made to PCMPs to incentivize chronic care management.

Incentive payments based upon episodes promote efficient and economic care utilization by making incentive payments based on the aggregate valid and paid claims across a PCMP's episodes of care ending during the twelve-month performance period specified for chronic condition episodes.

Episodes are a defined group of related Medicaid covered services provided to a specific patient over a specific period of time where the characteristics of an episode will vary according to the medical condition for which a patient has been treated.

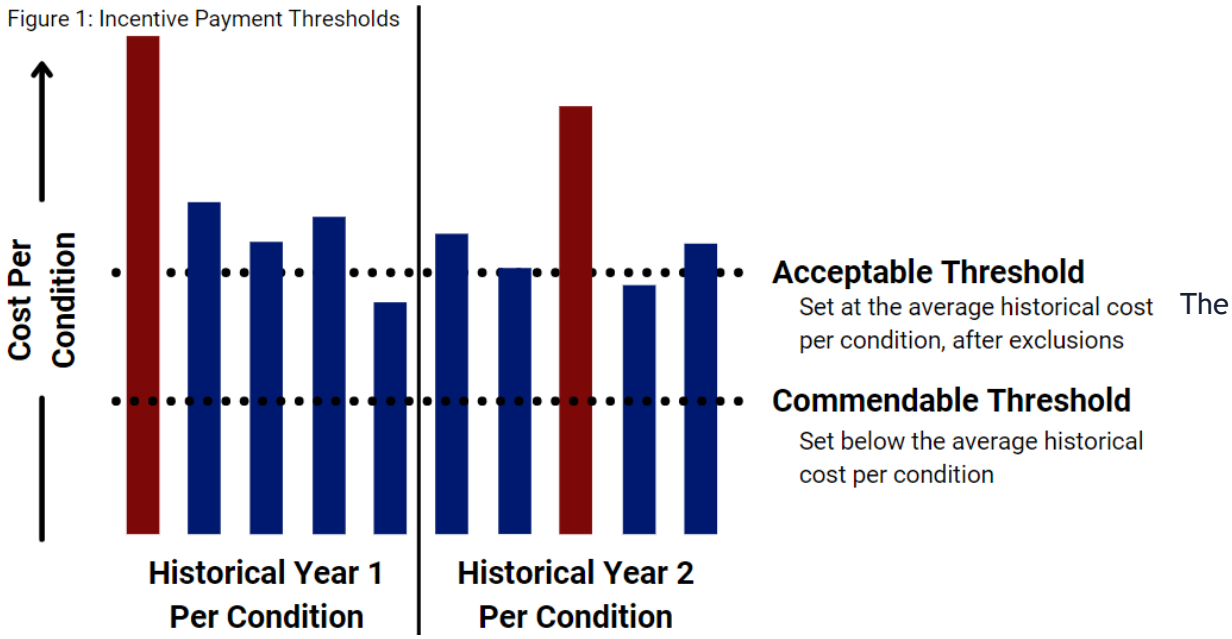
PCMPs are held accountable for both the quality and cost of care delivered to a qualifying patient for an entire episode.

Incentive Payment Thresholds

When joining APM 2, providers will receive information on their incentive payment thresholds. **Thresholds** are the prospective targets for the incentive payments. The Department's actuary will calculate each PCMP's threshold by using two years' worth of claims to determine historical episode performance, or a statewide average if that is not available. Each year the Department will add the next fiscal year data and will calculate the thresholds based on the previous two years of data. High-cost outliers above the 95th percentile will be removed from the threshold calculations.

Incentive Payment Based Upon Episodes

Figure 1: Incentive Payment Thresholds



Acceptable Threshold is set at the average historical cost-per-episode with a trend applied by the actuary after all calculation exclusions.

The **Commendable Threshold** is set below the historical average cost-per episode and, for positive incentive payments, includes a minimum savings rate of 2% applied to ensure PCMPs are lowering costs and improving the quality of care delivered. The thresholds used for reconciliation will be updated prior to the final reconciliation calculation to account for any CMS approved policy changes that are effective during the performance period that impact fee-for- service reimbursement levels. This adjustment will ensure that the final threshold is on the same fee schedule basis as the actual expenditures the provider will be measured against.

If the average episode reimbursement is **higher** than the commendable threshold, the PCMP will **not** receive an incentive payment.

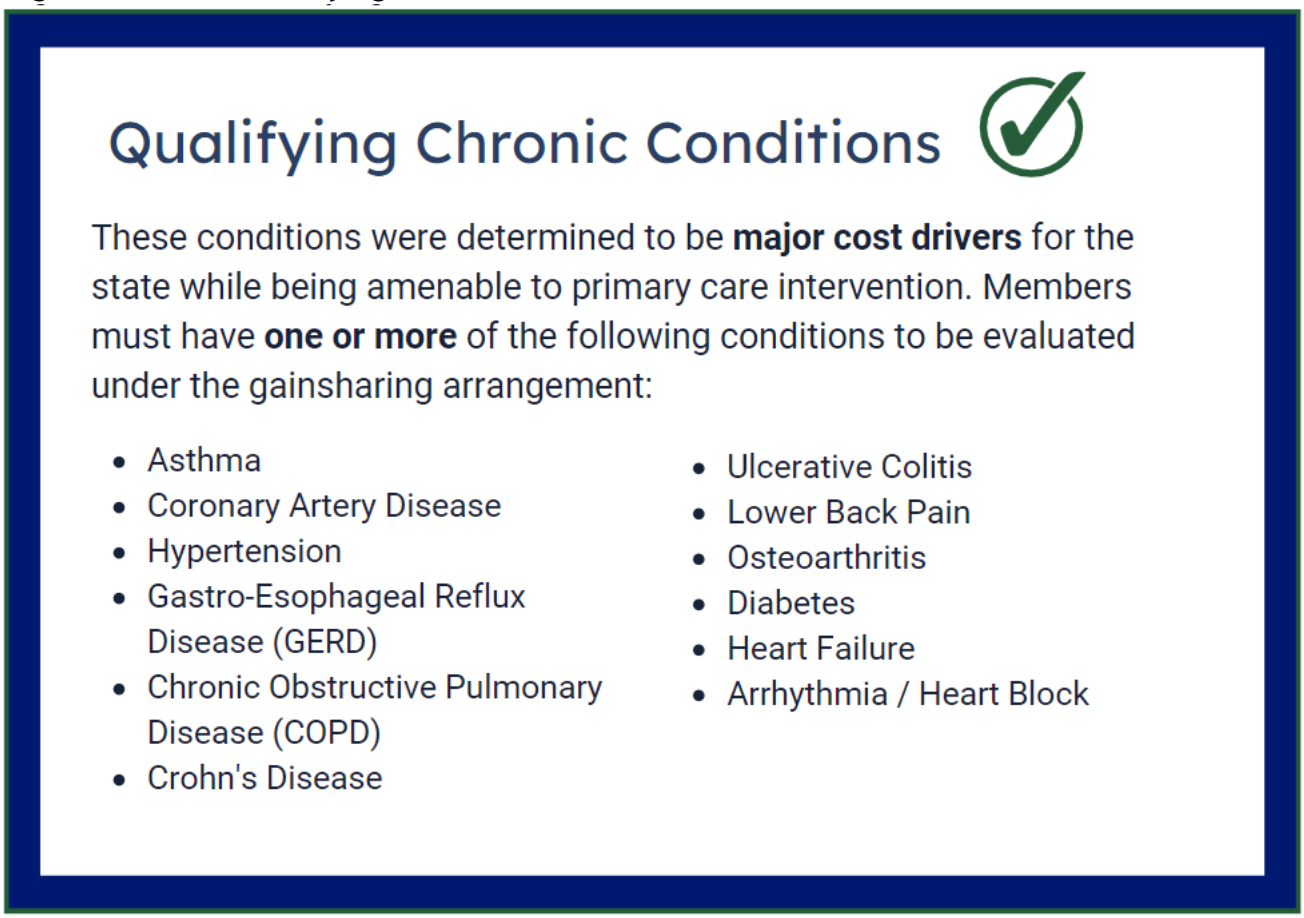
After the conclusion of a full performance period, eligibility for an incentive payment is determined on an annual basis. Payments equal 50% of the savings between the actual cost per qualifying chronic condition and the Commendable Threshold, if the actual cost is less than that Threshold. The Commendable Threshold will be calculated using the average cost for 12 qualifying conditions over the two previous years. The comparison between the Commendable Threshold and the actual incurred claims will include a modification of the Commendable Threshold to account for any CMS approved rate changes that are effective between the acceptance of the Commendable Threshold by the provider and the end of the performance period. Because the incentive payments are based on aggregated and averaged claims data for a performance period, payments cannot be attributed to specific provider claims. Performance reports are sent to providers on a quarterly basis.

Incentive Payment Based Upon Episodes

Episode Risk Adjustment

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 is based on observed variation in episode cost due to category of aid, gender, number of comorbid chronic conditions, and the number of and presence of behavioral health conditions. The Risk adjustment methodology is described on the Colorado Primary Care Payment Reform website.

Figure 2: List of Qualifying Conditions



Reconciliation to Quality Threshold

To ensure that quality care is maintained, the Department will evaluate quality metrics for each participating PCMP. If a participating practice:

meets or exceeds the quality threshold → The participating PCMP **will be eligible** for incentive payments and an enhanced fee-for-service rate

falls below the quality threshold → The participating PCMP **will be ineligible for incentive payments for that program year**

Note: Data used for reconciliation will be actual member attribution data and claims data for services within the modified APM code set for attributed members for the program year being reconciled. Please see the APM 1 Webpage for more information.

Reconciliation Additional Information

After the conclusion of each Performance Year, the Department will perform a reconciliation for participating PCMPs. Typically, this process will occur no more than nine months after the end of the Performance Year. The Department will allow a six-month run- out period before conducting the reconciliation process.

All Partial Fee for Service Payments and Partial Prospective Payments are only made on behalf of Qualifying Patients. Other payments made to PCMPs are not included in this reconciliation. Next, the Department will determine the amounts that would have been paid to PCMPs in absence of program participation during that particular Performance Year. These amounts are from the fee schedule in place at actual dates of service for Modified APM Code Set services provided to Qualifying Patients during the Performance Year, without reduction from the application of a Fee For Service Percentage.

If the Health First Colorado Fee Schedule is higher, in the aggregate, than the actual amounts paid to the PCMP, then the Department will recover the actual amounts made to the PCMP and will replace them with the fee schedule payments, leading to an aggregate increase in payments, but only if the PCMP met the Quality Threshold. The Quality Threshold is effective for each Performance Year and is posted at (https://hcpf.colorado.gov/alternative-payment-model-1-apm-1).

If the Health First Colorado Fee Schedule is lower, in the aggregate, than the actual amounts paid to the PCMP, then the Department will recover the actual amounts made to the PCMP and will replace them with the fee schedule payments, leading to an aggregate decrease in payments, but only if the PCMP did not meet the Quality Threshold, and only subsequent to a PCMP's first Performance Year.

Attribution Methodology

All Health First Colorado beneficiaries are enrolled in the Accountable Care Collaborative and are attributed to a participating PCMP; the APM 2 program includes all of a provider's attributed patient panel **except the following**:

- 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)
- Per Member Per Month payments to the participating practices will be adjusted based on attributed members.

The attribution of Qualifying Patients applies to the payment and rate calculations described for Partial Prospective Payment, Partial Fee for Service, and the Incentive Payment. At least every six months, Qualifying Patient attribution is reprocessed to potentially reattribute Qualifying Patients. Qualifying Patients who have received services delivered by other PCMPs may be reattributed. If reattributed, payments will only be made to the PCMP's Participating Physicians for dates of service within the attribution period. Only Qualifying Patients are used to calculate or pay the Partial Prospective Payment. For those beneficiaries that are reattributed to a non-participating PCMP, no Partial Prospective Payment will be made. Each month, the Department generates PCMP attribution lists available to the PCMP. Partial Prospective Payments to PCMPs will change based on the number of attributed Qualifying Patients each month. Furthermore, Qualifying Patients may choose a new PCMP at any time.

Attributions will be done using a hierarchical process as follows:

- Qualifying Patient's choice of a PCMP made with the enrollment broker.
- Qualifying Patient's utilization of a PCMP, which assigns a Qualifying Patient to a PCMP based on their claims or service utilization records during the most recent 18 months.
- Qualifying Patient's family connection, in which a Qualifying Patient of the same household has a claims history with a PCMP that is appropriate for the Qualifying Patient.
- Geographical attribution - when a member cannot be attributed based on utilization or family connection, the beneficiary will be attributed to the closest appropriate PCMP. Members that are geographically attributed to a PCMP are however not Qualifying Patients.

A Qualifying Patient is attributed to only one PCMP at a time. This eliminates the possibility of duplication of Partial Prospective Payments to multiple PCMPs for the same Qualifying Patient.

Quality Measures

APM 2 builds off the original APM model developed by the Department. APM 1 is used as the quality model for performance in APM 2, which aids in reconciliation and incentive payment calculations. In this model, providers designated as Primary Care Medical Providers (PCMPs) report on 10 quality measures from the APM Measure Set: three mandatory measures and seven measures selected by the PCMP. The APM Quality Score is the sum of all points a practice has earned through individual quality measures. Each practice must earn an APM Quality Score of least 200 points to meet the quality thresholds for incentive payments. For more detail on the measure selection and APM Quality Score calculation process, please see the APM Guidebook.

Modified APM Code Set

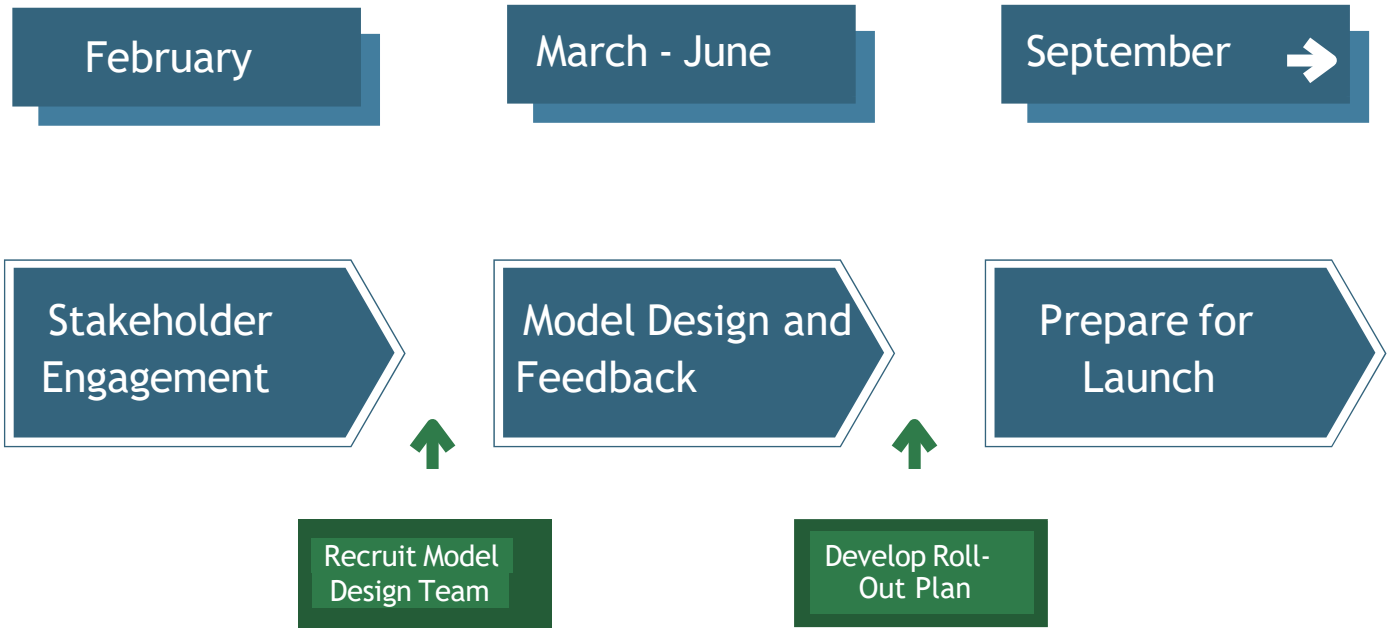
The APM 2 program uses a modified APM code set for rate setting and the codes that are subject to the Fee for Service Percentage during the rate effective period. The Modified APM code set is identical to the APM code set for the APM 1 program, except for services that are defined as family planning.

APM 2 excludes Long-Acting Reversible Contraceptive codes from the Partial Prospective Payment calculation to ensure that Qualified Patients have free choice of all qualified and willing providers of those Long Acting Reversible Contraceptive services.

The Modified APM Code Set is listed in the appendix.

How was this program developed?

The Department created this program using an iterative stakeholder feedback process in year 2021 to ensure an inclusive model.



Activities

Gather perceptions from stakeholder groups via virtual

- listening sessions 2 Provider sessions
- 2 Advocate sessions
- 1 Member session

Activities

Use stakeholder insights and existing data to design the model

- Chose a model design team that included advocates and providers
- Held 7 workshops to develop the model

Activities

Developed implementation strategy

- Raise awareness
- Establish provider agreements Gather baseline data
- Specify feedback mechanisms

*For more information on the Accountable Care Collaborative, visit: https://hcpf.colorado.gov/accphase2

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		

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		