From FY 2015-2018, the Accountable Care Collaborative (ACC) offered additional payment to Primary Care Medical Providers (PCMPs) that met certain enhanced standards as a patient-centered medical home. This fact sheet summarizes the enhanced factors and provides an update on how many PCMPs were identified in FY 17-18 as meeting these standards.

**Enhanced Primary Care Medical Provider Standards and Payment**

The nine enhanced PCMP factors outlined below were based on the medical home standards from National Committee on Quality Assurance, recommendations from the Regional Care Collaborative Organizations (RCCOs) and other stakeholders, and Colorado Senate Bill 07-130, which defined the criteria for medical homes for children.

A PCMP that met at least five of the nine factors qualified as an enhanced Primary Care Medical Provider (ePCMP). EPCMPs received a payment of $0.50 per member per month, in addition to their standard ACC per member per month payment and fee-for-service reimbursement for billable services rendered to members. The additional payment was distributed once annually as a lump-sum payment.

1. **Extended Hours.** Has regularly scheduled appointments (at least once per month) on a weekend and/or a weekday outside of typical work day hours.

2. **Timely Clinical Advice.** Provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures.

3. **Data Use and Population Health.** Uses available data to identify special patient populations that may require extra services and support for medical and/or social reasons. The practice has procedures to proactively address the identified health needs.

4. **Behavioral Health Integration.** Provides on-site access to behavioral health care providers.

5. **Behavioral Health Screening.** Collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents, and/or developmental screening for children (newborn to five years of age) using a Medicaid approved tool. In addition, the practice has documented procedures to
address positive screens and has established relationships with providers to accept referred patients or utilizes the standard referral and release form created by the behavioral health organizations.

6. **Patient Registry.** Generates a list of patients actively receiving care coordination.

7. **Specialty Care Follow-Up.** Tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.

8. **Consistent Medicaid Provider.** Accepts new Medicaid clients for the majority of the year.

9. **Patient-Centered Care Plans.** Collaborates with the patient, family or caregiver to develop and update an individual care plan.

**Summary**

In FY 17-18, there were 374 ePCMP practice locations, up from 269 in FY 14-15. The percent of ePCMPs meeting seven or more factors increased to 45%, from approximately 27% in FY 14-15. Timely Clinical Advice (Factor 2), Data Use and Population Health (Factor 3), and Specialty Care Follow-up (Factor 7) remained the three most commonly met factors. Patient-Centered Care Plans (Factor 9) was consistently the least commonly met factor.

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<th>F3</th>
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**Next Steps**

FY 17-18 was the fourth and final year of the ePCMP initiative. EPCMP components were incorporated into the PCMP requirements for ACC Phase II, as well as the Health First Colorado primary care payment model. This aligns with the original goals for continuous evolution and improvement.

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