Center for Health Care Strategies

Implementing Primary Care Population-Based Payment in Medicaid

Colorado's Alternative Payment Model 2

State Context and Model Goals

Colorado's Alternative Payment Model 2 (APM 2), launched in 2022, is a voluntary primary care population-based payment (PBP) model, designed to incentivize improved health outcomes and care coordination, while also reducing total health care costs for state-defined episodes of care.[3] Colorado directly contracts with Medicaid providers for most services (i.e., does not have a Medicaid managed care program) and has a long-standing history of payment and delivery system reform efforts that APM 2 builds on and aligns with.

In 2011, Colorado launched its Accountable Care Collaborative (ACC), a program that defines state quality improvement goals and, since 2018, has implemented seven Regional Accountable Entities (RAEs) to manage primary care and behavioral health provider networks and support coordinated care within their regions. Supporting robust primary care is a central component of the ACC. RAEs support primary care practices serving as medical homes for Medicaid beneficiaries by providing practice transformation and financial supports.[4,5]

AT-A-GLANCE

Overview: Building on previous Medicaid value-based payment models, Colorado launched its primary care population-based payment (PBP) model,[1] Alternative Payment Model 2 (APM 2), in 2022. APM 2 allows practices to adopt either full or partial PBP.[2]

Goal: Emphasizes flexibility and financial stability for providers and incentivizes high-quality, cost-effective care.

Context: Allow practices to choose the percentage of revenue they receive through per-member per-month payments, rather than fee-for-service payments, and provide incentives for chronic care management.

Coverage: Approximately 28% of eligible practice sites participate, covering over 50% (about 520,000) of eligible members.

Impact: Has not yet been formally evaluated, but practices report satisfaction with enhanced financial stability.

Case Study Series: Implementing Primary Care Population-Based Payment in Medicaid

This case study is part of a series highlighting innovative state approaches to primary care population-based payment in Medicaid. The series is a product of the ***Medicaid Primary Care Population-Based Payment Learning Collaborative***, a technical assistance and peer-learning initiative that is working with Medicaid agencies in six states to design, launch, and refine primary care population-based payment approaches. The initiative is led by the Center for Health Care Strategies (CHCS) through support from the Commonwealth Fund and Arnold Ventures. **LEARN MORE »**

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The state recognized that, in addition to the ACC/RAE structure, payment reform at the primary care practice level was needed to achieve its goals of improving health equity, outcomes, access, and affordability.[6,7] In 2017, Colorado's General Assembly authorized the Department of Health Care Policy and Financing (HCPF), the department responsible for managing Colorado's Medicaid program, to develop a value-based payment structure to continue the primary care rate bump temporarily established through the Affordable Care Act.[89] To this end, HCPF established Alternative Payment Model 1 (APM 1) in 2018, ending in 2026. [10,11] Under APM 1, fee-for-service (FFS) payments for primary care practices are enhanced or reduced based on the practice's ability to meet state-defined quality targets based on 10 quality measures.[12] Building on this work, HCPF launched APM 2 to shift further away from traditional FFS payment. APM 2 is a PBP model aimed at providing qualified primary care practices within the ACC program financial stability, flexibility to best address patient needs, and incentives for quality improvement and cost containment.[13,14]

Design Features

Payment Structure

APM 2 pays participating primary care practices a customizable combination of upfront, per-member per-month (PMPM) payments and FFS payments, as well as a chronic condition shared savings incentive.[15] The PMPM payments provide practices with predictable, steady funding while giving providers enhanced flexibility to deliver care in ways not adequately supported through traditional FFS reimbursement (e.g., enhanced care coordination).[16] The chronic condition shared savings payments incentivize delivery of high-quality, cost-effective care to Medicaid members with high-cost chronic conditions that primary care is well positioned to impact.[17] In designing APM 2, HCPF sought to gain provider buy-in by developing a model that is feasible for a wide range of practices, provides adequate levels of payment for primary care, and addresses provider concerns about potential financial loss under a new payment approach.

Staffing for Colorado's Primary Care PBP Program

HCPF has three full-time equivalent (FTE) employees to staff three related primary care APMs: APM 1, APM 2, and Payment Alternative for Colorado Kids. This team also receives approximately 0.5 FTE worth of technical and data support from another unit and is planning to hire an additional staff member who will spend at least half their time supporting primary care APMs. The primary care APM work is also supported by a wide range of HCPF staff and external vendors who contribute expertise and guidance on topics, such as quality measurement, rate setting, actuarial, budgeting, policy, communications, and legal support.

PMPM and FFS Payments

Primary care practices choose what portion of their payment is PMPM, instead of FFS, on a scale from zero to 100 percent.[24] This allows practices to adjust the portion of total payments received from PMPM payments over time, providing the opportunity for a gradual shift away from FFS. PMPM rates are based on historical costs, calculated at the tax identification number (TIN) level, based on two previous years of the practice's claims data for a defined set of primary care services, adjusted for changes in service utilization over time.[25] If a practice chooses a partial PMPM arrangement (e.g., more than zero but less than 100 percent), payment for FFS claims will be reduced proportionally to the chosen PMPM rate.[26] For example, if a practice chooses to receive 75 percent of their payment as PMPM, primary care FFS claims will be paid at 25 percent of their original rate.

Federally Qualified Health Center Participation

Federally qualified health center (FQHC) participation in value-based payment programs is an important strategy for supporting access to care and advancing more equitable outcomes, since FQHCs serve a high proportion of patients with low incomes and who identify as people of color.[18] Because FQHCs in Colorado have historically been paid under a unique, cost-based arrangement that is distinct from other primary care providers,[19,20] the state needed to develop FQHC-specific rules to support their participation in APM 2. The FQHC track is similar to the standard APM 2 arrangement with modifications to payment flexibilities, enrollment level, and rate setting to accommodate FQHCs' unique historic payment structure.[21,22,23]

To encourage participation and support primary care practices' financial stability and enhanced primary care capabilities, APM 2 currently provides practices who choose to earn 25 percent or more of their revenue from PMPM payments a 16 percent rate increase in base PMPM payments.[27] Practices that choose to receive less than 25 percent of their revenue from PMPM payments receive a smaller rate increase.[28]

Participating practices receiving PMPM payment must continue to submit claims data to inform rate setting.[29] This enables comparing payments under APM 2 to traditional FFS payment levels. In all performance years, practices that earn more under the PMPM than they would have under forgone FFS payments keep the extra earnings if they meet program quality thresholds (described on the next page, under *Quality Measurement*). In the first performance year of the model only, there is no risk of providers earning less under APM 2 than they would have under FFS. In other words, if submitted claims show that a practice's PMPM payment is less than what it would have earned under FFS, HCPF will provide a supplemental payment to make up the difference.[30]

Chronic Condition Shared Savings

The second component of APM 2 is chronic condition shared savings incentive payments, which encourage providers to deliver high-quality, cost-effective care for Medicaid members with one or more of 12 qualifying chronic conditions, such as diabetes, heart failure, and asthma.[31] Practices can earn a portion of the total cost

savings when they reduce costs for applicable chronic condition episodes below state-defined benchmarks.[32,33] To qualify for these payments, practices must meet program quality thresholds (see *Quality Measurement*, below), ensuring that cost reductions do not compromise patient outcomes.[34,35]

Quality Measurement

APM 2 uses APM 1's established quality measurement and incentive approach. Under this approach, practices are held accountable for performance on 10 quality measures (three mandatory, seven chosen by the practice) out of a state-defined set of 30 measures.[36,37] Practices receive "quality points" based on their performance on each measure[38] and must achieve a certain point threshold to qualify for chronic condition shared savings and retain any excess payments beyond what they would have been paid under FFS (as described further under *Next Steps*, this methodology will change in July 2025).[39]

Model Scope

The scope of the APM 2 model is defined by three components:

- **Eligible providers:** Eligibility for APM 2 is determined at the practice location level. Primary care practices participating in the ACC and APM 1 are eligible to participate in APM 2.[40] This includes practices with physicians or nurse practitioners specializing in internal medicine, family medicine, pediatrics, obstetrics and gynecology, or geriatrics.[41,42] Generally, participating practice locations must have at least 500 attributed Medicaid members to accommodate quality performance calculations.[43] Practices that do not meet this threshold may petition the state to participate (e.g., if they are a small practice that is part of a larger system). For providers choosing to participate in APM 2, all eligible practice sites within the organization (e.g., within the TIN) must participate.
- **Patient eligibility and attribution to practices:** Through the ACC, Colorado Medicaid members are assigned to a participating primary care practice based on the following factors, in order of priority: member choice, service utilization, family connection, and geography.[44,45] The APM 2 model includes most Medicaid members, but does not serve Medicare-Medicaid dual eligible members, members enrolled in the Program for All-Inclusive Care for the Elderly (PACE), and geographically attributed members.[46] Members excluded from APM 2 remain fully FFS.
- **Services included in APM 2:** Colorado developed a list of CPT codes defining the services included in the PMPM rate. Payment for services outside this code set will not be affected by APM 2 participation.[47] The list covers most primary care services (e.g., evaluation and management codes) while leaving specialty services paid through FFS. HCPF also developed a detailed primary care taxonomy to identify

primary care clinicians within practices; this, in combination with the CPT code list, is used to determine which claims are included in APM 2 and support rate setting.[48]

Care Delivery Requirements

Unlike some primary care PBP models,[49] APM 2 does not have delivery system standards that practices must meet to participate in the model. This provides practices flexibility in determining how to adapt workflows and capabilities to meet patient needs and achieve chronic condition management and quality improvement targets.

Stakeholder Engagement

For the initial design of APM 2, HCPF implemented a robust stakeholder engagement process to gain input and buy-in reflecting a diverse range of perspectives. One component of the engagement process included listening sessions to solicit input and feedback from providers, members, and patient advocates. HCPF also recruited about 40 individuals, comprised mostly of primary care clinicians and practice administrators, as well as members and patient advocates, to regularly meet in a series of intensive model design workgroups. Provider engagement helped design a model that was both financially and operationally feasible for a wide range of practices and supports practices in improving care. Engaging Medicaid members and patient advocates helped address member priorities and identify opportunities to improve health access and outcomes through the model.

Since model launch, HCPF staff have continued to meet with stakeholders to refine the model. Staff regularly meet with participating practices to understand provider experience with APM 2, as well as practices that have not yet joined APM 2, to understand what additional provider support is needed to expand model adoption. During 2024, Colorado engaged in a similar process as described above to engage providers and members and inform a refined version of APM 2, which will be implemented in July 2025.[50] On an ongoing basis, the state plans to have annual feedback and information sessions on the model.

Key Design Decisions

Many of HCPF's design decisions for APM 2 were responsive to provider feedback on model feasibility and aimed at supporting widespread model adoption, given the voluntary nature of the program. To gain provider buy-in, it was critical to work toward addressing provider concerns about potential financial loss under a new model and work to assure providers that PMPM rates would be predictable and adequate. Key decisions included:

- **Eligible providers:** Eligibility for APM 2 is determined at the practice location level. Primary care practices participating in the ACC and APM 1 are eligible to participate in APM 2.[51] This includes practices with physicians or nurse practitioners specializing in internal medicine, family medicine, pediatrics, obstetrics and gynecology, or geriatrics.[52,53] Generally, participating practice locations must have at least 500 attributed Medicaid members to accommodate quality performance calculations.[54] Practices that do not meet this threshold may petition the state to participate (e.g., if they are a small practice that is part of a larger system). For providers choosing to participate in APM 2, all eligible practice sites within the organization (e.g., within the TIN) must participate.
- **Allowing practices flexibility to select their level of PMPM payment:** Experience with APM 1, as well as the stakeholder engagement process, revealed that PCPs varied in terms of readiness to implement advanced value-based payment. For example, practices had different capacities for managing downside risk and making the administrative changes needed to move to a new payment method. HCPF decided to meet practices where they are by allowing practices to choose how much of their payment would be transitioned to an upfront PMPM. This design feature supports the movement away from FFS payment while allowing practices to change on a timeline appropriate to their individual capabilities.
- **Breaking away from the FFS structure:** Early on, HCPF decided that allowing practices to keep any PMPM earnings above what they would have earned under FFS was important for incentivizing practice transformation and the movement away from FFS payment. This decision recognizes that practices may choose to change the way they deliver care under PBP, in a way that equates to providing less services that are "billable" under FFS. More challenging was determining whether to introduce financial risk to practices by allowing the possibility that practices may earn less under PBP than FFS during the same performance period. HCPF initially considered introducing provider financial risk immediately to help limit costs to the state, but ultimately decided to introduce financial risk in the second performance year to build provider confidence in the new payment model.
- **Rate setting based on practices' historical utilization:** Informed by provider feedback, HCPF decided to set PMPM rates based on each practice's historical utilization instead of developing rates based on aggregate or market-wide data, to encourage provider buy-in to the model. HCPF staff also work closely with practices to help them understand how their rate was developed, which has been valuable for continued relationship building and understanding implementation challenges. While this rate-setting methodology is administratively complex and time-consuming for state staff, it has successfully supported initial model uptake and provider satisfaction as intended.

At the same time, rate setting based on historical utilization may not be sustainable in the long term. HCPF has seen that providers paid through the PMPM submit fewer FFS claims. This likely means the model is working as intended and is giving providers flexibility to change care delivery by providing services not traditionally billable under FFS. However, this also poses a rate-setting challenge as less FFS billing will cause future PMPM rates to decrease. HCPF is exploring options for adapting its rate-setting methodology to avoid inappropriately penalizing providers.

- **Focusing incentives on chronic conditions:** When designing the model, HCPF explored the possibility of holding practices accountable for managing total cost of care. However, the team ultimately decided to focus on savings for chronic conditions as this better aligned payment incentives with outcomes that could be impacted by primary care. This choice also made quality improvement priorities more concrete for participating providers and enabled the state to share more actionable data with providers.

Implementation Lessons

- **Don't rush model development — but don't "recreate the wheel."** Shifting away from FFS payment is a big undertaking that requires a thoughtful design process. The HCPF team urges other states to be patient and realize that getting a model off the ground will likely take more time than initially expected — this may be especially true for smaller, less well-resourced Medicaid agencies. At the same time, it is also important for states to understand that they do not need to start the model design process from scratch. In developing APM 2, Colorado drew from value-based payment models and lessons from other states.
- **Consider how to meet the needs of different provider types.** Colorado seeks widespread adoption of APM 2, which means the state needs to accommodate practices of varying sizes, serving diverse populations, and in different regions. Understanding varying practice needs and building appropriate levels of flexibility into APM 2 has required continued iteration. As one example, pediatric providers have been hesitant to join APM 2 due to concerns that: (1) the chronic condition incentives do not apply to children; and (2) PMPM payments may be less beneficial for pediatric providers, due to different health care utilization patterns for children than adults. Time pressure to implement APM 2 meant these nuances were not accommodated in the initial model design, but HCPF committed to focusing on pediatric provider needs during future iterations. Based on focused engagement with pediatric providers to inform refinements for APM 2, HCPF plans to develop policies to better accommodate providers serving children (see *Next Steps*).

- **Ensure that partners have the support to succeed.** Assisting providers in understanding the financial implications of the new model has been an important means of encouraging APM 2 uptake. Initially, HCPF met with practices one-on-one and provided a data workbook allowing them to model their rates.[55] HCPF is working to improve existing materials and streamline the technical assistance process. For example, improvements will include a plain-language version of the workbook and an automated tool that allows practices to better model their payments and track performance in real time. Additionally, the state hired a contractor to train RAE practice facilitators (who work with practices separately from HCPF staff) on the APM 2 model to support practice participation.
- **Build strong data and analytics capabilities.** Primary care PBP models are complex, requiring timely and accurate data systems to make them run smoothly. For instance, in Colorado, there were initial challenges with patient attribution and helping providers understand which patients were attributed to them. The state had to modify some aspects of its data system and update provider reports to solve these issues. Similarly, the state has had to modify its rate development methodology over time. Colorado's initial PMPM rates were higher than intended, at least partly due to the use of pre-COVID data in rate setting that differed from utilization during the performance period. To provide more accurate rates going forward, the state is now modifying assumptions about utilization trending and doing more to validate developed rates.
- **Continually work to build trusting relationships with providers.** Because primary care PBP models are a big shift from the status quo, and new payment and incentive structures can have unintended impacts, it is important for states to recognize that they will not develop a perfect model. Continued iteration will be needed, and the HCPF team emphasizes that fostering strong relationships with providers is critical to support ongoing model refinement. HCPF staff spent considerable time meeting with practices one-on-one as they joined APM 2 and aimed to be as transparent and upfront with providers as possible as the model was implemented. The trusting relationships that resulted were critical later on as the state had to work through difficult decisions, such as revising rates.

Impact

While APM 2 has not been formally evaluated, provider feedback is largely positive. HCPF credits this continued provider participation to the strength of the model and the trust built through stakeholder engagement. HCPF also notes that providers report that the PMPM payment predictability and increased level of payment have supported financial stability, allowing practices to maintain staffing levels and invest in care delivery improvements.

Next Steps

Informed by stakeholder engagement during 2024, Colorado Medicaid will implement updates to APM 2 in July 2025. In revising the model, the state aims to further align its portfolio of value-based payment programs, improve health outcomes, advance health equity, and address provider and member priorities of supporting primary care access.[56] Model refinements include:

- **Better integration of APM 2 within the ACC by aligning APM 2 and RAE payment incentives.** Both APM 2 and the RAEs currently operate at the primary care practice level, and each has a unique set of quality incentives. Colorado is simplifying and removing duplicative quality measurement by merging APM and RAE quality payment strategies. Under this new approach, primary care practices participating in the ACC will be automatically enrolled in the chronic condition incentive component of APM 2 (as described under *Payment Structure*) and be eligible for additional quality incentives that will replace APM 1.
- **Changing how the state measures quality performance for APM 2.** Under its current quality approach, the state has faced challenges incentivizing care delivery improvement. To address this, HCPF plans to change how it sets quality targets for APM 2 to better measure quality and reward high-performing providers.[57]
- **Seeking to further improve access to primary care for members.** HCPF is planning to modify its rate increase. Instead of providing a 16 percent rate increase to all APM 2 participants that meet the PMPM threshold, HCPF aims to repurpose the funds for a more targeted "access stabilization payment" for practices most in need of enhanced funds to stay in operation, including pediatric, rural, and small providers.[58] HCPF is also exploring the development of new utilization measures to assess whether the chronic condition shared savings incentives are impacting primary care access.
- **Introducing a pediatric-specific track for APM 2, called Payment Alternatives for Colorado Kids.** In addition to the access stabilization payments mentioned above, this track will include pediatric-focused quality measures and remove the requirement for pediatric practices to participate in the chronic condition savings component of APM 2.

While a challenging undertaking, HCPF has found the initial rollout of APM 2 largely successful and is committed to continued movement away from FFS payment. By building on state learnings, being responsive to stakeholder priorities, and driving toward state goals of program alignment and more equitable care, the next iteration of the model is poised to advance this work.

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ENDNOTES

[1] CHCS uses the term "population-based payment" to describe an upfront, prospective, value-based payment approach in which providers are accountable both for quality and cost of care. Payment is based on the number of patients a provider serves, as opposed to the number of services a provider performs. Population-based payment replaces some or all fee-for-service payment for providers. Sometimes this type of payment is also referred to as "capitated" or "prospective" payment. The Colorado Department of Health Care Policy and Financing uses the term "prospective payment".

[2] Colorado Department of Health Care Policy & Financing. (2024, July). *APM 2 Investments in Primary Care FY 2024 – FY 2025.* https://hcpf.colorado.gov/sites/hcpf/files/Alternative Payment Methodology Program Provider Guidebook.pdf

[3] Colorado Department of Health Care Policy & Financing, 2024, July.

[4] Colorado Department of Health Care Policy & Financing. (2023, August). *Accountable Care Collaborative Phase III Concept Paper.* https://hcpf.colorado.gov/sites/hcpf/files/2023 ACC Phase III Concept Paper 8-29-23.pdf

[5] Bontrager, J., Boone, E., Clark, B., Esposito, C., Foster, C., Hanel, J., & Zubrzycki, J. (2018, October). *The Ways of the RAEs: Regional Accountable Entities and Their Role in Colorado Medicaid's Newest Chapter.* Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Ways of the RAEs_1.pdf

[6] Colorado Department of Health Care Policy & Financing, 2024, July.

[7] Colorado Department of Health Care Policy & Financing, 2023, August.

[8]Colorado Department of Health Care Policy & Financing. (2023, November). *Alternative payment model 1 for primary care guidebook*. Alternative Payment Model 1 for Primary Care Guidebook. https://hcpf.colorado.gov/sites/hcpf/files/Alternative Payment Methodology 1 Guidebook Program Year 2023.pdf

[9]Colorado Department of Health Care Policy & Financing, 2023, November.

[10]Colorado Department of Health Care Policy & Financing, 2023, November.

[11] Colorado Department of Health Care Policy & Financing. (2024, December). *APM Office Hours.* https://hcpf.colorado.gov/sites/hcpf/files/December 2024 Alternative Payment Model Office Hours Slide Deck.pdf

[12]Colorado Department of Health Care Policy & Financing, 2023, November.

[13] Colorado Department of Health Care Policy & Financing, 2024, July.

[14] Colorado Department of Health Care Policy & Financing, 2023, August.

[15] Colorado Department of Health Care Policy & Financing, 2024, July.

[16] Colorado Department of Health Care Policy & Financing, 2024, July.

[17] Colorado Department of Health Care Policy & Financing, 2024, July.

[18] National Association of Community Health Centers. (2024, September 6). *Community health center chartbook 2024: Analysis of 2022 UDS Data*. https://www.nachc.org/resource/community-health-center-chartbook/

[19] In general, FQHCs are paid differently than other providers in Medicaid, under the Federal Prospective Payment System (PPS) methodology. In Colorado, prior to APM 2, the state developed an alternative payment methodology for FQHCs that also differs from the PPS.

[20] Colorado Department of Health Care Policy & Financing. (2022, July). Federally Qualified Health Center Alternative Payment Methodology 2 Billing Guidance. https://hcpf.colorado.gov/sites/hcpf/files/Federally Qualified Health Center - Alternative Payment Methodology 2 Billing Guidance.pdf

[21] Colorado Department of Health Care Policy & Financing. (n.d.). *Alternative payment model 2 (APM 2)*. https://hcpf.colorado.gov/alternative-payment-model-2-apm-2

[22] Colorado Department of Health Care Policy & Financing. (n.d.) *R-06 Supporting PCMP Transition with Value Based Payments.* https://hcpf.colorado.gov/sites/hcpf/files/R06 One Pager.pdf

[23] Specifically, FQHC participation in APM 2 differs from other practice in that: (a) Whereas other practices may take partial PMPM payments, FQHCs can only take 100 percent PMPM payments to more accurately reflect their cost-based encounter payments; (b) Enrollment in the chronic condition shared savings component is optional as it was not originally available to FQHCs when the PMPM payments launched in 2022; (c) FQHCs enroll in APM 2 at the federal tax identification number (TIN) level, whereas other providers enroll at the practice location level, consistent with how their cost-based encounter rates are set in Colorado; (d) FQHCs do not receive a rate increase for PMPM participation because, unlike other providers, their PMPM is set based on actual costs from their audited cost reports.

[24] Colorado Department of Health Care Policy & Financing, 2024, July.

[25] Colorado Department of Health Care Policy & Financing, 2024, July.

[26] Colorado Department of Health Care Policy & Financing, 2024, July.

[27] Colorado Department of Health Care Policy & Financing, 2024, July.

[28] Colorado Department of Health Care Policy & Financing, 2024, July.

[29] Colorado Department of Health Care Policy & Financing, 2024, July.

[30] Colorado Department of Health Care Policy & Financing, 2024, July.

[31] Colorado Department of Health Care Policy & Financing, 2024, July.

[32] Colorado Department of Health Care Policy & Financing, 2024, July.

[33] Colorado Department of Health Care Policy & Financing, 2023, November.

[34] Colorado Department of Health Care Policy & Financing, 2024, July.

[35] Colorado Department of Health Care Policy & Financing, 2023, November.

[36] Colorado Department of Health Care Policy & Financing, 2024, July.

[37] Colorado Department of Health Care Policy & Financing, 2023, November.

[38] Colorado Department of Health Care Policy & Financing, 2023, November.

[39] Colorado Department of Health Care Policy & Financing. (n.d.). *Alternative payment model 2 (APM 2)*.

[40] Colorado Department of Health Care Policy & Financing, 2024, July.

[41] Colorado Department of Health Care Policy & Financing, 2023, August.

[42] Colorado Department of Health Care Policy & Financing, 2023, November.

[43] Colorado Department of Health Care Policy & Financing, 2024, July.

[44] Colorado Department of Health Care Policy & Financing, 2023, August.

[45] This attribution methodology will be changing July 1, 2025, and at that point will no longer attribute members to PCPs based on family connection or geography.

[46] Colorado Department of Health Care Policy & Financing, 2024, July.

[47] Colorado Department of Health Care Policy & Financing, 2024, July.

[48] Colorado Department of Health Care Policy & Financing, 2024, July.

[49] Center for Health Care Strategies. (2024, May). *Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States*. https://www.chcs.org/media/Developing-Primary-Care-Population-Based-Payment-Models-in-Medicaid-A-Primer-For-States.pdf

[50] Colorado Department of Health Care Policy & Financing. (2024, February). *APM 2 Design Review Team: Session 1*. https://hcpf.colorado.gov/sites/hcpf/files/Design Review Team Slides_Meeting 1_ 02.06.24.pdf

[51] Colorado Department of Health Care Policy & Financing, 2024, July.

[52] Colorado Department of Health Care Policy & Financing, 2023, August.

[53] Colorado Department of Health Care Policy & Financing, 2023, November.

[54] Colorado Department of Health Care Policy & Financing, 2024, July.

[55] Colorado Department of Health Care Policy & Financing, 2024, July.

[56]Colorado Department of Health Care Policy & Financing. (2024, February). *APM 2 Design Review Team: Session 2*. https://hcpf.colorado.gov/sites/hcpf/files/Alternative Payment Model 2 Meeting Presentation Feb 28 2024.pdf

[57]Colorado Department of Health Care Policy & Financing. (2024, November). *Primary Care Payment Structure in ACC Phase III.* https://hcpf.colorado.gov/sites/hcpf/files/Primary Care Payment Structure in ACC Phase III%3B PCMP Education Session Presentation November 19 2024.pdf

[58] Colorado Department of Health Care Policy & Financing, 2024, November.