



Enhanced Primary Care Medical Provider Factors: Findings and Next Steps

Primary Care Medical Providers (PCMPs) within the Accountable Care Collaborative (ACC) are eligible to receive additional payment for demonstrating the capacity to provide enhanced medical home services to their ACC clients. To be eligible for the additional payment, PCMPs must meet at least five of the nine [Enhanced Primary Care Factors](#). These factors were developed by the Department through an extensive stakeholder process and incorporate elements of [NCOA recognition](#) as well as factors developed to meet the aims of the ACC program. Each Regional Care Collaborative Organization (RCCO) is responsible for certifying which practices within their region meet the criteria for receiving the additional payment.

Summary

For FY 2014-2015, a total of **269** practices were awarded incentive payments for being an Enhanced Primary Care Medical Provider (EPCMP)--meeting at least 5 enhanced primary care factors, serving 456,761 attributed clients. The breakdown by RCCO:

- Rocky Mountain Health Plans (RCCO 1): 48 practices
- Colorado Access (RCCOs 2, 3, 5): 127 practices
- Integrated Community Health Partners (RCCO 4): 39 practices
- Colorado Community Health Alliance: 13 practices
- Community Care of Central Colorado: 42 practices

Factors:	F1	F2	F3	F4	F5	F6	F7	F8	F9
# of Times the factor was Reported	137	254	209	145	191	152	202	184	108
% of Practices Reporting this factor	51%	94%	78%	54%	71%	57%	75%	68%	40%

# Factors Met:	5	6	7	8	9
# Practices Meeting Factors	139	60	43	21	7
% of Practices Meeting Factors	52%	22%	16%	8%	3%



Review of Documentation

In order to better understand the RCCO's process of verification of the 9 factors, the Department asked the RCCOs to submit documentation for 7 sampled providers in their region that met at least 5 of the nine factors.

Findings

After reviewing the supporting documentation, reviewers have noted the following trends and issues:

- Some providers submitted actual documentation, while others simply attested to meeting the factor. Reviewers suggest that the submission of tangible documentation be the requirement for evidence of meeting factors.
- Many practices stopped assessments after meeting the first 5 factors. Reviewers suggest the amount of factors that are met be related to the payment received.
- Reviewers suggested that HCPF provide guidance and clarification that all factors be assessed, even if the amount of factors is not related to the payment received.
- Reviewers felt that some factors should be required to address certain areas of service related to gaps in coverage and/or that align with Department focus areas (i.e. behavioral health integration).
- There are factors that could be strengthened to ensure they support meeting the goals of the factor. One example is the factor requiring extended office hours. Reviewers suggest an increase in those necessary hours (i.e. 4 times a month vs. 1 time a month).
- There are factors that seem systematically difficult or even unable to be verified. In addition, some blank templates were submitted without official letterhead, which do not provide evidence of having been used in practice. Reviewers suggest that required documentation template submitted show operational use.
- Reviewers were concerned that some factors are out of a provider's control. One example is the factor citing a referral process for behavioral health screenings. Long wait times and a behavioral health provider shortage might make the factor impossible to be reached and/or confirmed.

Next Steps

- Internal analysis: Department staff analysis on performance differences by provider type, including EPCMPs, is underway.

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- External analysis: A Clinical Associate Professor at Anschutz School of Medicine and the Director of Research Innovation at Jefferson's Center Office of Health Care Transformation are doing a comparison study of Colorado PCMPs vs. Oregon's Patient-Centered Primary Care Homes (PCPCHs). The findings may help support the notion that clients who see EPCMPs have better health outcomes.
- Factor updates/edits: The Department will work with various stakeholders, such as Medical Home Coalition, PIAC & its subcommittees, and RCCO partners to form recommendations on the factors and their validation moving forward.
 - For SFY 16-17:
 - There will be no change to the factors, as the Department would like to complete the data analysis prior to making a decision on suggested changes. This analysis will not be complete prior to the need to draft contract amendment language (the factors are in the contract).
 - There will likely be changes to the required documentation and verification, based on the review described above. Department staff will work with the RCCOs and the stakeholders to make these changes.
 - All practices will need to be re-validated for SFY 16-17
 - For SFY 17-18:
 - There will likely be a change to the factors. The change might be adding or changing factors, requiring that practices must meet specific factors, requiring that a greater number of factors be met, or a change to differential payment for the number of factors met (see recommendation above that payment be tied to the number of factors met).
 - The Department will work with RCCOs, the PIAC, and subcommittees to make these changes such that they can be incorporated in to the contract amendments for SFY 17-18.

