WASHINGTON
COMMUNITY
MENTAL HEALTH
COUNCIL

July 16, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

...creating healthy and secure communities through partnerships...

Dear Mr. Nah:

I am writing on behalf of community behavioral health providers across Washington to strongly support the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on extensive cross-system planning, analysis and input from multiple community contributors representing an array of expertise, perspective and roles within the current health and behavioral health systems. The resulting product is a forward-looking five-year plan for health care innovation.

Member:
National Council for Community Behavioral Healthcare

There are numerous promising innovations already underway throughout our state. Many have emerged from provider organization and health system efforts to improve health outcomes; others represent local and regional collaborative initiatives to coordinate resources and care and still others are part of Washington state's proactive implementation of the ACA and related reforms. The model testing grant offers a unique opportunity for synthesizing, further testing and making targeted infrastructure investments needed to bring to bring the most promising innovations to scale in a coordinated and systematic manner.

In my capacity as CEO of the Washington Community Mental Health Council, I understand both the importance and the complexity of actualizing the triple aim of better health, better care and lower costs. The Council's member organizations – licensed community mental health agencies – provide over 90% of publicly funded outpatient mental health care, serving 130,000 low-income individuals each year, primarily adults with serious mental illness and/or substance use disorders, and children or youth with severe emotional disturbances. We have been active partners in health reform implementation and are deeply committed to the goals of whole-person healthcare and improved health status for the people we serve.

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•
ANN E. CHRISTIAN
CHIEF EXECUTIVE OFFICER

Washington has built a solid base for successful implementation of our State Health Care Innovation Plan. Public and private partners are connected and engaged, and ready to move into action. My organization commits to continuing as an active contributor and collaborator in health care innovation, with particular expertise to offer in these areas:

- Integration of physical and behavioral health. Community mental health agencies are experienced cross-system collaborators, serving among the most complex high risk and high cost population groups in our state. They are national leaders in developing and delivering integrated care and stand ready to offer planning and design expertise and institutionalize scale up proven successful models. A primary goal is to change the reality that people with serious mental illness and substance use disorders constitute the greatest health disparity population in our country.

- Practice transformation. Over the past 5-6 years our association has initiative practice improvement initiatives at the provider level in areas spanning care management, psychiatric medication practice improvement and reduction of psychiatric rehospitalization. We have partnered with our state Health Care Authority, Research and Data Analysis Division and Division of Behavioral Health and Recovery; the University of Washington and Rutgers University with support from CMS, the Agency for Healthcare Research & Quality, the Office of the Attorney General and SAMHSA.

- Public education, prevention and early identification of mental illness. This focus area for population health has been sorely neglected in our state and across our country: We are anxious to move from planning to execution. As a member of the Public Health – Health Care Delivery System Partnership and contributor to the Prevention Framework, we have recommended specific evidence-based approaches for mental health promotion and prevention to be implemented.

The Washington Community Mental Health Council will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. We are excited about the opportunity to transform the way that health care is financed and delivered in Washington state. I look forward to participating in this collaborative endeavor.

Sincerely,

Ann Christian
Chief Executive Officer

July 14, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

In my capacity as Executive Director at the Washington Low Income Housing Alliance, I know the triple aim of better health, better care and lower costs will require a coordinated effort. We are ready to play a significant role in coordinating these efforts with Washington's affordable housing and homelessness provider and advocacy community. As a state known for its innovation and cross-sector collaboration, Washington and its community-based partners are well situated to take on the challenges and achieve the opportunities reflected in this grant application.

Over the coming months, the Washington Low Income Housing Alliance will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. Specifically, the Washington Low Income Housing Alliance commits to the following:

- We will work closely with the Governor's office and Health Care Authority to provide feedback on how housing stability and homelessness prevention programs can coordinate with and complement the strategies outlined in Washington's grant application.

- We will communicate testing grant implementation updates to our statewide membership, which is comprised of nearly 150 non-profit organizations, community-based organizations, and local government entities. In turn, we will communicate implementation feedback from our members to the Governor's office and Health Care Authority.

This grant presents a real opportunity to address the social determinants of health, including housing instability and homelessness. In turn, improved health outcomes, particularly among vulnerable populations, will help reduce homelessness and improve housing stability across Washington. We look forward to participating in this collaborative endeavor.

Sincerely,

Rachael Myers
Executive Director
Washington Low Income Housing Alliance
1411 Fourth Avenue, Suite 850
Seattle, WA 98101
www.wliha.org

July 16, 2014

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Elma, WA 98541
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Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application. In my capacity as Executive Director of the Washington Rural Health Collaborative (WRHC), I know the triple aim of better health, better care and lower costs will require a team effort and we are ready to play a significant role.

WRHC is an existing, mature and robust rural network consisting of 13 Critical Access Hospitals, all separately governed serving the rural areas of Washington State. The Collaborative, which has been in existence since 2003, enjoys stable and competent leadership, a well-defined mission, and a formalized organizational structure. Most importantly, it has a demonstrated history of delivering value to its members and the rural communities they serve.

The Collaborative's strength has always been its ability to come together to achieve much more as a group than the individual members could ever hope to achieve separately. Our mission is simple; to improve the health care delivery systems of our rural communities.

In 2014, we have focused on improving the overall quality and efficiencies of our hospitals. We have spent the last year preparing for the shift from volume to value-based purchasing. This shift will improve the quality of care and increase efficiencies that will result in better health outcomes at reduced costs for the patients we serve. By the end of 2014, we fully expect to have

developed and implemented a quality and financial performance initiative that will link standardized quality measures to financial outcomes.

The Collaborative has also spent considerable time exploring Accountable Care Organizations. While not all of our members are positioned to participate at this time; several of the Collaborative members will be collectively forming a rural accountable care organization. The Washington Rural Health ACO (WRH ACO) will mark history as the first rural ACO to form in Washington State among rural hospitals partners. In July, the WRH ACO will submit an application to CMS to participate in the Medicare Shared Saving Program with the intent to start January 1, 2015. We fully intend to leverage the model and framework to extend contracts with commercial and Medicaid payors.

Over the coming months, my organization will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. Specifically, I am committing my organization to the following:

- Partner with the State to test innovative service and delivery models
- Participate in multi-stakeholder/multi-payer efforts
- Share what we learn from the implementation of our rural ACO model

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this collaborative endeavor.

Sincerely,

Holly Greenwood, Executive Director
Washington Rural Health Collaborative
holly@washingtonruralhealth.org
(360)346-2351
www.washingtonruralhealth.org

STATE OF WASHINGTON
DEPARTMENT OF COMMERCE
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July 15, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington State application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

In my capacity as the Director of the Washington State Department of Commerce, I know the triple aim of better health, better care and lower costs will require a team effort and we are ready to play a significant role. States that transition quickly and get this right are providing a competitive advantage to their incumbent businesses. There is a clear link between the triple aim and economic development. Over the coming months, the Washington State Department of Commerce will continue to partner closely with the Governor and state leadership to further develop and implement the testing grant.

As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application. This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this collaborative endeavor.

Sincerely,

Brian Bonlender
Director

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47890, Olympia, Washington 98504-7890
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July 7, 2014

Gabriel Nah, Grants Management Specialist
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda
5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work to develop a forward looking five year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

As the Department of Health Secretary, I know the triple aim of better health, better care and lower costs requires a team effort. We at the department have made health transformation and innovation one of my top four goals, and have fully engaged the Health Care Authority and our partners in narrowing the gap between clinical care and population health. Being known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application.

The department is an engaged partner, eager to strengthen our collaboration with a common goal of improved population health. Over the coming months, my organization will work closely with Governor Inslee and state leadership in the further development and implementation of this testing grant. Specifically, I am committing my organization to:

- Investing energy, staff and time to lead the Practice Transformation Support Hub. The hub is a key element to provide support, technical assistance and training to the various entities involved in health improvement across the state.
- Finalizing, by February 2016, the Plan for Population Health. We have been working on this plan over the last year with the Health Care Authority, local public health, health care providers, health plans, and many others.
- Working with the Health Care Authority to ensure success of the Accountable Communities of Health.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington. My department and I look forward to participating in this collaborative endeavor.

Sincerely,

John Wiesman, DrPH, MPH
Secretary of Health

Washington
State
Hospital
Association

July 16, 2104

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

Washington hospitals and health systems are currently in the midst of a significant transformation. Our 99 member hospitals and health systems are working toward the triple aim of better health, better care and lower costs. The Washington State Hospital Association (WSHA) supports our state as it works to provide leadership and create an environment for health innovation. A critical starting point, included in the proposal, is to reform the system for treatment of patients with behavioral health needs.

WSHA strongly encourages The Centers for Medicare and Medicaid Services to fund the state's application for the Round 2 State Innovation Model. If awarded, the funds will secure additional resources to advance the state's work and achieve the triple aim. The Washington application builds on the state's previously submitted innovation plan and foundational work already in place across multiple stakeholders. WSHA and key members participated actively in design discussions with the state as well as in support of the state's legislation to implement components of the innovation plan (an all-payer claims data base, a set of common performance measures, and local collaboratives to better integrate care).

WSHA is very interested in working with the state in further development and implementation of the strategies. We believe our association can play a significant role in helping share best practices among Washington hospitals and communities. We already have a structure and a track record from our successful work on quality improvement as a Hospital Engagement

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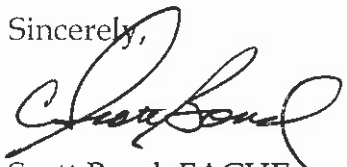
Contractor. Building on collaborations with the Washington State Medical Association and the Washington State Association of Local Public Health Officials, we are positioned to support and spread local practices that prove to be effective. We are also keenly interested in working with the state on a new rural health care delivery system. Our hospitals and the communities they serve need a new model to ensure care continues to be available close to home with an emphasis on prevention, care coordination, and referral links to other centers for specialty and tertiary services.

The association and its members are eager to continue and accelerate our work and the state's work on transformation as part of a State Innovation Model.

Sincerely,



Scott Bond, FACHE
President and CEO

Washington State Medical Association
WSMA
Physician Driven
Patient Focused

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July 14, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

The Washington State Medical Association (WSMA) offers this letter of support for the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. The WSMA has participated in the state's activities to develop a forward-looking five-year plan for health care innovation, and the awarding of this grant would significantly support Washington state's efforts.

The WSMA has provided tangible assistance and guidance to Washington's physicians, physician assistants, practice administrators and their staff to aid in the adoption and transition to models of health care delivery that embrace the Triple Aim of improving the health of the populations, improving the patient experience of care, and reducing the per capita cost of health care.

The WSMA also has been participating on the Dr. Robert Bree Collaborative since its inception, and WSMA President, Dale Reisner, MD, has been appointed to serve on the Washington State Performance Measures Coordinating Committee.

Going forward, the WSMA will continue its commitment to working closely with Governor Inslee, his staff and state leadership in the further development and implementation of this testing grant. The WSMA commits to building upon the strong foundation of education and guidance on these emerging models of health care delivery.

Sincerely,

Jennifer Hanscom
Executive Director/CEO

WSNA™

Washington State Nurses Association
575 Andover Park West, Suite 101, Seattle, WA 98188
206.575.7979 PHONE 206.575.1908 FAX wsna@wsna.org EMAIL www.wsna.org WEB

July 15, 2014,

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

In my capacity as Executive Director of the Washington State Nurses Association, I know the triple aim of better health, better care and lower costs will require a team effort and we are ready to play a significant role. As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application.

Over the coming months, my organization will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. As the largest health profession, registered nurses and advanced registered nurse practitioners exert considerable influence over the health system and are an effective channel to make positive change as outlined by the plan. Specifically, I am committing my organization to the following:

- Be an engaged stakeholder by continuing to lend our expertise in delivering care that results in quality chronic care management and prevention.
- Share information on how to increase workforce capacity and flexibility. We are willing to identify and share best practices in assuring patient safety when working with assistive personnel. Additionally we actively encourage and promote nurses to practice to the full extent of one's license, education and expertise.
- Explore ways to partner with the State to engage individuals and families more fully in their healthcare by lending our expertise in public education efforts.
- As the largest professional association representing registered nurses in Washington State since 1908, we are well positioned to encourage and support practice transformation, and help disseminate best practices among registered nurses and advanced practice nurses statewide.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this collaborative endeavor.

Sincerely,

Judy Huntington (JH)
Judy Huntington, MN, RN

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

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www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

July 16, 2014

Gabriel Nah, Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation. This grant would greatly accelerate our efforts.

As Insurance Commissioner, I know the triple aim of better health, better care and lower costs will require a team effort, and we are ready to play a significant role. As a state known for its innovation, Washington is ready to take on the challenges and live up to the opportunities reflected in this grant application.

The Office of Insurance Commissioner (OIC) plays a key role in health care transformation in Washington state. The OIC protects insurance consumers and oversees the insurance industry. In addition to regulatory duties, the OIC also plays a key role in various interagency health reform projects: the Executive Management Advisory Council (EMAC), a cross-agency group that oversees implementation of Washington's State Innovation Plan; the Washington Health Benefit Exchange board; the All Payer Claims Database initiative; and state purchasing and accountable care model development.

Over the coming months, the OIC will continue to partner closely with the Governor and state leadership in further development and implementation of this testing grant. Specifically, I am committing my organization to:

- Serve on the project's advisory council and work collaboratively with 11 other state agencies;
- Use my regulatory authority to accelerate health transformation and influence change when necessary and appropriate.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington state. I look forward to participating in this collaborative endeavor.

Sincerely,

Mike Kreidler
Insurance Commissioner

Mailing Address: P. O. Box 40255 • Olympia, WA 98504-0255
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

Advocacy. Action. Answers on Aging.
Washington Association of Area Agencies on Aging
2404 Heritage Court SW, Olympia, WA 98502
w4a@agingwashington.org

July 11, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

On behalf of the Washington Association of Area Agencies on Aging (W4A), I am writing in support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on the work already completed in this state to develop a forward-looking five-year plan for health care innovation.

W4A recognizes that the triple aim of better health, better care and lower costs will require a team effort. The Area Agencies on Aging provide direct support to many of the people most affected by medical issues, and we look forward to opportunities to improve care for our state's most vulnerable citizens.

As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application. This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. W4A looks forward to the opportunity to improve the health of our citizens through this collaborative endeavor.

Sincerely,

Lori J. Brown

Lori Brown, Chair
WA Association of Area Agencies on Aging (W4A)

Washington Dental Service Foundation

Community Advocates for Oral Health

July 9, 2014

Gabriel Nah, Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop #7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

The Washington Dental Service Foundation (WDS Foundation) strongly supports the Washington state application for a Round 2 State Innovation Model (SIM) testing grant from the Center for Medicare and Medicaid Innovation. The State Health Care Innovation Plan (SCHIP) provides a clear vision and framework for transforming our health care system across the continuum of care necessary to achieve the Triple Aim of better health, better care and reduced costs outlined in the SHCIP.

WDS Foundation is a non-profit funded by Delta Dental of Washington – the leading non-profit dental benefits company in Washington State. Our mission is to eliminate oral disease, to improve overall health for everyone. Our strategies reflect a preventive framework, a population level focus, a multidisciplinary approach, and are data driven. The Foundation will continue supporting the advancement of whole person care through Accountable Communities of Health (ACHs), a core strategy of SCHIP.

The Washington State Round 2 SIM application reflects a thoughtful, systems change approach, from the state policy level down to local neighborhoods of care. The WDS Foundation supports this approach and will work hard to ensure its' success.

Sincerely

Laura Smith

Laura Smith
President and CEO
Washington Dental Service Foundation

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

July 16, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

Select members* of the Washington Health Alliance Purchaser Affinity Group are writing to express their strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation.

The Washington Health Alliance is a purchaser-led, multi-stakeholder collaborative with more than 175 participants, focused on bringing together those who give, get and pay for health care to create a high-quality, affordable health care system for the people of Washington State. Among its many activities, the Alliance regularly convenes a Purchaser Affinity Group which consists of two dozen employers, labor trusts and business associations who share a common interest in improving the return on investment from health care. Washington State, a major purchaser of health care, is an active member of our Purchaser Affinity Group.

This CMMI-SIM application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the SIM grant would greatly accelerate our efforts. The Purchaser Affinity Group supports the broad aims of this work: (1) improve overall health by building healthy communities and people through prevention and early mitigation of disease; (2) improve chronic illness care through better delivery system performance and integration of care with social supports; and, (3) drive value-based purchasing and provider payment.

This grant presents an important opportunity to transform the way we pay for and deliver health care in Washington state and we urge you to approve Washington state's application for funding. We look forward to participating in this collaborative endeavor.

Thank you for your consideration. If you have questions, please contact Susanne Dade at sdade@wahealthalliance.org

*Select Members, Washington Health Alliance Purchaser Affinity Group

- Alaska Air Group
- The Boeing Company
- Fairmont Hotels & Resorts
- King County
- Northwest Administrators, Inc.
- Parker, Smith and Feek
- Point B
- Puget Sound Energy
- Seattle Area Plumbers Health and Welfare Trust
- Seattle Metropolitan Chamber of Commerce
- SEIU Healthcare NW Training Partnership and Health Benefits Trust
- Sound Health and Wellness Trust
- Sound Transit
- Starbucks Corporation
- WA Teamsters Health & Welfare Trust
- WA State Health Care Authority

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

July 9, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
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U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
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Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate the state's efforts.

As Executive Director of the Washington Health Alliance, I know the triple aim of better health, better care and lower costs requires a team effort, and we will continue our contribution as a purchaser-led, multi-stakeholder coalition. As a state known for innovation, Washington is well positioned to take on the challenges and live up to the opportunities reflected in this grant application.

The Alliance was pleased to play a role in facilitating stakeholder input to innovation planning in 2013, drawing upon our ten years' experience as the convener of purchasers, providers, plans, consumers and others committed to transformation. We bring singular capabilities for measuring and reporting on the quality and cost of health care in Washington on a voluntary basis, so that transparency can be used to support payment reform and delivery system improvement. This expertise has been recognized in the state's partnering with the Alliance on a Cycle III data center grant to enhance the Alliance's voluntary database. In addition, the Alliance expects to contract with the state as the lead organization to administer a new All Payer Claims Database (APCD) established under recent legislation to undergird the innovation plan.

Over the coming months, the Alliance will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. Specifically, the Alliance will expand our data infrastructure to meet the requirements of the new legislation and serve as a true community asset. In addition, we are assisting in a public process to identify common metrics for statewide performance reporting, purchasing and payment reform, and we expect to provide the data from the APCD and the analysis to report on the results with the benefit of grant funding.

This grant presents a significant opportunity to transform the way we pay for and deliver health care in Washington state. The Alliance looks forward to contributing to this collaborative endeavor.

Sincerely,

Mary McWilliams
Executive Director

July 14, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

We are writing on behalf of the Washington Healthcare Forum Board in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. The Forum Board members are the CEOs of the leading hospitals, physician practices, health plans and associations in the Washington state health care market. Our members unanimously agree that the status quo in our industry is not sustainable. We strongly believe that our individual organizations need to innovate and improve as does the entire Washington state health care system. In this context, we believe the plan the state has developed provides leadership, an important organizing framework and badly needed resources to accelerate innovation and improvement in our state's health care system over the next five years.

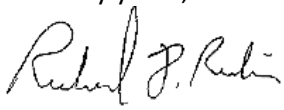
It is our belief that transformation of the Washington state health care system is most likely to occur if individual public and private sector organizations move forward with their own improvement efforts while the community as whole moves forward collaboratively on targeted initiatives. We believe one of the great strengths of the Washington state application is the judicious blend of public and private sector activities the plan promotes. We commend the state for the inclusive approach they have pursued to develop the plan.

Many of our individual member organizations have been actively involved in the development of the plan and have indicated to us they intend to support the implementation phase. Similarly, the Forum will continue to provide its support, engagement and leadership as the state moves forward with the innovation plan. We believe this is a worthy and important effort. We strongly urge your support of the Washington state application for a Round 2 Innovation testing grant. Thank you for your consideration of our request.

Sincerely yours

Richard Cooper
Forum Board Chair

Sincerely yours,



Richard D. Rubin
Executive Director

Cc: Forum Board

State of Washington
House of Representatives

July 18, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

As a Washington State Legislator and Chair of the House Health Care committee, I am writing to express my strong support for the *State Innovation Models: Round Two of Funding for Design and Test Assistance* application being submitted by the state of Washington.

Building on a strong policy framework established in our state health care innovation plan, this testing grant application represents a bold step for Washington towards a health care payment and delivery system that is less fragmented, more accountable and better connected to the community.

Specifically, this grant application places an emphasis on linking communities with the health delivery system through Accountable Communities of Health. It moves us forward on much-needed integration of physical and behavioral health services to achieve whole person care. It also enables new payment and delivery system models that will help us achieve better population health, increased quality of care and lower costs.

In early 2014, our state legislature worked across party lines to enact House Bill 2572 and Senate Bill 6312. These bills adopted the state's health care innovation plan and serve as a strong foundation for this grant application.

I urge your strong consideration of this application and look forward to playing a continued role in its success.

Sincerely,

Eileen Cody, R.N.
Washington State Representative
34th District

Legislative Building
Olympia, WA 98504-0482

Washington State Senate

Phone: (360) 786-7550
FAX: (360) 786-1999

July 14, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

In my capacity as a State Senator serving on the Health Care Committee, I know the triple aim of better health, better care and lower costs will require a team effort and we are ready to play a significant role. As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application.

Over the coming months, I am sure the legislature will partner closely with the Governor and state leadership in the further development and implementation of this testing grant.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this collaborative endeavor.

Sincerely,

State Senator
33rd Legislative District

7/11/2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Nah:

The Western Washington Area Health Education Center strongly supports the Washington State application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts. As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application.

In my capacity as Executive Director of the Western Washington Area Health Education Center I know the triple aim of better health, better care and lower costs will require a team effort. We are ready to play a significant role as this application aligns with our mission to assure equity of and access to health care for underserved rural and urban populations in western Washington through education and workforce development.

Over the coming months, my organization will partner closely with the Governor and state leadership in the further development and implementation of this testing grant. Specifically, the Western Washington Area Health Education Center will collaborate with the state to increase the capacity and flexibility of the healthcare workforce.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this shared endeavor.

Sincerely,

Jodi Perlmutter, MSW
Chief Executive Office/Executive Director

Western Washington Area Health Education Center
2033 Sixth Avenue • Suite 310 • Seattle, WA • 206-441-7137 • FAX 206-441-7158 • wwahec@wwahec.org

Confederated Tribes and Bands
of the Yakama Nation

Established by the
Treaty of June 9, 1855

Yakama Nation Behavioral Health Services

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

July 11, 2014

Dear Mr. Nah:

I am writing in strong support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. This application builds on our work within this state to develop a forward-looking five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts. In my capacity as Program Manager for Yakama Nation Behavior Health Services, I know the triple aim of better health, better care and lower costs will require a team effort and we are ready to play a significant role. As a state known for its innovation, Washington is well situated to take on the challenges and live up to the opportunities reflected in this grant application. Over the coming months, my organization will partner closely with the Governor and state leadership in the further development and implementation of this testing grant.

Specifically, I am committing my organization to the following:

- Start to integrate mental health and substance abuse treatment in primary medical care, treating the whole person to improve health and lower costs.

- Provide verifiable data, so consumers and policymakers can identify price and access issues that could bring down the cost of care. In turn, individuals could make better, data-backed purchasing decisions.

This grant presents a real opportunity to transform the way we pay for and deliver health care in Washington State. I look forward to participating in this collaborative endeavor.

If you have any questions, please contact me by the phone numbers and my email address provided below.

Sincerely,

Katherine Saluskin, MSW
Program Manager
Yakama Nation Behavioral Health Services
POB 151
Toppenish, WA 98948
(509)865-5121 ext. 6208
(509)865-2064 FAX
(509)949-3711 MOBILE
ksaluskin@yakama.com

Yakima Valley
Farm Workers Clinic

July 14, 2014

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda 5600 Fishers Lane
Rockville, MD 20857

RE: Washington State's CMS State Innovation Model Grant Round 2 Application

Dear Mr. Nah:

Please accept this letter as Yakima Valley Farm Workers Clinic's (YVFWC) support of the Washington state application for a Round 2 State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. The Department of Health has assembled an application which builds upon our work within this state to develop a progressive five-year plan for health care innovation, and receipt of the grant would greatly accelerate our efforts.

The triple aim of better health, better care and lower costs will require a team effort and we feel the State's plan aligns with our organizational mission which states, "Together we are dedicated to lead, with the courage to care, the determination to promote personal growth, and the compassion to champion the cause of those who have no voice." If funded YVFWC is committed to supporting the state by providing on-going feedback regarding the plan and initiatives; participating in trainings; and providing the necessary data and resources required to implement reforms.

We believe this application presents a forward-thinking approach to transforming the way we pay for and deliver health care in Washington State. We look forward to participating in this collaborative endeavor. Please do not hesitate to contact me if you have any questions.

Sincerely,

Juan Carlos Olivares
Executive Director

Central Administration
604 West 1st Avenue | Toppenish, WA 98948
Phone 509-865-5898 | Fax 509-865-4337 | www.yvfwc.com

Appendix D: Healthier Washington Video Testimonials

The following active link directs readers to the Healthier Washington video testimonials:

http://www.youtube.com/user/InnovationPlan

Appendix E: ACH Initiative Community Partners

Below is a list of key partners participating in the ACH Initiative planning process and future the next phase under the ACH Initiative. Please note that this is not a comprehensive list of potential partners. In addition, these partners may be engaged in different capacities based on the governance and engagement strategies.

- Accountable Care Organizations
- Assisted living facilities
- Behavioral health providers
- Community based non-profit or for profit organizations
- Community mental health centers
- Community services organizations
- Community wellness programs
- Consumers and people who live in the community
- Criminal justice
- Dental providers
- Early learning
- Economic development
- Emergency Medical Services (EMS)
- Employers
- Employment services
- Faith based organizations
- Federally Qualified Health Centers (FQHC)
- Food systems
- Health plans
- Home health organizations
- Hospitals
- Housing
- Labor organizations
- Large and small businesses
- Law enforcement and correction agencies
- Local governments
- Long-term care system
- Payers
- Pediatricians or Pediatric Associations
- Pharmacies
- Philanthropy
- Physical health care providers
- Public health
- Purchasers
- Schools and educational institutions or districts
- Social services or social supports
- Transportation
- Tribal governments

Appendix F: Accountable Community of Health Initiative Planning Opportunity and Successful Applicants

The listed 10 communities successfully applied for Community of Health Planning grants as part of the Accountable Community of Health Initiative. The grant opportunity announcement follows in the subsequent pages. The following active links direct readers to each Community of Health Planning grant application.

- Pierce County Health Innovation Partnership
- North Sound Accountable Community of Health
- King County
- Better Health Together
- Cascade Pacific Action Alliance
- Benton-Franklin Community Health Alliance
- Southwest Washington Regional Health Alliance
- South Puget Intertribal Planning Agency
- Yakima County Accountable Community of Health
- North Central Health Partnership

Washington State Health Care Authority

Appendix G

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

Accountable Community of Health (ACH)
Grant Opportunity Announcement (GOA)
for Community of Health Planning
GOA #14-015

GOA APPLICATION SCHEDULE:

Activity	Due Dates	Time
Grant Opportunity Release Date	May 2, 2014	
Mandatory Letter of Intent to Apply Due	May 9, 2014	**3:00 PM, Pacific Time**
Applicant Questions Due	May 14, 2014	**3:00 PM, Pacific Time**
Pre-Application Conference Call	May 16, 2014	**10:00 AM, Pacific Time**
Answers from HCA	May 19, 2014	
Application Deadline	May 30, 2014	**3:00 PM, Pacific Time**
Evaluation Period (approximate time frame)	June 2, 2014 – June 9, 2014	
Projected Announcement of Apparently Successful Applicants (ASA)	June 13, 2014	
Final Execution and Grant Award	June 30, 2014	
Grant period of performance	June 30, 2014 – December 31, 2014	

TABLE OF CONTENTS

I. PURPOSE

The Health Care Authority (HCA) is announcing the Accountable Community of Health (ACH) initiative. The purpose of the ACH initiative is to formally recognize, resource, and evaluate the impact of cross-sector alignment, partnership, and commitments to improve health and lower costs in communities across Washington State. Recognizing health and health care are local, a collaborative community approach is necessary in order to achieve Washington's aims of better health, better care, and lower costs. This initiative is based on the premise that no single sector or organization in a community can create transformative, lasting change in health and health care alone; and clinical, community, and government entities must coordinate their efforts and actions around clearly defined goals that support whole-person health. Accountable Communities of Health will provide the forum, organizational support, and State-community partnership to achieve transformative results through collaboration.

The State is seeking to partner with communities and invest in community planning to develop and support mutually agreed-upon, aligned plans and actions across sectors and systems in communities to improve health and lower costs. The Community of Health Planning grant opportunity is intended for communities committed to planning how they would align, amplify, and evolve existing priorities and efforts to develop multi-sector shared priorities and approaches to achieving better health, better care, and lower costs, as well as establish an Accountable Community of Health structure to coordinate and link community action. HCA expects this planning opportunity to inform the State and help prepare communities in anticipation of an Accountable Community of Health designation process in late 2014.

In this Grant Opportunity Announcement (GOA), the term "community" is defined in three (3) contexts:

a. "Accountable Community of Health" or "ACH" refers to a regionally based, voluntary collaborative to align actions to achieve healthy communities and populations, improve health care quality, and lower costs.

b. "Community" refers to the region in which multiple sectors align to establish an Accountable Community of Health (ACH). Each to-be-determined regional service area is envisioned to have one (1) ACH. This does not in any way suggest that counties, cities, or otherwise local initiatives cannot have or continue additional improvement organizations or collaboratives. In many cases, such organizations and initiatives will provide increased opportunity to drive action at the local level and leverage best practices across the broader communities.

c. "Community" also can refer to a tribal forum aligned around a common agenda to achieve health, improve health care quality, and lower costs.

II. BACKGROUND

In 2012, Washington state moved to accelerate its efforts toward better health, better care, and lower costs by applying for a federal State Innovation Models (SIM) Testing Grant in Round One (1) of the SIM program. At that time, more than eighty (80) organizations joined state leaders in support of the initial vision, which led to a nearly $1 million SIM Pre-Testing Award to Washington state from the Center for Medicare and Medicaid Innovation (CMMI). The award funded a planning process to build a five (5) year State Health Care Innovation Plan (hereafter referred to as the Innovation Plan or plan) for Washington.

Hundreds of people from the public and private sectors contributed to the resulting Innovation Plan for a healthier Washington. The plan is built upon three (3) core strategies:

a. **Improve how we pay for services.** Presently, providers of health care services are paid every time they provide a service, even when the service doesn't work. The plan calls for rewarding providers when they achieve good outcomes. Information on effectiveness and cost will be collected and shared to help providers and consumers choose the best treatment options.

b. **Ensure health care focuses on the whole person.** The current system creates barriers to addressing physical health, mental health, chemical dependency, and basic living needs as early as possible and at the same time. The plan calls for methods of integrating care and connecting with community services to achieve the best possible result for individuals. It also adjusts how we pay for services to make care for the whole person possible.

c. **Build healthier communities through a broad collaborative regional approach.** Virtually all health care is delivered at the local level. Driven by local partners, the plan calls for a regional approach that empowers communities. Working together, communities can bring about changes that will improve health for the people they serve.

The Innovation Plan can be accessed through the initiative's web site:
http://www.hca.wa.gov/shcip/

The Innovation Plan was further supported in the 2014 legislative session with the passage of E2SHB 2572[1] and 2SSB 6312[2]. Adoption of these bills into law solidifies Washington's path for innovative state purchasing strategies and Apple Health (Medicaid) integrated delivery reforms. As a mechanism to achieve health system transformation for communities' most vulnerable residents, as well as the broader population, the legislation established "Communities of Health": regionally based, voluntary collaboratives to align actions to achieve healthy communities and populations, improve health care quality, and lower costs. HCA was granted the authority to designate entities as Communities of Health (COH) and award grants to support start-up costs for two (2) "pilot" COHs. The purpose of this funding opportunity is to support communities in planning for the designation process and/or the pilot opportunity.

[1] http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/House%20Passed%20Legislature/2572-S2.PL.pdf

[2] http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf

III. GRANT AWARD TERMS AND FUNDING OPPORTUNITY

a. Grant Awards

HCA intends to award up to ten (10) Community of Health Planning Grant Awards. Communities that apply for, but do not receive, a Community of Health Planning Grant Award may still submit a proposal to be designated as an Accountable Community of Health when the opportunity is announced. Entities are encouraged to collaborate with entities in the same community, as it is HCA's intention to designate no more than one (1) Accountable Community of Health serving the same geographic population. The funding amounts for Community of Health Planning Grant Awards will be based on a variety of factors, including proposed planning, and budget requirements. The proposed budget will be evaluated based on the following elements: the scope of the proposed plan and the size of the target population; the complexity of the plan proposed by the community; the activities necessary to complete the required plan; and the reasonableness of expenditures in the budget plan.

Communities that receive a Community of Health Planning Grant Award will be expected to sign grant award contracts that will require them to produce and deliver a community health plan, as outlined in Section IV. The grant award contracts may be terminated for failure to perform under the requirements of the agreement.

b. Funding Opportunity

The total Community of Health Planning Grant Awards funding is up to $50,000 per community for up to ten (10) communities, including government and tribal entities. The amount each community receives will be based on the community's request but is at the sole discretion of HCA.

Period of performance and budget: Award date through December 31, 2014.

IV. COMMUNITY OF HEALTH PLANNING PROGRAM REQUIREMENTS

The Community of Health Planning Grant Awards will provide financial and learning support to up to ten (10) communities to develop a shared vision for community health transformation. The approach must demonstrate collaborative engagement of stakeholders and governments that will lead to aligned, collective action. The shared vision should reflect the active pathway to drive toward better health and lower costs.

Communities that receive Community of Health Planning Grant Awards will be well positioned to be designated as Accountable Communities of Health (ACHs); however, designation status or further funding is not guaranteed. The first (1st) round of ACH designation is anticipated to begin in late 2014, with an opportunity for a second (2nd) round of designation in early 2015. Communities do not have to be recipients of a Community of Health Planning Grant Award in order to be designated as an ACH. Similarly, the Community of Health Planning opportunity will not be the only mechanism to partner with HCA or inform the development of ACHs.

The ACH initiative gives communities the opportunity to shift from traditional engagement approaches to those of partnership between and within communities and the State to achieve mutual aims of better health, better care, and lower costs. The design and development of ACHs requires major commitment by State agencies and community partners—including but not limited to, public health, housing, social service, behavioral health, and health care providers; payers; county and local government; education; philanthropy partners; consumers; and Tribes. Communities will need to provide leadership and embrace alignment to carry out the required multi-sector planning work.

HCA recognizes communities are at different levels of development with regard to health transformation and community mobilization. Community of Health Planning is intended for both promising and mature communities in preparation for the anticipated ACH designation process.

By the end of the six (6) month Community of Health Planning process, community health plans will clearly articulate progress toward planning for or implementation of the community's common agenda, intended performance milestones and outcomes, shared measurement strategy, communication framework, and the pathway to achieve community aims through a mutually reinforcing plan of action. The community plan also will describe the community's existing or planned "backbone," or lead organization—the coordinating forum for collaborative work.

Funding for Community of Health Planning will support the required work. During the period of performance, HCA expects communities to develop a community health plan to:

a. Authentically engage a broad range of stakeholders and government entities in the community planning process;

b. Partner with the State in identifying opportunities for alignment, barriers to achieving shared aims, and barrier resolution strategies;

c. Identify shared community health and health care priorities that align with State transformation priorities as outlined in the State Health Care Innovation Plan and related transformation efforts (e.g., Prevention Framework, Public-Private Transformation Action Strategy, clinical-community linkages, bi-directional integration of physical-behavioral health care, value-based payment, etc.);

d. Consider and articulate potential roles in driving community and State transformation, including:

    1. Partnership and engagement with HCA in regional Apple Health (Medicaid) purchasing (note: HCA would retain ultimate responsibility for selection and oversight in procurement and bear legal and financial responsibility);

    2. Completion of region-wide health assessments and development of regional health improvement plans;

    3. Acting as a forum for harmonizing payment models, performance measures, and investments;

4. Using innovative, aligned data (e.g., geographic information system [GIS] mapping);

5. Facilitating practice transformation support and linking clinical and community sectors and resources; and

6. Identifying and facilitating shared community workforce resources (e.g., community health workers, care coordination, tele-health, etc.).

e. Develop a pathway to achieve community aims through a mutually reinforcing plan of action that includes specific commitments from a broad range of stakeholders and government entities throughout the community, ideally building upon existing community priorities and efforts; and

f. Describe the development of, or plan to develop, the community's lead organization, including its governance, structure, shared measurement mechanisms, communication framework, and sustainability. The plan should consider the fall 2014 designation of regional service areas[3] and HCA's intention to designate no more than one (1) Accountable Community of Health per region. Communities also should consider that no single entity or sector may dominate the community agenda or have majority control.

V. GENERAL INFORMATION FOR APPLICANTS

a. GOA Coordinator

The GOA Coordinator is the sole point of contact in HCA for this application. Any other communication will be considered unofficial and non-binding on HCA. Applicants are to rely on written statements issued by the GOA Coordinator. Communication directed to parties other than the GOA Coordinator **may result in disqualification**. All communication between the applicants and HCA upon receipt of this application shall be with the GOA Coordinator or their designee, as follows:

Andria Howerton, GOA Coordinator
Email: contracts@hca.wa.gov

HCA does not take responsibility for any problems in e-mail, or Internet delivery services either within or outside HCA.

b. Applicant Questions and Answers

1. It is the responsibility of the potential applicants to carefully read, understand, and follow the instructions contained in this GOA document and all amendments, if any, to the GOA.

2. All questions regarding this GOA must be in writing (e-mail) and addressed to the GOA Coordinator. HCA will only answer questions received no later than date

[3] http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf

and time specified in GOA Schedule. Questions received after the date and time stated in the schedule will not be accepted.

3. Questions will not be individually answered prior to the date scheduled for HCA responses unless the response could determine whether that applicant submits a Letter of Intent. Those questions and the response will become part of the official questions and answers (GOA Amendment).

4. Applicant's questions and HCA's official written answers will be posted on the HCA website, www.hca.wa.gov/rfp, by the date in the GOA schedule. The GOA Coordinator will not send individual notification to applicants when responses to the questions are available.

VI. COMMUNITY OF HEALTH PLANNING APPLICATION REQUIREMENTS

Applications for the Community of Health Planning Grant Awards will focus on both the current state and achievements of the community and—primarily—the proposed future state of the community that would be achieved through planning resources and future implementation. Applicants for the Community of Health Planning Grant Awards must comply with the following requirements:

a. Letter of Intent (Mandatory)

1. The applicant must submit a Letter of Intent (LOI) to be eligible to submit a grant application. The applicant must submit the LOI by email to the GOA Coordinator no later than the GOA schedule and must be signed by an authorized representative of the applicant. A list of applicants who submitted a LOI and the geographic population applying for will be posted on the HCA website.

2. Under no circumstances will LOI be accepted after the deadline. Submitting a LOI does not obligate you to submit an application. Letters of Intent may be used as a pre-screening mechanism to determine whether minimum qualifications are met.

3. Information in your Letter of Intent should be placed in the same order as the following outline:

   a) Applicant's Organization Name;
   b) Applicant's authorized representative for this GOA (this representative shall also be named the authorized representative identified in the Application);
   c) Title of authorized representative;
   d) Address;
   e) Telephone number;
   f) Email address;
   g) An outline (less than one [1] page) of applicant's eligibility addressing all criteria listed in C.1 below;
   h) The intended geographic population served by the applicant; and
   i) A statement of applicant's intent to submit a Community of Health Planning Application.

b. Pre-Application Conference Call

A Pre-Application Conference Call is scheduled to be held on Friday, May 16, 2014. All applicants who submit a LOI will receive the Conference Call exact time and call-in information from the GOA Coordinator by close of business May 13, 2014. Prospective applicants are highly encouraged to participate. Administrative instructions, questions, as well as the format, process and instructions for the questions and answer period will be discussed during the Conference Call. All questions and answers will be posted on our website per the GOA schedule. HCA shall be bound only to written answers to the questions. Any oral responses given at the Pre-Application Conference Call shall be considered unofficial.

c. Eligibility Criteria (Mandatory)

1. Eligible applicants must demonstrate:

a) Their status as an organization or entity with the ability to enable public-private partnership and cross-organizational priority setting. Eligible entities may be engaged in a quasi-governmental arrangement, a 501(c)3 or (c)4 non-profit corporation or cooperative, or another entity that enables cross-sector engagement, commitment, and decision making. The entity preferably demonstrates that that it has been identified as a community convener;

b) Ability to receive and manage funding and learning assistance;

c) Plans to serve a geographic population based on county borders (i.e., must serve whole counties), which may include multiple contiguous counties. Multiple applicants proposing to serve the same geographic populations or segments of the same geographic population will not be successful. Exceptions will be made in the case of tribal applicants proposing to serve similar geographic populations as other applicants;

d) Evidence that some community health transformation activities have begun; and

e) Evidence that no single entity or sector will dominate the community agenda or have majority control. Exceptions will be made in the case of tribal applicants proposing a tribal forum.

2. Current Community—Where You Are.

The application must describe relevant community collaborative efforts to date to align actions to achieve healthy communities and populations, improve health care quality, and lower costs. This description of current and past activities should include stakeholders and government entities engaged, common health priorities of the community, and outcomes achieved.

3. Proposed Community—Where You Want to Be.

   The application must:

   a) Identify the proposed community stakeholders and government entities that will actively participate in the community planning process and present a clear strategy for authentic engagement and maintaining their commitment. Communities are expected to work with a broad group of stakeholders, government entities, and sectors throughout the community, where applicable to community and state goals, including potential participants such as:

      i. Accountable Care Organizations
      ii. Community and faith-based organizations
      iii. Consumers
      iv. Criminal justice
      v. Dental providers
      vi. Early learning
      vii. Employment
      viii. Food systems
      ix. Health plans
      x. Hospitals
      xi. Housing
      xii. Labor organizations
      xiii. Large and small businesses
      xiv. Local governments
      xv. Long-term care system
      xvi. Payers
      xvii. Philanthropy
      xviii. Physical and behavioral health care providers
      xix. Public health
      xx. Purchasers
      xxi. School districts
      xxii. Social services
      xxiii. Transportation
      xxiv. Tribal governments.

   b) Describe how the anticipated fall 2014 designation of regional service areas will impact and be positioned for alignment with community planning and engagement of key community stakeholders and governments.

   c) Describe how the planning process will take into account the Apple Health (Medicaid) population and the broader population of the community.

   d) Describe how the planning process will take into account rural needs, rural complexities, and rural stakeholders and government entities within the community, where applicable.

e) Describe how the planning process will take into account consumer engagement and activation.

f) Describe the proposed planning process, including:

i. How the community will partner with the State to identify opportunities for alignment and mutual benefit, as well as work together to identify State and community resolutions to barriers in achieving the community's desired state;

ii. How the community will identify and come to consensus around shared community health and health care priorities;

iii. The mechanism for generating and tracking specific commitments to action from a broad range of community sectors to achieve the identified community aims; and

iv. The process for considering potential community roles in achieving health and health care transformation (i.e., the role each sector plays in achieving common performance outcomes through collective community resources).

g) Present plans to coordinate and build upon existing community and State priorities, efforts and innovations to achieve better health, better care and lower costs, as well as any desired outcomes.

h) Describe how it might leverage existing community data resources, capabilities, and technology.

i) Describe a proposed process for planning for or evolving a lead organization's structure, governance and sustainability.

4. Project Plan and Timeline

All applicants must provide a project plan and timeline with high-level milestones for meeting program requirements as outlined in Section IV.

5. Budget Narrative

All applicants must submit a budget narrative for the six-month period of budget and performance. Project proposals should include applicable information around leveraging other funding resources, including foundations, matching funds, and other federal and State funding resources. The expected or needed amount of funding from other sources should be included in the budget. Overhead and administrative costs must be reasonable, with a strong focus on development of the community health plan. The budget narrative should include the cost of data collection, performance monitoring, and project expenditure reporting. The budget narrative should provide a detailed cost breakdown, including a breakdown of costs for each planning activity.

Allowable costs associated with Community of Health Planning could include:

a) Staff resources to engage in planning;
b) Community convening activities;
c) Technical resources necessary for planning; and
d) Participation in, and travel to, relevant learning opportunities and workshops.

VII. PROGRAM AND AWARD INFORMATION

The Accountable Community of Health (ACH) initiative intends to shift traditional State engagement techniques with communities. As such, this planning opportunity will be a collaborative process between and within communities and the State. To better enable communities to drive health improvement and lower costs, the State is prepared to commit to the following:

a. Funding and learning support for community planning and development, with the commitment to meet communities where they are and encourage the continued evolution of both mature and promising communities;

b. An amplified "Health in All Policies" approach to drive consistent priorities across multiple State agency policies, and better align agency activities across regions;

c. A learning culture that allows for continuous, real-time learning at the state and community levels, as well as enable regular checking and adjusting.

As part of Community of Health Planning Grant Awards, HCA will provide learning assistance through facilitated learning, dialogue, and planning sessions within communities; virtual opportunities for communities to connect with one another; and regular contact with and access to State project staff and consultants.

Reporting Requirements

During the period of performance, communities will be asked to submit mid-point and final progress reports. Reports will consist of narrative summaries on planning progress, lessons learned, and anticipated next steps. Additionally, a financial report of expenditures to date will be required at the mid-point of the performance period.

VIII. APPLICATION AND SUBMISSION INFORMATION

This Grant Opportunity Announcement (GOA) serves as the application package for this grant award and contains all instructions to enable a potential applicant to apply. The application should be written primarily as a narrative.

a. Submission of Application (Mandatory)

Applicants are required to submit their applications **by email only** to the GOA Coordinator only. All attachments to the email must be formatted in Microsoft Office

2003 or newer or Adobe PDF. Ensure the application is labeled with the date, GOA title, GOA number, and applicant's name.

The GOA Coordinator must receive the application at the email address specified no later than the date and time specified in GOA Application Schedule. Late applications will not be accepted and shall automatically be disqualified from further consideration. Applicant is solely responsible for timely delivery of their Application.

For the application to be considered complete the applicant must respond to **all requirements** of this GOA. Applicant's failure to comply with any part of HCA's GOA may result in the application being disqualified for being non-responsive to HCA request.

b. Application Format (Mandatory)

The application should be prepared simply and economically, providing straightforward concise description of the applicant's ability to meet the requirements of this GOA.

Application must be prepared using 11 to 12-size font Arial or Times Roman and must be signed by an authorized representative of the applicant. HCA will not accept zip files or faxed Applications.

c. Application (Mandatory Scored)

Community of Health Planning Application: The application narrative should focus on both the current state and achievements of the applicant and—primarily—the proposed future state of the community that would be achieved through planning, as well as a project plan and timeline and budget narrative, as outlined in Section VI.

APPLICATION PACKAGE	MAXIMUM PAGES
Project Narrative **1. Identify the geographic population served** **2. Current Community—Where You Are.** A. Describe relevant community collaborative efforts to date to align actions to achieve healthy communities and populations, improve health care quality, and lower costs. B. Describe stakeholders and government entities currently engaged. C. Describe past (within the last three [3] years) and current common community priorities to achieve better health, better care, and lower costs. D. Describe outcomes achieved to date. **3. Proposed Community—Where You Want to Be.**	17 pages

A. Stakeholders and government entities:

i. Describe entities that will actively participate in community planning process.

ii. Describe the strategy for engagement and maintaining commitment.

B. Regional service areas:

i. Describe how the anticipated fall 2014 designation of regional service areas will impact and be positioned for alignment with community planning and engagement of key community stakeholders and governments.

C. Population scope:

i. Describe how the planning process will take into account the Apple Health (Medicaid) population and the broader population of the community.

D. Rural populations:

i. Describe how the planning process will take into account rural needs, complexities, and stakeholders and government entities within the community, where applicable.

E. Consumer engagement:

ii. Describe how the planning process will take into account engagement and activation of individuals and families.

F. Anticipated planning outcomes:

i. Describe how the planning process addresses community partnership with the State to identify opportunities for alignment and mutual benefit.

ii. Describe how the planning process addresses how the community will identify and come to consensus around shared community health and health care priorities.

iii. Describe the planned mechanism for generating and tracking specific commitments to action from a broad range of community sectors to achieve the identified community aims.

iv. Describe the planned process for considering potential community roles (i.e., each sector's role in achieving

common outcomes through collective community resources). G. Aligning with and amplifying existing efforts to achieve better health, better care, lower costs: i. Describe the plan to coordinate and build upon existing community and State priorities, efforts and innovations, as well as any desired outcomes. H. Community data capacity: i. Describe how the community might leverage existing data capabilities. I. Developing and evolving community "backbone": i. Describe the proposed process for planning for or evolving a lead organization's structure, governance and sustainability.	
Project Plan and Timeline 1. Provide a project plan and timeline for meeting program requirements as outlined in Section IV. 2. Include high-level milestones for meeting program requirements.	3 pages
Budget Narrative 1. Detailed cost breakdown. 2. Describe plans to leverage other funding resources for the planning period of performance where applicable, including foundations, matching funds, and other federal and State funding resources. 3. Describe anticipated costs for reporting requirements, including any data collection, performance monitoring and project expenditure reporting.	5 pages
MAXIMUM NUMBER OF PAGES FOR COMMUNITY OF HEALTH PLANNING APPLICATION PACKAGES	25 pages

IX. APPLICATION CRITERIA

The evaluation process is designed to award grants to up to ten (10) communities, with only one community serving a respective geographic population. Evaluations will only be based upon information provided in the Application. In those cases where it is unclear to what extent a requirement has been addressed, the GOA Coordinator may, at their discretion, contact the applicant to clarify specific points in their application. Applicants should take every precaution to assure that all answers are clear, complete and directly address the specific requirement. Applications will be evaluated strictly in accordance with the requirements set forth in this GOA and any issued amendment.

a. Evaluation Procedures

The evaluation of Application shall be accomplished by an evaluation team, to be designated by HCA, and which will determine the scoring of the Applications.

1. All Applications received by the stated deadline will be reviewed by the GOA Coordinator to ensure that the Application contains all of the required information requested in the GOA. Only responsive Applications that meet the requirements will be forwarded to the evaluation team for further review. Any applicant who does not meet the stated qualifications or any Application that does not contain all of the required information will be rejected as non-responsive.

2. Responsive Applications will be reviewed and scored by a selection committee using a point/weighted scoring system. Applications will be evaluated strictly in accordance with the requirements set forth in this GOA and any amendments that are issued.

Up to ten (10) communities with the highest combined score will receive a grant award.

b. Scoring

Applications for Community of Health Planning will be reviewed and scored based on the quality of the application. The review criteria for Community of Health Planning applications are based on a total of one hundred (100) points. The following weighted points will be assigned to the Application for evaluation purposes:

Project Narrative	**Total Maximum Points**
• Community of Health Planning Strategy	40 Points
• Evidence of and Plans for Multi-Sector Engagement	25 Points
• Organizational Capacity	15 Points
Project Plan, Timeline, and Budget	20 Points
Total Maximum	**100 Points**

Evaluators will assign scores on a scale of zero (0) to five (5) where the end and midpoints are defined as follows:

0 = No value
1 = Poor
3 = Good
5 = Excellent

c. Successful Applicants

One (1) community will serve a geographic population. In the case of multiple applicants proposing to serve the same geographic population or segments of the same geographic population, the higher score determined by the above criteria will determine the successful applicant. Exceptions will be made in the case of tribal applicants proposing to serve similar geographic populations as other applicants.

Up to ten (10) communities with the highest combined score will receive a grant award. Successful applicants will be notified of their potential award by June 13, 2014. Grant Award Contracts will be established with successful applicants by June 30, 2014.

Washington State Health Care Authority

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

Grant Opportunity Announcement (GOA)
for
Accountable Community of Health (ACH)
Pilot and Design Grants
GOA #14-028

GOA APPLICATION SCHEDULE:

Pilot Activity	Design Activity	Due Dates	Time
GOA Release Date	GOA Release Date	November 7, 2014	
Mandatory Letter of Intent to Apply Due	Mandatory Letter of Intent to Apply Due	November 19, 2014	2:00 p.m. Pacific Time
Applicant Questions Due	Applicant Questions Due	November 19, 2014	2:00 p.m. Pacific Time
Pre-Application Conference Call	Pre-Application Conference Call	November 24, 2014	Noon – 1:00 p.m. Pacific Time
Answers from HCA	Answers from HCA	November 25, 2014	
Pilot Complaint Deadline		December 1, 2014	2:00 p.m. Pacific Time
Pilot Application Deadline		December 8, 2014	2:00 p.m. Pacific Time
Pilot Evaluation Period (approximate time frame)		December 9, 2014 – December 19, 2014	
Projected Announcement of Apparently Successful Applicants (ASA) for Pilot Awards – State Funded (E2SHB 2572)		January 2, 2015	
	Design Complaint Deadline	January 2, 2015	2:00 p.m. Pacific Time
	Design Application Deadline	January 9, 2015	2:00 p.m. Pacific Time
	Design Evaluation Period	January 12, 2015 – January 19, 2015	
	Projected Announcement of Apparently Successful Applicants (ASA) for Design Awards – Contingent Upon SIM Round 2	January 21, 2015	

Pilot Period of Performance	N/A	January 19 2015 - June 30, 2015	
	Design Period of Performance	February 2, 2015- December 31, 2015	

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EXHIBITS:

Important Note: The following exhibits indicate whether they are required for Pilot Applicants, Design Applicants, or both. That being said, **Design Grant funding is contingent upon SIM Round 2 funding while Pilot Grants are funded through State funding (E2SHB 2572).**

ATTACHMENT:

I. DEFINITIONS

Please note definitions are intended to provide clarity regarding terms used within this GOA and does not constitute a change or establishment of policy. The ACH initiative is an iterative process, and definitions will likely evolve over time. Many of these definitions are pulled from the State Health Care Innovation Plan (Innovation Plan).[1]

Accountable Community of Health (ACH) – A regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of participants in order to achieve healthy communities and populations.

Backbone Support – The backbone support in a Collective Impact[2] effort helps maintain overall strategic coherence and coordinates and manages the day-to-day operations and implementation of work, including stakeholder engagement, communications, data collection and analysis, and other responsibilities. Backbone support may fall within one lead organization or multiple organizations committed to specific backbone functions.

Center for Medicare and Medicaid Innovation (CMMI) – Created by Congress for the purpose of testing "innovative payment and service delivery models to reduce program expenditures….while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program Benefits.

Community Engagement – Loosely defined, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.[3]

Communities of Health (COHs) – The 10 communities funded by E2SHB 2572[4] for the purpose of developing Community Health Plans that describe how they will align, amplify and evolve existing priorities and efforts to develop multi-sector shared priorities and approaches to achieving better health, better care and lower costs. The COH planning process was the first step in formalizing Community Engagement under the ACH initiative, leveraging and building on existing infrastructure and strengths within each community.

Healthier Washington – The initiative that came out of the State Health Care Innovation Plan and the application for the State Innovation Model Round 2 Testing grant.

Plan for Improving Population Health – A required deliverable for CMMI SIM Round 2 grant. Washington, if awarded SIM Round 2, will utilize the Prevention Framework developed through in the Public Health - Private Health Care Delivery System Workgroup as a foundation.

Regional Service Area (RSA) – New service areas for Medicaid purchasing for physical and behavioral health care. They also serve as a foundation for aligning state agencies' along a "Health in all Policies" approach. Boundaries for Regional Service Areas are included in Attachment F.

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[1] Innovation Plan: http://www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf
[2] Evolving Our Understanding of Backbone Organizations: http://www.fsg.org/KnowledgeExchange/Blogs/CollectiveImpact/PostID/389.aspx
[3] Fawcett et al., 1995
[4] E2SHB 2572: http://www.governor.wa.gov/documents/2014_health_care_papers.pdf

Social Determinants of Health – The complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services and structural and societal factors.[5] Social Determinants of Health are based on the premise that health starts where we live, learn, work and play.[6]

State Innovation Models (SIM) Initiative – An initiative of CMMI to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states.

State Health Care Innovation Plan (Innovation Plan) – The State Innovation Model deliverable that describes the state's five-year strategy to transform its health care delivery system through multi-payer payment reform and other initiatives to improve health and health care while reducing costs.

Testing Grant – The response to a CMMI State Innovation Models competitive funding opportunity that sets forth a state proposal to design and test multi-payer payment and delivery models that aim to deliver high quality health care and improve health system performance.

Triple Aim – Originally coined by the Institute for Healthcare Improvement, the "Triple Aim" is a framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience), and reduce cost.

[5] Centers for Disease Control and Prevention: http://www.cdc.gov/socialdeterminants/
[6] Robert Wood Johnson Foundation: http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/10/health-starts-where-we-live.html

II. PURPOSE

The Health Care Authority (HCA) is announcing this Grant Opportunity Announcement (GOA) for further testing and design of the Accountable Community of Health (ACH) initiative as directed by E2SHB 2572 and as part of the Healthier Washington Community Empowerment and Accountability investment[7]. **Two ACH Pilots will be awarded through this GOA. In addition, this GOA anticipates a potential SIM Round 2 award from CMMI that would provide funding for Design grants that will allow communities to continue their design, coordinating with and learning from the Pilot ACHs. In combination, the Pilot ACHs and the design elements from other communities will inform the future ACH role and function.**

The purpose of the ACH initiative is to formally recognize, support, and evaluate the impact of cross-sector alignment, partnership, and commitments to improve health and lower costs in communities across Washington state.

Recognizing health and health care are local, a collaborative community approach is necessary in order to achieve Washington's aims of better health, better care, and lower costs. The ACH initiative is based on the premise that no single sector or organization in a community can independently create transformative, lasting change in health and health care. Clinical, community, and government entities must coordinate their efforts and actions around clearly defined goals that support whole-person health. ACHs will provide the forum, organizational support, and State-regional partnership to achieve transformative results through collaboration.

HCA is seeking to partner with communities and invest in regional ACH proof of concept and design. The ACH Pilot and Design grant opportunity is intended for regions committed to future ACH designation, in alignment with the purpose outlined above. These grant opportunities focus on supporting the necessary foundation and framework within each regional ACH, as Washington prepares for potential statewide ACH implementation. Please refer to Attachments B, C, D and E for additional resources surrounding the vision and construct of the ACH.

III. BACKGROUND

In 2012, Washington State applied for a federal State Innovation Model (SIM) Testing Grant from the Center for Medicare and Medicaid Innovation (CMMI). At that time, more than eighty (80) organizations joined state leaders in support of the initial vision, which led to a nearly $1 million SIM Pre-Testing Award. The award funded the planning process of a five (5) year State Health Care Innovation Plan. A key element of the Innovation Plan is local innovation through regionally organized ACHs that will align actions and investments of diverse sectors to drive transformation in delivery of health and social services and improve population health.

Guided by the Innovation Plan, ten (10) Community of Health (COH) planning grants were authorized and funded by the State Legislature through E2SHB 2572. These grants provided a six (6)-month planning period, ending December 31, 2014, for communities to consider the design of the ACH, including the plan for governance and multi-sector engagement strategies.

[7] SIM Round Two Grant Application for Test Assistance: http://www.hca.wa.gov/hw/Documents/Healthier_Washington_Abstract_072314.pdf

Pilot ACH Grants:

E2SHB 2572 authorized funding to provide a proof of concept under the ACH initiative. This will be accomplished through two (2) Pilot ACHs that will demonstrate a strong governance structure and organizational capacity through the implementation of an initiative identified by the ACH Pilot.

Potential Design Grants:

Additionally, through anticipated SIM Round 2 funding, Design Grants may be awarded throughout the state to correspond with Regional Service Areas (RSAs). Design Grants would provide additional opportunity to coordinate and plan for potential ACH designation within each RSA. Both the Pilot and Design opportunities are included as part of this GOA, although **only the Pilot ACH Grants are guaranteed.**

Below is a summary of the phases under the ACH initiative, as described above:

- **Strategic Planning, 2013-2014:** Development of the Innovation Plan and initial plan on the role of community health collaboratives in driving transformation.
- **Community Engagement, 2014:** Implementation of the State-funded COH planning grants.
- **Community Empowerment, 2015:** Implementation of State-funded pilot ACH Pilot grants and SIM-funded (potential) Design Grants.
- **Community Empowerment and Accountability, 2015-2018 (anticipated):** Designation of ACHs statewide and implementation of accountability measures to align with capacity and funding levels, building upon learnings and promising practices of the previous phases, particularly the ACH Pilots.

IV. GRANT AWARD TERMS AND FUNDING OPPORTUNITY

1. Grant Awards

This GOA anticipates a potential SIM Round 2 award but only provides guaranteed funding for two Pilot ACHs. Design Grants serve a separate purpose and will potentially be funded through a SIM Round 2 award.

a. Pilot ACH Grants

(1) State funded (E2SHB 2572).

(2) Each of the two (2) Pilot ACHs will be a proof-of-concept on critical ACH elements, including the governance structure and decision-making process, engagement, and backbone support functions within the ACH. These components will be demonstrated and enhanced through the execution of a regional initiative.

(3) Design Grants (contingent upon SIM Round 2 funding) will not be awarded within the two (2) RSAs awarded a Pilot ACH Grant.

Note: Pilot applicants will be scored based on the level of existing RSA representation and alignment within the partnership. Where RSA adjustments are resulting in new partnerships and new structure, it is expected that Design funding may be more appropriate, although Pilot application is still allowable.

b. Design Community Grants

(1) Contingent upon SIM Round 2 funding.

(2) The purpose of the Design Community Grants is to allow regions to build on the ACH design efforts that occurred in the COH planning grants and other efforts.

(3) Governance, decision-making, engagement and backbone support are primary considerations for continued development under the Design Grants and deliverables will be aligned as such. A regionally reflective governance model is a key deliverable of the grant. For this reason, it is appropriate for entities within an RSA to collaborate on a single application. HCA is committed to ensuring existing COH efforts are leveraged within the scope of Design Grants.

2. Funding Opportunity

a. Pilot ACHs

Up to $300,000.00 total is available for two (2) Pilot awards, in alignment with the following:

(1) Two (2) Pilot ACHs will be designated and funded.

(2) Each Pilot ACH must represent an entire RSA.

(3) The Pilot ACHs will be funded through June 30, 2015.

(4) Up to $150,000 will be awarded to each Pilot ACH based on the scope of the application.

(5) If not awarded a Pilot Grant, a Pilot application will automatically result in consideration for Design funding.

(6) At HCA's discretion, Pilot ACH awardees will also be eligible for additional support based on the availability of additional federal grant funding. The process to receive additional support and full designation will be established in 2015. It will utilize lessons learned during the Community Engagement and Community Empowerment phases[8] to inform the process.

[8] COH Planning, September 22, 2014: http://www.hca.wa.gov/hw/Documents/COH_NextSteps_92214.pdf

b. Design Grants

Funding for Design Grants is **contingent upon a SIM Round Two award.** Potential awards will align with the following:

(1) No more than one (1) Design Community Grant per RSA.

(2) No more than one (1) Design Community Grant per Applicant (i.e., an applicant is eligible for one (1) Grant regardless of the number of RSAs represented).

(3) The Design Communities will be funded through December 31, 2015.

(4) Up to $100,000 will be awarded to each Design Community, based on population or number of counties within the applicant's RSA and the scope of the proposal.

Note: in alignment with Exhibit B (Application Narrative) and section IX (Evaluation), applications that describe how they build upon COH planning efforts and leverage existing community collaboratives will score higher.

c. Allowable Uses

In alignment with Section V.2 and Exhibits B, C, D and E within this GOA, the following activities are allowable and/or required for use of the awarded grant funds:

Pilot Grants, in alignment with E2SHB 2572:

(1) Design and implementation of regional initiatives that make progress toward achievement of the Triple Aim;
(2) Formalization and improvement of the ACH governance model;
(3) Formalization and strengthening of ACH capacity;
(4) Regional Health Needs Inventory and plan to finalize and/or implement a Regional Health Improvement Plan;
(5) Participation and partnering in the ACH learning collaborative facilitated by HCA;
(6) Planning and testing sustainability of the ACH;
(7) Participation in and assistance with state and federal evaluation of the ACH model; and
(8) Project management activities of the ACH Pilot grant.

Design Grants, in alignment with the Innovation Plan, contingent upon SIM Round 2 funding:

(1) Development of the ACH governance model;
(2) Development of ACH capacity;
(3) Regional Health Needs Inventory and planning for a Regional Health Improvement Plan;
(4) Participation in the ACH learning collaborative facilitated by HCA;
(5) Planning for sustainability of the ACH;
(6) Participation in state and federal evaluation of the ACH model;
(7) Project management activities of the Design grant; and
(8) Design and/or early implementation of community or regional initiatives.

V. GOALS AND DELIVERABLES

The intent of this GOA is to test and develop the ACH initiative by supporting and evaluating the continued development of governance and decision-making, engagement and backbone support functions within RSAs, which will be a prerequisite to successfully engage in health system improvement as an ACH.

1. Goals

a. Pilot ACHs:

Pilot ACHs will test and build the core functions of the ACH by leveraging the existing governance, engagement and organizational capacity that has been developed through COH planning and other efforts. In addition, the Pilot ACHs will serve as peer leaders in opportunities for shared learning and coordinated development.

The Pilot initiative/project is described under required deliverables in section V.2.a and Exhibit E. The Pilot ACH will demonstrate how the governance, engagement and organizational capacity of the Pilot ACH will ensure success in execution of the initiative/project.

b. Design Grantees:

While Pilot ACHs will demonstrate and test the core functions of the ACH, Design Grantees will continue to plan and build these core functions. Design Grantees will continue to leverage existing planning and partnerships. In addition, Design Grantees are expected to build upon the Community Health Plan that was developed during the COH Planning process. Design Communities will also consider adjustments resulting from the newly established RSAs in an effort to achieve ACH alignment within the RSA.

c. Ongoing Technical Assistance

The ACH initiative intends to transform traditional State engagement techniques with communities. As such, this GOA will be a continuation of the collaborative process between and within regions and the State. To support this effort, the State is prepared to commit to the following:

(1) Funding and learning support for ACH design and development, with the commitment to meet communities where they are and encourage the continued evolution and evaluation of both mature and promising communities.

(2) Implementing an amplified “Health in All Policies” approach to drive consistent priorities across multiple State agency policies, and better align agency activities across regions.

(3) Promoting an environment where continuous improvements from real-time learning and data is encouraged and promoted through regular check-ins, discussions and data.

2. Deliverables

The required deliverables outlined below align with the allowable uses and Exhibits B, C, D and E within this GOA. **Pilot ACHs will move forward in alignment with E2SHB 2572’s guidance and funding, while Design Grants are contingent upon a SIM Round 2 award.**

a. Pilot ACHs

(1) Implement and complete the proposed Pilot initiative/project (refer to Exhibit E) and demonstrate how completion of the initiative utilized and enhanced the Pilot ACH’s proposed governance, decision-making and engagement model.

(2) Formalize an ACH governance model and engagement strategy that reflects the RSA and aligns with Attachments in this GOA.

(3) Formalize and strengthen the ACH’s capacity and backbone support. This includes stakeholdering, community engagement, community mobilization, coordination between ACH partners, convening necessary meetings, developing bylaws or charters, and establishing engagement and communication plans.

(4) Develop Regional Health Needs Inventory that reflects the RSA and planning for a Regional Health Improvement Plan.

(5) Establish initial plan for sustainability.

(6) Participate and provide the appropriate information to inform regional, State and federal evaluation needs.

(7) Participate in a statewide ACH learning network (partnering with the State and the other Pilot ACH), in addition to the development of a learning collaborative within the region.

(8) Develop or identify mechanisms or resources (partnering with the State and the other Pilot ACH) for grantees to formally connect health innovation and transformation efforts at the state and local level.

b. Design Regions

(1) Establish ACH governance model and engagement strategy that reflects the RSA and aligns with Attachments in this GOA.

(2) Establish capacity and backbone support for the ACH. This includes stakeholdering, community engagement, community mobilization, coordination between ACH members, convening necessary meetings, developing bylaws or charters, and establishing engagement and communication plans.

(3) Develop Regional Health Needs Inventory that reflects the RSA and planning for a Regional Health Improvement Plan.

(4) Establish initial plan for sustainability.

(5) Participate in a statewide ACH learning network.

(6) Participate and provide the appropriate information to inform regional, State and federal evaluation needs.

(7) Develop an ACH Readiness Proposal to identify and incorporate the deliverables of the grant period, leading toward potential ACH designation.

VI. GENERAL INFORMATION FOR APPLICANTS

1. GOA Coordinator

The GOA Coordinator is the sole point of contact in HCA for this application. Any other communication will be considered unofficial and non-binding on HCA. Applicants are to rely on written statements issued by the GOA Coordinator. Communication directed to parties other than the GOA Coordinator **may result in disqualification**. All communication between the applicants and HCA upon receipt of this application shall be with the GOA Coordinator or their designee, as follows:

Missy Derickson, GOA Coordinator
Email: contracts@hca.wa.gov

HCA does not take responsibility for any problems in e-mail, or Internet delivery services either within or outside HCA.

2. Applicant Questions and Answers

a. It is the responsibility of the potential applicants to carefully read, understand, and follow the instructions contained in this GOA document and all amendments, if any, to the GOA.

b. All questions regarding this GOA must be in writing (e-mail) and addressed to the GOA Coordinator. HCA will only answer questions received no later than date and time specified in GOA Schedule. Questions received after the date and time stated in the schedule will not be accepted.

c. Questions will not be individually answered prior to the date scheduled for HCA responses unless the response could determine whether that applicant submits a Letter

of Intent. Those questions and the response will become part of the official questions and answers (GOA Amendment).

d. Applicant's questions and HCA's official written answers will be posted on the HCA website, www.hca.wa.gov/rfp, by the date in the GOA schedule. The GOA Coordinator will not send individual notification to applicants when responses to the questions are available.

3. Complaint Process

A potential Bidder may submit a complaint regarding this RFP. Grounds for the complaint must be based on at least one (1) of the following:

a. The solicitation unnecessarily restricts competition.
b. The solicitation evaluation or scoring process is unfair or flawed.
c. The solicitation requirements are inadequate or insufficient to prepare a response.

The complaint must be submitted in writing to the RFP Coordinator by the Complaints Deadline. The complaint may not be raised again during the protest period.

The complaint must contain ALL of the following:

a. The complainant's name, name of primary point of contact, mailing address, telephone number, and e-mail address (if any).
b. A clear and specific statement articulating the basis for the complaint.
c. A proposed remedy.

HCA will send a written response to the complainant before the deadline for Proposal submissions. The response will explain HCA's decision and steps it will take in response to the complaint (if any). The complaint and the response, including any changes to the solicitation that may result, will be posted on WEBS. HCA's decision is final; no further appeal will be available.

VII. GRANT APPLICATION REQUIREMENTS

The Exhibits listed within this GOA represent required application materials. Applicants must indicate within Exhibit A if their intent is to pursue Pilot ACH designation, in alignment with section VIII.2. Application for Pilot ACH designation expedites the process for Design Grant application in the event a Pilot applicant is unsuccessful. An unsuccessful Pilot Application will require a revised budget and work plan in order to be considered for a Design Grant. This model ensures Pilot applicants are still eligible for Design grants if not awarded a Pilot grant.

Applicants for the Pilot and Design Grant Awards must comply with the following requirements:

1. Letter of Intent (Mandatory)

a. The applicant must submit a Letter of Intent (LOI) to be eligible to submit a grant application. The applicant must submit the LOI by email to the GOA Coordinator no later than 2:00 p.m. Pacific Time on November 19, 2014 and must be signed by an authorized representative of the applicant. The email must contain GOA #14-028 in the subject line.

A list of applicants who submitted a LOI and the geographic population their application represents will be posted on the HCA website.

b. Under no circumstances will a LOI be accepted after the deadline. Submitting a LOI does not obligate you to submit an application. Information in your LOI should be placed in the same order as the following outline:

(1) Applicant's Organization Name;

(2) Applicant's authorized representative for this GOA (this representative shall also be named the authorized representative identified in the Application);

(3) Title of authorized representative;

(4) Address;

(5) Telephone number;

(6) Email address;

(7) A statement of applicant's intent to submit a Grant Application.

(8) The intended RSA served by the applicant and any potential sub-awardees. Please include a statement reflecting the applicant's approach to incorporating and/or partnering with an existing COH or other recognized convener within the same RSA, if applicable;

(9) Whether they plan to apply for the Pilot or the Design Grant only;

(10) Description of how you meet the minimum requirements; and

(11) If applying for a Pilot Grant, please provide a list of the contacts and email addresses that align with the intent of the survey required as part of the Pilot application (refer to Exhibit E, section 3).

2. Pre-Application Conference Call (Recommended)

a. A Pre-Application Conference Call is scheduled to be held on November 24, 2014at 12:00-1:00 p.m. All applicants who submit a LOI will receive the Conference Call call-in information from the GOA Coordinator by close of business on November 21, 2014. Prospective applicants are highly encouraged to participate.

b. Administrative instructions, questions, as well as the format, process and instructions for the questions and answer period will be discussed during the Conference Call.

c. All questions and answers will be posted on our website per the GOA schedule. HCA shall be bound only to written answers to the questions. Any oral responses given at the Pre-Application Conference Call shall be considered unofficial.

3. Eligibility Criteria: (Mandatory)

The following minimum requirements should be evident within the content of the Application Cover sheet (Exhibit A).

a. Status as an organization or entity with the ability to enable public-private partnership and cross-organizational priority setting. Eligible entities may be engaged in a quasi-governmental arrangement, a 501(c)3 or (c)4 non-profit corporation or cooperative, or another model that enables cross-sector engagement, commitment, and decision making.

b. Ability to receive and manage funding and learning assistance within the represented RSA

c. Plans to serve an entire RSA and coordinate with existing COHs and other recognized conveners in the RSA, if applicable, to ensure COH plans are authentically incorporated into the regional approach.

d. Existence of a community partnership.

The Pilot ACH must demonstrate how the governance, engagement and organizational capacity of the Pilot ACH will ensure success in execution of an initiative/project for an allowable use described in V.2.a.

Note: ACHs are expected to engage individuals who live and work in the communities of the RSA. ACHs will include a combination of partner organizations that cross the continuum of health, community-based care, primary care, mental and behavioral health, oral health, specialty care, community-based care and organizations addressing the social determinants of health (e.g., housing and human service agencies; early learning, education and employment sectors).

VIII. APPLICATION CRITERIA AND SUBMISSION INFORMATION

1. Submission and format instructions:

a. Applicants are required to submit their applications **by email only** to the GOA Coordinator only. All attachments to the email must be formatted in Microsoft Office 2003 or newer or Adobe PDF. Ensure the application is labeled with the date, GOA title, GOA number, and applicant's name.

b. The GOA Coordinator must receive the application at the email address specified no later than the date and time specified in GOA Application Schedule. Late applications will not be accepted and shall automatically be disqualified from further consideration. Applicant is solely responsible for timely delivery of their Application.

c. The application should be prepared simply and efficiently, providing straightforward concise description of the applicant's ability to meet the requirements of this GOA.

d. Must be prepared using 11 to 12 point, Arial or Times Roman font and must be signed by an authorized representative of the applicant. HCA will not accept zip files or faxed Applications.

e. The applicable Exhibits (refer to Section b. below) must be submitted in the order they appear below:

Exhibit A: Application Coversheet (Pilot and Design Applicants);
Exhibit B: Application Narrative (Pilot and Design Applicants);
Exhibit C.1: Work Plan / Timeline (Pilot Applicants);
Exhibit C.2: Work Plan / Timeline (Design Applicants);
Exhibit D: Budget (Pilot and Design Applicants);
Exhibit E: Supplemental Pilot Application Narrative (Pilot Applicants Only); and
Exhibit F: Certifications and Assurances, signed by an authorized representative in blue ink (Pilot and Design Applicants).

f. Applications must provide information in the same order as presented in this document with the same headings. This will not only be helpful to the evaluators of the Application but should assist the Applicant in preparing the response.

g. All pages must be consecutively numbered. The Applicant name and the page number may be located at the top or bottom, but the location must be consistent throughout.

h. Title and number your response to each item in the same order it appears in the GOA Exhibits by restating the question number and text of the requirement in sequence and writing the response immediately after the requirement statement. Failure of the Applicant to respond to any mandatory requirements may cause the entire Application to be eliminated from further consideration.

i. Attachments must be labeled and the question number to which it responds must be indicated.

j. For Mandatory requirements (M) or Scored requirements (S), the Applicant must always indicate explicitly whether or not the Applicant's proposed solution meets the requirement. A response of "not applicable" is considered non-responsive. Do not respond by referring to other sections of your Application. Do not refer to websites or other sources in your GOA. The evaluators will only evaluate materials provided in the Proposal that are responsive to the requirements.

2. Application content instructions:

a. Pilot Grant ACH Applicants:

(1) Applicants must indicate in Exhibit A if their intent is to pursue Pilot ACH designation.

(2) Pilot applicants must complete Exhibits A, B, C.1, D, E and F to reflect a potential Pilot Grant (refer to the deliverables in section V.,2.,a.), including the intent and performance period for this Grant.

(3) If unsuccessful, Pilot applicants will be asked to submit a revised budget and Exhibit C.2 work plan to reflect the scope of work for the Design Grant. These revisions will be due by January 9, 2015 to coincide with the Design application deadline, and Pilot applicants are encouraged to prepare these revisions ahead of time in the event they are unsuccessful.

(4) This model ensures all communities are considered for appropriate levels of funding and support going forward, including unsuccessful Pilot applicants who may qualify for Design funding.

b. Design Grant Applicants:

(1) Design applicants must complete Exhibits A, B, C.2, D and F to reflect a potential Design Grant (refer to the deliverables in section V.,2.,b), including the intent and performance period of this Grant.

NOTE: For the application to be considered complete the applicant must respond to **all requirements** of this GOA. Applicant's failure to comply with any part of HCA's GOA may result in the application being disqualified for being non-responsive to HCA's request.

IX. EVALUATION

Evaluations of the Pilot and Design Applications will only be based upon information provided in the Application. In those cases where it is unclear to what extent a requirement has been addressed, the GOA Coordinator may, at their discretion, contact the applicant to clarify specific points in their application. Applicants should take every precaution to assure that all answers are clear, complete and directly address the specific requirement. Applications will be evaluated strictly in accordance with the requirements set forth in this GOA and any issued amendment.

1. Evaluation Procedures

a. All Applications received by the stated deadline will be reviewed by the GOA Coordinator to ensure that the Application contains all of the required information requested in the GOA. Only responsive Applications that meet the requirements will be forwarded to the evaluation team for further review. Any applicant who does not meet the stated qualifications or any Application that does not contain all of the required information will be rejected as non-responsive.

b. Responsive Applications will be reviewed and scored by an evaluation team using a point/weighted scoring system. Applications will be evaluated strictly in accordance with the requirements set forth in this GOA and any amendments that are issued.

c. The evaluation and scoring of both the Pilot and Design Applications shall be accomplished by two (2) separate evaluation teams, both teams to be designated by HCA.

d. There will be two (2) phases for evaluations; Phase one (1) will be for the Pilot Grants, and Phase two (2) will be for the Design Grants. Applications seeking Pilot ACH designation will be reviewed first by the Pilot evaluation team. The top two (2) scoring Pilot Applicants will be announced as the Apparently Successful Bidders.

e. Unsuccessful Pilot Applicants will be provided the opportunity to submit revised budgets and work plans to align with the scope of the Design Grant opportunity. The revised budgets will be due at the same time as the Design Grant Applications per the GOA Schedule. These applicants will then be scored along with all Design Applications for potential Design Grants.

f. The Design Grants will be awarded based on score. There will be no more than one (1) design grant per RSA and the amount awarded will be considered by the population and/or number of counties within the applicable RSA.

2. Scoring

a. Applications will be reviewed and scored based on the quality of the application. The review criteria for the Pilot ACH and Design Grant applications are based on a total of 130 and 100 points, respectively. The following weighted points will be assigned to the Application for evaluation purposes:

Category	**Pilots**	**Design Regions**
GOA Compliance (Mandatory)	N/A	N/A
Administrative Review (Mandatory)	N/A	N/A
Exhibit B: Application Narrative	80	80
Exhibit C: Work Plan and Timeline	10	10
Exhibit D: Budget	10	10
Exhibit E: Pilot Narrative	25	N/A
Exhibit E: Partner Survey	5	N/A
Total Maximum:	**130**	**100**

b. Applications that pass all Mandatory requirements will be fully evaluated and scored. Evaluators will evaluate and assign a score to each Scored (S) requirements using a point/weighted scoring system based on how well the Applicant response matches the requirement. The Evaluators scores will then be averaged to make the Applicants finals scores for each the Pilot Grant Applications and the Design Grant Applications.

Evaluators will assign scores on a scale of zero (0) to five (5) where the end and midpoints are defined as follows:

Score	Description	Discussion
0	No value	The Response has omitted any discussion of this requirement or the information provided is of no value.
1	Poor	The Response has not fully established the capability to perform the requirement, has marginally described its ability, or has simply restated the requirement.
3	Good	The Response indicates an above-average capability and has provided a complete description of the capability or alternative.

Score	Description	Discussion
5	Excellent	The Response has provided an innovative, detailed demonstration of the capability or established, by references and presentation of information or material, far superior capability in this area.

A score of zero (0) on any Scored (S) requirement may cause the entire Application to be eliminated from further consideration.

3. Final Scores

   a. Pilot Grants: The GOA Coordinator will compute the Applicants Final Score by totaling the Evaluators Averaged Scores from each scored exhibit.

      Exhibit B + Exhibit C.1 + Exhibit D + Exhibit E = Final Score

   b. Design Grants: The GOA Coordinator will compute the Applicants Final Score by totaling Evaluators Averaged Scores from each scored exhibit.

      Exhibit B + Exhibit C.2 + Exhibit D + Exhibit E = Final Score

   c. HCA reserves the right to follow up, conduct interviews, etc. if any additional information is required to clarify content within the application.

4. Successful Applicants

   a. The top two (2) Pilot Grant Applicants will be selected as Apparently Successful Applicants (ASA) and will be awarded up to $150,000. Successful applicants will be notified of their potential award by January 2, 2015. Grant Award Contracts will be established with successful applicants by January 19, 2015.

   b. Contingent on SIM Grant Funding, up to eight (8) Design Grants, one (1) per RSA (not otherwise represented by a Pilot ACH), may be selected as ASAs and will be awarded up to $100,000. Successful applicants will be notified of their potential award by January 21, 2015. The intent is to establish Grant Award Contracts with successful applicants by February 2, 2015.

   c. Maximum award amounts for Design Grants will consider population, County representation with the RSA, and scope of the proposal.

EXHIBIT A: APPLICATION COVERSHEET
Mandatory: Pilot and Design Applicants

1. Applicant's Organization Name;

2. Applicant's authorized representative for this GOA (this representative shall also be named the authorized representative identified in the Application);

3. Title of authorized representative;

4. Address;

5. Telephone number;

6. Email address;

7. A statement of applicant's intent to submit a Grant Application, including intent to apply for a Pilot Grant or Design Grant;

8. The intended RSA served by the applicant and any potential sub-awardees;

9. A statement reflecting the applicant's approach to incorporating and/or partnering with an existing COH or other recognized convener within the same RSA, if applicable.

10. Please describe how you meet the minimum requirements:

    a. Status as an organization or entity with the ability to enable public-private partnership and cross-organizational priority setting. Eligible entities may be engaged in a quasi-governmental arrangement, a 501(c)3 or (c)4 non-profit corporation or cooperative, or another model that enables cross-sector engagement, commitment, and decision making.

    b. Ability to receive and manage funding and learning assistance within the represented RSA.

    c. Plans to serve an entire RSA and coordinate with existing COHs and other recognized conveners in the RSA, if applicable, to ensure COH plans are authentically incorporated into the regional approach.

    d. Existence of a community partnership.

11. If applying for a Pilot Grant, please provide a list of the contacts and email addresses that HCA will use to distribute the survey required as part of the Pilot application (refer to Exhibit E, section 3).

EXHIBIT B: Application Narrative

Scored: Pilot and Design Applicants (Max 80 Points)

These questions are designed to allow for an honest assessment of your organization and the level of development within the community partnership.

1. **Population Served:** the Counties/population represented by the community partnership.

    a. Please describe the RSA represented by the partnership. If the partnership is proposing any sub-award to facilitate RSA adjustments that impact the ACH design, please describe.

    b. Please describe any unique challenges or opportunities within the population.

2. **Governance Structure:** the structure and process for decision making, leveraging community and multi-sector stakeholder input.

    a. Please describe your partnership's recent efforts to develop or consider the development of a governance structure to leverage broad multi-sector community and stakeholder input toward a common agenda of achievement of better health, better care at a lower cost.

    b. Please describe how you have built upon existing community based health improvement coalitions, leveraged and enhanced the existing relationships, commitments and initiatives already in place to ensure a diverse, multi-sector approach to health and health care.

    c. Please describe the existing or planned decision-making process for the partnership. Include a description of any existing or planned policies or strategies to address conflicts of interest.

    d. Please describe the existing or planned committees/sub-committees and the scope of each.

    e. Please describe the existing or planned mediation and conflict resolution strategy that supports the decision making strategy and the ACH's voluntary compact.

    f. Please describe additional strengths and/or challenges regarding your existing and/or proposed governance model.

    g. Describe what mechanisms are in place or planned for keeping committees, sub-committees and other involved entities, including the ACH, accountable.

3. **Engagement**: representation and participation of community members and multi-sector stakeholders, either as members of the partnership or as informants at the community level.

    a. If applicable, please describe your partnership's recent efforts to develop or consider the development of an engagement strategy to increase multi-sector representation and participation.

    b. To the extent possible, indicate if there is a sense of urgency in your region around health improvement, including commitment from champions who are willing to make a commitment to addressing the issue. Have you identified any relevant successes or barriers?

    c. Please list the sectors and stakeholders currently engaged in your community partnership, including any committees or workgroups they are engaged in.

    d. If not included above, please provide a list of the sectors that are expected to engage in your community partnership in the future. How do you propose to engage them?

    e. Please describe the existing or planned community mobilization plan, including the bidirectional process to inform and learn from activities across the region and in individual communities.

    f. Please describe strategies to engage underserved and underrepresented communities/populations within your region.

    g. Please describe strategies you will employ to engage health care consumer populations in your efforts.

    h. In light of recently established RSAs (Attachment F), please describe your partnership's recent efforts to consider or begin the development of a Regional Health Needs Assessment or inventory of existing assessments. Please include a description of the relationship to elements to be included in the Community of Health Plan (if applicable). If you have not begun the effort, describe what your first steps would be.

    i. How will you engage existing regional and/or local collaborative efforts within your RSA? If there is an existing COH within your RSA, how will you partner and engage with this entity to promote cross regional collaboration and coordination, including alignment with their COH plan?

4. **Backbone Support**: the necessary administrative and coordinating functions and processes that support the partnership. Refer to Attachment A for additional information.

    a. If applicable, please describe your partnership's recent efforts to implement or develop a backbone support function or shared functions, including the relationship with the governance and engagement models.

    b. Please describe the existing or planned backbone support for the partnership. If these functions are or will be shared or subcontracted, please describe this process and identify the contributing organizations.

c. Please describe the distinction between the backbone support function and the governing body, including safeguards that are in place to protect any organization or sector from dominating the agenda.

d. To what extent has the partnership assessed and subsequently tapped the strengths and assets of those partnering entities?

5. Governance and Operational Image:

a. Please provide a visual representation of your community partnership's governance structure and backbone support, and please indicate whether this is an existing or planned structure. This visual should identify the decision-making council or committee, sub-committees, community engagement functions, the operational arm or shared operational functions, etc. Please insert within this section or add as an attachment.

6. **Sustainability and Support**:

a. Please describe the level of existing community support and commitment, inside and outside of the partnership.

b. Please demonstrate how you have sought and captured participant resource commitment.

c. Please describe any in-kind support that is or will be provided, including the types of organizations providing support.

d. Please describe the extent to which any discussions or agreements have been sought to share data and/or resources.

e. Please describe the level of existing or anticipated community support to promote the partnership (e.g., philanthropy).

f. Please demonstrate existing involvement of philanthropy within your partnership.

EXHIBIT C: WORK PLAN AND TIMELINE
Exhibit C.1, Scored: Pilot Applicants (Max 10 Points)
Exhibit C.2, Scored: Design Applicants (Max 10 Points)

Every applicant will need to provide a work plan and timeline (Exhibit C.1). In addition, each Pilot applicant must provide a Pilot work plan and timeline (Exhibit C.2). Each set should reflect the proposed work in alignment with the performance periods of the two funding opportunities. This process guarantees fair assessment of the applications if Pilot Applicants do not qualify and/or get selected as a pilot.

While there are shared deliverables for Pilot ACHs and Design Regions, the required Exhibits within this GOA should reflect each applicant's existing progress and next steps to meet the deliverables. For example, a Pilot work plan will likely focus on the formalization, testing and evaluation of existing governance and engagement strategies, while Design applicants will likely focus on development.

Instructions:

1. Enter activities, tracking methods, and milestones/timelines.

2. Use the key objectives and deliverables in the work plan to crosswalk to the budget narrative and budget form.

3. These deliverables and the corresponding objectives, activities and milestones should reflect the deliverables within this GOA, ACH resources outlined in Attachment A, and responses in Exhibit B.

Exhibit C.1 (Pilot Applicants Only)				
Deliverable	**Objectives**	**Activities**	**Tracking Methods**	**Milestones / Timelines**
1. Pilot initiative that leverages the existing governance, engagement and sustainability				

2. Finalizing the ACH governance model that represents the entire RSA				
3. Finalizing the ACH Engagement Strategy				
4. Capacity Development, including the backbone support needed for community engagement and community mobilization				
5. Development of the backbone support within the ACH, including community support and endorsement				
6. Regional Health Needs Inventory to reflect the RSA and plans to finalize and/or implement a Regional Health Improvement Plan				

7. Initial plan for sustainability				
8. ACH Readiness Proposal				
9. Assistance with and participation in statewide ACH evaluation				
10. Partnership with state in developing ACH learning network and Development of a regional learning network, mechanisms or resources for grantees (e.g. ACH logic model)				
11. Other				

Exhibit C.2 (Design Applicants Only)				
Deliverable	**Objectives**	**Activities**	**Tracking Methods**	**Milestones / Timelines**
1. ACH governance model that represents the entire RSA				
2. ACH Engagement Strategy				
3. Capacity Development, including the backbone support needed for community engagement and community mobilization				
4. Development of the backbone support within the ACH, including community support and endorsement				
5. Regional Health Needs Inventory to reflect the RSA and plans to create a Regional Health Improvement Plan				

6. Initial plan for sustainability				
7. Other				

EXHIBIT D: BUDGET
Scored: Pilot and Design Applicants (Max 10 Points)

Instructions:

1. Complete the budget template and the corresponding budget narrative.

2. If applicable, describe sub-award relationship with existing Community of Health planning grantees.

3. Unsuccessful Pilot applicants will be asked to submit a revised budget and work plan after the apparently successful applicants are announced. To expedite this process, Pilot applicants may choose to prepare these materials ahead of the January 2, 2015 announcement.

4. Please ensure the line items provided within the budget(s) align with the budget narrative and the work plan. The line items should clearly support the required deliverables.

5. Include costs for the grant recipient (fiscal agent), including internal staff, in Salaries & Wages, Fringe, Supplies, Travel, and Other categories.

6. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation).

Note: Matching funds are not required but will be considered as part of the application review and evaluation process.

Budget Line Item	Pilot/Design Grant Budget	Matching Funds Estimate	Total Budget
Personnel *(Internal Staff)*	$	$	$
Fringe Benefits *(Internal Staff)*	$	$	$
External Consultants/Contracts:	$	$	$
COH / Backbone Sub-award(s)	$	$	$
Travel	$	$	$
Supplies	$	$	$
Event Expenses	$	$	$

Other (e.g., community / regional initiative)	**$**	**$**	**$**
Total Direct Costs	**$**	**$**	**$**
Indirect	**$**	**$**	**$**
Total (Direct & Indirect)	**$**	**$**	**$**

**Design Grant Budget: For applicants who are applying for Design Grant funding, please fill out this budget worksheet, not to exceed a total of $100,000. For Pilot Grant applicants, please fill out this budget worksheet in addition to the Pilot budget worksheet to reflect your work plan and timeline, in the event you are not awarded a Pilot Grant.*

Budget Narrative:

The budget narrative should provide clear linkages between the work plan (Exhibit C) and the budget (Exhibit D).

EXHIBIT E: PILOT NARRATIVE
Scored, Pilot Applicants Only (Max 30 Points)

This form is only required for applicants choosing to pursue Pilot ACH designation, in alignment with Exhibit B. Application for Pilot ACH designation does not rescind your application for a Design Grant award. Applicants who apply for both a Design and a Pilot grant award are only eligible to receive one (1) grant (either a design or pilot). Please refer to Sec. V and Sec. IX for additional information regarding parameters for Pilot ACH designation and the application evaluation process.

The intent of the pilot initiative or project is to leverage and enhance the ACH framework of governance, engagement and sustainability. Recognizing the breadth of the Triple Aim and the limits of this six (6) month Pilot Grant, the State intends to support two (2) Pilot projects that demonstrate early wins or initial deliverables as part of a broader, longer-term ACH vision. While focusing on a specific regional health initiative, the projects should leverage the ACH's unique framework for achieving regional decision-making and collaboration and enhance and support the development of the ACH's sustainability plan.

1. Initiative or Project Proposal

    a. Please describe the proposed project, including how it aligns with the Triple Aim and the State's ACH strategies and outcomes (Refer to Attachment D).

    b. Please describe how the proposed project or initiative will leverage the governance, engagement and operational support described in Exhibit B, including the demonstration of these components as essential functions within the ACH construct.

    c. Please describe how the proposed project or initiative will accelerate, enhance and/or expand the governance, engagement and organizational capacity described in Exhibit B.

2. Peer Leader

    a. Please describe how your partnership is well equipped to provide guidance and be a thought partner with other Design and Pilot Grantees in the progression toward potential statewide ACH implementation. Please include examples of potential shared learning opportunities or mechanisms.

    b. Please describe how your partnership will ensure shared learning at the regional level as well, sharing innovation and transformation across other regions and with the state and within your own region as well.

3. Partner Attestation

    a. In alignment with the contact list provided within your LOI, HCA will utilize a survey to gauge stakeholder support and engagement. The contact list should reflect the core community partnership. The intent of this survey is to confirm the existence of backbone support functions, authentic engagement, and a governance structure that is supported by both. Below are questions:

Please note that this survey will be part of the applicant's scored application and is therefore **not anonymous.**

- Please list the organization you represent.
- Please list the existing community partnership (the applicant) you are affiliated with, if applicable.
- What sector do you represent within the partnership?
- Please indicate your level of support for the applicant.
- Provide examples of how you as a partner have supported this community partnership.
- Do you feel the necessary information is provided to the community partnership and is this information provided in a timely manner?
- Is there a process for all voices to be heard and is it working?

4. Please provide a proposed ACH Logic Model (Refer to Attachment A for additional resources).

EXHIBIT F

CERTIFICATIONS AND ASSURANCES
GOA #14-028 – ACH Pilot and Design Grants
(Mandatory)

I/we make the following certifications and assurances as a required element of the Application to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. I/we declare that all answers and statements made in the Application are true and correct.

2. In preparing this Application, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this Application or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this Application. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).

3. I/we understand that the HCA will not reimburse me/us for any costs incurred in the preparation of this Application. All Applications become the property of the HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this Application.

4. No attempt has been made or will be made by the Applicant to induce any other person or Applicant to submit or not to submit an Application for the purpose of restricting competition.

On behalf of the firm submitting this Application, my name below attests to the accuracy of the above statements.

_____
Signature of Applicant

_____
Title Date

Attachment A

References

1. **Collective Impact**

    a. Collective Insights on Collective Impact: http://collectiveinsights.ssireview.org/
    b. Backbone Support: http://www.fsg.org/KnowledgeExchange/Blogs/CollectiveImpact/PostID/389.aspx
    c. Backbone Activities and Outcomes:

2. **Legislation**

    a. E2SHB 2572: http://www.governor.wa.gov/documents/2014_health_care_papers.pdf
    b. 2SSB 6312: http://www.governor.wa.gov/documents/2014_behavorial_health_paper.pdf

3. **Logic Models**
    a. University of Wisconsin, Program Development and Evaluation: http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
    b. W.K. Kellogg Foundation, Logic Model Development Guide: http://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide

4. **Strategic Planning and SIM Round 2**
    a. Innovation Plan, Three Core Strategies:

    - **Improve how we pay for services.** Presently, providers of health care services are paid every time they provide a service, even when the service doesn't work. The plan calls for rewarding providers when they achieve good outcomes. Information on effectiveness and cost will be collected and shared to help providers and consumers choose the best treatment options.

    - **Ensure health care focuses on the whole person.** The current system creates barriers to addressing physical health, mental health, chemical dependency, and basic living needs as early as possible and at the same time. The plan calls for methods of integrating care and connecting with community services to achieve the best possible result for individuals. It also adjusts how we pay for services to make care for the whole person possible.

    - **Build healthier communities through a broad collaborative regional approach.** Virtually all health care is delivered at the local level. Driven by local partners, the Innovation Plan calls for a regional approach that empowers communities. Working together, communities can bring about changes that will improve health for the people they serve. http://www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf

b. Innovation Plan, Appendix E:
http://www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf

c. COH Planning, September 22, 2014:
http://www.hca.wa.gov/hw/Documents/COH_NextSteps_92214.pdf

Attachment B

ACH Backbone and Governance Guidance

Defining "backbone support:"

- Could represent roles filled by multiple entities rather than functioning as a single backbone organization.
- Not the power center of the initiative but the "support leader." A neutral convener.
- Provides operational and administrative support and guidance to the governing members and facilitates and informs the decision-making process. Some key roles over time could include: guide vision and strategy, support aligned activities, establish shared measurement practices, build public will, advance policy and mobilize funding.
- May be the recipient or a subcontractor. Should reflect local circumstances and leverage local strengths.
- For the ACH granting process, the backbone support function could be the grant recipient. There should be demonstration of a community process and agreement of the core members of the ACH that the backbone or shared backbone support functions are indeed recognized and supported by the region. If a region decides to utilize a "bifurcated" or decentralized model they should explain and differentiate roles and responsibilities as well as how they will align.

Defining the ACH:

- The ACH represents the entire partnership and is not the same as the backbone support. The ACH includes the engagement, governance and decision making structure, along with the backbone support functions.
- The ACH is the decision-making body, supported by the backbone, which is not the decision-making body.
- The governance and decision-making function may be developed and led by the backbone support. There may be overlap in representation, but if there is overlap there will need to be safeguards in place (e.g., bylaws, charters, etc).

Attachment C

ACH and RSA Alignment Proposal

Introduction:

Washington's regional Medicaid purchasing strategy and Accountable Community of Health (ACH) initiative are operating in parallel tracks but are integral to one another and to Washington achieving better health, better care at a lower cost. As Washington moves closer to designating Regional Service Areas (RSAs) for Medicaid purchasing, Washington needs to establish a policy regarding ACH and RSA ratio. Refer to Attachment F for the RSA map.

Context and Recommendation:

Currently, service areas differ for many state financed health care, social support and other essential state services. With a common regional approach for Medicaid purchasing, the state intends to:

- Promote alignment of state services across common regions starting with Medicaid purchasing, but encouraging additional alignment over time with other state agencies and local services to support a "Health in all Policies" approach.

- Facilitate shared accountability within each RSA for the health and well-being of its residents.

- Empower entities within the region to develop bottom up collaborative approaches to health transformation that are representative of community priorities, populations and environments.

While moving toward fully integrated purchasing on a regional basis will create administrative and financial efficiency and support service integration, health system transformation requires additional alignment. Health system transformation depends upon further coordination and integration at the delivery system level with community services, social services and public health and building the necessary linkages and supportive environments to address the needs of the whole person. This strategy will be greatly enhanced by the development of ***one*** ACH within each RSA.

Though not required in statute, it is desirable from an administrative, business, and community linkages perspective to align Medicaid purchasing regions and ACH. The State is currently in the process of developing policies around engagement of the ACH as a partner in purchasing. The partnerships expected of the ACH for the region (i.e., with State and the managed care plans) are strengthened if there is one ACH within each RSA. Furthermore, engaging other agencies and entities to adopt RSAs to support a health in all policies approach will be more difficult, if not unrealistic, if the State pursues multiple ACHs within one RSA. This is represented on the ACH/RSA ratio matrix below.

Below is a matrix of ACH/RSA ratio models along a preference continuum from ideal to highly undesirable, which supports the context and recommendation above.

Continuum	Ratio: ACH-RSA	Possible Governance and Organizational Structure
Ideal	1:1	There are multiple governance models that could be viable for this option. • **Single County RSA:** Multiple governance models will work, and there is an advantage in only having to work with one county structure. Most likely a stronger, centralized governance structure will be present. Most likely, sub-committees will reflect functional areas, rather than individual communities within the County. • **Multi-County RSA (A):** Similar governance structures employed by a single county RSA, however added complexity exists in incorporating multi-county representation. In a region with a strong history of regional health improvement work, a governance structure with cross county representation on functional and/or "aim" focused sub-committees is viable. • **Multi-County RSA (B):** Utilize a centralized governance model, in additional to functional and/or "aim" focused sub-committees; the ACH will have county level sub-committees to reflect the needs of each county.
Viable	1:1	• **Multi-County RSA (C):** Utilize a federated model, which still employs a central governance structure, but places more decision-making within regional sub-committees that represent either counties or pre-formed alliances created due to Community of Health Planning and/or other regional health planning efforts. • **Multi-County RSA (D):** Utilize a confederated model, which rests a small amount of power in a central governing structure which is representative of all counties or initial community of health planning grantees within a region, but places much more control in the county and/or existing community of health structures. Accountability to the State would still reflect demonstration of health improvement and coordination at the regional level.
Potentially viable	1:1 with shared backbone support	• Multiple ACHs could leverage a single backbone organization to provide consolidated support in a continuous region, while still maintaining separate ACH governance structures. • This is a potential option when (multiple) RSAs fall within the geographic planning region for a single Community of Health grantee.
Potentially viable	1 ACH: Multiple	• It is possible for one ACH governance model to serve multiple RSAs.

	RSAs	• The backbone support would need to reflect the specific governance model to ensure appropriate coordination, facilitation, engagement, etc. • It would still be critical for each RSA to have a forum for engagement and coordination that contributes to the collective decision-making process. • It would be critical to ensure community partners support the shared governance model, otherwise this is not viable.
Not Viable*	Multiple ACHs: 1 RSA	• As reflected above, the governance structures are accommodating for the level of centralization of governance desired to recognize sub-regional, county and community uniqueness. The State does not believe setting up multiple ACH structures within a RSA meets the desired goals the State envisions for the ACHs, especially in regards to their role as a partner in purchasing.

*This GOA does not allow for multiple awards within a single RSA. For the purpose of this GOA, there can be no more than one Design Grant or Pilot Grant within an RSA, regardless of the proposed governance structure.

Attachment D

The Proposed Role of Accountable Communities of Health in Washington State

Accountable Communities of Health (ACHs) are a precondition to achieving better health, better care and lower costs under the Healthier Washington initiative.

1. ACHs are designed to implement the following proposed strategies:

    - **Build upon existing community-based health improvement coalitions, leveraging and enhancing the relationships, commitments, and initiatives already in place** to ensure a diverse, multi-sector approach to health and health care. The precise organizational and governance structure will not be dictated at the state level. ACHs will utilize a "collective impact" model to guide development.

    - **Strengthen community linkages between the local health care delivery system, public health, and others who influence a community's physical and social environments**, better informing and coordinating the priorities of each and placing a greater emphasis on social determinants of health and population health improvement.

    - **Formally connect health innovation and transformation efforts at the state and local level**, allowing each to focus on its strengths, and leverage shared resources.

    - **Coordinate and connect at the regional and local level** the delivery of the range of health care services and community and social supports contributing to individual and community well-being.

    - **Be a resource that managed care organizations draw upon to meet the state's new expectations as it transitions medical assistance programs** more rapidly from payment for particular health care services to payment for value and improved outcomes.

    - **Evaluate and elevate health innovations happening at the local level and facilitate the sharing of information about successes and failures statewide**, enabling replication of success and avoidance of failures.

2. Utilizing the functions introduced above, ACHs will accomplish the following goals:

    - Leverage the unique strengths of the region by providing a strong and organized local voice **to tailor and adapt state health care purchasing, delivery system reform and other health improvement activities within a region** so programs are responsive to the unique strengths and needs of the region.

    - **Implement regional strategies and interventions set forth in the Plan for Improving Population Health**. Engage and mobilize its multi-sector members in implementation.

    - **Accelerate the integration of physical and behavioral health care at the financing and delivery system level, starting with Medicaid**, and inform the reinvestment of shared savings to support the community.

- **Invest in promising and evidence-based practices and evaluating the results, scaling and spreading effective models, and capturing savings for reinvestment and sustainability** through statewide learning collaboratives and testing innovative financing mechanisms.

- **Address community health needs with the use of innovative data.** ACHs will be armed with health mapping capabilities that will leverage improved statewide data analytics and integration.

- **Partner with the state in successful achievement of quantitative and qualitative measures targets set as bars of success,** specifically those tied to population health improvement and scaling efforts statewide.

- Amplify the role and responsibility of multiple sectors in health improvement to **further address the social determinants of health.**

3. What is the relationship between ACHs and Risk-Bearing Entities (e.g., Behavioral Health Organizations and Managed Care Organizations)?

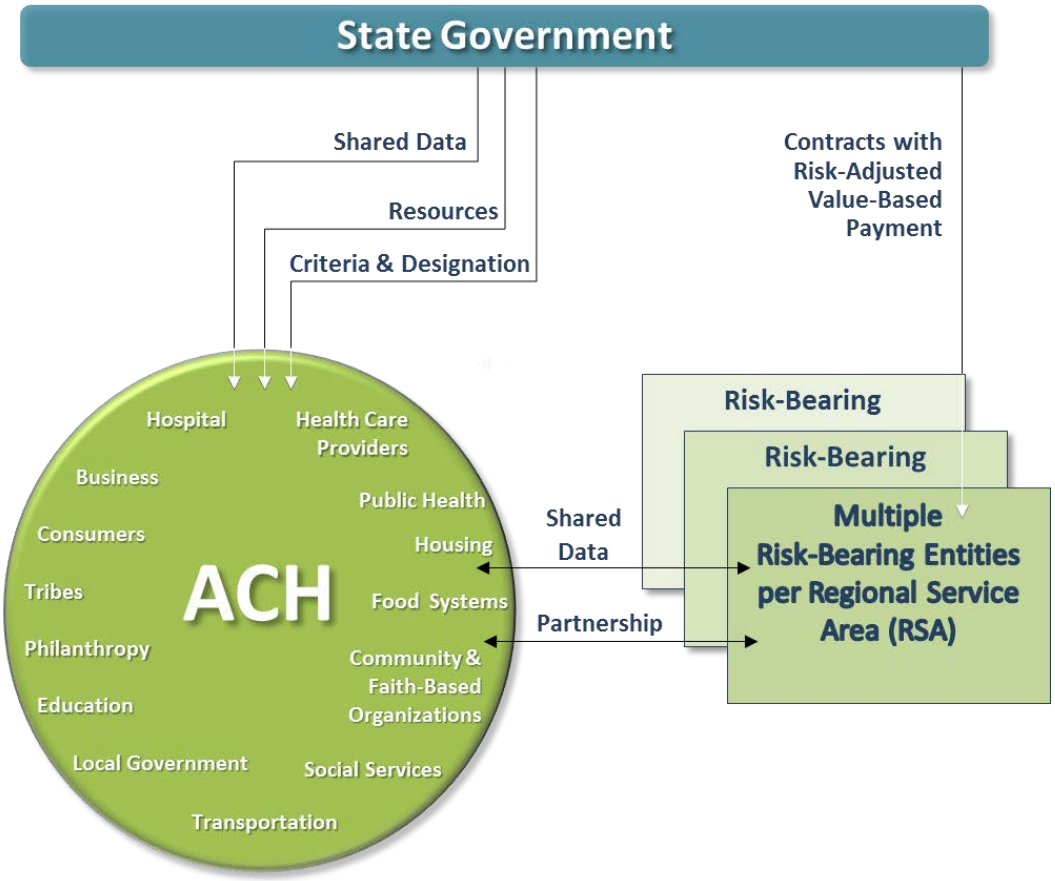
As indicated in the illustration below, the relationship between ACHs and risk-bearing entities is as follows:

- **The geographic area of an ACH will align with Regional Service Areas (RSA) for Medicaid purchasing** and it is likely there will only be one ACH per RSA.

- Whether an RSA decides to be an early adopter (integrated purchasing in 2016) or a transition region (integrated purchasing by 2020), **the ACH will be actively engaged in health improvement initiatives within the RSA and work in partnership with the risk bearing entity.**

- **ACHs will inform the state's purchasing of Medicaid in their region**, including strategies for incentivizing health plans based on regional needs and priorities.

- **As ACHs progress they are expected to partner with HCA and with risk-bearing entities to improve health delivery systems.** ACH influence will increase as the partnership with risk-bearing entities matures.


State Government
Shared Data
Resources
Criteria & Designation
Contracts with Risk-Adjusted Value-Based Payment
Hospital
Health Care Providers
Business
Public Health
Consumers
Housing
ACH
Tribes
Food Systems
Philanthropy
Community & Faith-Based Organizations
Education
Local Government
Social Services
Transportation
Shared Data
Partnership
Risk-Bearing
Risk-Bearing
Multiple Risk-Bearing Entities per Regional Service Area (RSA)

Attachment E

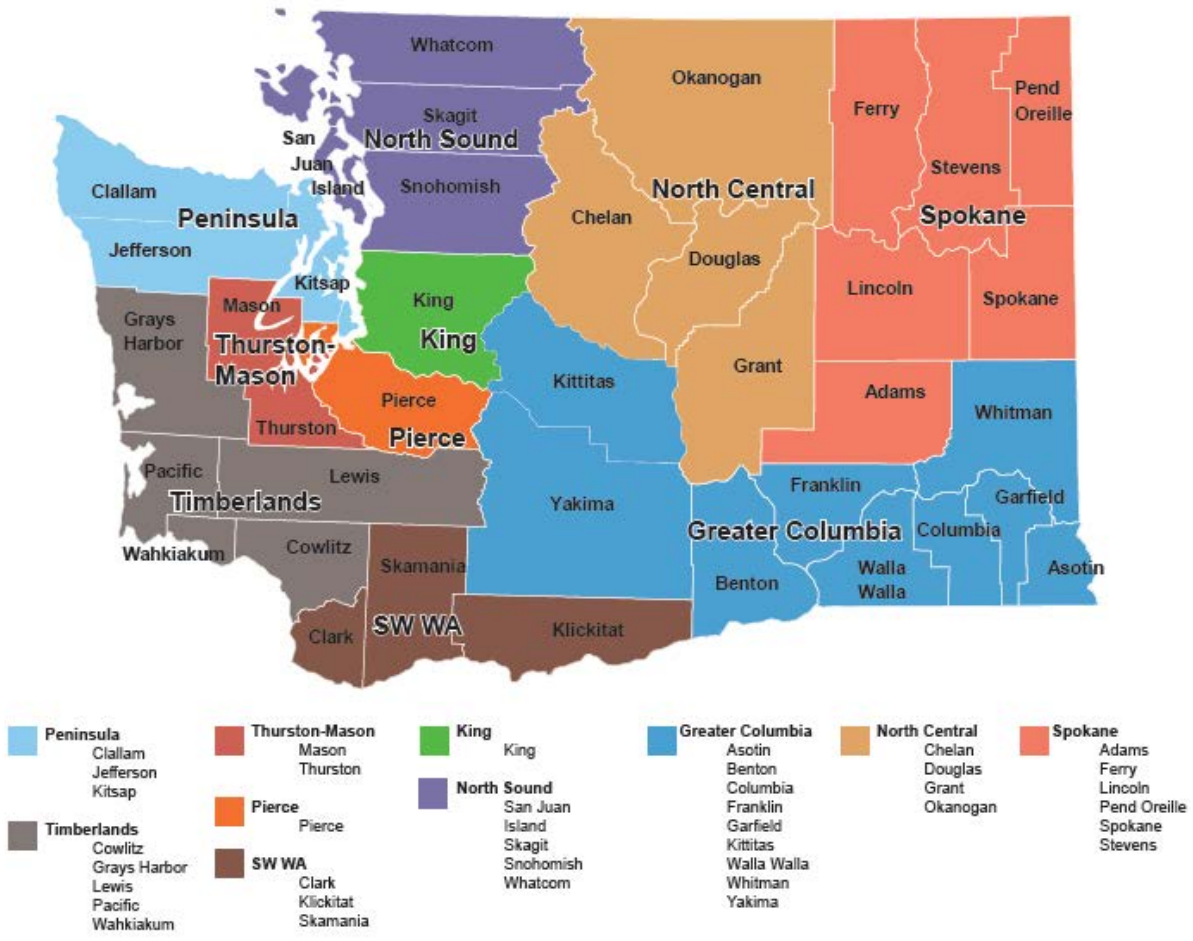
Potential ACH Partners

Please note that this is not a comprehensive list of potential partners. In addition, these partners may be engaged in different capacities based on the governance and engagement strategy (e.g., cascading engagement).

- Accountable Care Organizations
- Assisted living facilities
- Behavioral health providers
- Community based non-profit or for profit organizations
- Community mental health centers
- Community services organizations
- Community wellness programs
- Consumers and people who live in the community
- Criminal justice
- Dental providers
- Early learning
- Economic development
- Emergency Medical Services (EMS)
- Employers
- Employment services
- Faith based organizations
- Federally Qualified Health Centers (FQHC)
- Food systems
- Health plans
- Home health organizations
- Hospitals
- Housing
- Labor organizations
- Large and small businesses
- Law enforcement and correction agencies
- Local governments
- Long-term care system
- Payers
- Pediatricians or Pediatric Associations
- Pharmacies
- Philanthropy
- Physical health care providers
- Public health
- Purchasers
- Schools and educational institutions or districts
- Social services or social supports
- Transportation
- Tribal governments

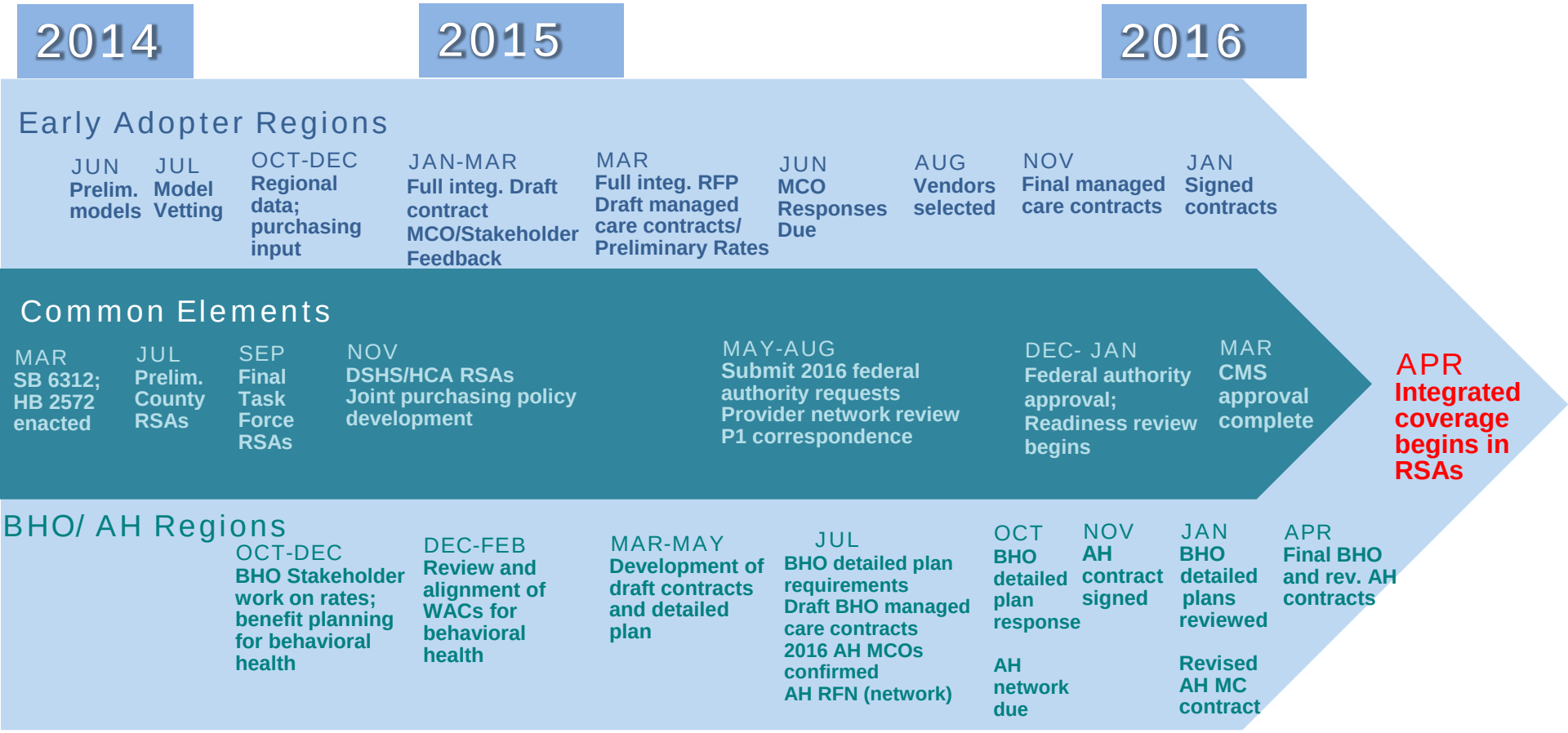
Attachment F

Regional Service Areas



Appendix H

Medicaid Integration Timeline



RSA – Regional service areas
MCO – Managed Care Organization
BHO – Behavioral Health Organization
AH – Apple Health (medical managed care)
SPA – Medicaid State Plan amendment
CMS – Centers for Medicare and Medicaid Services
Early Adopter Regions: Fully integrated purchasing
BHO/AH Regions: Separate managed care arrangements for physical and behavioral health care

Appendix I

WASHINGTON STATE HEALTH CARE AUTHORITY & KING COUNTY

REQUEST FOR INFORMATION (RFI) 2014-014

TITLE:

CURRENT AND FUTURE ACCOUNTABLE DELIVERY AND PAYMENT MODELS AND STRATEGIES

RELEASE DATE: APRIL 8, 2014

CONTENTS

1. Washington State's Vision for Transformation

The State Health Care Innovation Plan (Innovation Plan)[1] charts a bold course for transformative change in the way health care is delivered and paid for in Washington State. By 2019, Washington State expects to attain the 'Triple Aim' and related goals:

- Healthy people and communities – 90 percent of Washington residents and their communities will be healthier;
- Better Care – Individuals with physical and behavioral comorbidities receive high-quality care; and
- Affordable Care – Annual health care cost growth will be two percent less than national health expenditure trend.

For more details on each strategy and key actions, see Appendix A for a one-page summary of Washington's Five-Year Plan for Health Care Innovation Plan.

2. HCA, King County and Value-Based Purchasing Expectations

To support higher quality and more affordable health, the Washington State Health Care Authority (HCA) will change how it purchases health care coverage, so that payment is based on value, not volume. We intend to move 80 percent of state-financed health care and 50 percent of the commercial market to outcomes-based payment within five years (by 2019). As the largest purchaser of health care services in Washington State, HCA will drive value-based purchasing (VBP) statewide in an effort to phase out Fee-For-Service (FFS) payment models; align provider, payer, and consumer incentives; and reward value, quality, effectiveness and efficiency. HCA in tandem with its own State-purchasing efforts will engage multiple payers[2], providers, and purchasers in aligning common VBP strategies, alternative payment models, and basic delivery system requirements across Washington State to accelerate market transformation, eliminate duplication and waste, and encourage innovative strategies that drive towards the Triple Aim.

"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."—Meyer, Rybowski, and Eichler, 1997, p.1

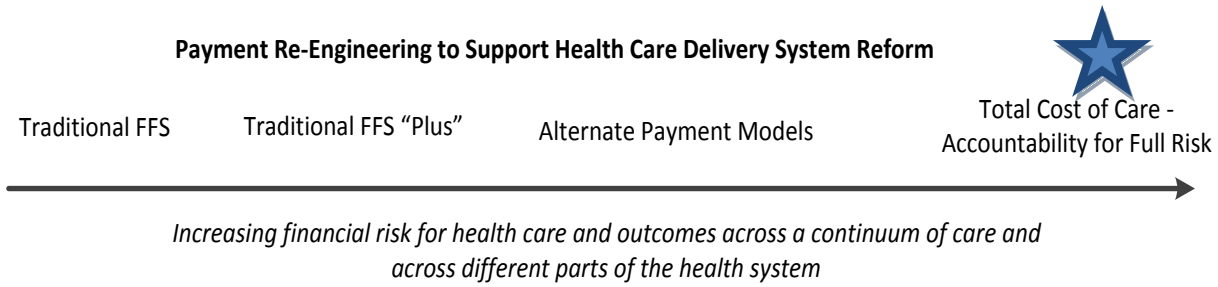
[1] For the Washington State Health Care Innovation Plan, go to: http://www.hca.wa.gov/shcip/Documents/SHCIP_InnovationPlan.pdf.

[2] In this RFI 'payer' is defined as an insurance company and/or Third Party Administrator (TPA) offering a health benefit plan or product purchased by employers.

HCA and King County are Washington's two largest public purchasers of health care coverage. As such, they are responsible for a quarter of Washington State's insured population. HCA and King County government share the same purchasing goals and expectations. In addition, we have common aspirations for a health care delivery system that strives to:

- Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening;
- Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients; and
- Use the lowest cost, highest quality care for acute, non-emergency conditions.

We recognize that providers are at varying stages of interest and ability to take on financial risk or accountability for services. Payers also have different levels of engagement in supporting providers who are ready to transform care delivery and transition to more comprehensive payment reforms. However, over the next five years, we will expand our partnerships with providers and payers who will actively support integrated care models including formal Accountable Care Organizations (ACOs) because we want to work with partners (1) with experience and capacity to integrate care, (2) that manage financial and clinical risk for a defined population, and (3) have the ability to produce tangible improved outcomes using a total cost of care payment model[3]. To that end, we have established a phased path to payment reform (see diagram below). At the same time, we will continue to encourage existing innovative efforts to flourish in the marketplace, but in a more aligned fashion, in order for transformation of the entire market to be successful.



For more information on the re-engineering payment systems path to support health care delivery system reform see Appendix B.

[3] In this RFI 'total cost of care' is defined as a risk-adjusted payment that captures all costs of care for a defined population, including all professional, pharmacy, hospital, and ancillary care.

3. RFI Purpose

HCA and King County are partnering on this joint RFI to obtain details on providers and payers' current organizational capacity and status as well as their future plans (next five years, by 2019) to 1) manage financial and clinical risk for a defined population, and 2) produce tangible improved outcomes using a total cost of care payment model. Specifically, we want to understand the scope of strategies providers and payers are currently engaged in or planning, as well as any challenges both stakeholder groups have faced, related to redesigning health care delivery systems to achieve the Triple Aim; restructuring health care payment systems to support and reward providers who deliver high-value health care; working with purchasers to align delivery system and payment reform models with benefit design changes; and educating and encouraging state residents to improve their health and use high-value health care services.

In addition, we have partnered on this RFI because we share the same purchasing principles and values, and we want to support efficiency for responders. RFI responses may inform HCA and King County's own separate selection processes for health coverage and benefits, in 2016 and 2017, respectively.

4. Background

HCA currently purchases health coverage for more than 1.8 million people through its Washington Apple Health (Medicaid) program and Public Employees Benefits (PEBB) program, and is projected to provide health insurance to upwards of 2 million people, or nearly a third of Washington's insured population by 2017. Of this, approximately 350,000 state employees and their families currently receive health coverage and benefits through the PEBB program.

Both programs have different rules and regulations and are administered separately. Regardless of programmatic and regulatory differences, HCA will align and implement joint purchasing strategies between the two programs where appropriate.

As outlined in the Innovation Plan and mentioned above, Washington's immediate five-year purchasing strategy includes reforms to transition our health care delivery away from a largely FFS payment system to one that is outcomes-based and achieves the Triple Aim. Hundreds of stakeholders participated in the design of the Innovation Plan, which was further embraced in the 2014 legislative session with passage of E2SHB 2572 (2014)[4]and 2SSB 6312 (2014)[5]. The passage of these bills solidifies Washington State's path for innovative state purchasing strategies (2572) and Medicaid integrated delivery (6312) reforms. While innovation in the Medicaid program is currently directed towards serving clients through managed care delivery systems in which physical and behavioral health care are fully integrated, HCA anticipates that accountable payment and delivery system approaches in the PEBB program will be applicable to Medicaid.

[4] http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/House%20Passed%20Legislature/2572-S2.PL.pdf
[5] http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf

King County (as an employer) has over 13,500 benefits-eligible employees and an additional 18,500 covered family members bringing the total covered lives to roughly 32,000. An early innovator, King County in 2006 was one of the first public sector employers to create a wellness program with financial incentives. From 2007-2011, King County improved employee health (800 people quit smoking and more than 2000 employees/domestic partners lost at least 5 percent of body weight and maintained a lower BMI for 5 years), saved $46 million in health care costs, and lowered its health care cost trend rate from nearly twice the national average to less than half of the national average. King County's Healthy Incentives program has received national awards and recognition, most recently the top award for employee wellness programs from Seattle Business magazine in 2013 and the 2014 Innovations in American Government Award from Harvard's Kennedy School of Government.

5. HCA and King County's Estimated Procurement Timeline

- April 2014 – HCA/King County Joint RFI released
- End of May 2014 – RFI responses due
- June 2014– Estimated start date of HCA procurement cycle for 2016 (for Medicaid and PEBB program)
- Mid-2015 – Estimated start date of King County procurement cycle for 2017
- 2016 – New Medicaid and PEBB program health coverage contracts take effect
- 2017 – King County health coverage contracts take effect

6. RFI Directions

We encourage all types of entities—large and small provider practices and groups, integrated delivery systems, payers, managed care organizations, and other health stakeholders—to respond.

- If your organization is a provider or delivery system, please respond to Section 1 (including Attachments A and C);
- If your organization is a payer, please respond to Section 2 (including Attachments B and C); and
- All other entities, please respond to any or all of Section 1 and/or 2 (including Attachments A or B)

Please note: If your organization represents multiple stakeholder views and perspectives (e.g., your organization is a delivery system and a payer), please feel free to submit more than one response.

SECTION 1. ACCOUNTABLE DELIVERY AND PAYMENT STRATEGIES AND MODLES: PROVIDERS[6]

Instructions: For each question, please state which strategies are currently in place (implemented) as well as future plans (planning) (during the next five years, by 2019). Please include a scale of 0% to 100% progress made to date in both planning and penetration (percent of target population to which initiative is currently operational). Please include as much specificity as possible.

- 100% planning score = planning phase is complete and execution of the initiative has begun.
- 100% penetration score = the initiative has been implemented and is serving all of your enrollees/patients/members the initiative is intended to target.

1.1. Organizational Structure, Partners, and Risk Experience

A. Please describe your organization, including names and types of major contracted/business associates or community partners.

B. What criteria did your organization use to create networks/select partners? How do you assure network adequacy?

C. What are your organization's previous experiences with bearing financial and clinical risk and contracting capability for care outside your organization or structure's walls to assure appropriateness of care and total cost of care accountability?

1.2. Primary Care/Prevention/Chronic Disease Management

A. How does your organization proactively monitor patients—within and outside your organization or structure's walls—to ensure primary care, preventive services, and screenings are appropriate, evidence-based, and delivered in ways that are culturally appropriate for the patient? How do you identify barriers patients are facing in obtaining those services, and how does your organization overcome those barriers?

B. How is primary care used to manage and meet the needs of patients (including social needs) with chronic and complex care needs and conditions?

[6] Key concepts from the Washington Health Alliance's Purchaser Guidelines to Evaluate Contracts for Accountable Care Organizations (ACOs) (www.wahealthalliance.org). For more information, please contact Susie Dade (sdade@wahealthalliance.org).

C. What specific tools, systems, and approaches have you found effective and/or ineffective to help reach and provide primary care/preventive care/screening/chronic disease management to hard to reach populations?

D. What types of non-traditional or community-based care delivery approaches does your organization use to provide effective and efficient care (e.g., tele-health, group visits, peer counseling, community health workers/navigators, email)?

1.3. Financial Incentives/Alternative Payment Models and Strategies

See Attachment A.

1.4. Coordination of Care

A. How does your organization ensure seamless care for patients with chronic or complex care needs, including medical care, mental health, substance use disorders, long-term care supports, and dental care within and outside your organizations walls? Please include a description of the role(s) of community-based and social service organizations and local government play in your strategies; any experience with leveraging a regional or state health information exchange and exchanging clinical information; and how your organization promotes the active sharing of clinical information to eliminate unwarranted variation and unnecessary care.

B. What barriers has or does your organization face as it moves towards integrated care models that address both physical and behavioral (mental health and substance use) health needs of patients?

1.5. Measuring Performance

A. What is your organization's capacity and experience with leveraging claims and clinical data for measure collection and reporting on:

- Health status;
- Clinical outcomes;
- Functional status/productivity;
- Appropriateness;
- Patient/caregiver experience;
- Preventive health;
- Care coordination/patient safety/care transitions;
- At-risk populations;
- Cost; and
- Utilization and resource use?

B. Does your organization employ utilization benchmarking (e.g., if your organization sets targets and how).

1.6. Use of Data for Patient Care and Continuous Quality Improvement

A. How does your organization use clinical, experience, and other patient data (e.g., from Electronic Health Record (EHR), chronic disease registry, etc.) at the point of care for individual patients and population health management?

B. How does your organization use data to continually improve quality and patient care over time?

1.7. Patient Engagement

A. What educational tools and activities does your organization use to proactively engage patients and encourage healthy behaviors, as well as help patients choose which types of testing and treatments are appropriate for acute, non-emergency conditions, (e.g., shared decision-making, videos, provider listings, information on how to access primary, specialty, and behavioral health and substance use providers, auto enrollment/selection of a primary care physician, etc.)? What incentives for providers and/or patients does your organization use to encourage the use of these tools and activities?

B. How does your organization measure and assess the impact and effectiveness of patient engagement activities (e.g., improved use of preventive services, reduction in unnecessary treatments or services, patient activation levels and self-management)?

1.8. Partnering with Purchasers on Strategies

Does your organization have experience working with and assisting purchasers/Washington State (or other states/governments) with benefit design recommendations that support value-based purchasing success, including sharing performance/reporting data with them?

1.9. Multi-Payer & Multi-Stakeholder Activities

A. Does your organization participate in multi-payer and multi-stakeholder activities (e.g., Patient Centered Medical Home, quality improvement activities, participation in the Washington Health Alliance, etc.)? If yes, please include details on payers involved in each activity (e.g., Medicare, Medicaid, commercial, etc.).

B. How is your organization preparing to participate in an organized process with other providers, payers, purchasers, and other health and health care stakeholders to align agreed upon delivery and payment reform strategies in complementary ways?

1.10. Feedback on Developing Accountable Care Delivery and Payment Components in Partnership with Payers, Providers, and Purchasers

From your organization's perspective, what design components should purchasers consider in designing accountable care delivery and payment models, including ACOs (e.g., ramp up or baseline period, auto enrollment, minimum population size, methods to distribute savings, inclusions/exclusions in total cost of care methodology, risk mitigation, etc.)?

SECTION 2. ACCOUNTABLE DELIVERY AND PAYMENT STRATEGIES AND MODELS: PAYERS[7]

Instructions: For each question, please state which strategies are currently in place (implemented) as well as future plans (planning) (during the next five years, by 2019). Please include a scale of 0% to 100% progress made to date in both planning and penetration (percent of target population to which initiative is currently operational). Please include as much specificity as possible.

- 100% planning score = planning phase is complete, and execution of the initiative has begun.
- 100% penetration score = the initiative has been implemented and is serving all of your enrollees/patients/members the initiative is intended to target.

2.1. Organizational Structure, Partners, and Risk Experience

A. Please describe your organization, including names and types of major contracted/business associates or community partners.

B. What criteria did your organization use to create networks/select partners? How do you assure network adequacy?

C. What are your organization's previous experiences with bearing financial and clinical risk and contracting capability for care outside your organization or structure's walls to assure appropriateness of care and total cost of care accountability?

2.2. Primary Care/Prevention/Chronic Disease Management

A. How does your organization support providers to proactively monitor patients—within and outside your organization or structure's walls—to ensure primary care, preventive services, and screenings are appropriate, evidence-based, and delivered in ways that are culturally appropriate for the patient? What, if any, barriers has your organization faced in supporting providers?

B. How does your organization support and/or incent providers to manage and meet the needs of patients (including social needs) with chronic and complex care needs and conditions?

[7] Key concepts from the Washington Health Alliance's Purchaser Guidelines to Evaluate Contracts for Accountable Care Organizations (ACOs) (www.wahealthalliance.org). For more information, please contact Susie Dade (sdade@wahealthalliance.org).

C. What specific tools, systems, and approaches have you found effective and/or ineffective to help providers deliver primary care/preventive care/screening/chronic disease management to hard to reach populations?

2.3. Financial Incentives/Alternative Payment Models and Strategies

See Attachment B.

2.4. Coordination of Care

A. How does your organization support providers' care coordination practices (rather than administering and implementing it from outside of the clinical practice), including for patients with chronic or complex care needs? Please comment on the following specific areas: medical care, mental health, substance use disorders, long-term care supports and dental care. Please include a description of the role(s) of community-based and social service organizations and local government in your strategies; any experience with leveraging a regional or state health information exchange and exchanging clinical information; and how your organization promotes the active sharing of clinical information to eliminate unwarranted variation and unnecessary care.

B. What barriers has or does your organization face as it supports providers in moving towards integrated care models that address both physical and behavioral health (mental health and substance use) needs of patients?

2.5. Measuring Performance

A. What is your organization's capacity and experience with supporting providers with leveraging claims and clinical data for measure collection and reporting on:

- Health status;
- Clinical outcomes;
- Functional status/productivity;
- Appropriateness;
- Patient/caregiver experience;
- Preventive health;
- Care coordination/patient safety/care transitions;
- At-risk populations;
- Utilization and resource use?

B. Does your organization employ utilization benchmarking or support providers in utilization benchmarking (e.g., if your organization sets targets and how)?

2.6. Use of Data for Patient Care and Continuous Quality Improvement

A. How does your organization promote provider use of clinical, patient reported experience, and other patient data (e.g., from Electronic Health Record (EHR), chronic disease registry, etc.) at the point of care for individual patients and population health management?

B. How does your organization support providers in the use data to continually improve quality and patient care over time?

2.7. Patient Engagement

A. What educational tools and activities does your organization use to proactively engage patients and encourage healthy behaviors as well as help patients choose which types of testing and treatments are appropriate for acute, non-emergency conditions (e.g., shared decision-making, videos, provider listings, information on how to access primary, specialty, and behavioral health and substance use providers, auto enrollment/selection of a primary care physician, etc.)? What incentives for providers and/or patients does your organization use to encourage the use of these tools and activities?

B. How does your organization measure and assess the impact and effectiveness of patient engagement activities (e.g., improved use of preventive services, reduction in unnecessary treatments or services, patient activation levels and self-management)?

C. Does your organization have a consumer website for consumers/members that includes (but is not limited to) a cost calculator as well as the following information: cost information linked to members' benefit design; medical costs searchable by procedures, drugs, and episodes of care, cost comparisons for alternative treatments linked to shared decision making tools, and cost comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data?

2.8. Partnering with Purchasers on Strategies

Does your organization have experience working with and assisting purchasers/Washington State (or other states/governments) with benefit design recommendations that support value-based purchasing success, including sharing performance/reporting data with them?

2.9. Multi-Payer & Multi-Stakeholder Activities

A. Does your organization participate in multi-payer and multi-stakeholder activities (e.g., Patient Centered Medical Home, quality improvement activities, participation in the Washington Health Alliance, etc.)? If yes, please include details on payers involved in each activity (e.g., Medicare, Medicaid, commercial, etc.).

B. How is your organization preparing to participate in an organized process with other providers, payers, purchasers, and other health and health care stakeholders to align agreed upon delivery and payment reform strategies in complementary ways?

2.10. Feedback on Developing Accountable Care Delivery and Payment Components in Partnership with Payers, Providers, and Purchasers

From your organization's perspective, what design components should or should not purchasers consider in designing accountable care delivery and payment models, including ACOs (e.g., ramp up or baseline period, auto enrollment, minimum population size, methods to distribute savings, inclusions/exclusions in total cost of care methodology, risk mitigation, etc.)?

SECTION 3. INFORMATION FOR RFI RESPONDENTS

3.1. RFI Review Process

After a review of the RFI responses and assessment of the marketplace, HCA and/or King County may or may not choose to conduct a selection process for further development and/or implementation of all or part of one or more of the responses received. Issuance of this RFI in no way constitutes a commitment or guarantee by HCA or King County to award any contract or any selection process for the goods and services described in the RFI. However, if a selection process did follow, the process would be open and transparent as both HCA and King County are public organizations.

Participation in the RFI process is not a requirement for any subsequent competitive procurement, although the results of this RFI may be used to build, refine, or conduct a selection process.

HCA reserves the right to refrain from conducting a selection process or any other formal solicitation document for this endeavor. This RFI is not a formal solicitation and no contract will be awarded as a result.

This RFI and RFI process is solely for HCA and King County's benefit and is intended to provide information to both entities. The RFI is designed to provide respondents with the information necessary for the preparation of informative responses. The RFI is not intended to be comprehensive, and each respondent is responsible for determining all the factors necessary for submission of a response. The RFI response will not be subject to a Request For Proposal (RFP)-type evaluation, but only to a review of the information respondents provide.

3.2. Proprietary Information/Public Disclosure

HCA and King County are subject to the Public Records Act (Chapter 42.56 RCW) and all material and information provided in response to this RFI shall be considered a public record and the property of HCA and King County.

Any information in a response that a Respondent considers to be protected from the disclosure requirements in the Public Records Act or other state or federal law because it is "confidential," "proprietary," or a "trade secret," must be clearly designated as such. Specifically, Respondent shall clearly print this designation on the lower right hand corner of each page of its response that it believes contains protected information and fill out a more detailed description of the protected information using Attachment C. Designating an entire response as being protected or using footers on every page, is not acceptable.

If a request is made under the Public Records Act to view a response to this RFI, HCA or King County will notify the affected Respondent of the request and the date that the response,

including any information the Respondent had designated as protected from disclosure, will be released to the requester unless Respondent obtains a court order from a court of competent jurisdiction enjoining that disclosure under RCW 42.56.540. If Respondent fails to obtain the court order enjoining disclosure, the RFI response will be released on the date specified in the notification.

HCA and King County's sole responsibility shall be limited to maintaining responses in a secure area and to notifying Respondents of any request(s) for disclosure for so long as HCA and King County are required to meet records retention requirements. Failure to designate information in a response that a Respondent considers to be protected or failure to timely respond after notice of request for public disclosure has been given, shall be deemed a waiver by Respondent of any claim that such materials are exempt from disclosure.

By submitting a response to this RFI, Respondent assents to the procedures outlined in this section and shall have no claim against either HCA or King County.

3.3. RFI Coordinator and Schedule

RFI Coordinator	Charles Pugh
Address	Washington State Health Care Authority Administrative Services Contracts Office P.O. Box 42702 Olympia, WA 98504-2702
Phone	(360) 725-1843
E-mail	contracts@hca.wa.gov

RFI SCHEDULE

Release RFI	April 8, 2014
Respondent Questions Due by 3:00 PM PDT*	April 18, 2014
Responses to Respondent Questions posted to HCA contracts website by 3:00 PM PDT	April 25, 2014
Potential Respondents Conference Call* with HCA (Medicaid and PEBB program) and King County purchasing leaders 2:00 PM-3:00 PM PDT *We are using webinar technology for this Conference Call. To register, go to https://www2.gotomeeting.com/register/562813050	April 30, 2014
Respondent Responses Due by 3:00 PM PDT	May 21, 2014

*Pacific Time; HCA and King County reserve the right to revise the above timeline.

3.4. Response Preparation Instructions

Respondents are to provide responses via email in an electronic format such as Adobe Acrobat or Microsoft Word. All communications must reference the RFI acquisition number 2014-014-RFI in the subject or title area. This will assist in our review process.

- If your organization is a provider or delivery system, your response should include the following:
    - Cover letter
    - Response to Section 1
    - Attachment A
    - Attachment C (if necessary)
- If your organization is a payer, your response should include the following:
    - Cover letter
    - Response to Section 2
    - Attachment B
    - Attachment C (if necessary)
- All other entities, your response should include the following:
    - Cover letter
    - Responses to Section 1 and/or 2
    - Responses to Attachment A and/or B
    - Attachment C (if necessary)

Responses to this RFI should be submitted to the RFI Coordinator no later than 3:00 pm PDT on May 21, 2014, as appropriate. Provide your response as a separate document and include numbers referencing the RFI section to which you are responding. Only one electronic copy needs be submitted.

Please submit responses to the RFI Coordinator via email. The RFI Coordinator may email an acknowledgement of receipt to the submitting Respondent.

3.5. Addendums to RFI

HCA and King County will post any addendums to the RFI to the HCA contracts website. It is the responsibility of respondents to check the website frequently for addendums and updates.

3.6. Cost of Response Preparation

Respondents will not be reimbursed for costs associated with preparing or presenting any response to this RFI.

3.7. Response Property of HCA and King County

All materials submitted in proposal to this RFI become the property of the HCA and King County. HCA and King County have the right to use any of the ideas presented in any proposal to the RFI. Selection or rejection of a proposal does not affect this right.

3.8. Respondent Comments and Questions

Respondents may submit comments and questions in writing to the RFI Coordinator prior to responding to the RFI by the date indicated in the RFI schedule in Section 3.3. Responses to respondent questions will be considered addendums to the RFI and posted to the HCA contracts website by the date indicated in the RFI schedule in Section 3.3. Modifications to the RFI that may result from respondent comments will be sent to all respondents. Where there appears to be a conflict between the RFI and any amendment or addenda issued, the last amendment or addendum issued will prevail.

3.9. Respondent Conference Call

HCA and King County will hold a conference call for potential respondents on the date and time and using the conference call number and passcode as indicated in the RFI schedule in Section 3.3. The purpose of the conference call will be for HCA and King County leadership to discuss specific components of the RFI and provide additional clarification on a select number of questions submitted by respondents.

Attachment A

Payment systems must support and drive delivery system changes. By 2019, HCA and King County expect that delivery systems will be accountable and take clinical and performance risk for controlling the total cost of care for their patients, However, we understand providers and delivery systems are at varying degrees of implementing alternative payment systems and models in their journey to move towards the ultimate goal of total cost of care model.

To that end, HCA and King County are interested in learning what financial incentives/alternative payment models and strategies your organization currently has in place or is planning to implement in the next five years (by 2019).

Please fill in the table below.

Strategy	Percentage of Current Business & Providers Covered Under this Model	Defined Population and # Served (Medicaid, Medicare, PEB, commercial etc.)	How Payment is Tied to Quality/ Performance	Experience (years payment strategy in place)	In Place Now	Actively Engaged in Planning Efforts to Implement in the next 5 Years	Comments
Fee for Service (FFS) Payment for unbundled and separate services.							
Pay for Performance (P4P) Incentive payments built on a FFS base to reward structure, process, or health outcome achievements.							
Patient Centered Medical Home Payment Activities and functions related to care management, data/utilization management, and population health are reimbursed by an extra fee that may be							

Strategy	Percentage of Current Business & Providers Covered Under this Model	Defined Population and # Served (Medicaid, Medicare, PEB, commercial etc.)	How Payment is Tied to Quality/ Performance	Experience (years payment strategy in place)	In Place Now	Actively Engaged in Planning Efforts to Implement in the next 5 Years	Comments
capitation or FFS based.							
Shared Savings (upside and downside risk) A payment strategy that offers incentives and disincentives for provider entities to reduce health care spending for a defined patient population by offering or penalizing them a percentage of any net savings realized as a result of their efforts.							
Bundled Payment A set amount for all services rendered during a defined "episode" of care.							
Warranty A defined guarantee for a procedure.							
Reference Pricing A set price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount.							

Strategy	Percentage of Current Business & Providers Covered Under this Model	Defined Population and # Served (Medicaid, Medicare, PEB, commercial etc.)	How Payment is Tied to Quality/ Performance	Experience (years payment strategy in place)	In Place Now	Actively Engaged in Planning Efforts to Implement in the next 5 Years	Comments
Traditional Capitation A set amount payment for each enrolled person assigned to them, per period of time, whether or not that person seeks care, regardless of quality of care delivered.							
Total Cost of Care A risk-adjusted payment that captures all costs of care for a defined population, including all professional, pharmacy, hospital, and ancillary care.							
Other: Please describe							
Other: Please describe							
What percentage of your revenue overall is linked to alternative payment arrangements, or what percentage of members are receiving care from a provider who is paid based on value, not volume?							

Additional questions on next page.

1) How do current payment systems impede your organization's care delivery improvement efforts? Please prioritize barriers.

2) How is your organization approaching the transition from FFS to alternative payment models (e.g., phasing in geographically or by provider type)? What barriers are you experiencing?

3) What supports/information would be most helpful as your organization implements alternative payment and a total cost of care models in the next five years?

4) How is risk is handled in different models, e.g., is your organization able to manage and bear performance and insurance risk for a defined population (e.g., Medicaid, Medicare, etc.).

5) Is your organization utilizing flexible payment or payments for non-traditional care? (e.g., non-visit based care, non-physician care where appropriate, specialty consultation without requiring an office visit, home and community-based services and supports, and coordination for care)? If yes, for which populations?

Attachment B

Payment systems must support and drive delivery system changes. By 2019, HCA and King County expect that payers will hold providers accountable for cost, quality, and patient experience of care and provide incentives for controlling the total cost of care for their patients. However, we understand payers are at varying degrees of implementing alternative payment systems and models in their journey to move towards the ultimate goal of total cost of care model.

To that end, HCA and King County are interested in learning what financial incentives/alternative payment models and strategies your organization currently has in place or is planning to implement in the next five years (by 2019).

Please fill in the table below.

Strategy	Percentage of Current Business & Providers Covered Under this Model	Defined Population & # Served (Medicaid, Medicare, PEB, commercial etc.)	How Payment is Tied to Quality/ Performance	Experience (years payment strategy in place)	In Place Now	Actively Engaged in Planning Efforts to implement in the next 5 years (by 2019)	Comments
Fee for Service (FFS) Payment for unbundled and separate services.							
Pay for Performance (P4P) Incentive payments built on a FFS base to reward structure, process, or health outcome achievements.							
Patient Centered Medical Home Payment Activities and functions related to care management, data/utilization management, and population health are							

Strategy	Percentage of Current Business & Providers Covered Under this Model	Defined Population & # Served (Medicaid, Medicare, PEB, commercial etc.)	How Payment is Tied to Quality/ Performance	Experience (years payment strategy in place)	In Place Now	Actively Engaged in Planning Efforts to implement in the next 5 years (by 2019)	Comments
reimbursed by an extra fee that may be capitation or FFS based.							
Shared Savings (upside and downside risk) A payment strategy that offers incentives and disincentives for provider entities to reduce health care spending for a defined patient population by offering or penalizing them a percentage of any net savings realized as a result of their efforts.							
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members pay any allowed charges beyond this amount.							
Traditional Capitation A set amount payment for each enrolled person assigned to them, per period of time, whether or not that person seeks care, regardless of quality of care delivered.							
Total Cost of Care A risk-adjusted payment that captures all costs of care for a defined population, including all professional, pharmacy, hospital, and ancillary care.							
Other: Please describe							
Other: Please describe							
What percentage of your revenue overall is linked to alternative payment arrangements, or what percentage of members are receiving care from a provider who is paid based on value, not volume?							

Additional questions on next page.

1) How do current payment systems impede your organization's approach to assist providers with care delivery improvement efforts? Please prioritize barriers.

2) How is your organization supporting providers to transition from FFS to alternative payment models (e.g., phasing in geographically or by provider type)? What barriers are you experiencing?

3) What supports/information would be most helpful as your organization implements alternative payment and a total cost of care models in the next five years?

4) How is risk handled in different models, e.g., is your organization able to manage and bear insurance risk for a defined population (e.g., Medicaid, Medicare, etc.)

5) Is your organization utilizing flexible payment or payments for non-traditional care? (e.g., non-visit based care, non-physician care where appropriate, specialty consultation without requiring an office visit, home and community-based services and supports, and coordination for care)? If yes, for which populations?

Attachment C

Summary of Proprietary Information

Current and Future Innovative Incentives and

Accountable Payment Models and Strategies

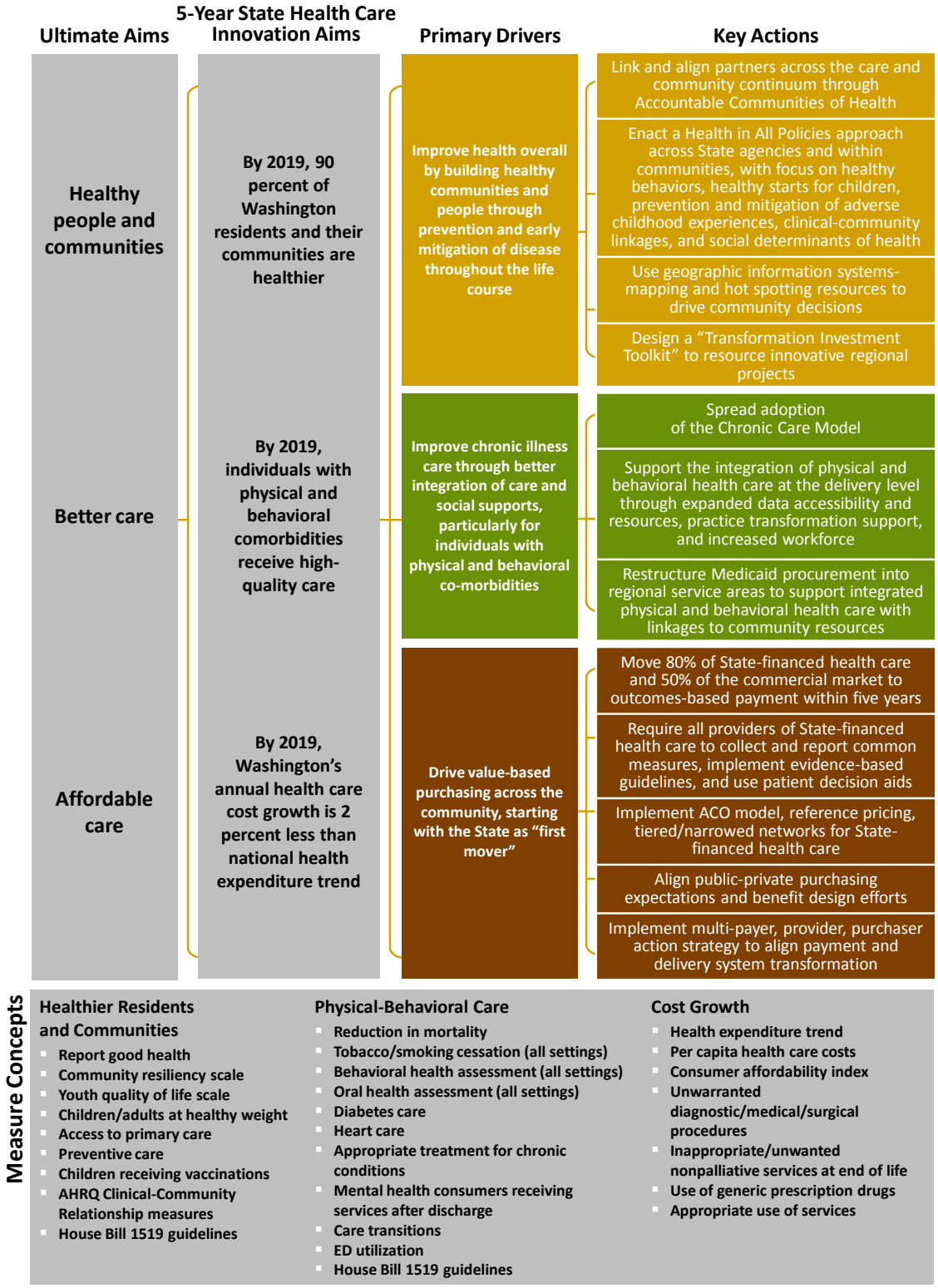
Respondent Name: _____

Respondent must provide a summary of all portions of their Response marked as "proprietary" or "confidential" in nature in accordance with the Proprietary Information/Public Disclosure section. If Respondent has not marked any portions of their response as proprietary, state so.

Summary of Proprietary Information (list Section name and number, and page number, and the particular exemption from disclosure):

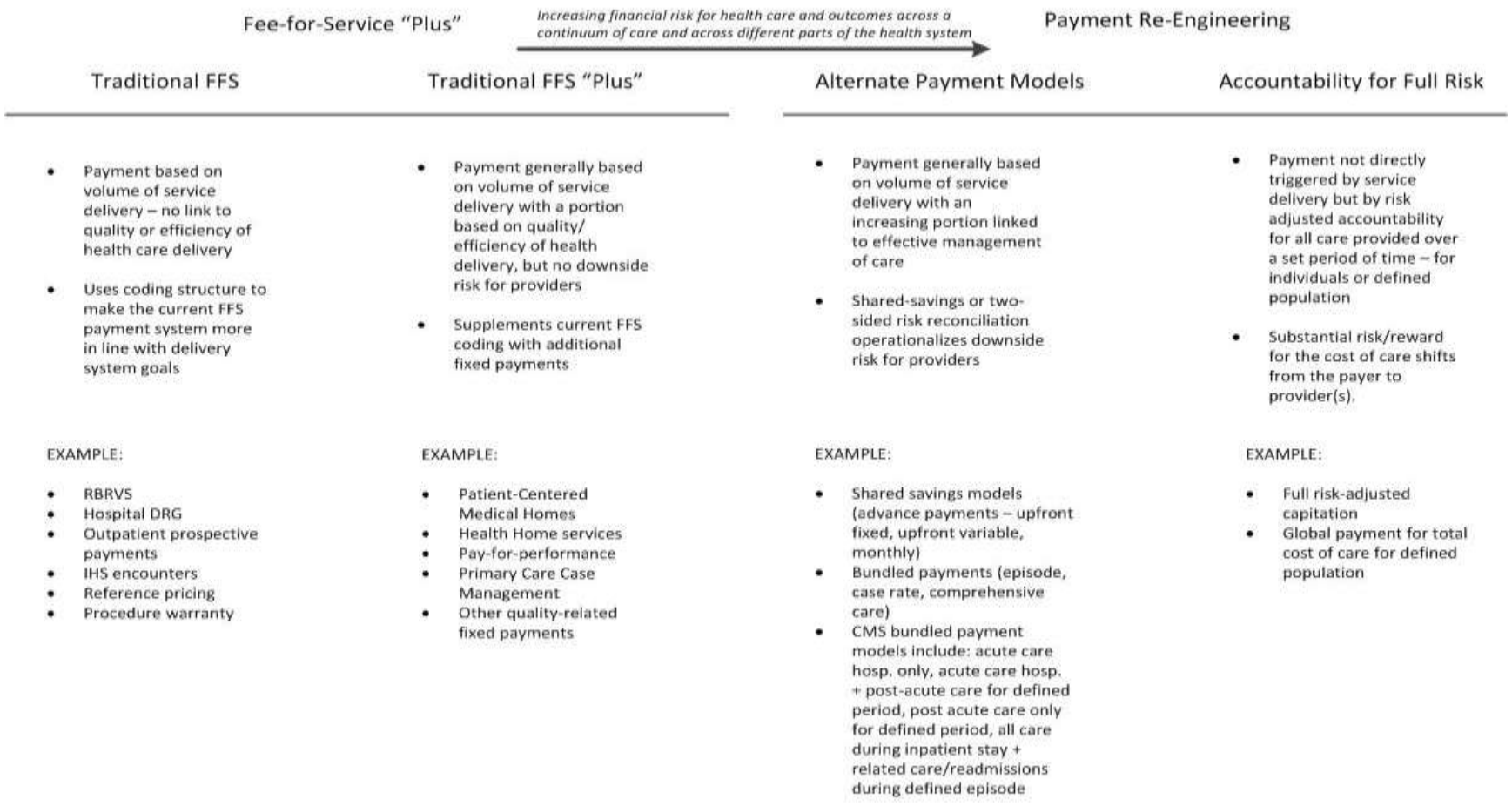
Section Number and Title	Response Page Number	Describe Why information Should be Protected from Disclosure

APPENDIX A: WA ST. FIVE-YEAR STATE HEALTH CARE INNOVATION PLAN



APPENDIX B: CATEGORIES OF PROVIDER PAYMENT TO SUPPORT HEALTH CARE DELIVERY SYSTEM REFORM

Categories of Provider Payment to Support Health Care Delivery System Reform



Transitioning to accountable care requires determining where the greatest opportunity exists for improving value. No one payment methodology will be effective for all providers; multiple models will be necessary - as transitional payment reforms – to support improvements in cost and quality for payers and patients as providers build the capacity to transition to more comprehensive payment reforms and accountability.
From "Transitioning to Accountable Care" - Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care. Harold D. Miller

WASHINGTON HEALTH ALLIANCE

Leading health system improvement

Appendix J

Purchaser Guidelines to Evaluate Contracts for Accountable Care Organizations (ACOs)

Purpose:

The purpose of this document is to clarify and outline purchaser specifications for accountable care that may be used in evaluating a health plan's provider contracting methods and networks and/or for direct contracting between purchasers and provider organizations that wish to function as an ACO.

The *use* of these specifications in purchasing decisions will demonstrate purchasers' intentions to support the rapid development of accountable care arrangements with provider organizations, explicitly rewarding doctors and hospitals for quality, outcomes of care and competitive pricing instead of rewarding them for quantity and complexity of services provided.

These guidelines are intended to be at a high level and have been developed and approved by the Purchaser Affinity Group of the Washington Health Alliance. Individual purchasers may choose to *add* specificity to meet the unique needs of their covered population.

These guidelines are presented in two categories including expectations for provider accountable care organizations and expectations for health plans.

Purchaser Expectations for Provider Accountable Care Organizations

Accountable care organizations *will show clear evidence of the following*:

1. Strong leadership structure and culture that supports the goals of accountable care (better outcomes at a lower total cost), *including the financial competency and maturity to align payment with gain and risk sharing tied to outcomes*
2. Well-resourced primary care network organized around patient-centered medical home principles and standard work flow, and exhibiting timely access to care, including evening and weekend appointments and the ability to contact the health care team via phone and secure email
3. Demonstrated ability to provide for and incentivize *appropriate* referrals for specialty and inpatient care to achieve the highest quality at a competitive price, including electronic and/or virtual consultation
4. Demonstration of programs, systems and tools *in place* to:
    a. provide proactive patient education to preserve and improve health
    b. maximize evidence-based prevention and screening to avoid chronic disease and major acute conditions
    c. provide sophisticated care management that proactively manages disease in the outpatient setting, particularly for patients with chronic and/or complex conditions, including strong integration of physical and behavioral health[1] interventions and education on disease self-management
    d. eliminate unnecessary, non-value added or duplicative tests and procedures (e.g., Choosing Wisely), and minimize avoidable complications, hospitalizations and use of expensive emergency-oriented care
5. Demonstrated use of shared decision-making with the patient, and an organizational focus on improving or stabilizing functional status and quality of life, timely return to work and effective use of palliative care for debilitating chronic conditions and/or end-of-life care
6. Proficient use of electronic health records (including both data input and data extraction) for:
    a. individual patient management including a shared care plan for patients with complex conditions
    b. population health management
    c. coordination of care across care settings and across time
7. Ability to produce and use timely data at the group/provider/patient level (quality, patient experience, utilization and cost) to continually evaluate and improve care and manage total cost of care
8. Capacity to effectively contract for and manage patient care "outside the ACO walls" to achieve the highest quality at a competitive price
9. *Executive endorsement* of community-wide transparency on quality, utilization and price, including (but not limited to) support for health plans routinely sharing medical claims information with the Washington Health Alliance
10. Strong commitment to participation in statewide and community initiatives, such as:
    a. Sharing patient information with other physical and behavioral health care provider organizations (both within and outside the "ACO walls"), in a manner consistent with federal laws regarding patient privacy, to effectively manage patient care across care settings
    b. Quality improvement efforts such as the Foundation for Healthcare Quality's Clinical Outcomes Assessment Programs (OB, Spine, Cardiac) and the Robert Bree Collaborative
    c. Accountable Collaboratives for Health (also known as regional health improvement collaboratives)

[1] Includes mental health and chemical dependency

Purchaser Expectations for Health Plans in Promoting Accountable Care

1. Health plan will provide benefit design recommendations that support ACO success
2. Health Plan's accountable care products include "hard enrollment," where the member is required to prospectively select the ACO and affiliate with a primary care team and/or clinic within the ACO
3. Health plan dedicates resources and support for promotion of the ACO plan, including educating members regarding benefits, how it works, etc.
4. **Health Plan contracts with Provider accountable care organizations:**
    a. **Emphasize/promote all delivery system characteristics described in Provider section**
    b. Align provider payment with gain and risk sharing tied to measurable outcomes in five areas of requirement[2]:
        i. Evidence-based Medicine
        ii. Right Time, Right Setting
        iii. Member Experience
        iv. Optimize Function
        v. Decrease in Total Cost
    c. Provides for payment method that is sufficiently flexible to enable provider organization to provide non-visit based care, non-physician care where appropriate, specialty consultation without requiring an office visit, home and community-based services and supports, and coordination of care including proactive outreach to patients
5. Health plan has the demonstrated capacity to effectively contract for patient care "outside the ACO walls" with the goal of promoting well-coordinated care that produces quality outcomes at an affordable price -- this includes the health plan routinely sharing data with the ACO and integrating data across ACO and non-ACO care delivery sites on a timely basis *to facilitate effective patient care*
6. Health plan will provide and/or coordinate routine, standardized reporting of ACO performance to purchasers in (at least) the five areas of requirement, incorporating ACO/delivery system data where appropriate[2]
7. Health plan enables[3] a robust consumer website for members that includes (but is not limited to) a cost calculator with the following types of functionality:
    a. Cost information that considers members' benefit designs relative to:
        i. copays and cost sharing
        ii. coverage exceptions and service limits
        iii. pharmacy benefits (tiering, brand/generic, retail/mail, etc.)
        iv. accumulated deductibles and out-of-pocket maximums
    b. Medical costs searchable by procedures, drugs, and episodes of care, that include both the professional and facility fees
    c. Cost comparisons for alternative treatments linked to shared decision-making tools for preference-sensitive treatments
    d. Cost *comparisons* for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data as much as possible
8. Health plan permits access to and use of enrollment and priced claims data at the purchaser's discretion; health plan has strong *executive endorsement* of community-wide transparency on quality, utilization and price, including willingness to routinely provide priced medical claims information to the Washington Health Alliance for aggregated community-wide/statewide measurement and reporting on quality, utilization and price variation
9. Facilitate/support direct conversations between purchasers and provider organizations

[2] See definitions for Five Requirement and *potential* measure set.
[3] Consumer website may be offered through the health plan and/or separately through the ACO or an outside vendor selected by the purchaser

What Purchasers Are Willing to Do to Support Development of Accountable Care Payment Arrangements with Provider Organizations

1. Select health plans that display support for a strong purchaser role in defining and evaluating accountable care arrangements through execution of the health plan criteria noted above
2. Willing to offer and promote ACO plan (alongside other plan options), including devoting time to educating employees and family members regarding benefits, how it works, etc., and handling employee push-back on plan requirements
3. For the ACO plan option:
    a. Require enrollee to participate in "hard enrollment ", i.e., prospectively select ACO and affiliate with a primary care team and/or clinic within the ACO
    b. Offer favorable out-of-pocket requirements for selecting ACO option as permitted (e.g., premium sharing, cost sharing, co-pays)
    c. Minimal coverage when enrollee seeks care outside of the ACO except for:
        i. Clinically necessary service(s) not available within the ACO and referred/approved by the ACO
        ii. out-of-area emergencies
4. The ACO option must stand on its own financial performance when being evaluated against other plan options
5. Willing to share information, lessons learned, etc., with one another about their experience with health plans and provider accountable care organizations implementing these purchasing expectations

Five Requirements, Definitions and *Potential** Measures – DRAFT!!

Requirement	Definition[4]	*Potential* Measure Areas[3]
1. Evidence-based Medicine	The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient.	• Screening (breast, cervical, colon cancers; chlamydia) • Vaccinations (childhood, influenza, pneumococcal) • Diabetes and Heart Disease Management • Depression Screening and Management
2. Right Time, Right Setting	The ability to receive appropriate level of care within 24 hours.	• Access to appointments (e.g., time to third next appt) • Nurse call-back response time (e.g., within 4 hours) • Response times to e-messaging • Rate of ED visits (total) and avoidable ED visits • Rate of ambulatory sensitive hospitalizations • Rate of all cause 30-day hospital readmissions
3. Member Experience	The measurement of a patient's experience throughout the continuum of care and use of results to guide improvement efforts in the delivery of care.	• How Well Providers Communicate (CAHPS) • Getting Timely Appointments, Care and Information (CAHPS) • Helpful, Courteous and Respectful Office Staff (CAHPS) • Overall Rating of Provider (CAHPS) • Patient Activation Measure (PAM)
4. Optimize Function	Rapid return to function.	• # of Short Term Disability Cases in defined period • Return to Function (CAHPS or other)
5. Cost	Lowest total cost to achieve the other four requirements; demonstration of reduced cost trend over time.	• Total Per member per month (PMPM) Allowed (delivery system performance against target) • PMPM spending on treatment of potentially preventable care (e.g. avoidable ER, readmissions, ambulatory sensitive admissions) • PMPM spending for individuals with chronic conditions

[4]Informed by Intel, Global Sourcing and Procurement of Health Care Services
*Needs additional definition and measure specifications

Appendix K

Accountable Delivery and Payment Strategies under Healthier Washington

Health Care Authority and King County

November 7, 2014

King County

Washington State Health Care Authority

Healthier WASHINGTON

Today's Topics

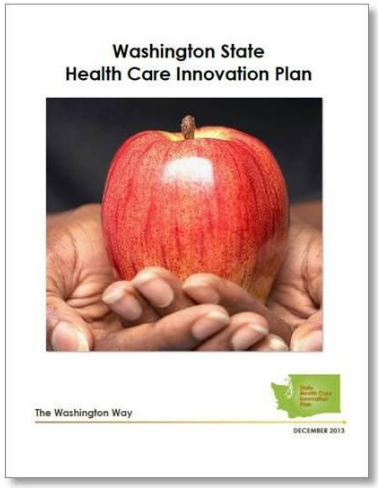
- Healthier Washington Initiative
- Responses to Joint HCA & King County RFI
- Accountable Delivery & Payment
- King County Purchasing Vision
- Comments & Questions
- Closing

Healthier WASHINGTON

2

Healthier Washington

State Health Care Innovation Plan



Goal – **a Healthier Washington**

- **Pay for value and outcomes** starting with the State as "first mover"
- **Empower communities** to improve health and better link with health delivery
- **Integrate physical and behavioral health** to address the needs of the whole person

Critical – **Legislation Enacted**

- **ESHB 2572** – Purchasing reform, greater transparency, empowered communities
- **ESSB 6312** – Integrated whole-person care

Healthier WASHINGTON

4

Strategies, Investments & Goals

Achieving the goal of a "Healthier Washington" requires an integrated strategic investment plan.

WASHINGTON'S APPROACH TO INNOVATION

STRATEGIES:	INVESTMENTS:	GOALS:
1. Healthy communities 2. Integrated care & social support 3. Pay for value – State as first mover	1. Community empowerment & accountability 2. Practice transformation support 3. Payment redesign 4. Analytics: Interoperability and measurement 5. Project management	• Improve population health • Transform delivery systems • Reduce per capita spending A HEALTHIER WASHINGTON

Legislative Support – HB 2573, SB 6312

Healthier WASHINGTON

5

Paying for Value

- State as First Mover
  - Common framework and alignment for 2016 procurement cycle (Medicaid and PEB)
  - VBP emphasizing primary care, care coordination, appropriateness, and EBM
  - Encourage members to pursue quality care
- State as Market Convener and Organizer
  - Create statewide core measure set
  - All payer claims database
  - Engage stakeholders in payment and benefit redesign and consumer engagement

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6

Paying for Value Activities

- Purchasing
  - RFI issued in April 2014
  - New purchasing strategies
- All payer claims database
  - Legislatively created, 2014
  - Includes Medicaid and PEBB populations
- Statewide core measure set
  - Legislatively created, 2013 & 2014
  - Measure Committee and 3 workgroups currently convened (Prevention, Acute and Chronic Illness)
  - Recommendations due by January 2015

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7

Responses to Joint HCA & King County RFI

RFI Responders Breakdown

Providers (13)	• Major providers and hospital systems • One FQHC, and Community Health Centers Association
Health Plans/TPAs (15)	• Most WA commercial health plans including dental • All Medicaid Managed Care Plans
Others (6)	• Individual providers • Labor • DMEs • Associations

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RFI Responses

- **Identified a rapid adoption of value-based reimbursement (VBR)**
  - All respondents involved in VBR now with plans to expand over the next five years
  - Consistent quality measures tied to value based purchasing
- **Acknowledgment of the importance of Accountable Care Organizations/Network**
  - Establish a long term partnership with Accountable Care Organization/Network
  - ACO partner must be able to manage risk

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10

RFI Responses

- **Other common responses:**
  - Clear patient attribution methods that deliver a critical mass of patients
  - Develop meaningful plan designs resulting in higher quality of care, reduced cost and increased access
  - Require selection of a PCP/primary care medical home

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RFI Responses

- **Other common responses:**
  - Recognize care management costs
  - Patient engagement is key
  - Integrate medical and behavioral health
  - Provide provider transformation support
  - Partner must have population management data infrastructure

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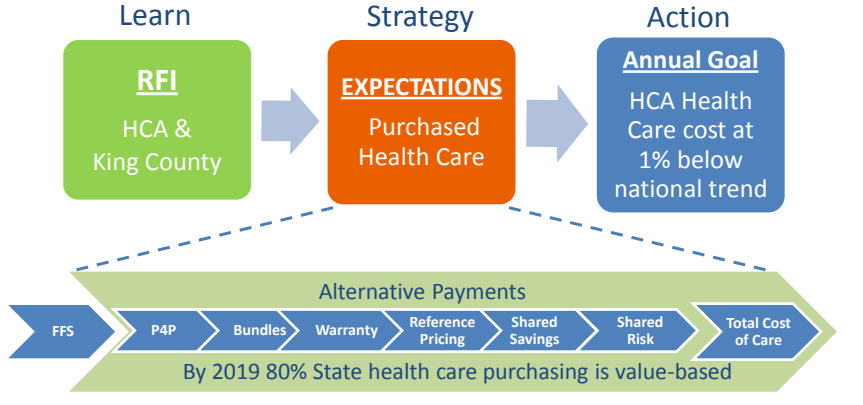
12

Accountable Delivery and Payment

Paying for Value and Outcomes

The Health Care Authority/King County RFI validated the market's readiness for change and helped set HCA's strategic focus and execution plan.



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Delivery & Payment Models

- **MODEL 1:** *Early Adopter of Medicaid Integration*
- **MODEL 2:** *Encounter-based to Value-based*
- **MODEL 3:** *Puget Sound PEB and Multi-Purchaser*
- **MODEL 4:** *Greater Washington Multi-Payer*

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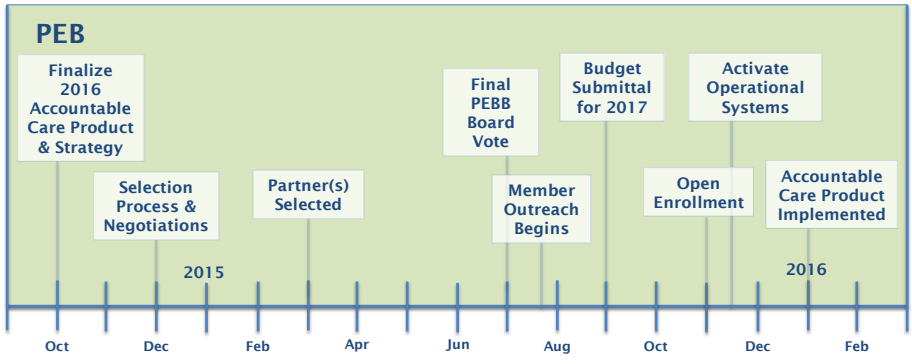
HCA Purchasing Timeline



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Joint Expectations for ACOs

Partnerships with health care providers and payers, focused on five specific outcomes:

- Accountability for costs of care and for annual cost increases
- Ensuring optimized quality for a defined population
- Appropriate level of care, emphasizing evidence-based primary care
- Care coordination strategies resulting in better integrated care
- Design benefit plans that incentivize patient engagement, education, and experience

Additional expectations:

- Clear quality and performance measures
- Alternative payment models leading to total cost of care and shared risk with providers
- EHR, Health IT and data analytics focused on care management and system improvement

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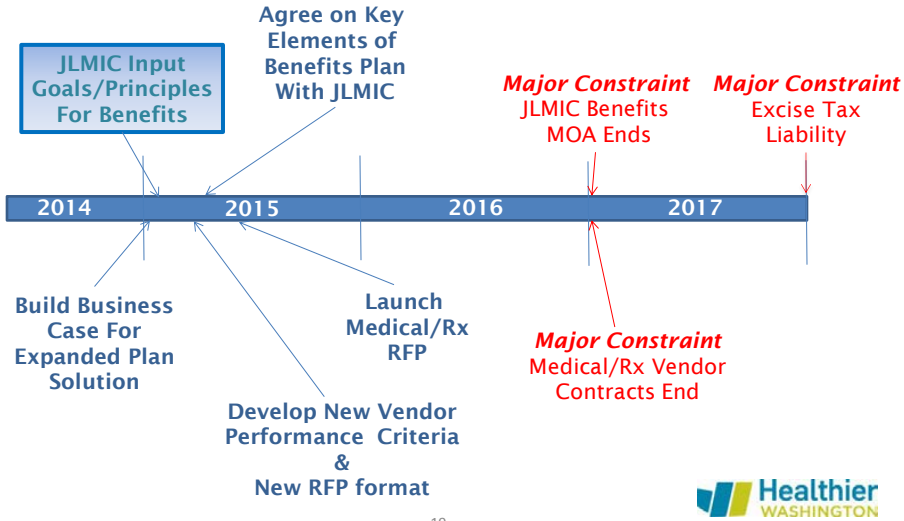
King County Purchasing Vision

Decision/Action Timeline



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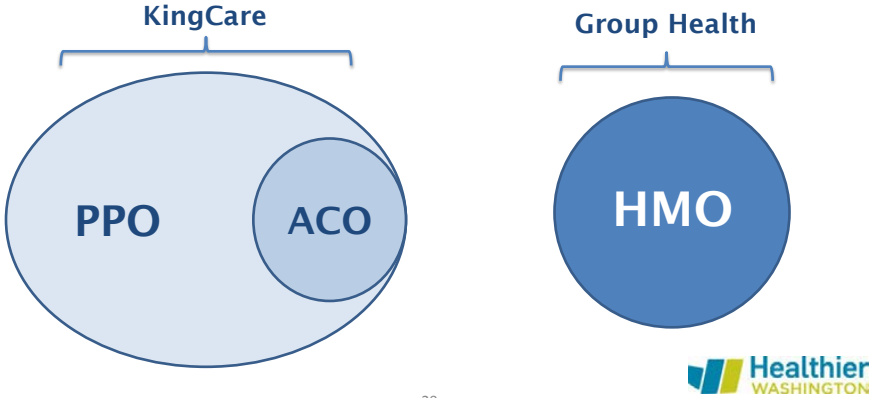
Plan Structure 2017-2019

- Positive enrollment in ACO required
  - PCP selection strongly encouraged
- Large differentials in member cost share to incent movement to ACO and HMO



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Consumer Engagement

Requirements:

- Robust set of personalized consumer tools and incentives to support health literacy
  - Easy to use
  - Include provider quality information from the WHA Community Checkup Report
  - Include tools for framing health care options (i.e. Choosing Wisely) and decisions
  - Multiple access options including mobile apps
- Potential for on-site care (face-to-face or telehealth)

Ease of use and functionality of consumer tools will be assessed by a panel of employees

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Action Steps for 2017-2019

Design	• Plan options with strong price & quality performance guarantees • Enrollment targets that achieve benefits cost growth targets • Price differentials between plan options to maximize enrollment in the higher value plans
Engage	• Educate members on new opportunities for higher value care • Provide strong consumer tools to help members make plan, provider and care choices
Measure	• Health plan vendor performance • Success in meeting enrollment targets • Overall cost results against budget targets • Patient activation
Adjust	• Adjust plans and incentives as needed on an annual basis • Continually improve member health literacy and patient activation level

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Questions & Comments

Healthier WASHINGTON

For more information, contact:

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King County
Kerry Schaefer
kerry.schaefer@kingcounty.gov

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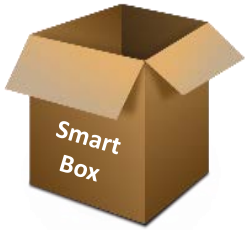
King County
Washington State Health Care Authority

Where is Washington State?

Consolidation **Integration**



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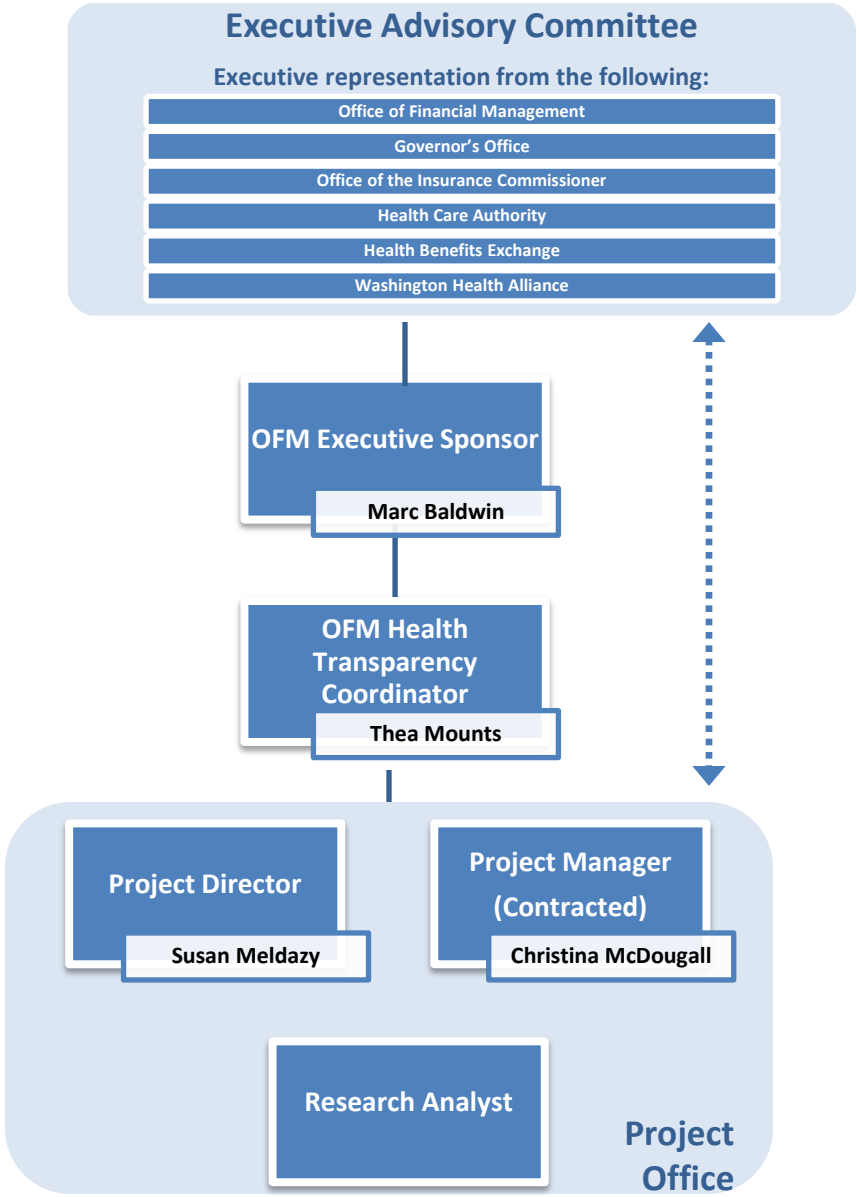
Appendix L

Organizational Chart for Health Insurance Rate Review Grant Program – Cycle III and IV



Appendix M

Washington State: Standard Statewide Measures of Health Care Performance

Project Overview

In 2014, the Washington State Legislature passed ESHB 2572, which is a law relating to improving the effectiveness of health care purchasing and transforming the health care delivery system. A portion of this legislation (Section 6) relates to the development of a statewide core measure set. Specifically, the Washington Health Care Authority (HCA) with support from the Washington Health Alliance (the Alliance) is directed to facilitate a Performance Measures Committee (the Committee) that is charged with recommending standard statewide measures of health performance by January 1, 2015. It is intended that use of these measures will inform public and private health care purchasers, and will enable identification of benchmarks (i.e., goals) against which to track costs and improve health care outcomes.

Principles

The following are principles, some of which are included in the legislation and others proposed by HCA and Alliance staff, that further define this work and form the "guard rails" that determine the scope of this effort.

1. The Committee's planned work in 2014 shall represent an *initial* effort to recommend standard statewide measures of health care performance. As an initial effort, the resulting product will be considered a "starter set" of health performance measures rather than an all-encompassing set of measures that that would create undue burden on providers and payers alike. As such, the Committee shall recommend a measure set that:

    - Is of manageable size with no more than 45 measures included;
    - Is based on *readily available* health care insurance claims and/or clinical data, and
    - Gives preference to nationally vetted measures, particularly measures endorsed by the National Quality Forum.

2. Recommended measures will fall within three domains: 1) prevention, 2) acute care, and 3) chronic illness care. Cross-cutting considerations will help to focus on the overall performance of the system; these include dimensions of access, clinical process and outcomes, care coordination, patient safety, cost, efficiency, utilization and patient experience. The measures may be either evaluative or descriptive in nature. The Committee shall take into account, to the extent possible, the Governor's performance management system measures and common measure requirements specific to the Medicaid program.

    Taken as a whole, the measures will help to identify the lowest cost, highest quality care for preventive care and acute and chronic conditions.

3. Results from the recommended measure set may be used to assess performance at the county, health plan, medical group and/or hospital level. It is anticipated that results will be reported in an un-blinded manner when numerators and denominators are sufficient to produce results that are statistically valid and reliable. The measures can be applied to other types of health care delivery organizations. Future iterations of the measure set may focus measures specifically on other types of providers.
4. The goal is ultimately to promote voluntary measure alignment among state and private payers. To that end, efforts will be made to establish a measure set that can be used by multiple payers, clinicians, hospitals, purchasers, and counties for health improvement, care improvement, provider payment system design, benefit design, and administrative simplification efforts, as appropriate.

Approach

The **Performance Measures Committee** is made up of stakeholders named in the legislation and appointed by the Governor. The Committee will be chaired by the Director of the Washington State Health Care Authority (HCA) and co-chaired by the Executive Director of the Washington Health Alliance (the Alliance); the co-chairs are charged with developing a transparent process for measure selection which includes opportunities for public comment. The HCA will provide the coordination, facilitation and staff support for the Committee.

The Committee is responsible for:

- Setting the overall direction for developing recommendations regarding a core measure set, including finalizing the scope of measurement, the measure selection process, and potential measurement stratifications;
- Providing ample opportunity for public comment to inform the selection of measures;
- Reviewing and recommending a final core measure set to the HCA; and,
- Recommending an ongoing process to periodically evaluate the measure set, adding to it and/or modifying it as needed over time.

The Committee will meet three times between June and December 2014.

- During the first meeting in June, the Committee will discuss an overall approach to developing the core measure set and will define an approach for technical work groups to identify and recommend proposed measures.
- During the second meeting in October, the Committee will hear of the progress of the technical work groups to date, discuss particular issues that have been raised during the work group process and provide direction.
- A proposed core measure set will be released for public comment by the Committee prior to finalizing the proposed measure set.
- During the final meeting in December, the Committee will review and vote on a measure set, based on work and recommendations of the technical work groups and informed by public comment.

The **HCA** has the responsibility to facilitate public input and the final authority to formally accept recommendations from this process and establish a statewide measure set.

There will be three **Technical Work Groups** focusing on 1) prevention, 2) acute care, and 3) chronic illness care. In considering the three domains, both the prevention and the chronic illness care domains will focus on population or primary care-related measures, and the acute care domain will focus on population, hospital or specialty care-related measures. Performance may be assessed at the county, health plan, medical group and/or hospital level. Under each domain, consideration will be given to the populations served.

- The Alliance will provide the coordination and facilitation for the technical work groups.
- Each technical work group will be charged with reviewing specific measures within their domain against the criteria selected and prioritized by the Committee during its initial meeting.
- The technical work groups will consider a range of access, clinical process and outcomes, care coordination, patient safety, cost, efficiency, utilization and patient experience measures across the domains.
- The technical work group will consider how measures might be stratified for particular populations (such as persons with disabilities and individuals with serious mental illness).
- The HCA will post high-level summaries of the technical work groups' meetings online and accept public feedback. The technical work groups will consider public comment in their deliberations.
- The technical work groups will recommend specific measures for inclusion in the measure set, as well as measures to consider for adoption.
- The technical work groups will each be comprised of fewer than 10 individuals. Members of the technical work groups will be selected for participation by the Alliance and the HCA.

Measure Selection Criteria

At its first meeting, the Committee will be asked to approve measure selection criteria to be used by the technical work groups as they select proposed measures for recommendation to the Committee. *At a minimum*, these selection criteria must be consistent with the guiding principles laid out for this effort. Specifically, measures must:

- be based on *readily available* health care insurance claims and/or clinical data to enable relatively fast implementation;
- be nationally vetted and preferably endorsed by the National Quality Forum; and
- take into account, to the extent possible, the Governor's performance management system measures and common measure requirements specific to the Medicaid program

Appendix N

Statewide Quality and Outcomes Core Measure Set

Performance Measurement Committee

Dorothy Teeter, *co-chair*	Washington State Health Care Authority
Nancy Guinto, *co-chair*	Washington Health Alliance
Chris Barton	SEIU Healthcare 1199NW
Jane Beyer	Washington State Department of Social and Health Services
C. Craig Blackmore	Virginia Mason Medical Center
Gordon Bopp	NAMI-Washington
Patrick Bucknum	Columbia Valley Community Health
Frederick M. Chen	UW Medicine
Ann Christian	Washington Community Mental Health Council
Victor A. Collymore	Community Health Plan of Washington
Patrick Conner	National Federation of Independent Business
Jessica Cromer	Amerigroup Washington
Sue Deitz	Critical Access Hospital Network of Eastern WA
John Espinola	Premera Blue Cross
Gary Franklin	Labor and Industries
Vacant	National Multiple Sclerosis Society, Greater NW
Teresa Fulton	Western Washington Rural Health Collaborative
Anne Hirsch	Seattle University
Larry Kessler	UW School of Public Health, Department of Sciences
Byron Larson	Urban Indian Health Institute
Daniel Lessler	Washington State Health Care Authority
Kathy Lofy	Washington State Department of Health
Susie McDonald	Group Health Cooperative
Julie McDonald	Providence Regional Medical Center Everett
Sheri D. Nelson	Association of Washington Business
Mary Kay O'Neil	Regence BlueShield
Scott Ramsey	Fred Hutchinson Cancer Research Center
Charissa Raynor	SEIU Healthcare NW Training Partnership/Health Benefits Trust
Dale P. Reisner	Washington State Medical Association
Marguerite Ro	Public Health – Seattle and King County
Rick Rubin	OneHealthPort
Marilyn Scott	Upper Skagit Indian Tribe
Torney Smith	Spokane Regional Health District
Jonathan R. Sugarman	Qualis Health
Carol Wagner	Washington State Hospital Association

As of October 29, 2014

Appendix O

Statewide Quality and Outcomes Core Measure Set

Prevention Measures Technical Workgroup

Joan Brewster	Grays Harbor Public Health & Social Services
Ian Corbridge	Washington State Hospital Association
Bev Green	Group Health Research Institute
Jeff Harris	University of Washington
Jesus Hernandez	Community Choice
Dan Kent	Premera Blue Cross
Mark Koday	Yakima Valley Farmworkers Clinic
Mary Kay O'Neil	Regence Blue Shield
Janet Piehl	UW Neighborhood Clinics
Bailey Raiz	Community Health Plan of Washington
Kyle Unland	Spokane Regional Health District
Kristen Wendorf	Public Health – Seattle and King County

Chronic Illness Measures Technical Workgroup

Christopher Dale	Swedish Health Services
Stacey Devenney	Kitsap Mental Health Services
Erin Hafer	Community Health Plan of Washington
Kimberley Herner	UW/VMC Clinic Network
Jutta Joesch	King County
Dan Kent	Premera Blue Cross
Julie Lindberg	Molina Health Care of Washington
Paige Nelson	The Everett Clinic
Kari Nelson	VA Puget Sound
Kim Orchard	Franciscan Health System
Larry Schecter	Washington State Hospital Association
Julie Sylvester	Qualis Health
Craig Wilson	SignalHealth

Acute Care Measures Technical Workgroup

Connie Davis	Skagit Regional Health
Mark Delbeccaro	Seattle Childrens
Tim Dellit	University of Washington
Sue Deitz	Critical Access Hospital Network
Jennifer Graves	Washington State Nurses Association
Patrick Jones	Eastern Washington University Institute for Public Policy & Economic Analysis
Kim Kelley	Washington State Department of Health
Dan Kent	Premera Blue Cross
Michael Myint	Swedish Health Services
Terry Rogers	Foundation for Healthcare Quality
Carol Wagner	Washington State Hospital Association

Appendix P

Statewide Health Care Core Measure Set
Measurement Selection Criteria
June 30, 2014

Required by Legislation:

1. The measure set is of manageable size.
2. Measures are based on *readily available* health care insurance claims and/or clinical data, and survey data.
3. Preference should be given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies.
4. Measures assess overall system performance, including outcomes and cost.
5. The measure set is aligned to the extent possible with the Governor's performance management system measures and common measures specific to the Medicaid program.
6. The measure set considers the needs of different stakeholders and populations served.
7. The measure set is useable by multiple parties (payers, providers, hospitals, health systems, public health and communities).

Added by the Committee:

8. Measures should be aligned with national measure sets and other measure sets commonly used in Washington, whenever possible.
9. Measures should have significant potential to improve health system performance in a way that will positively impact health outcomes (including morbidity, disability, mortality, health equity, and quality of life) and reduce costs.
10. Measures should be amenable to influence of health care providers.
11. There should be a sufficient numerator and denominator size for each measure to produce valid and reliable results.

Appendix Q

High Priority Topics by Workgroup

PREVENTION	ACUTE CARE	CHRONIC ILLNESS
Adult Screening(s)	Avoidance of Overuse/ Potentially Avoidable Care	Asthma
Behavioral Health/Depression	Behavioral Health	Care Coordination
Childhood: early and adolescents	Cardiac	Depression
Immunizations	Cost and Utilization	Diabetes
Nutrition/ Physical Activity/ Obesity	Readmissions/Care Transitions	Drug and Alcohol Use
Obstetrics	Obstetrics	Functional Status
Oral Health	Patient Experience	Hypertension and Cardiovascular Disease
Safety/Accident Prevention	Patient Safety	Medications
Tobacco Cessation	Pediatric	
	Stroke	

Appendix R

WORK GROUP RECOMMENDATIONS

Released for Public Comment: November 4 - 21, 2014

Prepared by: Susie Dade, Washington Health Alliance with assistance from Bailit Health Purchasing

Washington State Common Measure Set for Health Care Quality and Cost