COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

September 15, 2021

Program Improvement Advisory Committee (PIAC)
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

RE: Recommendations on Equity and Performance Measurement from the Performance Measurement and Member Engagement (PMME) Subcommittee

Dear PIAC Members and Department Leadership:

PMME co-chairs and voting members respectfully submit the following set of recommendations for your consideration. These recommendations are the result of a six-month exploratory initiative on health equity and performance measurement. Contributors to this work include RAEs, providers, Health First Colorado members, subject matter experts, community stakeholders, and students from the University of Denver.

In December 2020, PMME decided to dive deep into one performance measure to understand and identify disparities and opportunities for improvement. Behavioral health – specifically, depression screenings and follow up care – was selected for the following reasons: (1) depression would comprehensively cover all subpopulations as opposed to a more narrowly focused measure; (2) literature suggested disparities and differences exist across subpopulations with opportunities for improvement; (3) the COVID-19 pandemic and civil unrest in 2020 made this topic timely; and (4) RAEs were already working on this measure through their Performance Improvement Projects so existing efforts could be leveraged.

From January through June 2021, PMME performed the activities listed below.

- PMME worked with Department staff to disaggregate performance measure data by race, ethnicity, age, gender, disability status, and other identities. The focus was on depression screenings and follow up care with a behavioral health provider, but PMME also looked at disaggregated data for behavioral health access and positivity rates for depression screenings.
- After exploring this data, the group then developed a journey map that illustrated a step-by-step process of accessing depression-related mental health services through the lenses

of Health First Colorado members, providers, and RAEs. Potential gaps in the system were identified, especially around referrals to follow up care.

- At that point, there were some clear disparities, but generally there were more questions than answers. The data did not always reflect the community narrative or the national literature. Subsequently, the group partnered with the University of Denver to conduct qualitative research with primary care practices serving Medicaid members. A class of doctoral clinical psychology students reviewed existing best practices, interviewed providers, reviewed process maps, and developed a set of recommendations for improving mental health equity for the Medicaid population.

At the conclusion of these efforts, PMME determined that the quality of data on depression screening and follow-up care is too low to continue pursuing opportunities to improve health equity for this specific performance measure. The reason for the low data quality is that the Department's measure does not fully capture the number of screenings completed in reality due to billing practices. For example, federally qualified health centers are reimbursed with an encounter rate so they do not bill for individual depression screenings. With fewer screenings appearing in the Medicaid data, the follow up rates were also low. Additionally, the measure excluded members who had not been in for a well visit in the most recent 12 months, further reducing the population size. In light of these discoveries, PMME learned a great deal about how performance data can be improved or evaluated differently to support health equity. The recommendations below reflect what was learned and could be applied across all performance measures, including the measure selection process, over the next few years.

Recommendations

#1: Disaggregate all performance measures by demographics by January 1, 2022. At a minimum, disaggregate each measure by race/ethnicity, language, disability status, age, gender, and geography (rural, frontier, urban). Baseline data should also be disaggregated so that the equity implications are clear from the start.

Data disaggregation is an essential first step in understanding disparities among subpopulations. A RAE could be achieving a performance measure for the overall population, yet performance for a subgroup could be lagging significantly or the gap between the highest and lowest performing subgroups could even be widening. By disaggregating data, the Department, RAEs, and providers have the opportunity to understand which subpopulations are driving performance improvement and to intervene to support the subpopulations that are lagging behind.

Performance measures referenced in this recommendation include the Key Performance Indicators, the Behavioral Health Incentive Program (BHIP) measures, Performance Pool measures, and the Alternative Payment Model (APM) measures. Disaggregated data should be available to the public (posted online) and kept up-to-date. The presentation of the data

should allow for intersectional views, such as looking at performance by race and gender together. Data should be disaggregated for all results as well as the baseline data, so that the starting point is clear.

PMME would like to see data disaggregation be a priority of the Department. If January 1, 2022 is not possible, then before the next fiscal year (July 1, 2022) is ideal.

#2: Before selecting new measures or modifying existing measures, the Department should analyze whether specific groups of members are excluded from the base population and what impact that could have on health equity. The Department should also conduct a one-time analysis of members who do not meet continuous eligibility requirements to identify the demographics and health needs of these members and the equity implications of their exclusion.

There may be multiple reasons why groups of Health First Colorado members are excluded from a performance measure. Examples:

- A group of people are filtered out due to some criterion not being met. For instance, the BHIP depression screening and follow up measure filters out anyone who did not have a well visit within the last year. In this situation, people who are less likely to utilize services, such as members of color, would be excluded.
- Most performance measures have continuous eligibility requirements, especially national measures that are the gold standard of performance measurement. Groups of members who are more likely to churn on and off Medicaid, such as people who are housing unstable, would therefore not be a focus of RAE quality improvement efforts.

To the extent possible, the Department should avoid filtering out members when it is not necessary (example 1 above) to achieve a broader and more inclusive performance population. If members are filtered out, the Department should make the case for why this is necessary.

In instances in which continuous eligibility requirements are in place, the Department should name the excluded subpopulations, at a minimum. Even if they cannot be formally included in the measure, it is important to identify who is excluded, why, and opportunities to include them in performance efforts in other ways. This step is critical for supporting transparency and understanding of who performance is and is not targeting.

PMME recommends that the Department conduct a one-time analysis of members who tend to be excluded through continuous eligibility requirements across all measures and use that data to inform and improve more equitable quality improvement efforts overall.

#3: The Department should evaluate the health equity implications for each performance measure, ideally in advance of implementing a measure. This information should be made available in the annual quality report that will be public-facing.

The Department should identify the disparity or disparities that exist for each performance measure, which subpopulations are most impacted, the magnitude of those disparities, and confirm that there are actionable steps that can be taken to ameliorate the disparities. In

other words, there should be opportunities for change, either through the implementation of evidence-based practices or by trying innovative or promising approaches. There are sometimes instances in which change is not under the control of RAEs and providers, so it is important to be mindful of where and how we incentivize performance.

The Department should make this information known to stakeholders in the annual quality report and also before any new measure is selected for implementation.

#4: If one RAE is a high performer and rigorous evidence is available for their intervention, then the Department should require that other RAEs implement the intervention under the premise that there is sufficient reason to believe it may lead to better health outcomes for Health First Colorado members.

If an approach is evidence-based and has demonstrated significant positive impact for a specific population or subgroup, then that practice should be scaled across RAEs to ensure that what works is actually implemented and can benefit more members sooner.

There are varying levels of what is considered "evidence-based" ranging from systematic reviews and randomized controlled trials (most rigorous) to case studies and expert opinion (least rigorous). If evidence meets the highest tier of standards, then the Department should require that RAEs adopt that approach. At less rigorous levels, approaches can be encouraged but not required.

To facilitate learning and scaling, PMME suggests that the Department establish multiple RAE learning collaboratives each year (bi-annually or quarterly) focused on one or more measures. The objective of these collaborative sessions would be to dive deeper into what is working and not working and to allow for follow up as RAEs implement, test, learn, and ideally, replicate. The Department should weigh in on what forum and frequency are best and how information can be shared with stakeholders. PMME is particularly interested in having similar conversations with the Department and the RAEs and could support this work.

#5: Tie performance dollars to disparity reduction in the future.

PMME views financial incentives for disparity reduction as essential to achieving health equity goals within performance measurement. By July 1, 2023, the Department should tie performance incentive dollars to at least two measures. This means that RAEs would not earn full payment on those measures unless they achieved the disparity reduction goals set by the Department. Theoretically, the disparity reduction would focus on one or more groups that are lagging behind on a measure. At this time PMME is not suggesting a methodology for setting targets; rather, PMME recommends that for a given measure, half of the incentive dollars are tied to disparity reduction and half to overall improvement. This will incentivize RAEs to improve performance on the measure as a whole (all populations), while also elevating a lower-performing subgroup.

#6: All RAEs should be required to actively support providers to ensure that 100% of providers screen for suicidality and have the training and tools necessary to engage in safety planning for members who screen positive.

This final recommendation is not specific to performance measurement. Of the many equity intervention points that the DU student team identified, PMME feels that suicide prevention is an area of opportunity. In particular, providers utilize many different depression screening tools, so it is critical that every provider have at least one tool that is consistently used to assess for suicidality. RAEs should also be required to support providers in suicide safety planning, share resources (e.g., Zero Suicide Framework, Suicide Prevention Resource Center), follow up to ensure they are being implemented, and offer training when needed to ensure providers feel competent to discuss suicide with patients. PMME members are particularly concerned about whether a member gets the support they need when a warm handoff or immediate connection to a behavioral health provider is not available.

PMME requests PIAC's assistance in how best to move forward on this recommendation since suicide prevention is not an ACC performance measure. One option could be to start on a smaller scale by requiring RAEs to support a targeted cohort of providers -- those most likely to see patients in the months prior to suicide -- to help with their adoption of Zero Suicide practices, similar to what hospitals are required to do in the HQIP program. PIAC may wish to involve the Behavioral Health and Integration Strategies (BHIS) PIAC subcommittee to weigh in on next steps.

Thank you for your thoughtful consideration of these recommendations. Please direct any follow up questions, concerns, or comments to the PMME co-chairs named in the signature below.

Sincerely,

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Christina Suh, PMME Co-Chair, csuh@phreesia.com

cc: Matt Sundeen, Jeff Eggert, Tracy Johnson, Anne Saumur, Ann Marie Stein, Nicole Nyberg, Sally Langston