CHASE Board

April 27, 2021

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HCPF Update -Focus on Health Equity

Peter Walsh, MD, MPH
Chief Medical Officer- HCPF

Health Equity at HCPF

- Ensure high quality care and services for underrepresented & underserved communities
  - Maximize healthcare investments by working collaboratively with partners to identify and remove obstacles to access & utilization among historically marginalized populations
- Identify utilization data for marginalized communities
  - Inclusive of ability, race & ethnicity, gender, language, sexual orientation, among other protected classes
  - Intersectionality - race & gender; ability & gender
  - Incorporate disparities data into key dashboards and/or develop equity dashboard

Equity Lens / Framework

- Developed and implementing an equity framework to guide equitable and inclusive decision-making processes and outcomes.
- The equity framework will determine root causes and barriers through HCPF programs, policies and procedures.

Health Inequities - Focus Areas

- Improving analytics to analyze programs/metrics via race/ethnicity lens
- Incorporating race/ethnicity data in all dashboards to enhance analysis
- Improving race/ethnicity, gender, and language data – synchronize application forms
- Addressing health disparities – maternity, diabetes, and behavioral health program.

Quality and Safety Equity

Allison Sabel, MD, PhD
Medical Director of Clinical Data, Quality and Analytics

Presented at CHASE – April 26, 2021

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Background

- 2005 UHC/Vizient Quality & Accountability Scorecard
  - First disparity identified in 2013

- 2019 Analyses of Target Zero, Falls, Readmissions, Hypertension
  - By race/ethnicity, gender, age, payer, language, employment
  - Few unexpected findings

- 2020 Commitment to greater transparency
  - Equity dashboard development

- 2021
  - Equity dashboard deployed
  - Separate but important work on how we collect race/ethnicity and language data (REAL) – to be implemented later this year

Key Goals

- To have broadly accessible current data on potential care disparities
- To collect input on important hospital-based measures
  - Sufficient data to stratify
  - Potentially actionable by hospital-based interventions
- Color-code outcomes to highlight potential disparities

Clinical Equity Dashboard

Inpatient Quality Metrics by Demographic

Clinical Equity Dashboard with reference group comparison*

* Reference group is last row of table.
Tables include patients from 4/1/2020 - 3/31/2021

Select demographic: Race/Ethnicity

Additional filters: Gender (All) | Race/Eth... (All) | Language (All)

	30-Day All-Cause Readmission	Mortality O/E	LOS O/E
OVERALL MEAN	8.3%	0.84	0.99
Black	8.8%	0.97	0.99
Hispanic	7.4%	0.78	0.95
Other	5.9%	1.22	0.94
White	9.5%	0.77	1.03

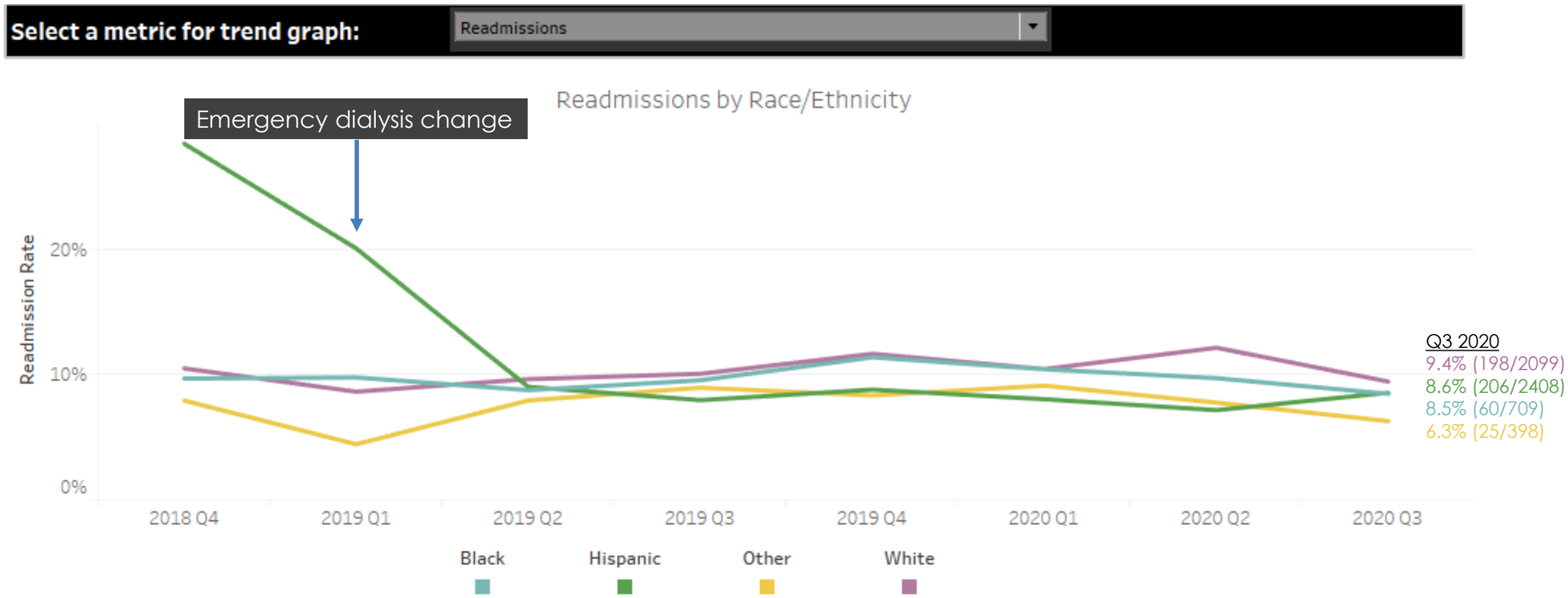
	Target Zero events	NDNQI Falls
OVERALL MEAN	0.68%	1.49%
Black	0.75%	1.88%
Hispanic	0.91%	1.07%
Other	0.42%	1.54%
White	0.44%	1.82%

	Post-Partum Hemorrhage	NTSV Cesarean Birth	Timely Treatment of OB Severe HTN
OVERALL MEAN	17.5%	21.1%	61.2%
Black	14.0%	21.6%	53.3%
Hispanic	19.7%	20.5%	63.0%
Other	14.9%	28.2%	64.3%
White	13.3%	19.2%	61.3%

	Opioids Administered During Stay	Opioids Prescribed at Discharge	ALTOs Administered During Stay	ALTOs Prescribed at Discharge
OVERALL MEAN	49.6%	16.8%	70.0%	33.9%
Black	50.9%	17.1%	70.1%	34.6%
Hispanic	51.6%	15.4%	68.8%	36.7%
Other	45.6%	13.7%	63.2%	33.6%
White	47.5%	19.0%	72.5%	30.4%

THRESHOLDS (based on comparison to reference group): >25% worse | 10-25% worse | Within 10% | 10-25% better | ≥ 25% better

Equity Dashboard - Trends



Equity Dashboard - Ambulatory

ACS Demographics

Ambulatory Quality Scorecard by Demographics

December 2020

Demographic Strata
- Race/ethnicity
- Language
- Gender
- Insurance

Report month: December 2020

Primary Demographic Strata: Language

Secondary Demographic Strata: Gender

Measure type: Strategic

Clinic: (All)

Population: CHS All

Strategic Metrics by Language | Population: CHS All

		Diabetes A1c <=9	Diabetic Medical Attention for Nephropathy	Hypertension BP Controlled	Breast Cancer Screening	Cervical Cancer Screening	Colorectal Cancer Screening	Persistent Asthma on Controller Meds 5-64 yrs	Peds Vaccinations Combo 7	First Trimester Entry into Prenatal Care	Depression Screen and Follow-up Plan if Positive	Chlamydia Screening at Visit 14-24 yrs
		77%	91%	68%	68%	77%	66%	75%	73%	73%	70%	67%
Grand Total		65.9%	86.2%	62.3%	54.4%	67.0%	53.7%	76.1%	72.7%	75.2%	59.8%	62.9%
English	Female	63.7%	83.2%	63.1%	49.7%	64.0%	53.4%	74.8%	70.8%	77.4%	58.9%	73.6%
	Male	63.4%	85.2%	57.7%			52.0%	77.1%	70.9%		57.0%	34.8%
Other	Female	75.5%	85.0%	65.1%	51.9%	70.2%	56.5%	70.7%	73.0%	66.3%	64.0%	61.1%
	Male	76.9%	87.6%	63.8%			56.4%	79.6%	68.9%		59.3%	20.0%
Spanish	Female	70.2%	89.9%	69.1%	66.4%	75.3%	58.2%	78.3%	79.6%	70.9%	64.8%	65.6%
	Male	63.3%	89.5%	61.5%			51.7%	78.3%	77.9%		61.5%	27.6%

Questions and Suggestions?

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Health Equity

COLORADO HOSPITAL ASSOCIATION

SYLVIA PARK – DIRECTOR, CLINICAL QUALITY & PATIENT SAFETY

CHA – Priority Area of Focus

- Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of race, language or socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.
- America is growing more and more diverse every day. The U.S. Census Bureau predicts we will become a majority-minority country by 2045. Specifically, the multi-racial population is projected to be the fastest growing over the next several decades, followed by Asians and Hispanics.
- Diversity is not only racial. It’s multi-dimensional, encompassing not just race and ethnicity but gender, sexual orientation, religion and more. And understanding individual differences can be critical to delivering care that best meets their needs.

Successes

- Collecting standardized patient demographic and language data across health care organizations and agencies that are aligned with OMB and HHS standards is an important first step toward improving population health.
- Best practices and guidelines for health care organizations in implementing standardized data collection, including information to address key challenges in collecting these data;
- Training tools and webinars to help health care organizations educate their staff on the importance of standardized data collection and best practices for data collection; and
- Sentinel articles and books that provide in-depth discussion of issues, challenges, recommendations, and best practices in standardized data collection

Major Threat

- Rolling out the Racial and Ethnic Disparities Measure or adding components of race and equity into other measures before having a **standardized** approach to collecting, maintaining data and analyzing the data
- A standardized approach to Readiness, Recognition/Prevention, Response, Reporting/Systems Learning part of standardizing data collection and identifying opportunities to improve care
- HQIP measure – Reduction of Peripartum Racial and Ethnic Disparities Patient Safety Bundle
  - Non-birthing hospitals must report hospital wide process
  - In order to earn points for this measure, hospitals must have all elements of Readiness in place. Additional points earned for having additional elements of the bundle

Standardized approach to Data collection, Maintenance and Analysis

- The primary reason for standardizing categories for the variables of race and ethnicity is to enable consistent comparison or aggregation of the data across multiple entities
- At the same time, standardized categories must enable persons to self-identify with the categories and increase the utility of the data to the entity collecting them
- The Office of Management and Budget (OMB) is the minimum – additionally there need for collection of granular ethnicity data beyond the OMB categories
- Major Barrier to Vital Statistics Data, Demographic Data, Enrollment Files, Hospital Discharge Data
- Failure to use standard categories and nonreporting or misreporting of data complicate efforts to calculate national and state birth, mortality, and morbidity rates by the OMB race and Hispanic ethnicity categories or for more detailed categories.
- The National Vital Statistics System (NVSS), hospital discharge data, and state registries provide data needed to calculate these rates, but the data may not be collected and reported according to the OMB categories or may be of poor quality. While the standard birth, death, and fetal death certificates now include the OMB categories plus 13 other categories, not all jurisdictions have adopted these standard certificates.
- Identification of Multiracial Individuals - OMB standards require that respondents be allowed to report more than one race and recommend "Mark one or more" and "Select one or more" as the included instruction – not wide/standard adoption

Addressing Health Care Disparities through Race, Ethnicity and Language (REaL) Data

- Data and Analytics is critical to:
  - Informing the need for the availability of testing and deployment of resources to impacted areas
  - Ensuring response and treatment does not vary by race, ethnicity or language
  - Identifying disparities in rates of infection and mortality among populations
  - Addressing the impact of the burden of underlying medical conditions
- Stronger REaL Data when a paired with information on a patient's social needs (Social Determinant of Health – SDOH)

ReAL & SDoH Data

HTP Measure – SW-CP1 Social Needs Screening and Notification

Definition: Measurement of the number of Medicaid patients discharged to home from an inpatient admission who have formal social needs screening done within 12 months of the admission or at the time of visit, results documented in the medical record and, if there is a positive social needs screen, referral to an appropriate entity and notification to the RAE utilizing a process that is mutually agreed upon.

A patient with a positive social needs screen must be referred to an appropriate entity and the RAE notified for the patient to be considered having met this measure and included in the numerator. Screening alone without appropriate referral and RAE notification for a patient who screens positive is not considered adequate for this measure. The measure is reported as one overall score counting all patients who are screened and screen negative, and patients with positive screens only if they are appropriately referred and the RAE is notified about them.

Social needs screening should include at a minimum, five core domains consisting of housing instability; food insecurity; transportation problems; utility help needs and interpersonal safety

Barriers/Opportunities

- States (and hospitals) face difficulties in consistently collecting accurate and reliable data that are uniformly classified
- A national standard set of race and ethnicity categories is necessary to stratify and compare these quality metrics across the Nation.
- Not all states were collecting the six OMB minimum categories
- People not asking about race and ethnicity. For example, including Hispanic as a race question instead of asking a separate question about ethnicity.
- Now – not having the appropriate training to ask about race and ethnicity
- Vital statistics data – inconsistency

Weaknesses

- A diverse health care workforce
  - A diverse health care workforce that is more representative of the patients it serves is crucial to promote understanding among physicians and other health care professionals and patients, facilitate quality care, and promote equity in the health care system. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals in minority communities.
- Health literacy
  - Defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”
- Cultural Competency Training

OMB Standard - Example

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Proposed FFY 2020-21 CHASE Fees & Payments

Nancy Dolson
Special Financing Division

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

2020-21 Fees and Payments Overview

- $1.07 billion in fees
  - $47.0 million to offset the General Fund
  - Limited to 6.00% NPR
- $1.48 billion in hospital supplemental payments including $89.1 million in quality incentive payments
  - UPL at 96%
  - DSH limit at 96%
- $410.2 million in net reimbursement

2020-21 Fees and Payments Overview

Expenditures	Cash Fund	Federal Fund	Total Fund
IP Supplemental Payment	$218,500,000	$356,490,000	$574,990,000
OP Supplemental Payment	$215,830,000	$352,120,000	$567,950,000
Essential Access Supplemental Payment	$7,410,000	$12,090,000	$19,500,000
Rural Support Program Supplemental Payment	$4,560,000	$7,440,000	$12,000,000
HQIP Supplemental Payment	$44,580,000	$44,570,000	$89,150,000
DSH Supplemental Payment	$109,690,000	$109,680,000	$219,370,000
Total Supplemental Payment	**$600,570,000**	**882,390,000**	**$1,482,960,000**
MAGI Parents/Caretakers 60-68% FPL	$11,000,000	$13,500,000	$24,500,000
MAGI Parents/Caretakers 69-133% FPL	$32,600,000	$275,100,000	$307,700,000
MAGI Adults 0-133% FPL	$214,900,000	$1,783,000,000	$1,997,900,000
Buy-In for Adults & Children with Disabilities	$59,100,000	$73,300,000	$132,400,000
Twelve Month Continuous Eligibility for Children	$20,600,000	$25,500,000	$46,100,000
Non-Newly Eligible	$14,200,000	$60,600,000	$74,800,000
CHP+ 206-250% FPL	$20,800,000	$49,600,000	$70,400,000
Medicaid Expansion	**$373,200,000**	**$2,280,600,000**	**$2,653,800,000**
Administration	$36,300,000	$69,600,000	$105,900,000
General Fund Transfer	$62,700,000	$0	$62,700,000
Total Other Expenditures	**$99,000,000**	**$69,600,000**	**$168,600,000**
Grand Total	**1,072,770,000**	**$3,232,590,000**	**$4,305,360,000**

Return on Fee

- **$1.07 billion** in fees generates **$3.23 billion** in federal funds, a **301%** return rate
- Administrative expenditures ($105.9 million) are **2.45%** of total expenditures ($4.3 billion)
- Administrative expenditures include:
  - Staff costs, legal services, accounting, etc.
  - Contracted services, including utilization management and external quality review
  - IT systems (i.e., eligibility and claims) and staffing for the customer contact center for more than 500,000 covered lives

Increased Federal Matching Funds

- Now drawing down increased federal matching funds for the portion of Medicaid supplemental payments allocated to Affordable Care Act (ACA) populations.
- Implemented in FFY 19-20 to coincide with creation of Hospital Transformation Program (HTP).
- Will draw down an additional $140 million in federal matching funds in FFY 20-21, **reducing necessary provider fees collected from hospitals by $140 million.**

Inpatient and Outpatient Fee

- Inpatient fee assessed on managed care and non-managed care days
  - Inpatient fee - $497.0 million
    - Per non-managed care day: $431.01
    - Per managed care day: $96.42
- Outpatient fee assessed on percentage of total outpatient charges
  - Outpatient fee - $575.7 million
    - Percentage of total charges: 1.7592%
- High volume CICP and Essential Access hospitals pay discounted fees
- Psychiatric, long term care, and rehabilitation hospitals are fee exempt

Inpatient Supplemental Payment

- Reimbursement for inpatient (IP) Medicaid utilization
- Total payment: **$575.0 million**
- IP Payment = Medicaid patient days * IP adjustment factor
- Allows for greater variation in reimbursement due to changing Medicaid utilization

Outpatient Supplemental Payment

- Increase rates for outpatient (OP) hospital services for Medicaid members
- Total payment: **$568.0 million**
- OP Payment = estimated Medicaid OP cost * OP adjustment factor

Adjustment Factors

2020-21				
UPL Group	# of Hospitals	UPL Pool	IP Adjustment Factor	OP Adjustment Factor
Rehab/Long Term Acute	11	All	$ 28.00	28.00%
Teaching	1	State Gov.	$ 765.00	47.50%
Rural/CAH	28	Non-State Gov.	$ 970.00	84.00%
Teaching	1	Non-State Gov.	$ 295.00	13.00%
Non-State Gov.	2	Non-State Gov.	$ 900.00	14.00%
Rural/CAH	15	Private	$ 1,100.00	84.00%
Pediatric Specialty	2	Private	$ 465.00	11.25%
NICU	13	Private	$ 1,350.00	89.25%
Independent Metro	3	Private	$ 1,435.00	95.00%
Private	19	Private	$ 997.00	32.25%

Essential Access Supplemental Payment

- Reimbursement to Rural and Critical Access Hospitals with 25 or fewer beds
- Total payment: **$19.5 million**
- Essential Access Payment = (Essential Access beds / total Essential Access beds for all eligible hospitals) * $19.5 million

Rural Support Supplemental Payment

- Reimbursement to rural or Critical Access hospitals that meet revenue and fund balance requirements:
  - Must be a nonprofit hospital
  - Must fall within the bottom 10% NPR of all rural or Critical Access hospitals
  - Must fall within the bottom 2.5% fund balance of all rural or Critical Access hospitals that do not meet the NPR criteria
- Each qualified hospital required to submit an application showing how the funds will be used to implement initiatives that enable success in the Hospital Transformation Program (HTP)
- Total payment: **$12.0 million** per year of the HTP
- Rural Support Payment = $12 million / number of total qualified hospitals

HQIP Supplemental Payment

- Reimbursement to hospitals providing services that improve health care outcomes
- Total payment: **$89.1 million**
- Quality measures and payment methodology approval by the CHASE Board on 12/15/2020
- HQIP Payment = normalized awarded points * Medicaid adjusted discharges * dollars per adjusted discharge point

HQIP Tier	Lower Bound	Upper Bound	Dollars Per Adjusted Discharge Point
0	0	19	$0.00
1	20	39	$2.68
2	40	59	$5.36
3	60	79	$8.04
4	80	100	$10.72

DSH Supplemental Payment

- Reimbursement to hospitals providing services to the uninsured
- Total payment: **$219.4 million**
- DSH payment capped at 96% of a hospital's estimated DSH limit
  - High CICP cost hospital's DSH payment equals 88% of their estimated DSH limit
  - Critical Access hospital's DSH payment equals 96% of their estimated DSH limit
  - Small independent metropolitan hospital's DSH payment equals 88% of their estimated DSH limit
  - Low Medicaid IP utilization rate (MIUR) hospital's DSH payment limited to 10% of their estimated DSH limit

Net Reimbursement

- $17.5 million increase in net reimbursement
  - $75.5 million increase in supplemental payments
  - $58.0 million increase in fees
- Net reimbursement is impacted by:
  - $47.0 million fee increase to be used to offset the General Fund
  - Enhanced FMAP – 62.0% enhanced FMAP rate applied to IP, OP, Essential Access, and Rural Support payments

Item	2019-20	2020-21	Difference
Supplemental Payments (Total Funds)	$ 1,407,500,000	$ 1,483,000,000	$ 75,500,000
Fee (Cash Funds)	$ 1,014,800,000	$ 1,072,800,000	$ 58,000,000
Net Reimbursement	$ 392,700,00	$ 410,200,000	$ 17,500,000

Next Steps

- CHASE fees and supplemental payments have been at interim amounts since October 2020
- Following CHASE Board approval, we will
  - Present rules to the Medical Services Board
  - Continue pursuit CMS approval
  - Notify hospitals and host webinar
  - Reconcile between the approved figures and the interim figures by September

Thank You

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CHASE
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