Health Equity Plan Update Presentation

Closing the gap to address disparities and improve health care outcomes for Health First Colorado and Child Health Plan Plus (CHP+) members

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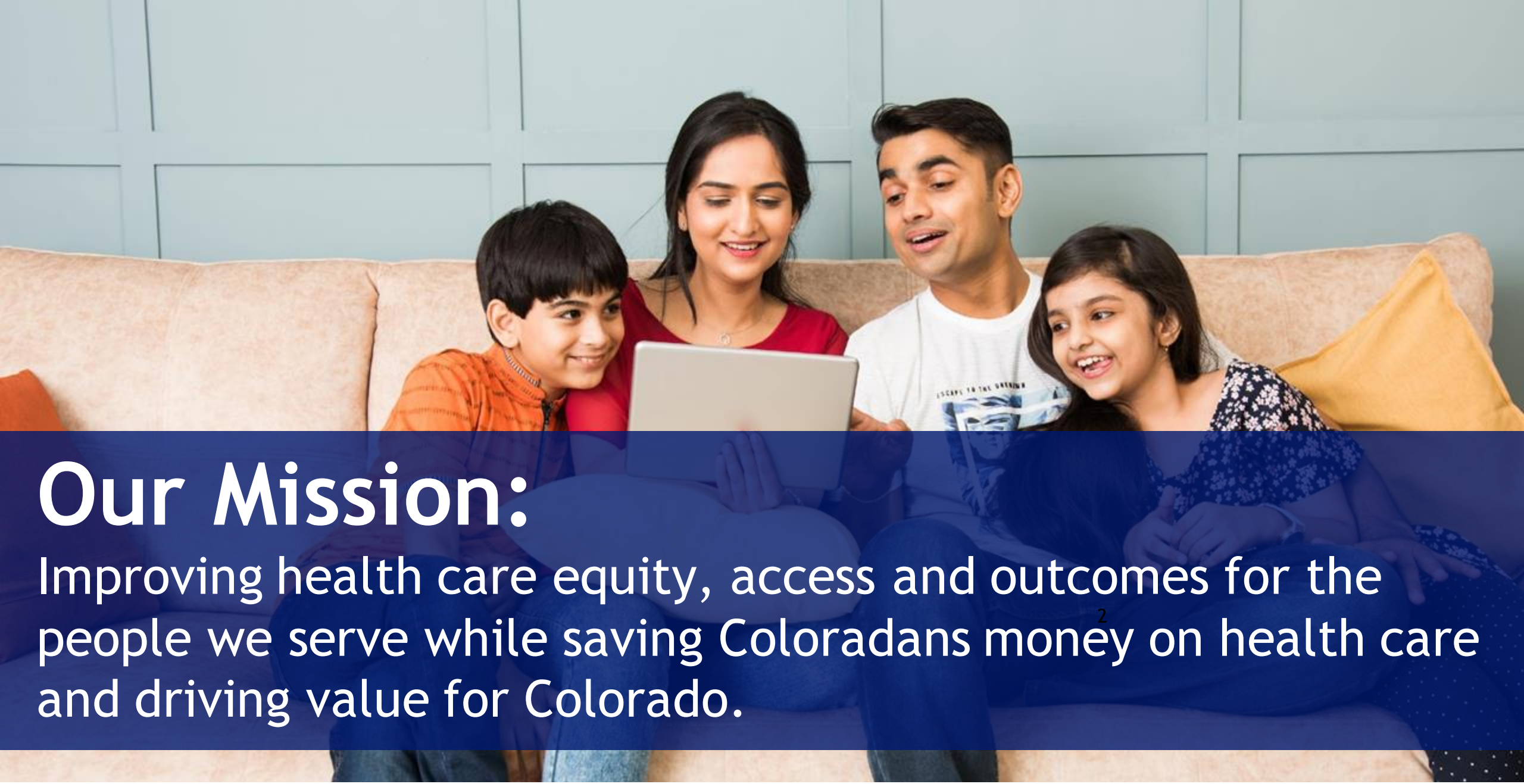
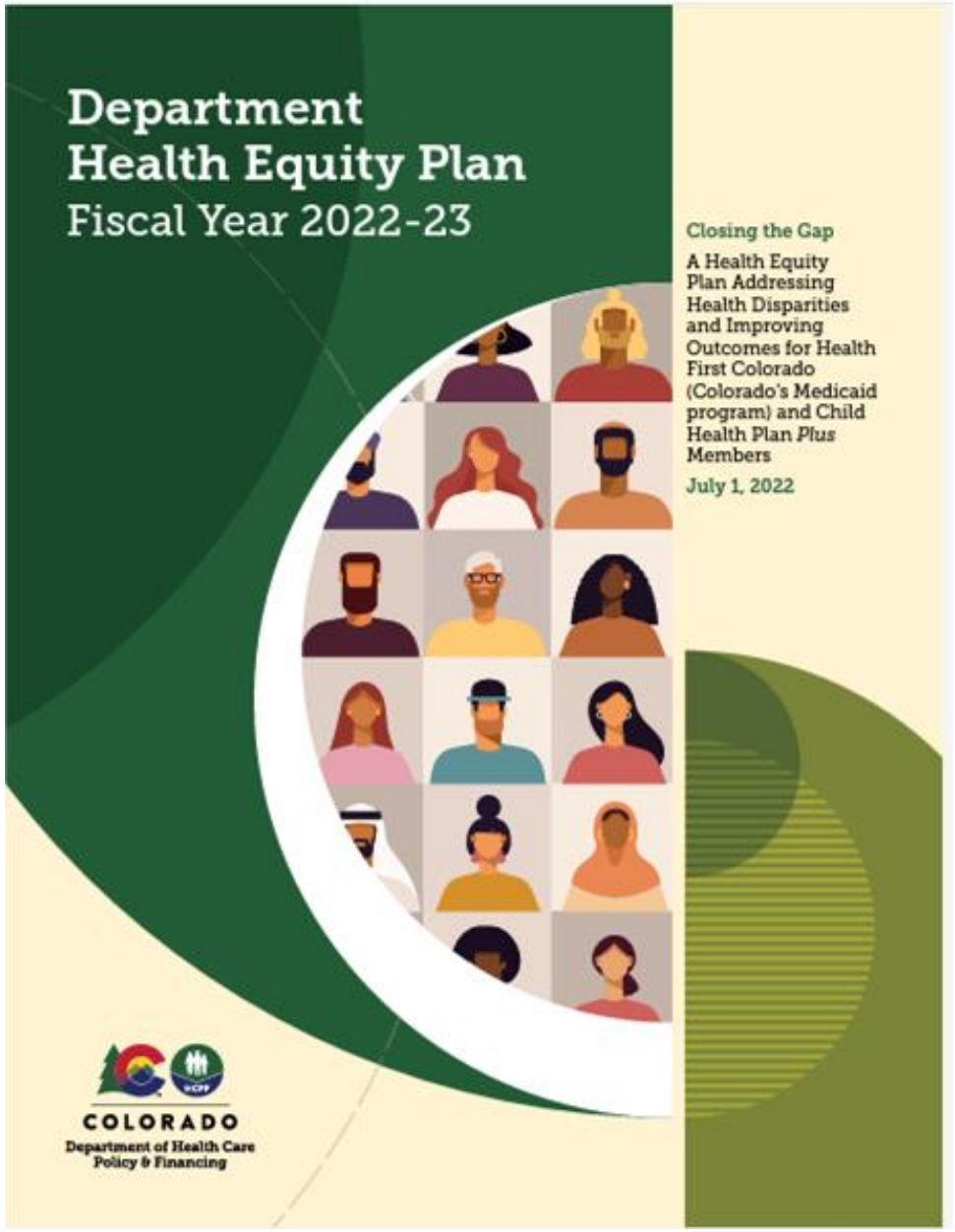


Our Mission:

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

COLORADO
Department of Health Care Policy & Financing



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 due to the Department December 31, 2023
- Statewide Health Equity Task Force (convening since July 2022) - Recommendations to HCPF by Q1 2024
- Health Equity Public Town Halls (~2000+ stakeholders, On track for 18 by October 2023)
- The department continues to explore and improve alignment in our policy goals and incentive metrics (Possible changes for FY 24/25)

Applying health equity lens across programs and initiatives

Progress

- Stratified data analytics to identify disparities, Health Equity Dashboard
- Health Equity Plans in RAE/MCE contracts eff. 7.1.22
- Stakeholder engagement: 18 health equity public meetings, >2,000 stakeholders participating by Oct. 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
- Utilize CMS core measures in focus areas
- Cultural responsiveness and member experience

Additional Health Equity Priorities

Health Equity Priorities

In addition to current health equity short term and long term goals and projects (*see plan*), the Department will move forward with the following 7 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

Concept 1: Changes to Medicaid Application

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

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

Concept 2: Spanish-Speaking Maternity Advisory Council (MAC)

- Inform policy for pregnant and birthing people who speak Spanish
- Help identify what is working
- Provide recommendations to help improve member experience
- Focus on Prenatal and postpartum access to quality care

Since 2020, The Maternity Advisory Committee (MAC), a group of primarily BIPOC Medicaid members who have experienced a pregnancy on Medicaid, continues to meet and inform Medicaid policy.

- Outcome, impact and measurement of success:
  - Reduced inequities in maternal health across the state
  - The Department is currently working on the logistics and process for recruitment, funding, translation services and facilitation for this group
  - **Current programs, resources or needs:** English-speaking MAC; As this group is developed, they will help inform the Department on challenges, opportunities and policy initiatives in this space

Concept 3: Prescriber Tool, Phase III

- Empower providers with information on prescription drug costs and affordable alternatives for members
- Improve and enhance the utilization of the tool, OpiSafe Module
- Increase outcomes for members and reduce disparities

Enabling providers to prescribe programs not just pills – programs that will address SDOH (such as public benefits programs) and programs that improve health at the root (like Diabetes management and prenatal health). Currently we have just under 11,000 providers using the tool monthly (~48% of Medicaid enrolled providers)

- Outcome, impact and measurement of success:
  - Reduce inappropriate opioid prescribing, patient specific benefit and cost information to prescribers; focuses on affordability and improved service to members
  - **Current programs, resources or needs:** Currently accessible through most electronic health record (EHR) systems; **Tool is not mandatory at this time**; Office of eHealth Innovation (OeHI) and HCPF in the process of phase III bidding; We have designed the Prescriber Tool APM which will give incentive payments from a shared savings pool generated by the tool. It is scheduled to start in July 2023

Concept 4: Comprehensive Behavioral Health Providers

- Improve ability to screen for social determinants of health
- Demonstrate consistent use of validated screening tools
- Referrals to support resources (and in some cases, immediate access to care)

In partnership with Regional Accountable Entities (RAEs), Community Mental Health Centers (CMHC) soon to be called Comprehensive Safety Net Providers, must demonstrate consistent use of validated screening tools for social determinants of health (SDOH).

- Outcome, impact and measurement of success:
  - Following a positive depression screen, the agency must provide referrals to supportive services. This will help address real barriers to health and treatment effectiveness, including food security, housing, utility needs, and interpersonal violence. Increased access to timely follow-up services within 30 days
  - Current programs, resources or needs: Identifying additional domains

Concept 5: Chronic Care Management and Preventative Care

- Childhood immunizations
- Adolescent immunizations
- Dental Care and Oral Health
- Improve Diabetes HbA1c Control
- Providers to screen for preventative care

As a contract requirement, Regional Accountable Entities (RAEs) and Child Health Plans (CHP) are exploring disparities in their regional health equity plans, to showcase current work being done, as well as opportunities to develop new innovations to decrease health disparities.

- Outcome, impact and measurement of success:
  - Close racial/ethnicity disparity gaps between highest and lowest performing groups by 30%
  - Increased screening for preventative care
  - **Current programs, resources or needs:** Plans due December 31st (FY23/24)

Concept 6: Equity Study for People with Disabilities

- Internal Data Analysis
- External Feedback and Recommendations
- Implementation Planning
- Improve access to Home and Community-Based Services (HCBS)

This project would aid in better understanding who receives HCBS in Colorado and what services they receive, where the gaps are, and target outreach to ensure HCBS services are provided to all Coloradans who are eligible

- Outcome, impact and measurement of success:
  - Improve access to long term services and supports (LTSS) for all eligible members
  - Identify disparities beyond White, English speaking members who are more likely to receive HCBS services
  - **Current programs, resources or needs:** Stakeholdering currently in process; Sustainability Plan: Upon completion of the Equity Study, the Department will consider the options to operationalize inclusion efforts.

Concept 7: Tribal Relations and Health Study

- Research and stakeholder interviews
- Explore Medicaid best practices, challenges and opportunities
- Focal point to supporting health care access and outcomes for Tribal Nations and American Indians/Alaska Native enrollees.

This study will look into specific areas of best practices, such as benefits, delivery system, eligibility, care coordination and other areas that impact access and outcomes for Tribal members with a large focus on exploring how other state Medicaid programs serve this population.

- This information will be used to inform future efforts to improve Colorado Medicaid's support and focus on disparities this population experiences, who has suffered from historical traumas and inequities that the Department is committed to addressing.

Health Equity Dashboard

Internal Health Equity Dashboard

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

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

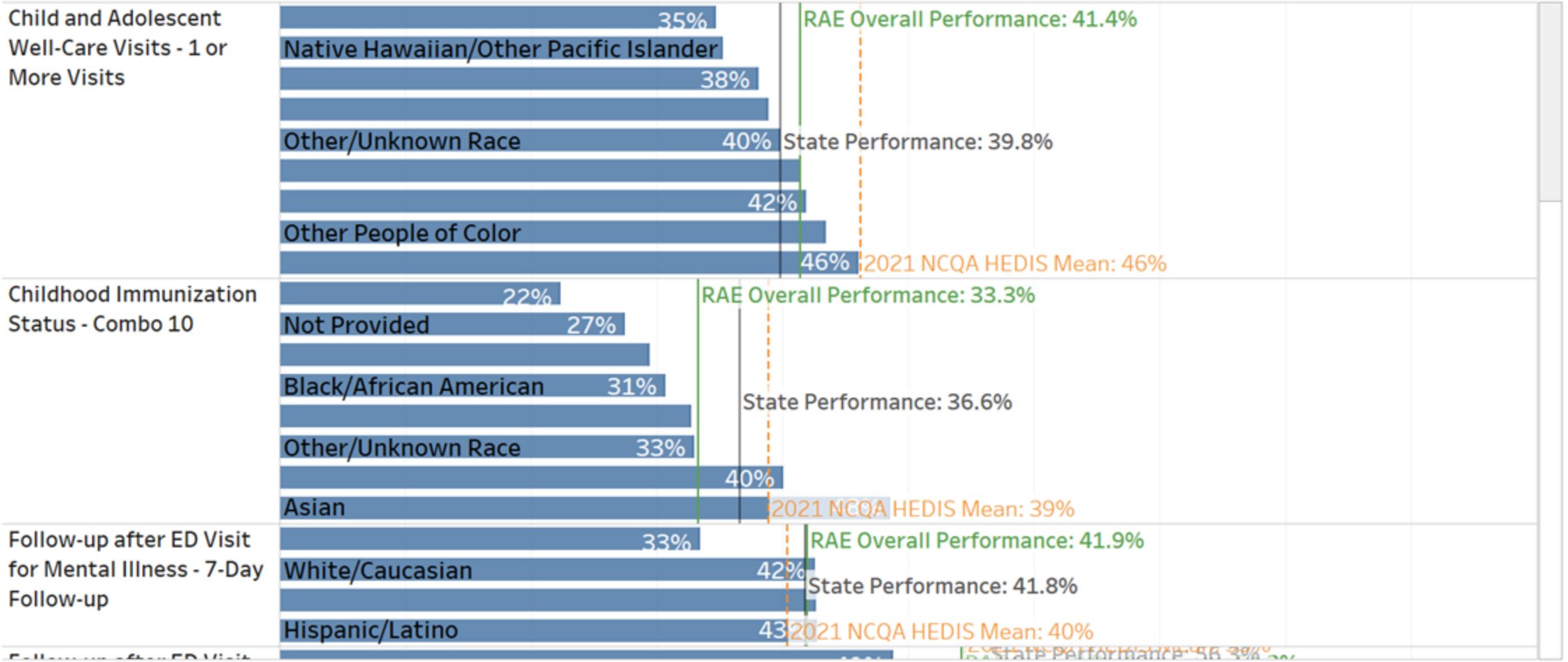
The following measures will be included in the future:

- **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:	Member Race/Ethnicity Sele..	Select Reporting Start Date of 12 Month Reporting Period 1/1/2022	Filter Denominator Count From 30

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



Dashboard Demo (Time Permitting)

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

Community Engagement

Task Force

- 60+ Ambassadors across the state; 5 workgroups
    - Access to Care, Prevention, Behavioral Health, Maternity, Vaccinations
- Provide specific recommendations to the Department and engage in health equity-related initiatives and policy. Due Jan/March 2024

Town Halls

- 18 focused public stakeholder events in the community by October 2023
    - ~2,000 stakeholders, target populations include Black/African American, Asian American Pacific Islander, Disability, Hispanic/Latino, American Indian/Alaska Native

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/MCE's 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 provide 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 and identify additional gaps and develop targeted interventions

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

2025 — ACC 3.0

Health equity will be embedded in ACC 3.0 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; **Propose 7 additional HE Measures**

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 as well)
  - 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

Thank you!

Contact Info

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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 behavioral health 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 alternative payment model (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: ▪ Analyze data in collaboration with RAE/MCO partners to identify disparities (race/ethnicity, age, gender, language, disability) and identify priority populations ▪ Inventory the percent of members with diabetes enrolled in RAE diabetes programs ▪ Continue to improve data quality by increasing access to provider lab data and improving provider documentation of services provided and level of disease control ▪ Collaborate 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 Black, Indigenous, People of Color (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 2nd 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