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

Frequently Asked Questions – Updated August 3, 2022

Previously updated on July 29, 2022

New questions and revisions since the last update appear in blue font.

Application Questions and Assistance

1. Who do I contact for questions about the Request for Applications (RFA)?
    - You can contact our program office via email at info@solvingdisparities.org. We are available during the hours of 9AM-5PM CDT. The program office will respond to questions within two business days of receipt.
    - Other opportunities to ask questions and gather more information include:
        - Informational Webinar – July 25, 2022, 2:00pm central time. Will be archived on the website by July 28, 2022.
        - Applicant Workshops – July 18 – September 23, 2022. See the RFA website for more information.

2. Are the applicant workshops required?
    - No. The workshops are voluntary but encouraged. Multiple people from your applicant team and participating organizations can attend a workshop. We can answer questions, talk-through your ideas, explore options, and suggest novel strategies and tactics. Please email info@solvingdisparities.org if you are interested in scheduling a workshop session. The program office will respond within two business days of receipt.

3. We did not submit a Letter-of-Intent. Can we still apply for the Learning Collaborative?
    - Yes. However, will are sending the application instructions directly to applicants. Thus, please contact us at info@solvingdisparities.org as soon as possible to let us know that you will apply, and we will send you the necessary information. The program office will respond within two business days of receipt.

4. **How does an organization go about identifying partnering organizations to form one applicant team? Does the Medicaid Agency or MMCO typically lead the team instead of health care provider organizations?**
    - MMCOs lead most of the teams in the first Learning Collaborative cohort. However, this is not a requirement and we would prefer a co-leadership approach that shares power across participating organizations.
    - We are happy to meet with you to talk through ideas and brainstorm opportunities for identifying partner organizations and building a team. Please schedule an application workshop session with us by emailing info@solvingdisparties.org, if you are interested.

5. Are you planning any future Requests For Applications?
    - Currently, we have no plans to offer additional requests for applications for future learning collaboratives. However, please contact our program office to indicate your interest in hearing about any additional opportunities that may arise. We will keep your contact information on file.

Eligibility - General

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

2. Is there an expectation or preference for the project to be statewide or can it be regional or local?
    - There are no expectations regarding geographic coverage.

3. What's the difference between a Medicaid Managed Care Organization and a Health Care Provider Organization?
    - "Health care provider organization" and "health care provider or system" refers to an organization that directly delivers health care to Medicaid members.

4. We are both a Medicaid Managed Care Organization as well as a health care provider organization. Can the MCO as well as the health care provider organization participate as distinct members of the Learning Collaborative team?
    - If your organization has a line of business that directly provides health care to patients and a line of business that operates a managed care insurance plan,

each of those business units can be considered a separate participant in the Learning Collaborative team, as long as the payment arrangements between the insurance plan and the health care provider sides of the company are in keeping with those typical to the industry. In other words, the payment arrangements that you would implement through your Learning Collaborative initiative could be replicated by non-jointly owned plans and providers.

5. How many health care provider organizations does a team need to be a part of the Learning Collaborative, and can they be owned by the same organization?
    - The RFA requires at least two health care provider organizations to participate as team members of the Learning Collaborative. Health care provider organizations must directly provide health care to patients. Applicants can propose two health care provider organizations that are the same setting (e.g., two FQHCs at different locations). Applicants can also propose two health care provider organizations that are owned and/or operated by the same company. For example, a hospital system with both hospitals and outpatient clinics could include a main hospital and one outpatient clinic as their two health care provider organizations.

6. Does the timing of generating and initiating contracts between partner organizations (e.g., between a state Medicaid office and a health plan) influence whether we can participate in the learning collaborative?
    - There are no eligibility requirements regarding contract status or activities (e.g., negotiation and contract generation) between organizations on the proposed Learning Collaborative team at the time of application.
    - 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.

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

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

Eligibility – Medicaid Member/Patient Populations and Health Conditions

1. Do you prefer which type of health or healthcare inequities that we address? Do you have a preferred patient or Medicaid member population that will be prioritized by the initiative?
    - No—the health equity area(s) of focus and the populations served by your team's LC initiative should be informed by quantitative and qualitative data internal and external to the participating organizations, the goals of the Medicaid members and organizations on the team, and ideally community-based organizations that serve those living with the prioritized health and healthcare inequities.

2. Your materials state the AHE and the LC operate with an anti-racist approach and activities. Does this mean that the LC teams must focus only on racial/ethnic health and healthcare inequities?
    - No. LC teams can select health equity priorities based on any population demographic including, but not limited to, race, ethnicity, age, sex, sexual orientation, gender identity, geography, and payer status.
    - Racism impacts all aspects of health and healthcare, and people hold multiple identities that are afforded varying levels of social power and capital. It is important to consider these factors in the design of any care or payment transformation initiative. For example, an LC team should work to identify and address the unique experiences of LGBTQ+ people of color in a broader initiative to reduce health and healthcare inequities experienced by LGBTQ+ Medicaid members.

3. What constitutes a "sufficiently large and diverse" population?
    - 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/members in their priority 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 initiative design, whether they have enough patients/members 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 assist teams as they address these questions during the Learning Collaborative.

Eligibility – Payment Reform

1. Can the payment reform be implemented at a provider group, hospital, or clinic level?
    - 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

2. What types of payment models or reforms eligible?
    - The LC is not intended to advance payment reform solely for the purposes of changing payment/costs. Rather, LC teams will be asked to create payment models to support care transformation that is designed to advance health and healthcare equity for one or more specific Medicaid member populations and health conditions. Thus, there is a need to think about payment reform and care transformation together.
    - 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 and here for key lessons learned.

Funding

1. Does this project provide any grant funding?
    a. This project is not a grant, and 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, quality improvement, and diversity, inclusion, and equity.
    b. Teams will receive technical assistance and reimbursement for travel to the required in-person meetings (for up to ten persons from each team). See "Learning Collaborative Timeline and Meetings" for more information.

Learning Collaborative Timeline and Meetings

1. Are we making a two-year commitment to this collaborative if our application is accepted?
    - Yes. The RFA document outlines the overall timeline and activities of the project. In addition to meetings with individual LC teams and cross team learning

sessions, AHE will host the following convenings for all Learning Collaborative participants (exact days/times to be announced):

- November 2022 – Virtual (Orientation Session)
- January 2023 – Chicago, IL
- October 2023 – Virtual
- October 2024 – Chicago, IL

2. Is attendance at the virtual convening and the two in-person convenings in Chicago for all team members? How many spots are available and who is required to attend? Is this paid for as part of the collaborative?
    - LC meetings are for all team members.
    - Ideally, at least one member from each of the participating organizations will attend the in-person meetings (e.g., the state Medicaid agency, MMCO, each healthcare delivery organization), including Medicaid member team partners. If your team is partnering with community-based organizations, it would be ideal if they also have representatives in attendance.
    - We will provide travel funding for up to ten members of each team to attend the in-person meetings.
    - We can work with each team after they have been selected to help them decide which of the people on their team should attend each meeting.

3. Are we expected to fully implement a health-equity integrated care and payment transformation by October 2024?
    - If they fully participate in the program, all teams will make significant strides to reach their goal of implementing a health-equity integrated care and payment transformation within the LC timeline. Teams are not expected, however, to fully implement their entire program by October 2024. We expect that each team will consistently engage with the LC and work to implement a health-equity integrated care and payment transformation, even if implementation occurs after the LC formally ends.
    - It is important for leadership at participating organizations to understand that unraveling and addressing health and healthcare inequities is complex, partly because the process needs to be tailored for each organization in the collaborative, as well as Medicaid members and their communities. The LC is not distributing "boxed" or standardized interventions that can be rolled out similarly for each LC team. The Roadmap to Advance Health Equity (the approach utilized by the LC) is a process of discovery and design that does not easily lend itself to pre-determined, strict timelines.
    - The experiences of LC teams in the first AHE cohort vary widely. How far and fast teams progressed in their workplans was rarely an indication of how hard they worked or whether they could be considered successful from a specific

perspective. Some teams took longer than they had hoped to progress because unexpected and exciting opportunities to expand their scope of work presented themselves well into their time in the LC. Thus, while some of the teams in the initial cohort have yet to implement their initiatives, they have the potential to make a larger reduction in health and healthcare inequities when they do.

- Advancing health and healthcare equity is long-term, never-ending work. One of our main objectives is that each LC team will learn key knowledge, skills, strategies, and tactics that will enhance their ability to individually and collaboratively advance health and healthcare equity in all their activities, not just those related to the AHE LC.

4. **How often do Learning Collaborative participants meet? Are they virtual or in-person meetings?**
    - Please see the Appendix on page 14 of the RFA for detail on Learning Collaborative activities and expected time commitment.
    - Most meetings are virtual. However, the goal is to have two in-person convenings (assuming it will be safe to do so): one in 2023 and one in 2024. See the Appendix for additional information.
    - While the chart in the Appendix includes estimates for time commitment to organized meetings and events, the majority of the work and time needed to advance equity will occur **outside** of these meetings.

Antiracism

1. Why does the AHE LC focus so much on antiracism? Doesn't it cause unnecessary controversy in these politically charged times and turn-off people who would otherwise benefit from participating in the LC?
    - The majority of past efforts have avoided directly naming the racism that is present in all aspects of the healthcare system, yet racial and ethnic health and healthcare inequities continue despite decades of significant resources invested in eliminating them. While there have been incremental advances, bold approaches to accelerate progress are necessary.
    - Health inequities will persist for People of Color and they will continue to receive substandard care unless we explore ways to eradicate the gaps. Advancing Health Equity is part of a movement to ensure equitable care for people of all races and backgrounds. It is no longer a question of why, but rather how to address systemic racism as a foundational aspect of health equity.
    - Directly naming and eliminating internal, interpersonal, and systemic racism can be difficult and challenging work. However, it is just as important to realize that taking anti-racist action can also build bridges, bring us closer together, improve our relationships, expand our skills, and energize our work.

- The topic of racism can raise difficult and charged conversations, but we strongly believe they are worth having because they are necessary to eliminate inequities.

AHE does not have all the answers; we are committed to learning with our LC participants. We are eager to partner with LC participants who genuinely want to try and eliminate racial and ethnic health and healthcare inequities.

General

1. How is the AHE Learning Collaborative different from others?
    a. This is not a one-size-fits-all approach to health and healthcare equity. The AHE Learning Collaborative utilizes the *Roadmap to Advance Health Equity* as the core of its training and technical assistance programming. The Roadmap guides teams as they develop equity-focused care and payment transformation models tailored to the specific circumstances of the participating organizations and the patients and communities living with the prioritized inequities. We strive to meet teams where they are and support them in a way that makes the most sense for them and the patients/members that they serve.

2. The AHE approach is more comprehensive because, in addition to supporting the technical components of care delivery and payment transformation to reduce health and health care inequities, it focuses heavily on the culture change within teams and organizations that is necessary for success.

3. What is the expected role of the state Medicaid agency in the Learning Collaborative team?
    - 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.

4. Which organization is expected to implement the payment reform?
    - 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.

Data

1. What type of data do you want?
    - Data should be able to evaluate whether the LC team initiative was successful, particularly whether the prioritized health and healthcare inequities were reduced or eliminated. While we can offer you guidance during the design and implementation phase of the LC, we cannot know beforehand what data will be most appropriate to collect.

2. How much data support would we need to complete the application?
    - We request that each organization participating on the team provide demographic information about the population/members served so that we can better understand how your team can reach specific Medicaid member populations experiencing health and healthcare inequities (e.g. race, ethnicity, socioeconomic status, sexual orientation, geography).
    - It is ok if not all of this information is available. Please include what you have. The AHE team is also willing to provide support to help answer questions about how to acquire data during application workshop sessions. Please schedule sessions by emailing info@solvingdisparties.org.

3. We can only provide data in aggregate form—is this sufficient?
    - If data in aggregate form allow you to sufficiently answer whether the payment reform was successful, then yes.

4. What kind of data sharing agreements will we need?
    - The important thing will be to make sure all entities/organizations are able to meet their legal obligations to maintain patient confidentiality and to keep proprietary information protected. Our project staff will not need any individual client-level data.