Alternative Payment Model 1 for Primary Care (APM 1)

APM 1 Community Forum #3 — Health Equity and Value-Based Care
Thursday, October 19, 2023
7:30-9:00 am

Aaron Green, MSM, MSW
Health Disparities and Equity, Diversity & Inclusion Officer
Executive Director's Office (EDO) & Office of Cost Control and Quality Improvement (CCQI)

Agenda

7:30 - 7:50	Welcome and Overview of the Health Equity Plan
7:50 - 8:10	Value-Based Payment Models and Health Equity
8:10 - 8:30	Data Management and the Role of Providers in Advancing Health Equity
8:30 - 9:00	Community Engagement Opportunities, Next Steps, and Q&A

Ways to Participate

Please share your comments and questions verbally or in the chat.

- Prior to sharing, please **share your name and organization, and disclose any financial interests** if appropriate.
- If you would like to comment verbally: Please use the raise hand function in Zoom. Guests will be invited one at a time to share.

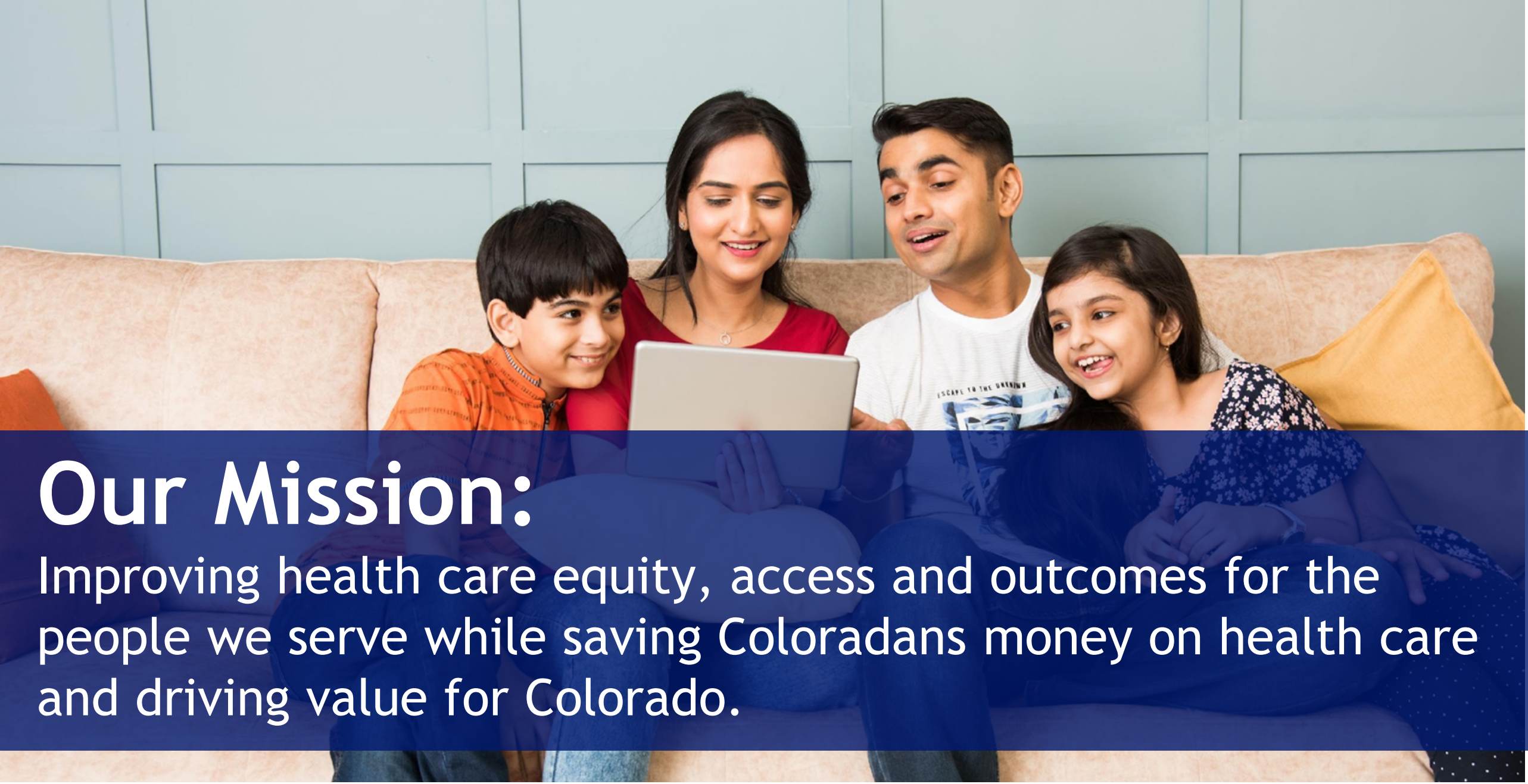
Written Feedback

Following the meeting, additional feedback can be submitted to the Colorado Health Institute at:

FocusGroups@coloradohealthinstitute.org

no later than Wednesday, October 25.

Overview of the Health Equity Plan



Our Mission:

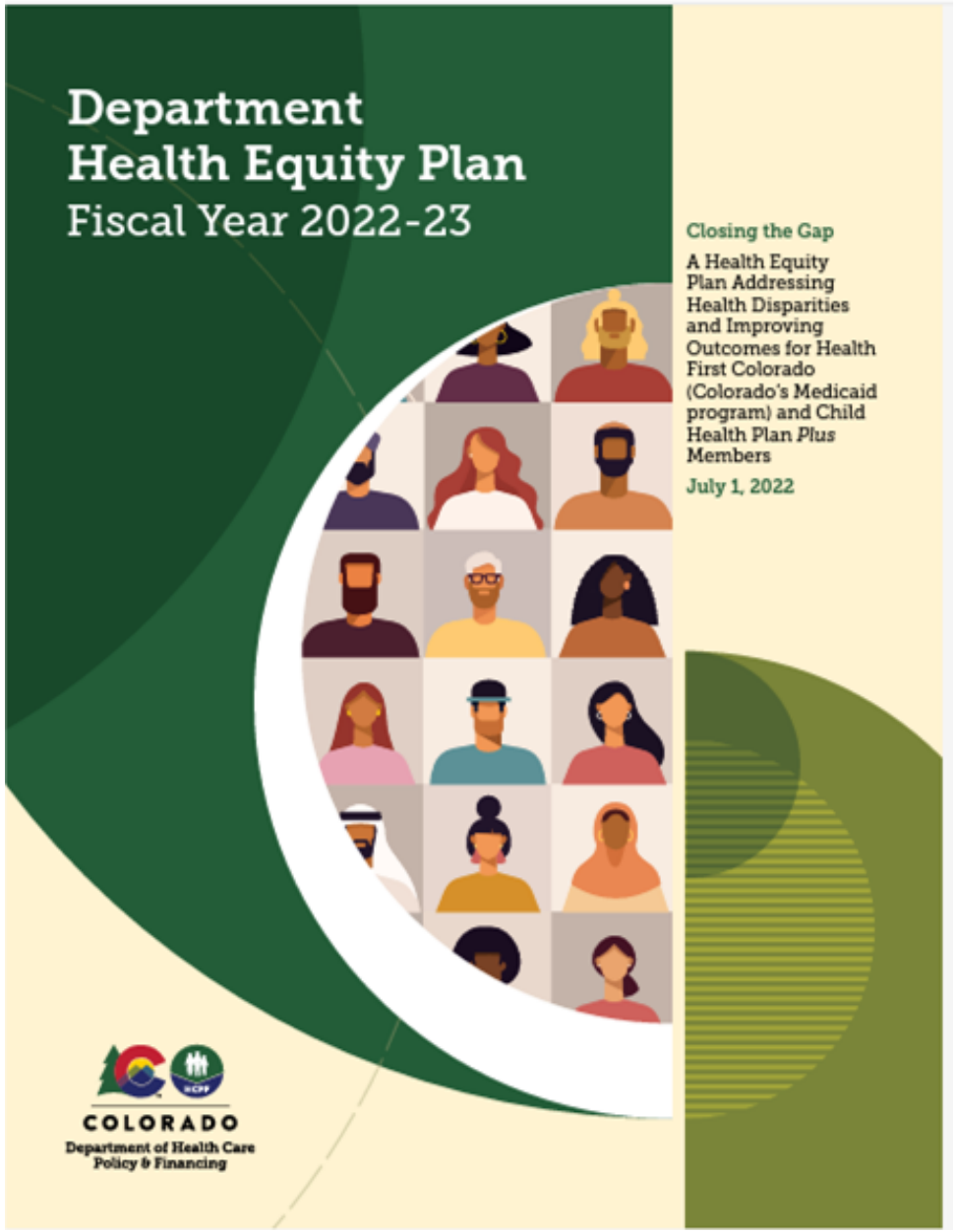
Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Land Acknowledgement

We would like to acknowledge that what is now Colorado includes the lands of the Ute, Arapaho, Cheyenne, Diné (di-NAY), Lakota, Apache, Puebloan nations, and many Tribes, and that the sovereign tribal governments of the Ute Mountain Ute and the Southern Ute Indian Tribes still reside in this state. These tribes are the original stewards of these natural areas. We want to take a moment to honor and respect these original stewards of the environment and their relationship with the land.

To Learn about the Importance of Land Acknowledgements:

- Native Land Map at https://native-land.ca/



Health Equity Plan Updates

- Health Equity Dashboard is LIVE! (Department use only at this time)
- Health Equity Plan Measure Specification Documents
- Health Equity Measures have been shared with RAE/CHP+ Plans
- RAE/MCO/CHP+ Health Equity Plans are due to HCPF December 31, 2023
- Statewide Health Equity Task Force (convening since July 2022) – Recommendations to HCPF by Q1 2024
- 20 Health Equity Public Town Halls (~2500+ stakeholders)
- HCPF continues to explore and improve alignment in our policy goals and incentive metrics. (Possible changes for FY 24/25)

Applying a health equity lens across programs and initiatives

Progress

- Stratified data analytics to identify disparities, Health Equity Dashboard
- Health Equity Plans in RAE/MCE contracts effective July 1, 2022
- Stakeholder engagement: 20 health equity public meetings, >2,500 stakeholders participating by Dec. 2023

Focus Areas

- Maternal health: published Vol. 2 Health First Colorado Maternity Report
- Behavioral health: investments and transformation
- Prevention: increase access and engagement to improve quality care and health outcomes
- Vaccinations: well child/adolescent visits

Looking Ahead

- Continue progress on health equity plan
- Based on disparity data, identify key populations, actionable strategies to close gaps
- Use CMS core measures in focus areas
- Cultural responsiveness and member experience
- ACC Phase 3.0

Health Equity Initiatives

Department priority

HE lens to additional departments

Contract requirement for RAE/ACC/CHP+/ MCO Plans

Dashboard

Statewide HE Taskforce

Quality Metrics
Tracking/monitoring regional and CHP+ HE performance

Modified Medicaid application

Value-Based Incentives

Value-Based Payment Models and Health Equity

Value-Based Incentive

- Paying for quality, not quantity
- Reduce health disparities
- Aligning with ACC Phase 3.0 priority initiatives (2025)
  - Accountability for Equity and Quality
  - Improved Member Experience
  - Referrals to Community Partners
  - Alternative Payment
  - Children and Youth
  - Technology and Data Sharing
  - Care Coordination
  - Behavioral Health Transformation

APM 1 and HEP Measure Alignment

Focus Area	Measures in Both APM 1 and HEP
Primary Care Access and Preventive Care	• Colorectal Cancer Screening • Cervical Cancer Screening • Chlamydia Screening in Women • Immunizations for Adolescents • Childhood Immunization Status • Child and Adolescent Well-Care Visits • Well-Child Visits in the First 30 Months
Care of Acute and Chronic Conditions	• Hemoglobin A1c Control for Patients with Diabetes • Controlling High Blood Pressure
Behavioral Health Care	• Follow-up after Emergency Department Visit for Mental Illness • Follow-up after Hospitalization for Mental Illness • Follow-up after Emergency Department Visit for Substance Use • Depression Screening and Follow-up Plan

Data Management and the Role of Providers in Advancing Health Equity

Data Management

Quality dashboards focused on disparity metrics and performance measures

- Develop robust dashboards that stratify data
- Provide current or most updated disparity data
- Embed health equity lens in metric deliverables with DAS Analytics section

Stratify data by race/ethnicity, gender, geography, disability, and other available identifiers

- Quality data
- Centers for Medicare and Medicaid Services (CMS) Core Measures
- HCPF goals and measurements
- Changes to Medicaid application; access to data

Internal Health Equity Dashboard, Priority Populations and System Calculations

- Currently displaying RAE 1 through 7 level Health Equity Measures
- Reporting period CY Jan-Dec 2022
- Filter denominator count 30 members or more
- HCPF use only; live demonstrations during meetings

Internal Health Equity Dashboard, Priority Populations and System Calculations

Dashboard highlights RAE Overall Performance, State Performance, NCQA HEDIS Mean, and measures broken out by the following filters:

- Member Race/Ethnicity
- Member Age
- Member Language
- Member County
- Member Disability Status

Note: HCPF is working to include the following considerations (at minimum) into future calculations: Location (e.g. rural, urban, frontier)

The following measures will be included in the future:

- Depression Screening and Follow-up [Core Measure NQF 0418]
- COVID Booster Vaccination Rate
- Diabetes Care Measure

Health Equity Plan Dashboard

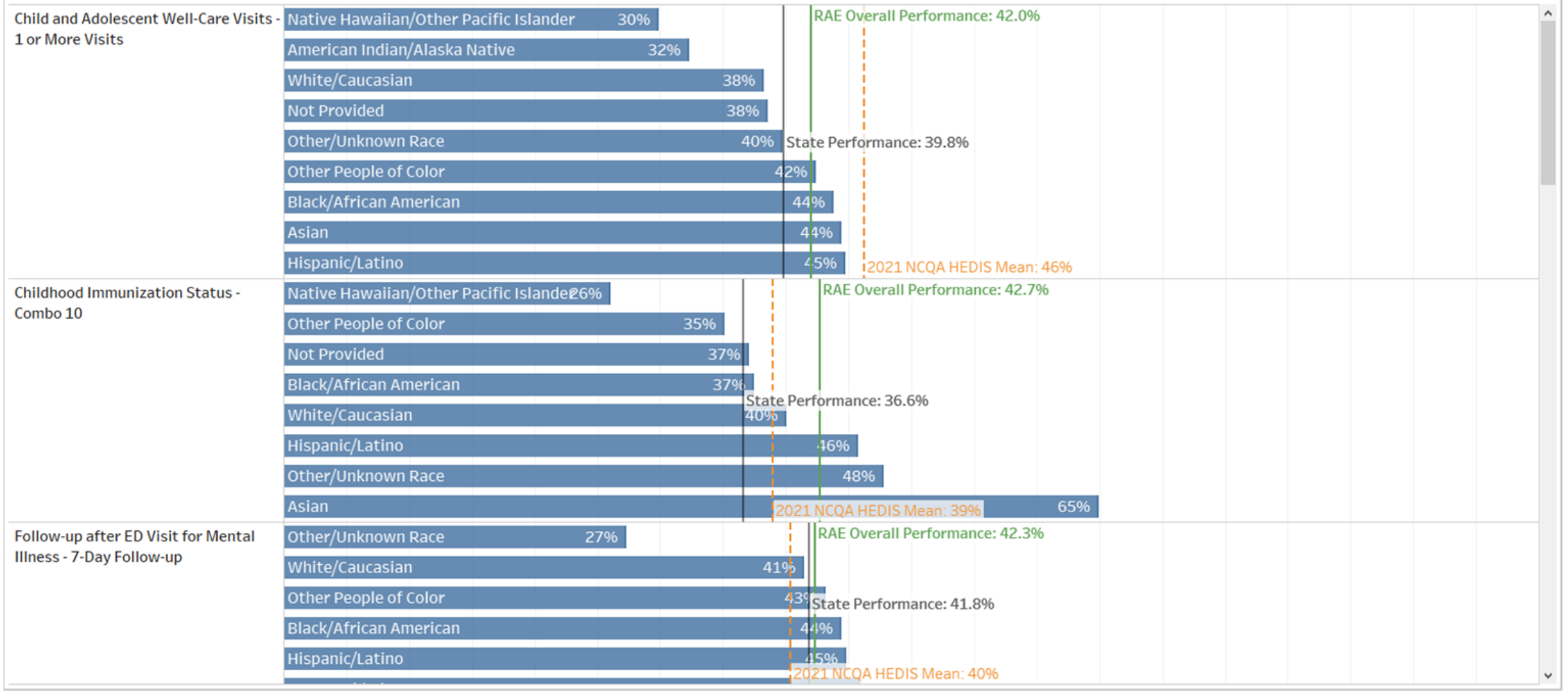
Select a RAE to View Health Equity Measures: 1 | 2 | 3 | 4 | 5 | 6 | 7

Select how to breakout measures results: Member Race/Ethnicity

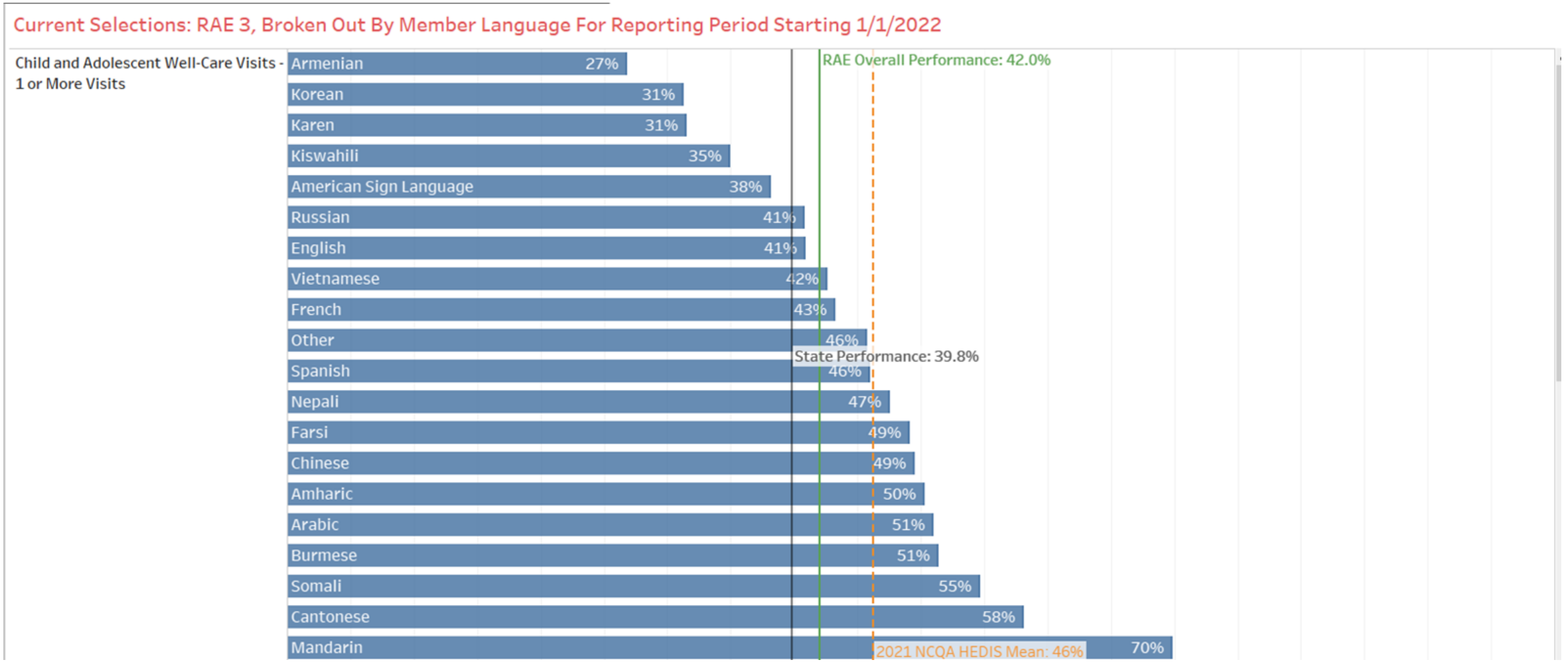
Select Reporting Start Date of 12 Month Reporting Period: 1/1/2022

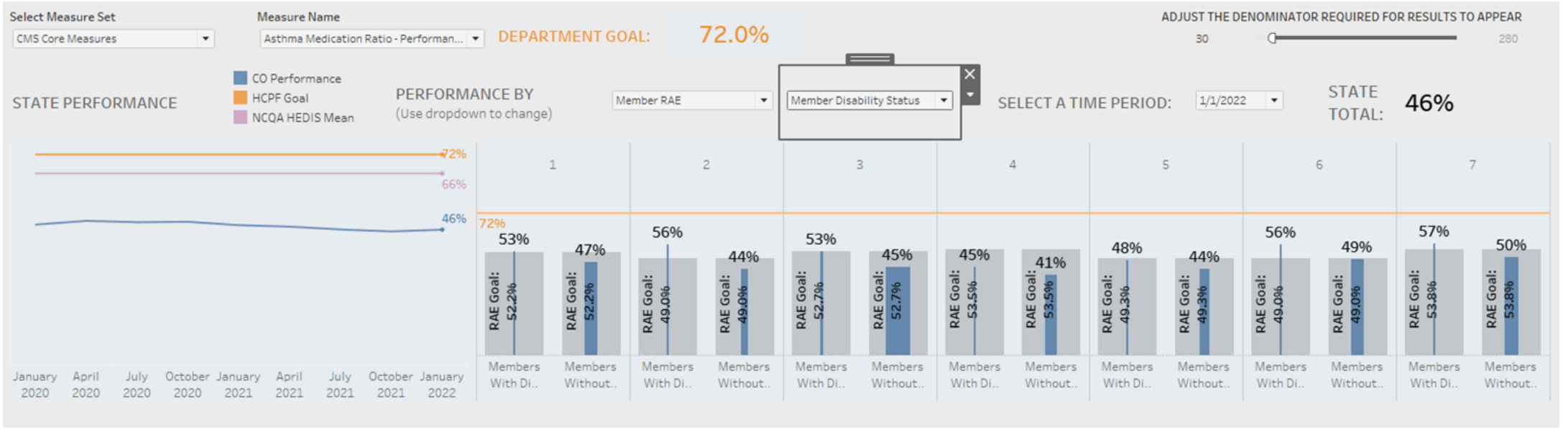
Filter Denominator Count: 30 — 65,053

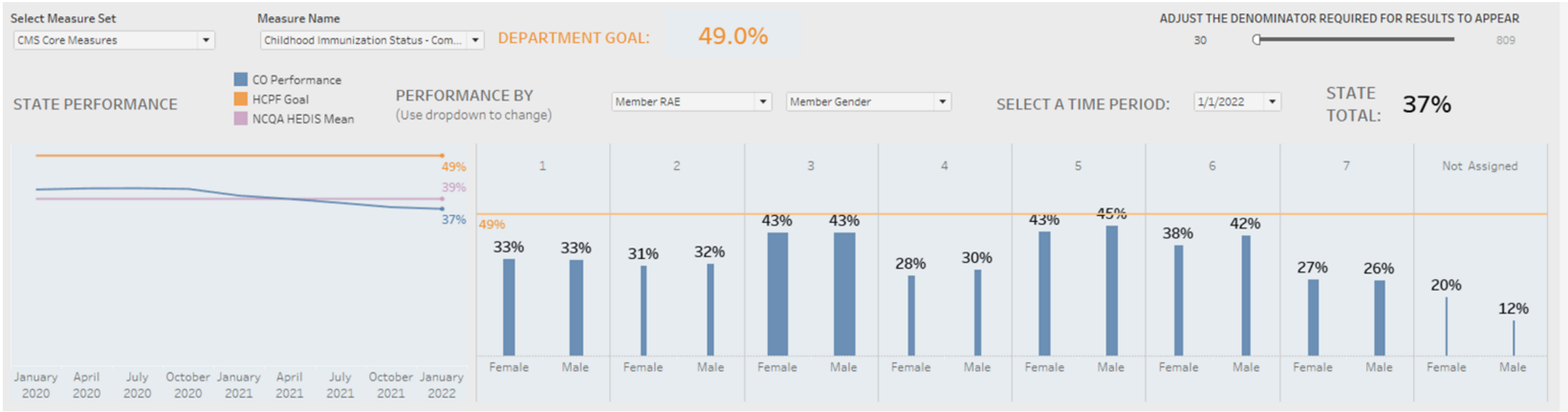
Current Selections: RAE 3, Broken Out By Member Race/Ethnicity For Reporting Period Starting 1/1/2022



Measures can be broken out by Member Language




Select Measure Set
CMS Core Measures
Measure Name
Asthma Medication Ratio - Performan...
DEPARTMENT GOAL: 72.0%
ADJUST THE DENOMINATOR REQUIRED FOR RESULTS TO APPEAR
30
280
STATE PERFORMANCE
CO Performance
HCPF Goal
NCQA HEDIS Mean
PERFORMANCE BY
(Use dropdown to change)
Member RAE
Member Disability Status
SELECT A TIME PERIOD:
1/1/2022
STATE TOTAL: 46%
72%
66%
46%
January 2020
April 2020
July 2020
October 2020
January 2021
April 2021
July 2021
October 2021
January 2022
1
2
3
4
5
6
7
72%
53%
47%
56%
44%
53%
45%
45%
41%
48%
44%
56%
49%
57%
50%
RAE Goal: 52.2%
RAE Goal: 52.2%
RAE Goal: 49.0%
RAE Goal: 49.0%
RAE Goal: 52.7%
RAE Goal: 52.7%
RAE Goal: 53.5%
RAE Goal: 53.5%
RAE Goal: 49.3%
RAE Goal: 49.3%
RAE Goal: 49.0%
RAE Goal: 49.0%
RAE Goal: 53.8%
RAE Goal: 53.8%
Members With Di..
Members Without..


Select Measure Set
CMS Core Measures
Measure Name
Childhood Immunization Status - Com...
DEPARTMENT GOAL: 49.0%
ADJUST THE DENOMINATOR REQUIRED FOR RESULTS TO APPEAR
30
809
STATE PERFORMANCE
CO Performance
HCPF Goal
NCQA HEDIS Mean
PERFORMANCE BY
(Use dropdown to change)
Member RAE
Member Gender
SELECT A TIME PERIOD:
1/1/2022
STATE TOTAL: 37%
49%
39%
37%
January 2020
April 2020
July 2020
October 2020
January 2021
April 2021
July 2021
October 2021
January 2022
1
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31%
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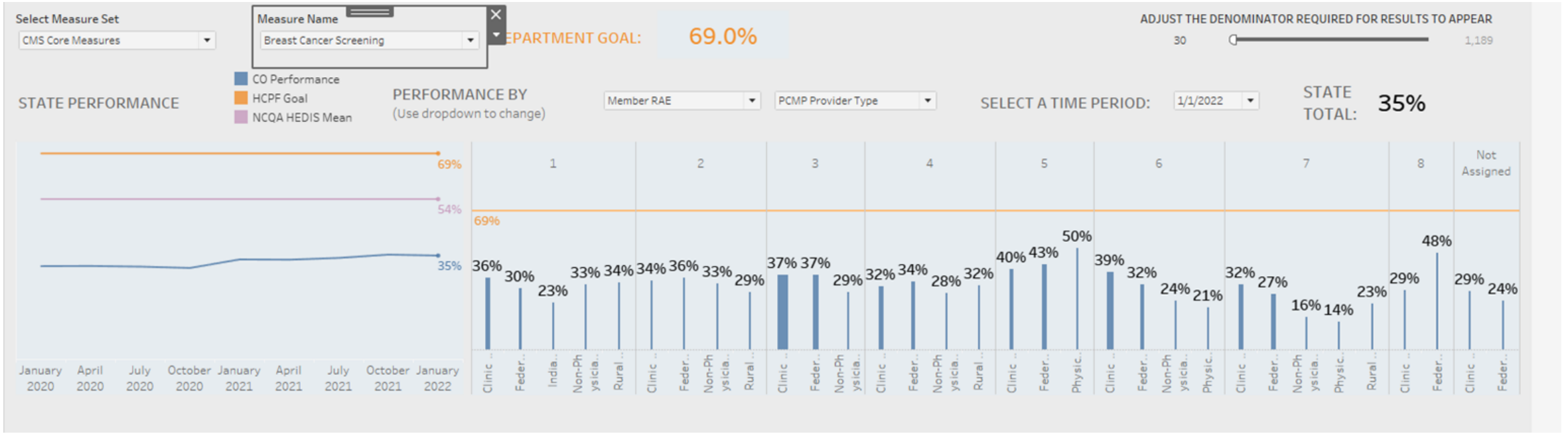
20%
12%
Female
Male


Select Measure Set
CMS Core Measures
Measure Name
Breast Cancer Screening
EPARTMENT GOAL:
69.0%
ADJUST THE DENOMINATOR REQUIRED FOR RESULTS TO APPEAR
30
1,189
CO Performance
HCPF Goal
NCQA HEDIS Mean
STATE PERFORMANCE
PERFORMANCE BY
(Use dropdown to change)
Member RAE
PCMP Provider Type
SELECT A TIME PERIOD:
1/1/2022
STATE TOTAL:
35%
69%
54%
35%
January 2020
April 2020
July 2020
October 2020
January 2021
April 2021
July 2021
October 2021
January 2022
1
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3
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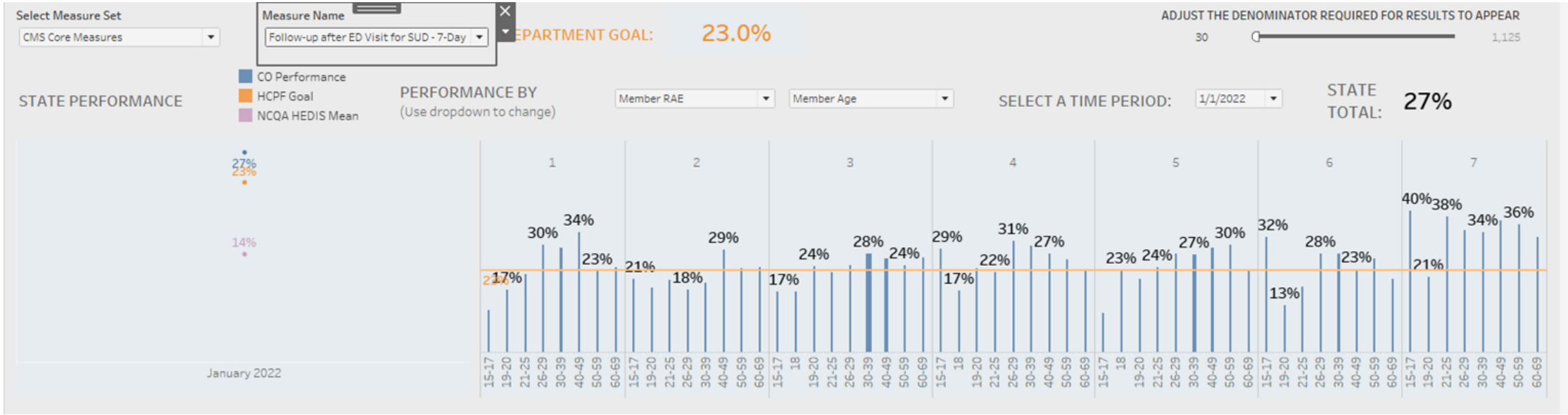
6
7
8
Not Assigned
69%
36% 30% 23% 33% 34%
34% 36% 33% 29%
37% 37% 29%
32% 34% 28% 32%
40% 43% 50%
39% 32% 24% 21%
32% 27% 16% 14% 23%
29% 48%
29% 24%
Clinic ..
Feder..
India..
Non-Physicia..
Rural ..
Physic..


Select Measure Set
CMS Core Measures
Measure Name
Follow-up after ED Visit for SUD - 7-Day
EPARTMENT GOAL:
23.0%
ADJUST THE DENOMINATOR REQUIRED FOR RESULTS TO APPEAR
30
1,125
CO Performance
HCPF Goal
NCQA HEDIS Mean
STATE PERFORMANCE
PERFORMANCE BY
(Use dropdown to change)
Member RAE
Member Age
SELECT A TIME PERIOD:
1/1/2022
STATE TOTAL:
27%
27%
23%
14%
January 2022
1
2
3
4
5
6
7
17% 30% 34% 23%
21% 18% 29%
17% 24% 28% 24%
17% 29% 22% 31% 27%
23% 24% 27% 30%
32% 13% 28% 23%
21% 40% 38% 34% 36%
15-17
19-20
21-25
26-29
30-39
40-49
50-59
60-69
18

Role of Providers in Advancing Health Equity

- Access to care
- Preventative care
- Cultural competency, responsiveness and humility
- Screening and early detection
- Health literacy and education
- Advocacy for vulnerable populations
- Advocacy for policies and resources
- Coordination of care
- Community engagement
- Data collection and research

Additional Health Equity Priorities

Health Equity Priorities

In addition to current health equity short term and long term goals and projects, the Department will move forward with the following concepts:

1. Changes to Medicaid Application
2. Spanish-Speaking Maternity Advisory Council (MAC)
3. Core 5: Prescriber Tool, Phase III
4. Comprehensive Behavioral Health Providers
5. Chronic Care Management & Preventative Care
6. Equity Study for People with Disabilities
7. Tribal Relations and Health Equity Study

Long Term Project: Changes to Medicaid Application

- Changes include *optional* self-identification questions
- Provide capability to identify and make informed program/policy and investment decisions
- Improve access to quality demographic data

Long Term Project:
Changes to Medicaid Application

Include a more robust ability to stratify data by race/ethnicity, gender identity, sexual orientation, language, and housing status

- Outcome, impact, and measurement of success:
  - Upstream ability to identify additional disparity data
  - Proposed questions are added to online and paper applications by **October 2024**
  - **Current programs or resources:** Quality Data Team, Need: Proposal dependent on collaboration and support of CDHS partners (pending), CMS approval TBD

Community Engagement: Statewide Health Equity Task Force and Public Town Halls

Community Engagement

Task Force

- 60+ Ambassadors across the state; Five workgroups
    - Access to Care, Prevention, Behavioral Health, Maternity, Vaccinations
- Provide specific recommendations to HCPF and engage in health equity-related initiatives and policy. Due Jan/March 2024

Town Halls

- 20 focused public stakeholder events in the community by December 2023
    - ~2,500 stakeholders, target populations include Black/African American, Asian American Pacific Islander, Disability, Hispanic/Latino, American Indian/Alaska Native

Building Equity Into Payment Models Workgroup, a Multifaceted Approach

- Equitable distribution, targeted outreach, data alignment and equity lens application
- Risk adjustments and aligned quality metrics
- Community partnerships and patient-centered care
- Health IT infrastructure, EHR
- Transparency and accountability
- Provider incentives
- Education and training
- Patient navigation services
- Flexibility, trailering, research, and evaluation over time

Next Steps

Health Equity Plan Phase I

SFY 2022-2025 (and beyond)

2022 — Implement Health Equity Plan

Effective June 30, 2022

HCPF formally launched strategic plan (SB 21-181) to address health disparities

2022 — Vendor Contracts

Effective July 1, 2022

RAEs/MCEs required to submit health equity plans by December 31, 2023

2022 — Statewide Task Force

Beginning July - September 2022

Convening of 60+ stakeholders focusing on addressing health disparities and providing actionable recommendations to HCPF

2022 — Dashboard & Spec Document

October - December

Creation of health equity plan dashboard to track and monitor performance measures; Specification document to establish expectations

23-24 — Explore Disparities & Policy Opportunities

Monitor performance measures, identify additional gaps, and develop targeted interventions

Identify additional health equity concepts (via Senate Bill 21-181)

2025 — ACC Phase III

Health equity will be embedded in ACC Phase III through member centricity

Health Equity Plan Phase II

SFY 2022-2025 (and beyond)

2023 — Execute Health Equity Plan

July 1, 2023

HCPF continues to prioritize health equity and focus on maternity, vaccinations, behavioral health and prevention

2023 — RAE/MCO/CHP+ Health Equity Plans

December 31

Plans submit Health Equity Strategies to reduce health disparities

Set up quarterly check-ins

2023 — Quality and Affordability

Ongoing

Tying quality metrics, affordability, and equity together to ensure greatest impact for members; **Added five additional HE Measures FY 24/25**

2024 — Statewide Health Equity Report

January / March

Governor's Office publishes statewide SB 21-181 Health Equity Report and Roadmap

2024 — Task Force Recommendations

April / June

Statewide Health Equity Task Force submits recommendations to HCPF Leadership

HCPF Publishes Version II HE Report

2025 — Data Validation

FY 25/26 Health Equity Measures are validated

Overall Measurement of Success

- Alignment with Health Equity Commission and other state department efforts
- CMS Medicaid Quality Core Measures – enhance ability to report
- Focus on preventive services, perinatal care, behavioral health, and immunizations (includes COVID)
  - Gap closure methodology (regional vs. statewide metrics)
  - Leverage initiatives that measurably reduce disparities
  - Increased access to quality care for all members, reduced cost, and affordability
- Timeline around progress: FY 23/24, Monthly updates from subject matter experts, project leads (Status 6/30/24)
- Version 2 report published by June 30, 2024


Questions/Feedback

Contact Info

Please submit any written feedback on this meeting no later than Wednesday, October 25 to:

Aaron Green, MSM, MSW
Health Disparities and Equity, Diversity & Inclusion Officer
Aaron.green@state.co.us

Moriah Bell, CHI
Program Manager
FocusGroups@coloradohealthinstitute.org

Join the Mailing List

Sign up to learn from CHI about future HCPF programs, click here:

https://lp.constantcontactpages.com/su/povy2DM

Thank you!

Appendix

Vaccination Rates (COVID-19)	Maternity and Perinatal Health	Behavioral Health	Prevention and Population Health
Short term projects: Activities or projects to accomplish in the near future (i.e. 12 months or less)			
• **Collaborate with Health First Colorado Primary Care Providers to eliminate barriers to COVID-19 vaccination rates** • **Monitor RAE compliance against submitted strategies to address COVID-19 vaccination rates. Identify barriers and create plans to further address barriers with a focus on target populations** • **Collaborate with congregant-setting providers to ensure a Health First Colorado member vaccination rate above 85% and that each provider is compliant with the CDPHE vaccination distribution requirements, as defined in rule.** • **Continue to collaborate with CDPHE on outreach activities.**	• **Evolve the Department's Health First Colorado Maternity Alternative Payment Model (APM).** • **Document the experience of Black, Indigenous, People of Color (BIPOC) birthing people to increase maternity health disparity drivers and insights** • **365 Days of Postpartum Coverage.** Implement SB21-194, which provides the Department with authority to ensure all members receive a full year (instead of 60 days) of postpartum coverage. • **Expanded Population Coverage for Family Planning Services.** Implement SB21-009 and SB21-025 which support family planning and coverage for undocumented Coloradans to reduce the incidence of unintended pregnancy, which reduces adverse perinatal and neonatal outcomes.	• **Increased the Health First Colorado behavioral health network to more than 11,000 active behavioral health providers.** • **Create a report that identifies those providers who are enrolled but not seeing patients, and create outreach to identify why.** • **Behavioral health community grants and training.** Provide Behavioral Health community grants to expand capacity specific to community members' needs with culturally relevant service access, availability, and delivery. • **Alternative Payment Model (APM).** Ensure the equity framework is utilized in developing a new APM and value measures during this interval and evaluate the effectiveness of the framework in current behavioral health efforts.	**Improve Diabetes A1C control** in populations at risk by: ▪ Analyzing data in collaboration with RAE/MCO partners to identify disparities (race/ethnicity, age, gender, language, disability) and identifying priority populations ▪ Inventorying the percent of members with diabetes enrolled in RAE diabetes programs ▪ Continuing to improve data quality by increasing access to provider lab data and improving provider documentation of services provided and level of disease control ▪ Collaborating with FQHCs to develop diabetes self-management education (DSME) program opportunities to improve patient health equity through evidence-based medicine **Create the initiatives to increase well child visits.**

Dept. Short Term Projects/Initiatives

Vaccination Rates (COVID-19)	Maternity and Perinatal Health	Behavioral Health	Prevention and Population Health
Long term projects: More than 12 months, requiring additional time and planning			
• **Determine additional strategies needed to close the COVID-19 vaccination disparity** equal to the overall Colorado population and Health First Colorado/CHP+ vaccination disparity.	• **Maternity Health Equity Plan.** Develop and implement a Maternity Equity Plan that addresses maternal morbidity in BIPOC communities. • **Leverage the Hospital Quality Incentive Payment (HQIP) Program. Hospital incentive program focused on maternal health, patient safety and patient experience measures. Includes measures on Maternal Depression and Anxiety, Maternal Emergencies, Zero Suicide, and Racial and Ethnic Disparities.** • **Leverage HTP. Improve hospital care by tying CHASE fee-funded hospital payments to quality-based initiatives through the Hospital Transformation Program (HTP).**	• **Work with sister departments to expand broadband and telehealth in rural communities** to improve tele-behavioral health care access and reduce reluctance to seek care due to stigma. • **Expand behavioral health mobile crisis benefit and develop secure transportation benefit** to reduce reliance on law enforcement and ensure equitable access to services, which will require providers to become proficient in procedures for crisis response and transport for individuals with disabilities, individuals who are deaf/hard of hearing, and individuals who are non-English speaking or non-English proficient.	• **Identify Social Risk Factors (SRF)** through the lens of social determinants of health and develop predictive analytics tools to gather appropriate data for social needs to promote health equity. • **Work with OeHI and state partners to release and review the Request for Proposals (RFP) that will procure a partner to implement the second phase of the Prescriber Tool**, which allows providers and case management to better address social determinants of health for Health First Colorado members. • **Work with providers and advocates to collect data to better screen for whole-person service needs and identify disparities related to upstream and downstream determinants.**

RAE/ACC Health Equity Plan Measures, Rev2_2023

Indicator	Description	Steward
Indicator 1	10% increase in booster vaccination rate - Adult and Child	HCPF
Indicator 2	Comprehensive Diabetes Care, Hemoglobin A1c Poor Control >9% (NQF 0059)	NCQA
Indicator 3	Well-child Visits in the First 30 Months of Life (NQF 1392)	NCQA
Indicator 4	Child and Adolescent Well-care Visits (NQF 1516)	NCQA
Indicator 5	Childhood Immunization Status (NQF 0038)	NCQA
Indicator 6	Immunizations for Adolescents (NQF 1407)	NCQA
Indicator 7	Follow-up after Emergency Department Visit for Mental Illness (NQF 3489)	NCQA
Indicator 8	Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (NQF 3488)	NCQA
Indicator 9	Follow-up after Hospitalization for Mental Illness (NQF 0576)	NCQA
Indicator 10	Screening for Depression and Follow-up Plan (NQF 0418)	CMS
Indicator 11	Prenatal and Postpartum Care (NQF 1517) *Timeliness of Prenatal Care & Postpartum Care*	NCQA
Indicator 12	Dental and Oral Health: Oral Evaluation, Dental Services (NQF 2517)	DQA

CHP+/MCO Health Equity Plan Measures_Rev2_2023

Indicator	Description	Steward
Indicator 1	Core Measure NQF 1392: Well-child Visits in the First 30 Months of Life (W30-CH)	NCQA
Indicator 2	Core Measure NQF 1516: Child and Adolescent Well-Care Visits (WCV-CH)	NCQA
Indicator 3	Core Measure NQF 0038: Childhood Immunization Status Combo 10	NCQA
Indicator 4	Core Measure NQF 1407: Immunizations for Adolescents Combo 2	NCQA
Indicator 5	10% increase in COVID booster vaccination rate: Children (ages 0-19)	CHP+/MCO
Indicator 6	Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness	NCQA
Indicator 7	Core Measure NQF 0418: Depression Screening and Follow-up	NCQA
Indicator 8	Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH)	NCQA
Indicator 9	Core Measure NQF 1517: Postpartum Care (PPC-AD)	NCQA

Proposed New Measures (SFY 24-25), Rev7_2023

Indicator	Description	Steward
Indicator 13	Core Measure NQF 0018: Controlling High Blood Pressure	NCQA
Indicator 14	Core Measure NQF 0034: Colorectal Cancer Screening	NCQA
Indicator 15	Core Measure NQF 0032: Cervical Cancer Screening	NCQA
Indicator 16*	Core Measure NQF 0033: Chlamydia Screening in Women	NCQA
Indicator 17*	Core Measure NQF 1448: Developmental Screening in the First Three Years of Life	NCQA

*Indicator 16 and 17 include Child Populations