


**Schedule 13**

**Department of Health Care Policy and Financing**

**Funding Request for The FY 2021-22 Budget Cycle**

Request Title

**R-24 Addressing Health Care Disparities**

Dept. Approval By: 

Supplemental FY 2020-21

OSPB Approval By: 

Budget Amendment FY 2021-22

X

Change Request FY 2021-22

| Summary Information                                       | Fund | FY 2020-21            |                      | FY 2021-22          |                    | FY 2022-23   |
|---|------|-----------------------|----------------------|---------------------|--------------------|--------------|
|   |      | Initial Appropriation | Supplemental Request | Base Request        | Change Request     | Continuation |
| <b>Total</b>  |      | <b>\$94,065,689</b>   | <b>\$0</b>           | <b>\$95,760,259</b> | <b>\$5,900,000</b> | <b>\$0</b>   |
| FTE   |      | 0.0                   | 0.0                  | 0.0                 | 0.0                | 0.0          |
| <b>Total of All Line Items Impacted by Change Request</b> | GF   | \$16,126,845          | \$0                  | \$16,503,157        | \$1,000,000        | \$0          |
|   | CF   | \$9,542,885           | \$0                  | \$10,173,063        | \$0                | \$0          |
|   | RF   | \$162,204             | \$0                  | \$162,204           | \$0                | \$0          |
|   | FF   | \$68,233,755          | \$0                  | \$68,921,835        | \$4,900,000        | \$0          |

| Line Item Information   | Fund | FY 2020-21            |                      | FY 2021-22          |                  | FY 2022-23   |
|---|------|-----------------------|----------------------|---------------------|------------------|--------------|
|   |      | Initial Appropriation | Supplemental Request | Base Request        | Change Request   | Continuation |
| <b>Total</b>  |      | <b>\$20,838,547</b>   | <b>\$0</b>           | <b>\$19,531,819</b> | <b>\$100,000</b> | <b>\$0</b>   |
| 01. Executive Director's Office, (A) General Administration, (1)            | FTE  | 0.0                   | 0.0                  | 0.0                 | 0.0              | 0.0          |
| General Administration - General Professional Services and Special Projects | GF   | \$6,423,623           | \$0                  | \$6,012,795         | \$100,000        | \$0          |
|   | CF   | \$3,230,464           | \$0                  | \$3,415,079         | \$0              | \$0          |
|   | RF   | \$150,000             | \$0                  | \$150,000           | \$0              | \$0          |
|   | FF   | \$11,034,460          | \$0                  | \$9,953,945         | \$0              | \$0          |

|   |     |                     |            |                     |                    |            |
|---|-----|---------------------|------------|---------------------|--------------------|------------|
| <b>Total</b>  |     | <b>\$73,227,142</b> | <b>\$0</b> | <b>\$76,228,440</b> | <b>\$5,800,000</b> | <b>\$0</b> |
| 01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) | FTE | 0.0                 | 0.0        | 0.0                 | 0.0                | 0.0        |
| Information Technology Contracts and Projects - MMIS Maintenance and Projects           | GF  | \$9,703,222         | \$0        | \$10,490,362        | \$900,000          | \$0        |
|   | CF  | \$6,312,421         | \$0        | \$6,757,984         | \$0                | \$0        |
|   | RF  | \$12,204            | \$0        | \$12,204            | \$0                | \$0        |
|   | FF  | \$57,199,295        | \$0        | \$58,967,890        | \$4,900,000        | \$0        |

**Auxiliary Data**

**Requires Legislation?** NO

**Type of Request?** Department of Health Care Policy and  
Financing Prioritized Request

**Interagency Approval or  
Related Schedule 13s:**

No Other Agency Impact



**Department Priority: R-24**  
**Request Detail: Addressing Health Care Disparities**

| <b>Summary of Funding Change for FY 2021-22</b> |                                     |                            |                               |                               |
|---|-------------------------------------|----------------------------|-------------------------------|-------------------------------|
|   | <b>Totals</b>                       |                            | <b>Incremental Change</b>     |                               |
|   | <b>FY 2020-21<br/>Appropriation</b> | <b>FY 2021-22<br/>Base</b> | <b>FY 2021-22<br/>Request</b> | <b>FY 2022-23<br/>Request</b> |
| Total Funds                                     | \$94,065,689                        | \$95,760,259               | \$5,900,000                   | \$0                           |
| FTE   | 0.0                                 | 0.0                        | 0.0                           | 0.0                           |
| General Fund                                    | \$16,126,845                        | \$16,503,157               | \$1,000,000                   | \$0                           |
| Cash Funds                                      | \$9,542,885                         | \$10,173,063               | \$0                           | \$0                           |
| Reappropriated Funds                            | \$162,204                           | \$162,204                  | \$0                           | \$0                           |
| Federal Funds                                   | \$68,233,755                        | \$68,921,835               | \$4,900,000                   | \$0                           |

**Summary of Request:**

The Department requests funding to address health disparities in the Medicaid program and Colorado by: collecting previously uncaptured data to identify health disparities by race and ethnicity; using that data to inform outcome-based value-based payments to Medicaid providers; and, support providers in their efforts to collect this data and use it to address health disparities. The Department would use the requested funding to support data transfer from community partners and provide data analytics to better target the efforts of community-based organizations, including outreach, training, and technical assistance. The work funded through this request would enable the Department to condition value-based payments to providers on evidence that they are improving health outcomes where disparities currently exist and enable new quality measurement that better allows the Department and providers to improve health disparities.

The Department believes that this type of data collection and outreach is on Step 2 of the Evidence Continuum, “Identify Outputs.” Robust data collection on race and ethnicity would enable direct outreach to populations with significant health disparities. Providers would be able to make direct interventions using the reported results. Once the data is collected and interventions can begin, the Department would be able measure the results and determine whether it has been successful in reducing health disparities.

***Current Program:***

Health disparities are differences and/or gaps in the quality of health and health care across racial, ethnic, and socio-economic groups. It can also be understood as population-specific differences in the presence of disease, health outcomes, or access to health care. In this sense, health inequities are systematic differences in health that could be avoided by reasonable means. The complexity of these factors, coupled with the fact that disparities in care are not always apparent to members or providers in clinical encounters, increases the need for data to better understand the extent of disparities and the circumstances under which disparities are likely to occur. In the 2002 landmark study *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*<sup>1</sup>, the Institute of Medicine documented evidence that race and ethnicity are significant predictors of the quality of care, observing that minorities who had the same insurance, status, and income as non-minorities received a lower quality of care. At the heart of efforts to develop effective outreach and strategies to address health care disparities and inequalities is the need for accurate and complete data. However, data describing racial, ethnic, language, cultural, and socioeconomic characteristics are frequently inaccurate, incomplete, and lacking in detail within the Department current data systems.

Standardized data collection with safeguards for privacy and confidentiality is critically important in the effort to understand and eliminate racial and ethnic disparities in health care. Having data on member and provider race and ethnicity would allow the Department and researchers to better disentangle factors that are associated with health care disparities. Further, collecting and analyzing patterns of health care by patient race, ethnicity, and other demographic data can help the Department to monitor the quality of care provided by its provider network. Such monitoring can help to ensure accountability to enrolled members, improve member choice, and allow for evaluation of intervention programs. Such evaluations are likely to improve service delivery for racial and ethnic minority populations, and therefore may result in cost savings that would offset the costs of data collection.

***Problem or Opportunity:***

Currently, the Department's data collection through eligibility data collected through the Colorado Benefits Management System (CBMS) and the claims data provided through the Medicaid Management Information System (MMIS) are inconsistent and inadequate to monitor the quality of care provided to racial and ethnic minorities. For example, race and ethnicity data, because of federal regulations, can only be collected through voluntary methods through CBMS so the data is often left blank. The Department's effort to collect this data must be improved to: ensure accountability of outreach and health care provided to members; to track disparities and assess the

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<sup>1</sup> Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Edited by Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. Washington, DC: National Academy Press, 2002

impact of quality improvement efforts; and to identify best practices that may be replicated by other health systems and analysts within Colorado.

With a lack of valid data, the Department is missing an opportunity to condition payments on improvements in health disparities. The Department has adopted innovative alternative payment and delivery models that support transition from traditional fee-for-service (FFS) payments to value-based payments, known as “bundled payments.”<sup>2</sup> Bundled payments involve providing a single, comprehensive payment that covers all the services within an episode of care. Under a bundled payment model, participating providers are only responsible for outcomes of the episode. At present, bundled payments are designed to align incentives for providers and encourage collaboration to improve the quality and coordination of care across care settings. However, without better data on race, ethnicity, and other demographics, the Department is unable to expand the bundled payments program to condition payments on broader outcomes, such as addressing health disparities in the community.

The COVID-19 pandemic is exacerbating health disparities. The downturn has caused the loss of employer-sponsored health insurance and an increase in unemployment insurance claimants. This loss of access to health insurance is exacerbating health disparities. Data provided by the Centers for Disease Control<sup>3</sup> demonstrate how racial and ethnic minorities are being disproportionately affected by the pandemic:

| <b>COVID-19 Hospitalization and Death by Race/Ethnicity</b> |  |                             |   |                            |
|---|--|-----------------------------|---|----------------------------|
| Rate ratios compared to White, Non-Hispanic Persons         | American Indian or Alaska Native, Non-Hispanic persons | Asian, Non-Hispanic persons | Black or African American, Non-Hispanic persons | Hispanic or Latino persons |
| Cases   | 2.8x higher  | 1.1x higher                 | 2.6x higher                                     | 2.8x higher                |
| Hospitalization   | 5.3x higher  | 1.3x higher                 | 4.7x higher                                     | 4.6x higher                |
| Death   | 1.4x higher  | No increase                 | 2.1x higher                                     | 1.1x higher                |

***Proposed Solution:***

The Department requests \$5,900,000 total funds, including \$1,000,000 General Fund, in FY 2021-22 in order to collect and utilize data on health care outreach, access and utilization by members' race, ethnicity, socioeconomic status, and where possible, primary language. The Department would work with the state’s two Health Information Exchanges (HIE) - Quality Health Network (QHN) and Colorado Regional Health Information Organization (CORHIO) – to integrate clinical

<sup>2</sup><https://www.colorado.gov/pacific/hcpf/bundled-payments>

<sup>3</sup><https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>

data from electronic health records (EHR) with the Department's eligibility and claims data. The data contained within the EHR includes demographic and medical results on Medicaid members. In addition, the Department will integrate demographic data from the Colorado All Payer Claims Database (APCD) and other resources, like the State's vital records and immunization databases to supplement the Department's datasets.

The Department would establish regular data feeds with these external databases to integrate EHR data into its data warehouse. This would allow integration of this information into the Department's existing quality measurement reporting tools which would enable the Department to measure how well current and newly enrolled Medicaid members are connected to a medical home and receiving appropriate preventive and chronic care services. Further, this work aligns the Department's Medicaid enterprise systems with the Health IT Roadmap established by the Governor's Office of eHealth Innovation (OeHI). The Department is a partner in OeHI's governance structure to support statewide health information sharing and use of the state's Master Patient Index (MPI) and Master Provider Directory (MPD) services under development and funded through OeHI.<sup>4</sup>

The Department would reserve a portion of the funding to better identify, develop culturally appropriate messaging and outreach to enroll difficult-to-enroll populations. As an example, the Department may identify difficult-to-enroll populations via partnership with the Colorado Community Managed Care Network (CCMCN) to conduct analyses on uninsured federally qualified health center (FQHC) members. CCMCN has the single largest repository of uninsured EHR data in the State. Analyses would be directed toward identifying population segments who are likely eligible but not enrolled (EBNE) in Medicaid with focus on closing racial/ethnic/neighborhood disparities in EBNE status. These analyses would facilitate the development of population-targeted messaging for HCPF's "We are Here for You" campaign<sup>5</sup> and would be shared with FQHCs and other community advocates for trusted partner messaging. To reach individuals more efficiently as they are losing employer sponsored coverage, a portion of the funds would support connections with unemployment insurance claimants.

The Department believes that this type of data collection and outreach is on Step 2 of the Evidence Continuum, "Identify Outputs." Robust data collection on race and ethnicity would enable direct outreach to populations with significant health disparities. Providers would be able to make direct interventions using the reported results. Once the data is collected and interventions can begin, the Department would be able measure the results and determine whether it has been successful in reducing health disparities.

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<sup>4</sup>[https://oehi.colorado.gov/sites/oehi/files/documents/Colorado%20Health%20IT%20Roadmap-19\\_Web%20%281%29.pdf](https://oehi.colorado.gov/sites/oehi/files/documents/Colorado%20Health%20IT%20Roadmap-19_Web%20%281%29.pdf)

<sup>5</sup><https://www.colorado.gov/pacific/hcpf/HereForYou>

***Anticipated Outcomes:***

If this request is approved, the Department would use the clinical data collected to better understand and intervene to address health care disparities. The Department anticipates that the data, if robust, would allow for the development of value-based payment methodologies where payments are conditioned on improving health disparities in the community, as opposed to only rewarding improvements in individual outcomes. When available, the Department would integrate the new data into its bundled payment program<sup>6</sup>, starting with the Maternity Bundled Payment Program, in order to make providers financially accountable for improving community outcomes and reducing health disparities.

The following examples demonstrate other ways that the Department would use the new data:

1. To improve existing and new fiscal analyses based upon the Department's existing claims-based data. The Department has identified differences between racial groups in terms of the utilization and spending on high value primary care services. Members who self-identified as White were very significantly more likely to have received a recent primary care visit. However, significant data on race and ethnicity is simply missing. The volume of missing data reduces confidence in the results of the analysis and means that some share of the population at risk will not be able to be identified for intervention.
2. To look at the quality of care and health outcomes for subdivisions of the population to inform problem identification and solutioning. Currently, with the poor quality of the racial demographic data available in claims, results from analysis are suspect. The Department uses claims data not only for fiscal analysis, but also for quality measurement purposes. The Department measures quality in many ways and relies heavily upon measures following the nationally recognized definitions, most commonly established by the National Committee for Quality Assurance's (NCQA) Health care Effectiveness Data and Information Set (more commonly called HEDIS). The Department has determined that augmenting the racial and ethnic data available in current administrative data sets with the more robust data on ethnicity that is available in medical records would provide a better perspective on disparities in care and would allow targeted interventions. In particular, the Department relies heavily on CareAnalyzer (certified in HEDIS reporting by NCQA) and believes that augmenting that tool with the higher quality race and ethnicity data found in clinical data from electronic health records (EHR) would provide much clearer understanding and insight into disparities in care.
3. To identify disparities in care for racial and ethnic minorities for that existing clinical PCMP data. The Department currently uses clinical data for quality measurement of primary care medical providers (PCMPs) in the ACC program; valid results by race and ethnicity require augmenting the current process of quality measurement.

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<sup>6</sup><https://www.colorado.gov/pacific/hcpf/bundled-payments>

4. To expand clinical quality measurement beyond primary care, with a drill down on race and ethnicity. The Department believes that there are uses for clinical data for quality measurement beyond the primary care setting. For example, the Department is examining maternal care (pre through postnatal). The Department received a great deal of stakeholder feedback, including formal testimony before the Medical Services Board, that its current measurement infrastructure for the quality of maternity services was too focused on claims, rather than clinical data, and that the lack of drill down on performance by race and ethnicity was a fundamental barrier to understanding the patterns of care delivery including obstacles to the provision of effective and appropriate care. Expanding clinical quality measurement beyond primary care, with a drill down on race and ethnicity, is important in addressing and closing health disparities that are made evident by the racial difference in health outcomes evident in COVID morbidity and mortality data.
5. To use clinical data, in combination with other data sources, to identify high risk individuals and populations that could be Medicaid eligible, and to target them with interventions designed to get them coverage and then to target their specific health needs. Because of the disparities in the economic impacts of COVID by race and gender, it is likely that those that are ‘eligible but not enrolled’ for Medicaid are disproportionately from historically disadvantaged demographic groups.

If approved, these investments would help the Department provide critical data to Regional Accountable Entities (RAEs) in the Accountable Care Collaborative which would allow for more targeted interventions for difficult-to-reach populations. If data quality allows, the Department would use the data to craft targeted performance metrics for RAEs that are specific to improving outcomes for these populations. The Department’s investment in receiving data on people without insurance would enable specific targeting of outreach efforts, which would increase the probability that these efforts are successful.

The Department’s request, if outreach is successful, may increase enrollment in both public and private insurance programs. The Department’s request does not specifically account for increases in, e.g., Medicaid caseload as a result of these efforts. If successful, the caseload for the Department’s programs may increase; however, it is uncertain if this increase in caseload will increase costs in either the short or long term. Individuals without coverage who experience adverse health events are likely to enroll in coverage at the time of the event; when this occurs, the cost of treatment can outweigh the cost of preventive care. It is also unclear how quickly people will enroll in coverage in the absence of this effort; recent data indicates that even though many people lost their jobs due to the pandemic, most did not immediately apply for health coverage. The Department’s current forecasts for Medicaid and the Child Health Plan *Plus* assume that caseload will continue to increase throughout the pandemic. To the extent that this effort causes changes in caseload and expenditure beyond what is currently projected, the Department would use the normal budget process to account for any experienced deviation from the existing forecasts.



This request aligns to the Governor’s Health Cabinet’s FY 2020-21 Wildly Important Goal to “Leverage New Normal Opportunities.”<sup>7</sup> By investing in data aggregation to determine where health disparities exist, and by performing outreach to ensure people who are eligible for health insurance get enrolled, the Department would proactively move to close gaps in health equity and disparities across race and geography and help add more accountability across the health care system.

***Assumptions and Calculations:***

The Department would pursue federal funding opportunities for data integration efforts. The Department assumes that it would receive 90% federal financial participation for the design, development, and implementation of the data integration efforts, and 50% federal financial participation for provider outreach and training activities. The Department assumes that the requested funding for member outreach would not receive any federal match. Marketing activities are generally not eligible for federal funding under federal regulations (2 CFR § 200.467).

The Department’s estimate for data integration efforts is based on existing costs to build a hospital Admit, Discharge, and Transfer daily data transmission from CORHIO (approximately \$600,000). The Department anticipates that creating a patient demographic interface and an interface to transfer additional EHR clinical data elements (labs, immunizations, screenings, etc.) from each HIEs would cost approximately the same amount. There are multiple HIEs (CORHIO and QHN), and the Department anticipates two feeds per entity (demographic information and patient health records), the Department estimates the total needed is for the component is \$2.4 million total funds. The Department anticipates additional upfront costs associated with gathering data from the APCD, CCMCN, and up to one other entity at \$600,000 each, totaling \$1.8 million. Until the statewide Master Patient Index (MPI) is in place, a significant cost driver in these projects would be matching Colorado state identifiers to external system identifiers in the Department’s data warehouse. The Department estimates that data warehouse integration costs would cost \$800,000 for database changes, testing and project management. In total, the Department is reserving \$500,000 General Fund of the total request for technology requirements, with the expectation that the Centers for Medicare and Medicaid Services would grant a 90% federal match, making the available project budget \$5,000,000 total funds. By appropriating the funding to the Department’s Medicaid Management Information System Maintenance and Projects line item, the Department would be able to take advantage of existing statutory rollforward authority to allow the funds to remain available if the projects cannot be completed by the end of FY 2021-22.

The Department assumes that it would use standard procurement processes to solicit and award grants for provider training, support, and outreach efforts. The Department anticipates that it would be making efforts to draft procurement documentation as soon as possible after the funding is approved with the goal of having solicitations available by July 1, 2021. The Department would

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<sup>7</sup><https://www.colorado.gov/pacific/sites/default/files/HCPF%202020-2021%20Performance%20Plan.pdf>

simultaneously pursue efforts with CCMCN to receive data that can be used to target the outreach efforts. The Department would make the results of those efforts available to its selected contractors as soon as data is available. The Department estimates that completing procurement and contracting activities would take approximately three months, and that contractors would need at least an additional two months to integrate the uninsured data with their outreach strategies. The Department estimates that outreach efforts would begin no later than January 1, 2022 and occur for the remaining six months in the fiscal year.

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R-24 Addressing Health Care Disparities  
Appendix A: Assumptions and Calculations

| Table 1.1<br>Summary by Line Item<br>FY 2021-22 |  |                    |            |                    |            |                      |                    |          |                    |
|---|--|--------------------|------------|--------------------|------------|----------------------|--------------------|----------|--------------------|
| Row   | Line Item  | Total Funds        | FTE        | General Fund       | Cash Funds | Reappropriated Funds | Federal Funds      | FFP Rate | Notes/Calculations |
| A   | (1) Executive Director's Office; (A) General Administration, General Professional Services   | \$100,000          | 0.0        | \$100,000          | \$0        | \$0                  | \$0                | 0.00%    | Table 2.1, Row D   |
| B   | (1) Executive Director's Office;(C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects | \$5,800,000        | 0.0        | \$900,000          | \$0        | \$0                  | \$4,900,000        | 90.00%   | Table 2.1, Row C   |
| C   | <b>Total Request</b>   | <b>\$5,900,000</b> | <b>0.0</b> | <b>\$1,000,000</b> | <b>\$0</b> | <b>\$0</b>           | <b>\$4,900,000</b> |          | Row A + Row B      |

| Table 1.2<br>Summary by Line Item<br>FY 2022-23 and ongoing |  |             |            |              |            |                      |               |          |                    |
|---|--|-------------|------------|--------------|------------|----------------------|---------------|----------|--------------------|
| Row   | Line Item  | Total Funds | FTE        | General Fund | Cash Funds | Reappropriated Funds | Federal Funds | FFP Rate | Notes/Calculations |
| A   | (1) Executive Director's Office; (A) General Administration, General Professional Services   | \$0         | 0.0        | \$0          | \$0        | \$0                  | \$0           |          | One-time funding   |
| B   | (1) Executive Director's Office;(C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects | \$0         | 0.0        | \$0          | \$0        | \$0                  | \$0           |          | One time funding   |
| C   | <b>Total Request</b>   | <b>\$0</b>  | <b>0.0</b> | <b>\$0</b>   | <b>\$0</b> | <b>\$0</b>           | <b>\$0</b>    |          | Row A + Row B      |

R-24 Addressing Health Care Disparities  
Appendix A: Assumptions and Calculations

| Table 2.1<br>Summary by Initiative<br>FY 2021-22 |  |                    |            |                    |            |                      |                    |          |                    |
|--|--|--------------------|------------|--------------------|------------|----------------------|--------------------|----------|--------------------|
| Row  | Item   | Total Funds        | FTE        | General Fund       | Cash Funds | Reappropriated Funds | Federal Funds      | FFP Rate | Notes/Calculations |
| A  | Health Disparities: Data Aggregation and Reporting | \$5,000,000        | 0.0        | \$500,000          | \$0        | \$0                  | \$4,500,000        | 90.00%   | See narrative      |
| B  | Health Disparities: Provider Outreach and Training | \$800,000          | 0.0        | \$400,000          | \$0        | \$0                  | \$400,000          | 50.00%   | See narrative      |
| C  | <i>Subtotal Health Disparities Funding</i>         | <i>\$5,800,000</i> | <i>0.0</i> | <i>\$900,000</i>   | <i>\$0</i> | <i>\$0</i>           | <i>\$4,900,000</i> |          | Row A + Row B      |
| D  | Marketing and Outreach Efforts                     | \$100,000          | 0.0        | \$100,000          | \$0        | \$0                  | \$0                | 0.00%    | See narrative      |
| E  | <b>Total Request</b>                               | <b>\$5,900,000</b> | <b>0.0</b> | <b>\$1,000,000</b> | <b>\$0</b> | <b>\$0</b>           | <b>\$4,900,000</b> |          | Row C + Row D      |

| Table 2.2<br>Summary by Initiative<br>FY 2022-23 |  |             |            |              |            |                      |               |          |                    |
|--|--|-------------|------------|--------------|------------|----------------------|---------------|----------|--------------------|
| Row  | Item   | Total Funds | FTE        | General Fund | Cash Funds | Reappropriated Funds | Federal Funds | FFP Rate | Notes/Calculations |
| A  | Health Disparities: Data Aggregation and Reporting | \$0         | 0.0        | \$0          | \$0        | \$0                  | \$0           | 90.00%   | One-time funding   |
| B  | Health Disparities: Provider Outreach and Training | \$0         | 0.0        | \$0          | \$0        | \$0                  | \$0           | 50.00%   | One-time funding   |
| C  | <i>Subtotal Health Disparities Funding</i>         | <i>\$0</i>  | <i>0.0</i> | <i>\$0</i>   | <i>\$0</i> | <i>\$0</i>           | <i>\$0</i>    |          | Row A + Row B      |
| D  | Marketing and Outreach Efforts                     | \$0         | 0.0        | \$0          | \$0        | \$0                  | \$0           | 0.00%    | One time funding   |
| E  | <b>Total Request</b>                               | <b>\$0</b>  | <b>0.0</b> | <b>\$0</b>   | <b>\$0</b> | <b>\$0</b>           | <b>\$0</b>    |          | Row C + Row D      |