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).**

- Exhibit A – Application Cover Sheet (Pilot and Design Applicants)
- Exhibit B – Application Narrative (Pilot and Design Applicants)
- Exhibit C.1 – Work Plan (Pilot Applicants)
- Exhibit C.2 – Work Plan (Design Applicants)
- Exhibit D – Budget (Pilot and Design Applicants)
- Exhibit E – Application Narrative Part II (Pilot Applicants Only)
- Exhibit F – Certifications and Assurances(Pilot and Design Applicants)

ATTACHMENT:

- Attachment A: Resources
- Attachment B: ACH Backbone and Governance Guidance
- Attachment C: ACH and RSA Alignment Proposal
- Attachment D: The Proposed Role of Accountable Communities of Health in Washington State
- Attachment E: Potential ACH Partners
- Attachment F: Regional Service Areas

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)?

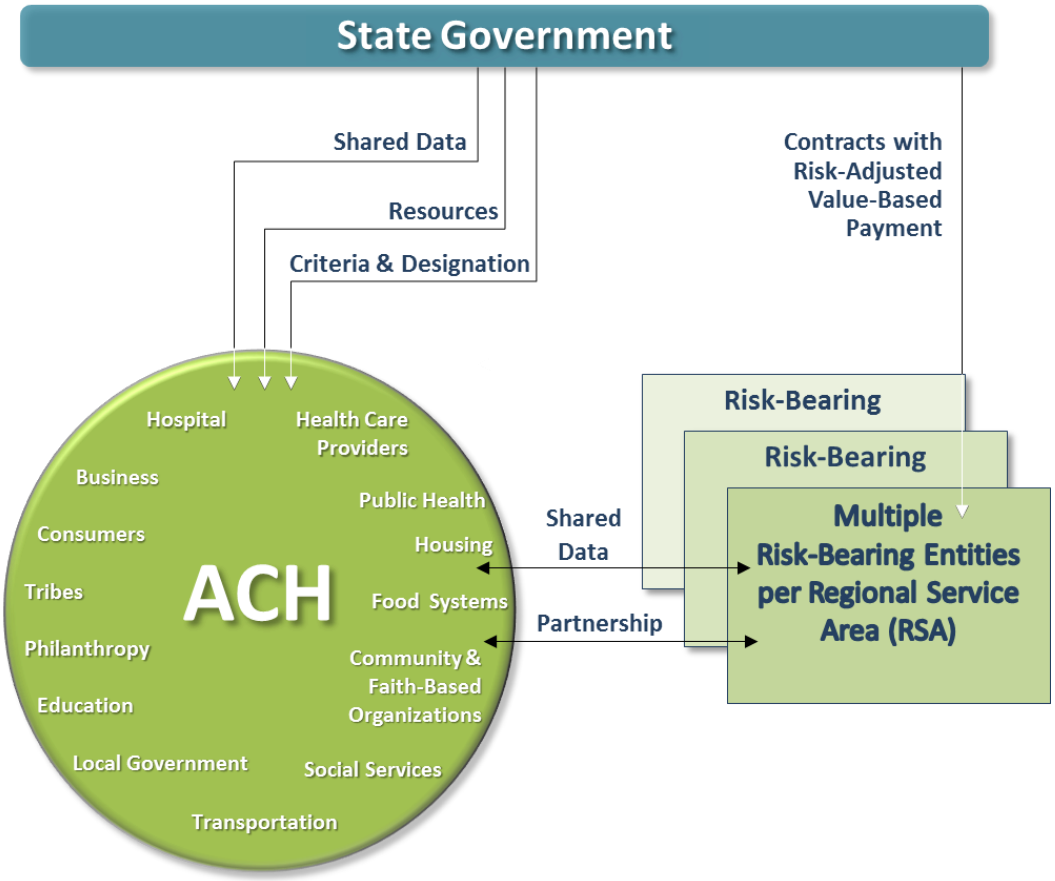
As indicated in the illustration below, the relationship between ACHs and risk-bearing entities is as follows:

- **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
Tribes
ACH
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