COLORADO
Department of Health Care Policy & Financing

To: Health Impact on Lives Sub-committee
From: Elisabeth Arenales and David Keller
Date: February 23, 2017
Subject: EPSDT and WCC Performance

Executive Summary: Colorado EPSDT performance (47.2 percent) is well below the federal target (80 percent). Two key entities, Healthy Communities and Regional Care Collaborative Organizations, work to serve similar populations but often struggle to do so in a coordinated way. The Health Impact on Lives Sub-committee recently developed the following recommendations to improve coordination between these entities and, in turn, EPSDT performance: 1) deployment of common information systems, 2) alignment of resources and incentives, 3) delineation of roles and responsibilities, 4) education and engagement of providers, 5) creation of member and family-focused processes, and 6) development of new community partnerships.

Background: Early periodic screening diagnostic and treatment (EPSDT) is a Medicaid benefit for children 20 and under that helps ensure children have access to appropriate developmental screenings and receive any necessary treatment. States serve as key partners in delivering these services. The Colorado Department of Health Care Policy and Financing (the Department) deploys two primary levers to orchestrate the delivery of EPSDT: 1) Healthy Communities, an outreach and case management program for eligible Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) members and 2) Regional Care Collaborative Organizations (RCCOs), care coordination entities that operate in the Accountable Care Collaborative (ACC) and coordinate the provider networks of enrolled Health First Colorado members. While contractually required to work together, Healthy Communities and RCCOs have often struggled to create and implement coordinated delivery approaches for their overlapping membership.

Current Performance: Colorado's current EPSDT performance rate is 47.2 percent, which ranks 37th across the nation and is significantly behind top performers, including Louisiana (100.0 percent), Washington, DC (96.0 percent), and Kansas (82.0 percent). The ACC monitors EPSDT using a different methodology and focuses on the three to nine year old cohort. The ACC's current performance is 48.9 percent, which is consistent with Colorado's performance for the same age cohort (48.6 percent). Both, however, are well below the 80 percent federal target. See Appendix 1 for more information.

Delivery System Recommendations: In August 2016, the Health Impact on Lives Sub-committee began work to improve ESPDT performance. After convening all seven RCCOs and key Healthy Communities staff to understand the current state of operations (see Appendix 2), the Sub-committee identified six key challenges to effective Healthy

Communities and RCCO collaborations and developed recommendations to address each challenge and, ultimately, to improve ESPDT performance.

1. **Data and Information Sharing**: Nearly all RCCOs identified challenges associated with sharing member data and initiative information with Healthy Communities.

   Sub-Committee Recommendation: RCCOs and Healthy Communities should leverage the Salesforce system to share data regarding members. This could include sharing data files from Salesforce, purchasing and deploying Salesforce licenses at each RCCO, or building integration platforms for Salesforce and each RCCO's care management systems.

2. **Resource and incentive alignment**: Healthy Communities is responsible for outreach and education regarding EPSDT. BHOs are responsible for providing EPSDT education for their members. RCCOs are responsible for coordinating access to and utilization of the benefit. Providers are responsible for the ultimate provision of EPSDT. All have some sort of financial incentive for their respective piece.

   Sub-Committee Recommendation: RCCOs should leverage KPI money to build community-based incentive programs with Health Communities or other community-based entities that have significant investment in and interaction with their respective members. Measures should also be aligned across and clearly defined among these respective stakeholders and partners.

3. **Duplication of roles and responsibilities**: Many RCCOs stated that Healthy Communities staff and care coordinators were confused about what the other player did and, more importantly, members experienced redundant services and were confused about how to access services.

   Sub-Committee Recommendation: Healthy Communities should provide guidance on best practices and standard care coordination efforts of its coordinators. RCCOs should work with Healthy Communities to build from these practices and define appropriate divisions of labor between the respective programs.

4. **Provider Education and Engagement**: RCCOs commented that many BH providers had no idea what EPSDT was. They also mentioned that some physical health providers didn't employ the best coding practices.

   Sub-Committee Recommendation: RCCOs and Healthy Communities staff should employ the Department's recent materials to inform providers on the benefits of well-child care. See also the Family Engagement recommendation.

5. **Family engagement/person-centered care v. system success**: While there is a programmatic KPI re: Well Child Checks, our ultimate goal is to engage families in a meaningful way so that they build generational habits of wellness and prevention.

   Sub-Committee Recommendation: RCCOs, Healthy Communities, and other community partners should develop consistent messaging regarding the issues and topics well-child care could address and deploy educational messaging as they were assisting members access well child care.

6. **New partnerships**: RCCOs, BHOs, and Healthy Communities are clearly not the only stakeholders that have a vested interest in this benefit and the members.

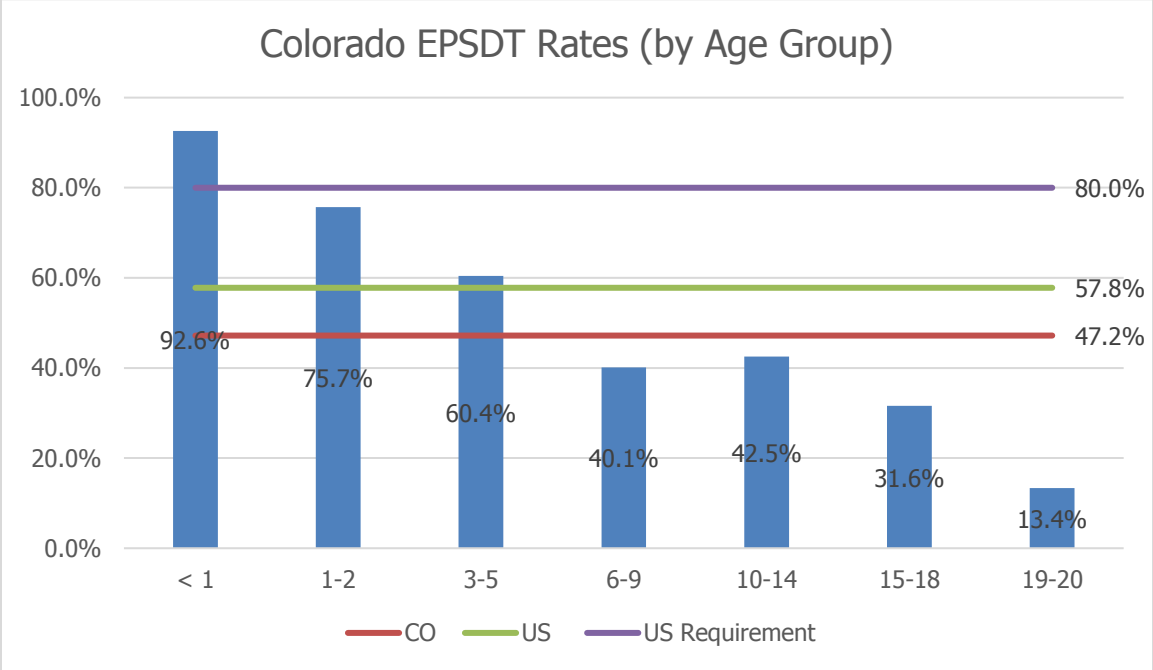
   Sub-Committee Recommendation: RCCOs should leverage KPI money to build community-based incentive programs with Health Communities or other community-based entities that have significant investment in and interaction with their respective members.

Appendix 1. Performance Definitions and Data

The two measures for EPSDT have noticeable differences. Unlike the national measure, the ACC indicator focuses only on children ages 3 to 9 who have been in the program for at least 90 continuous days. The ACC indicator also does not count dental visits or blood lead screenings as well child services, whereas the EPSDT measure does.

Across Colorado, EPSDT performance wanes as children get older, which is consistent with national trends (see Chart 1). In 2013, the ACC developed and implemented its own EPSDT measure but narrowed the age cohort in 2014 to three to nine year olds in light of declining performance trend. Current ACC varies by RCCO but is comparable to the overall state performance and other health plans (see Table 1).

Chart 1. Colorado EPSDT Rates (by Age Group)



Note: Data from CMS covering Oct 2014 to Sept 2015.

Table 1. Colorado EPSDT and WCC Rates (3-9 year olds)

	EPSDT/WCC Completion Rate
US	62.7%
CO	48.6%
ACC	48.6%
RCCO 1	47.4%
RCCO 2	44.1%
RCCO 3	51.4%
RCCO 4	44.3%
RCCO 5	57.1%
RCCO 6	51.5%
RCCO 7	42.5%
Other Medicaid Programs	
FFS	50.0%
MCO: Denver Health	50.0%
MCO: RMHP PRIME	51.0%

Note: US, CO, and Other Medicaid Programs rates are EPSDT rates for children ages 3 to 9 years old. ACC rates are WCC rates for children ages 3 to 9 years old. US and CO data is from CMS covering Oct 2014 to Sept 2015. Other Medicaid Programs data is from 416 Reports to CMS for 2015. ACC data is from the Colorado SDAC for April 2015 to March 2016.

Appendix 2. Current Delivery System Initiatives

RCCOs are currently implementing the following efforts to improve EPSDT performance.

RCCO 1 (Rocky Mountain Health Plans): Rocky has employed a variety of initiatives to increase awareness among its members and providers re: EPSDT. It does an annual gap analysis to identify members who have not had a recent well-child care appointment. It then sends a mailing to respective members, offers a gift-card to incentivize respective parents, and provides messaging to respective practices and providers to conduct subsequent outreach. Rocky has also been implementing a program called Healthy Harbors, which integrates a multi-disciplinary care team in a primary care medical home and provides care coordination services to high-risk children and families. The team, which consists of a social worker, nurse practitioner, care coordinator, and nurse, helps members overcome access barriers and ensures compliance with standards of care. The team also stays with the members until they are deemed "stable." The intervention has shown a significant improvement in well-child care compliance in members 3+ years old (78% in Healthy Harbor members compared to 46% in non-Healthy Harbor members).

RCCO 2, 3, and 5 (Colorado Access): Colorado Access has employed three key strategies to improve EPSDT rates. The first is a care coordination collaborative between Colorado Access, HCPF, Tri-County Health Department, and CDPHE called Team 4C (Colorado Care Coordination Collaborative). The collaborative works to reduce duplication and increase alignment in care coordination efforts for children and youth with special health needs. Colorado Access has also created a database of ESPDT providers, including pediatricians, vision providers, dentists, and other specialists. The third intervention has been a partnership with Colorado Children's Healthcare Access Program to improve practice transformation and benefit utilization among Colorado Access's providers who are patient-centered medical homes. Colorado Access has experienced challenges regarding sharing data on overlapping clients with Healthy Communities as well as with school districts, overlapping efforts between Healthy Communities and Colorado Access care coordinators, poor alignment of incentives, and poor access to behavioral health providers in rural regions.

RCCO 4 (Integrated Community Health Partners): ICHP is currently working with their BHO to utilize care coordinators at Health Solutions to connect families with an established relationship with a behavioral health provider to a PCP and EPSDT benefit. The pilot will be initiated in October and will focus on children who have five or more behavioral health visits but no well child visit. They are still determining their processes and the project's respective outcome measures. ICHP has noticed that there is a lack of clarity among behavioral health providers as to the RCCO's responsibilities in administering and coordinating the EPSDT benefit. ICHP also discussed their strong Healthy Communities efforts in Chaffee and Pueblo counties. The teams have done an

excellent job to ensure data sharing, build and align strategic plans across organizations, and utilize a variety of tools to encourage use of the EPSDT.

RCCO 6 (Colorado Community Health Alliance): CCHA has a number of pilots currently in place, including birthday reminder calls, targeted outreach and education to members, family health risk assessments, and a comprehensive outreach program through AmeriCorps. CCHA also offers practice transformation assistance (process development, billing and coding education, etc) to practices looking to improve their well-child performance. Recently, CCHA has begun to partner with Boulder Valley School District to implement an incentive program for 1st-4th graders who are Health First Colorado (Colorado's Medicaid Program) eligible. Students can select from a variety of incentives – school supplies, recreation center passes, shoes, etc – should they receive a well child care visit. CCHA has also been partnering with community clinics to do outreach and education at clinic-based health fairs. In addition to Healthy Communities, CCHA has partnered with Head Start, Prenatal Plus, and Nurse Family Partnership to identify and refer members for EPSDT.

RCCO 7 (Community Care of Central Colorado): CCCC has been partnering with Healthy Communities since 2014 to provide timely information and requests to the RCCO from Healthy Communities regarding the enrollment of pregnant women and children and provide information to Healthy Communities from the RCCO regarding available PCMPs. Over the past year, 76% of members contacted were connected and attributed to a PCMP. While no firm figures were available, data regarding the utilization of EPSDT and other community resources among these contacted members has been promising. CCCC is working to improve data sharing processes and reporting pilot outcomes.