The Advancing Health Equity: Leading Care, Payment, and Systems Transformation Learning Collaborative

Frequently Asked Questions

Updated as of 4/09/19

General

1. Who do I contact for questions about the Request for Applications (RFA)?
    a. You can contact our program office via email at info@solvingdisparities.org or on our toll free phone line at 1-866-344-9800. We are available during the hours of 9AM-5PM CDT. The program office will respond to questions within two business days of receipt.

2. Does this project provide any grant funding?
    a. This project is not a grant, and thus no grant funds will be dispersed. It is a Learning Collaborative that brings together a unique group of experts in the field of payment reform, health equity, and health disparities. Teams will receive technical assistance and reimbursement for travel to the required in-person meetings (for up to four persons from each team).

3. We don't have prior history of addressing disparities but we have identified disparities and want to address them. Can we still apply?
    a. Yes. All organizations in the applicant team are required to demonstrate a commitment to identifying and reducing disparities in health care processes and/or outcomes. A prior history is not required for application.

4. Are all entities required to attend the in-person meetings in Chicago?
    a. One representative at least from each applying entity should attend the meeting in Chicago.

Submitting the Application

5. What organization on the team should be the lead applicant?
    a. It is up to the applicant team to decide which organization will take the lead on submitting the application and being the primary contact during the application process. Note that the lead applicant organization will also need to

designate one member of their organization to serve as the Learning Collaborative team lead. The Learning Collaborative team lead will be responsible for convening the different organizations and participants throughout the Learning Collaborative process. Based upon initial inquiries, we anticipate that for most applicants the Medicaid managed care organization will be taking the lead. However, in some cases, it would be appropriate for the state Medicaid agency to take the lead. Either leader would be fine.

6. Should each question be answered by each organization individually and then compiled into one answer?
    a. Yes, that would be the suggested approach. If there is a situation where the question is not relevant to an organization on the team, please indicate the reason for that.

7. Who within each organization needs to sign the letter of agreement?
    a. The signatory should be someone who has the authority within the organization to ensure that proper resources will be committed to the project. A more formal memorandum of understanding will not be needed until after final selection of the teams.

8. Can we submit a paper application?
    a. No. All applications must be submitted online at https://is.gd/AHEapplication. Your applications must include the application form, cover letter, responses to the RFA questions, a readiness assessment for each organization, and any appendices requested throughout the RFA document. Full application instructions can be found at http://www.solvingdisparities.org.

9. I'm having trouble submitting the application. Who should I contact?
    a. You can contact our program office via email at info@solvingdisparities.org or on our toll free phone line at 1-866-344-9800. We are available during the hours of 9AM-5PM CDT. The program office will respond to questions within two business days of receipt.

Readiness Assessment

10. How many people from each organization are supposed to complete the Readiness Assessment?
    a. Each organization that is part of the applying team should complete one Readiness Assessment. The person(s) completing the Readiness Assessment should be able to represent the entire organization and to provide responses that take into account the various departments, culture and processes of the organization. The number of staff who work on the Readiness Assessment will vary by site.

11. What if some of the organizations within our applicant team have a high score for the Readiness Assessment, and some have a low score?
    a. Organizations within a Learning Collaborative team will potentially be at different stages of readiness. This is not unusual, and consensus on all items is not required. As a reminder, each organization should submit their own Readiness Assessment.

Team Dynamics

12. Is there a limit to the number of MMCOs that can participate on the team?
    a. There is no specific limit on the inclusion of multiple MMCOs other than the resources available on the project office to provide sufficient technical assistance. If the applicant team has a compelling rationale for including more than one Medicaid Managed Care Organization on the team, that should be explained in the application and that will be taken under consideration by the reviewers.

13. What the expected role of the state Medicaid agency in the Learning Collaborative team?
    a. The role of the State Medicaid agency is to take part in the Learning collaborative training sessions, to be a participant in the design of the initiative, and to participate in all virtual and in-person meetings. To the extent that the design of the initiative could benefit from changes or modifications in standard operating procedures at the Medicaid agency level, the learning collaborative team members representing the Medicaid agency would be tasked with involving any key agency personnel in the design process. Some state Medicaid agencies might be ready to implement changes immediately, and others might be better prepared to incorporate changes during upcoming contracting cycles with MCOs.

14. Does the timing of generating and initiating contracts between partner organizations (e.g., between a state Medicaid office and a health plan) influence whether or not we can participate in the learning collaborative?
    a. There are no eligibility requirements regarding contract status or activities (e.g., negotiation and contract generation) between organizations on the proposed Learning Collaborative team. The Learning Collaborative will begin with a kick-off meeting October 2-3, 2019. Training and program design activities of the collaborative will take place from October 2019 through April 2020. Programs will begin implementation in May of 2020. Please see the timeline in the RFA for more details.

       Some Learning Collaborative teams may wish to incorporate equity-focused requirements and guidelines in future contracts as part of their Learning Collaborative program design and implementation. We understand that

negotiation and contracting activities and timelines are complex and their timing may not align with the timeline of the Learning Collaborative. We encourage applicants to contact us to discuss specific questions they might have about their contracting activities and timeline.

15. Which organization is expected to implement the payment reform?
    a. Given how much variation in VBP approaches exist in Medicaid, we leave it to the teams to decide the approach that makes the most sense. In some states, particularly those that delegate VBP to their MCOs, it may be the MCOs that implement the payment reform. In other states, such as those that already have a statewide payment model in place or are planning to implement one, the team may choose to modify that model at the state level.

16. Our State Medicaid Director is new—can we still apply?
    a. Yes, you can still apply.

Data

17. When will we know what type of data you want?
    a. Data should be able to evaluate whether or not the efforts of the payment reform and care transformation were successful. While we can offer you guidance during the design and implementation phase, we cannot know beforehand what data will be most appropriate to collect.

18. We can only provide data in aggregate form—is this sufficient?
    a. If data in aggregate form allow you to sufficiently answer whether or not the payment reform was successful, then yes.

Disparity and Target Population

19. Do you have a preference for which type of disparity we select to address?
    a. No—the disparity selected should be informed by the data and the goals of the organizations on the team.

20. Do you have a preference for target population?
    a. No—the target population should be informed by the disparities identified in the data and the goals of the organizations on the team.

21. What constitutes a "sufficiently large and diverse" population?
    a. This will vary depending on the details of the payment reform model and the proposed care transformation intervention(s). The main consideration is whether the health care delivery organizations have enough patients in their target population(s) to demonstrate impact on health and/or health care disparities. It is our hope that Learning Collaborative teams will be able to make informed decisions (post implementation of their programs) about

which aspects of their projects were successful and the potential of sustaining them. Applicants are welcome to work with evaluators, statisticians, or other appropriate professionals in program evaluation to address questions about their overall proposal design, whether they have enough patients in their target population(s) to collect relevant data, their data collection procedures, and any plans for analyses they would like to conduct on their own. Advancing Health Equity will also be able to provide assistance as teams address these questions during the Learning Collaborative.

Payment Reform

22. Can the payment reform be implemented at a provider group, hospital, or clinic level?
    a. Yes, but it shouldn't be a provider-led and provider- implemented intervention that doesn't require the cooperation of the other stakeholder group in some fashion. The goal of the AHE project is to identify and address those situations where lack of alignment across the stakeholder groups creates barriers to health equity

23. Can the initiative involve expanding or working on a current Medicaid project?
    a. Yes

24. Can a different type of initiative besides a payment reform be implemented?
    a. The initiative must involve a different way of financing care than traditional fee-for-service. Example payment models that teams might eventually utilize include, but are not limited to: shared savings arrangements, population-based payments, bundled/episode-of-care payments; pay-for-performance linked to quality of care metrics; or patient centered medical homes or similar models that include reimbursement reform linked to clinical performance measurements. In our most recent iteration of the RWJF Finding Answers program, each of the 3 grantees utilized a combination of global or capitated payment and pay-for-performance to support disparities reduction efforts. Click here for more information.

       All that being said, this not intended to be payment reform solely for the purposes of changing payment/costs. Rather, the payment reform is to be implemented in order to support a vision of care transformation to achieve equity - so there is a need to think about payment reform and care transformation together.