Application Rubric

The following information provides detailed descriptions, requirements, and preferred elements regarding the six applicant questions found in the Request for Applications, Part IV (Application Questions).

1. Commitment by each organization in the applicant team to achieving health equity for Medicaid enrollees and to identifying and reducing disparities as key measures of progress. Demonstrable readiness to change at each organization.

Required	All organizations on the applicant team are required to demonstrate a commitment to identifying and reducing disparities in health care processes and/or outcomes.
Description	Disparities are defined here as differences in health care processes or outcomes for different demographic groups (e.g., race, ethnicity, language, age, sex, socioeconomic status, geography) that are **served by the health care provider organizations or systems** on the applicant team **(**e.g. minority Medicaid enrollees as compared to non-minority Medicaid enrollees, not Medicaid enrollees as compared to commercially insured populations.)
Preferred for highest score	- Concrete evidence of prior or current commitment by each of the organizations on the applicant team to achieve health equity for all Medicaid enrollees. -Concrete evidence of commitment by each organization on the applicant team to identify and eliminate health and health care disparities. -Inclusion within the application of concrete evidence of commitment to Equity, Diversity, and Inclusion within each organization on the applicant team. -A commitment to share stratified health care process and/or outcome data that illuminates the successes and challenges of the payment and health care delivery reforms implemented during the learning collaborative, as well as cost data.

2. The willingness of each organization in the applicant team to adopt payment reform strategies that will support care transformation initiatives focused on health equity.

Required	All organizations on the applicant team are required to demonstrate a willingness to utilize payment reform strategies that support equity-focused care transformations. *[Note: It is not necessary at the time of application to have identified exactly which payment reform strategy the Learning Collaborative team will be using.]*
Description	In order to advance health equity for Medicaid enrollees each Learning Collaborative team must first identify current health and health care disparities and take the necessary steps to understand why they exist in the patient populations and communities served by the health care providers or systems on the applicant team. Only then can the teams understand how health care delivery might be redesigned to address the unique causes of the disparities. And, only after that, can each Learning Collaborative team understand how best to design a value-based payment reform that is specifically structured to support the necessary health care delivery changes. The Learning Collaborative will help each team work through these steps. 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 payments 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. See http://www.solvingdisparities.org/reducing-health-care-disparities-through-payment-reform]
Preferred for highest score	- Willingness to use payment levers to support disparities-reduction efforts equity - Potential for significant initiative uptake across organizations and/or patients. -Clear understanding about the need to have health care redesign drive payment reforms (versus payment reforms driving care redesign)

3. Demonstrated recognition by each organization on the applicant team of how social needs and community factors contribute to health disparities.

Required	Each organization on the applicant team must demonstrate commitment to implement a payment reform initiative (or modify an existing one) that supports addressing social needs that play a role in creating or exacerbating the health and health care disparities targeted by the proposed project. This commitment can be demonstrated by describing past activities and/or describing their ideas for potential future activities.
Description	Social determinants and influencers of health contribute to some of the root causes of disparities. Ideally, the Learning Collaborative activities of each team will leverage the community outside of the health care setting in ways that address more upstream social determinants of health. Initiatives can vary from ones that ameliorate the impact of unmet social needs upon individual enrollees' health to ones that target and modify upstream social determinants of health. Examples of initiatives to ameliorate the impact of unmet social needs upon individual enrollees include: • Screening patients for social needs (e.g. food or housing security, drug or alcohol dependence), linking patients to appropriate community resources, and getting information about that referral back from the community partner. • Community health workers visiting the homes of patients with asthma to identify and remediate asthma triggers (e.g., mold, inadequately vented gas appliances). • Partnering with local grocers and a culinary institute to increase the availability of low-cost fresh produce, nutrition education, and healthy cooking classes for patients with diabetes living in food deserts. Examples of targeting upstream social determinants of health include: • State Medicaid agencies or MMCOs partnering with federal, state, or municipal programs to improve the quality and/or availability of affordable housing, improve the quality and/or availability of education and employment opportunities, or improve the quality and availability of safe and welcoming public spaces for exercise. • Providing technical assistance and resources to facilitate the payment of community based social service organizations to provide wrap-around services (e.g., culturally tailored case management for specific chronic illnesses, behavioral health services, supportive housing) to Medicaid enrollees that are closely coordinated with their health care provider(s).

	See https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/ for further reading and clarification of social needs versus social determinants of health. For more research and example interventions using social determinants, visit: The Nonprofit Finance Fund: https://nff.org Aging and Disability Business Institute: https://www.aginganddisabilitybusinessinstitute.org SIREN: https://sirenetwork.ucsf.edu/
Preferred for highest score	History of innovative and successful approaches by the organizations on the applicant team to identify and address social needs caused by the negative impacts of social determinants of health upon individual enrollees and/or taking action to directly address larger upstream social determinants of health. Description of an innovative and viable new idea of how to identify and address the negative impacts of social determinants of health. Demonstrated understanding of the distinction between broadly addressing one or more specific social determinants of health and addressing social determinants of health with an equity lens (e.g., how social determinants of health differentially impact the patients living with the targeted disparity/disparities compared to other patient populations, acknowledging the need to determine if the activities proposed to address social determinants of health might have a differential impact upon various patient populations).

4. Composition of Learning Collaborative Team and plans for engagement of key partners.

Required	Each organization on the applicant team is required to appoint at least one staff member from their organization and a minimum of one backup individual who will have the time and resources to lead the initiative from Sept of 2019 until August of 2021. Each team must describe how they will sincerely and actively engage, throughout the Learning Collaborative, with Medicaid enrollees, families, and/or caregivers, including those who are living with the identified disparities. Each team should also describe if they plan to engage community based organizations.
Description	Each organization on the applicant team must understand the need for dedicated personnel time and resources to maximize their potential to benefit from the Learning Collaborative experience. The chances of success are significantly improved if Medicaid enrollees, family, and/or caregivers, including those living with the identified health inequities, are active and equal participants in diagnosing the reasons for existing disparities and identifying the best initiatives to reduce or eliminate them. Similarly, chances of success are improved if community based organizations are actively engaged as equal participants in the activities of the Learning Collaborative team. For more on patient/family engagement, see: Community Catalyst: https://www.communitycatalyst.org/initiatives-and-issues/issues/community-benefit-and-community-engagement CHOPT for Medicaid: Section 2 of the CHOPT for Medicaid Implementation Toolkit) https://www.medicaidinnovation.org/_images/content/2018-IMI-Childhood-Obesity-Medicaid-Toolkit.pdf
Preferred for highest score	-Past experience of the organizations on the applicant team successfully collaborating for innovation -History of meaningful engagement of Medicaid enrollees, family, and/or caregivers in program development, planning, and/or evaluation [include in an appendix any documentary evidence such as meeting notes or reports] AND a willingness to replicate a similar or improved approach with this project. --History of meaningful engagement of community based organizations in program development, planning, and implementation; AND a willingness to replicate a similar or improved approach for this project.

5. Capacity to identify, measure, and track disparities.

Required	The MMCOs or the health care provider organizations or systems on the applicant team must routinely collect performance data that can be stratified by specific demographic variables at the health care provider organization or system level. Data should be collected for each participating health care provider organization or system (e.g., race, ethnicity, language, age, sex, socioeconomic status). Health care provider organizations or systems must have a large and sufficiently diverse enrollee/patient mix to measure change in disparities over a relatively short period of time or have multiple sites to allow measuring relative reductions in disparities across sites.
Description	The Advancing Health Equity program recognizes that the Learning Collaborative timeline may be too short for health care delivery reforms to result in measurable changes in health care process or outcome measures. In other words, the potential benefits of the Learning Collaborative activities may not be observable through data until after the Learning Collaborative ends. However, it is important that organizations on the applicant team have a way to measure the successes and challenges of their efforts, even if the timeline for such an evaluation extends beyond the end of the Learning Collaborative. Potential stratified performance measures include a mix of process of care and/or outcome measures relevant for the disparity population(s). See NQF Roadmap report for a description: https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx
Preferred for highest score	-Ability to identify the size of target population(s) within the health care provider organizations or systems with the target disparity condition(s). -Addresses multiple health care processes and/or outcomes (e.g., multiple measures related to diabetes such as HbA1c, blood pressure, cholesterol, and patient-reported outcome measures). - Selection of equity-sensitive measures (per NQF Roadmap)

6. Adequacy of the Quality Improvement (QI) infrastructure for each organization on the applicant team.

Required	Each organization on the applicant team must have an adequate quality improvement infrastructure. Additionally, they must have an existing mechanism through which to provide direct technical assistance (TA) at the practice level.
Description	Adequately staffed and adequately resourced quality improvement systems and processes will be key to the success of these care transformation efforts. Examples of TA at the practice level include practice coaches or similar quality improvement consulting services.
Preferred for highest score	Existing quality improvement infrastructure with an equity lens. Recent MMCO experience providing direct TA services to the health care provider organizations or systems on the applicant team. Fully staffed and resourced QI infrastructure at the health care provider organizations or systems. Past collaborations between the MMCOs and health care provider organizations or systems to improve health care quality; ideally including provision of direct TA services to the health care provider organizations or systems.