STATE OF WASHINGTON

HEALTH CARE AUTHORITY

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November 4, 2014

Dear Interested Partners:

SUBJECT: Joint HCA DSHS Designation of Regional Service Areas for 2016 Medicaid Purchasing

Health system transformation in Washington State depends on effectively coordinating and integrating the health care delivery system with community services, social services, and public health. During the 2014 Legislative Session, enactment of E2SSB 6312[1] established a pathway to define a regional structure to support these linkages and increase accountability for better health, better care, and reduced costs. This is a critical step to guide the transition of Medicaid programs towards a fully integrated managed care system that provides physical health and behavioral health (i.e., mental health and substance disorder) services on a statewide basis by January 1, 2020.

As directed by E2SSB 6312, the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) have jointly decided on common Regional Service Areas (RSAs) for Medicaid purchasing of physical and behavioral health care, beginning in 2016. We based our determination on the Adult Behavioral Health Task Force guidance[2] required by E2SSB 6312, subsequent community responses, and the criteria listed in Attachment A, "Background on RSA and Purchasing under E2SSB 6312." The map and table in Attachment B, "RSA boundary designation and transition to 2020" sets out the RSAs. A description of the planned transition of regional purchasing is found in that attachment as well.

Your engagement continues to be essential to help HCA and DSHS take steps towards implementing Washington State's vision for improved delivery of health services and a healthier Washington. Thank you for your ongoing efforts on behalf of Washington's Medicaid clients.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director
Health Care Authority

Jane Beyer, Assistant Secretary
Behavioral Health Service Integration Administration
Department of Social and Health Services

[1] See http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6312&year=2013.
[2] Proceedings available at: http://www.leg.wa.gov/jointcommittees/ABHS/Pages/default.aspx

cc: Dorothy F. Teeter, Director, HCA
Kevin Quigley, Secretary, DSHS
Preston Cody, Division Director, HCS, HCA
Nathan Johnson, Division Director, PPP, HCA
Chris Imhoff, Director, Division of Behavioral Health and Recovery, DSHS
Bob Crittenden, Senior Policy Advisor, Governor's Office
Andi Smith, Executive Policy Advisor, Governor's Office

ATTACHMENT A: Background on RSA and Purchasing under E2SSB 6312

Criteria used in determining RSA boundaries included an assessment of the degree to which geographic boundaries:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties.

- Reflect active collaboration and alignment with community planning that prioritizes the health and well-being of residents.

- Serve as a platform to expedite fully integrated Medicaid purchasing of physical and behavioral health services by 2020, as directed by statute.

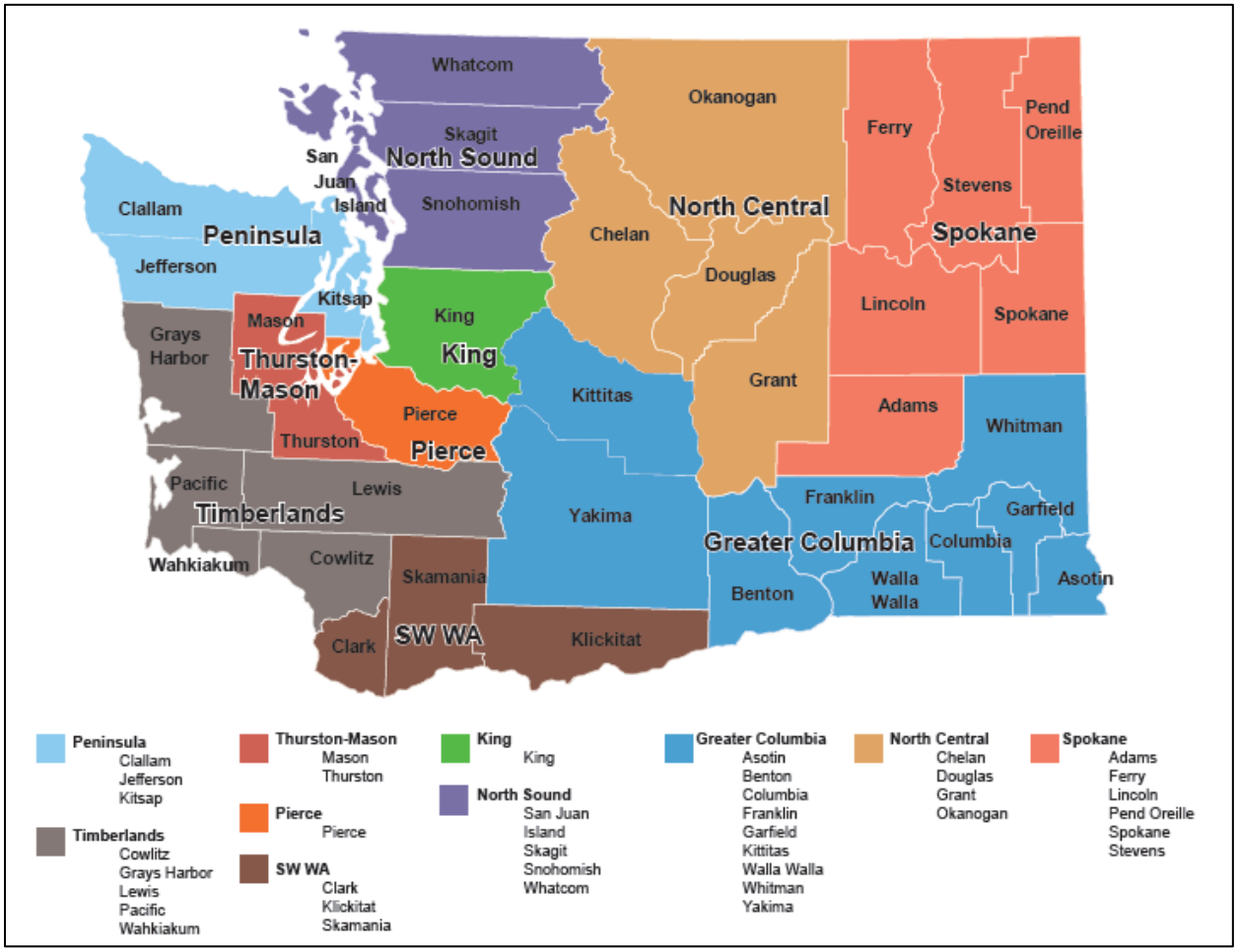
- Include a critical mass of beneficiaries (60,000 covered Medicaid lives) to ensure active and sustainable participation by risk-bearing organizations that serve whole region(s) and promote integrated delivery of care.

- Ensure access to adequate provider networks, considering typical utilization and travel patterns, the availability of specialty services, and continuity of care as enrollee circumstances change.

- Minimize disruption of business relationships (i.e., provider, payer and community) that have evolved over time.

ATTACHMENT B: RSA boundary designation and transition to 2020

RSA designation:
Counties are distributed across ten regional service areas as shown on the map below.



Throughout most of the state RSA boundaries are consistent with the guidance from the Adult Behavioral Health Task Force.

In north central Washington, discussions with community representatives have framed the following alternative:

- HCA and DSHS have decided on a "transition strategy" to a two-RSA approach for the counties presently assigned to the Chelan-Douglas and Spokane Regional Support Networks.

- Beginning in 2016, for purposes of purchasing physical care/Apple Health services, one four-county RSA will include Chelan, Douglas, Grant, and Okanogan counties. The remaining six counties – Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens – will compose a

separate RSA. Recognizing the transitional pathway we are on, HCA and DSHS will designate a single Behavioral Health Organization (BHO) to serve both RSAs during the transition period to full integration. This is to ensure development of appropriate community and delivery system capacity to serve the four-county RSA.

- No later than January 1, 2020, when full integration of medical and behavioral health services in a Managed Care system is required under E2SSB 6312, the two RSAs will be separate and distinguishable for purposes of integrated physical and behavioral health purchasing.

Early Adopter or BHO/Apple Health Plan Decision:
As provided in E2SSB 6312, counties in each RSA must collectively adopt one of two Medicaid Managed Care delivery system pathways.

- Beginning in 2016, counties in *early adopter RSAs* will adopt a purchasing model in which care is delivered through Managed Care Organizations (MCOs) at risk for physical and behavioral health services and where financing is leveraged to support the integrated delivery of whole-person care. Counties in these RSAs will share 10 percent of resulting state savings.

  For more information about the Early Adopter track:
  Visit http://www.hca.wa.gov/hw/Pages/fully_integrated_Medicaid_purchasing.aspx
  or email questions to earlyadopterquestion@hca.wa.gov.

- In *other RSAs*, counties will initially adopt a purchasing model in which care is delivered through separate but coordinated behavioral health and physical health Managed Care contracts. Under this model, behavioral health services will be delivered through a BHO, a Managed Care entity at risk for the mental health and substance disorder services for the population it serves. Traditional Medicaid MCOs will remain at risk for delivery of physical health services. As the delivery system transformation evolves, counties will transition towards fully integrated Managed Care systems.

  For more information on the BHO track:
  Visit http://www.dshs.wa.gov/dbhr/bho_transition.shtml.

The deadline for the counties in a designated RSA to collectively notify HCA and DSHS of their decision between early adopter and BHO/Apple Health status has not yet been set. Conversations are continuing with counties interested in potentially becoming early adopter regions. A formal request for the notification referenced above can be expected later this year, with decision-making timed to support development of MCO and BHO procurement documents and applicable payment rates for 2016 contracts. Meantime, counties that are potentially interested in the early adopter track should contact MaryAnne Lindeblad, Medicaid Director, by telephone at 360-725-1863 or via email at maryanne.lindeblad@hca.wa.gov if they have not already done so.

Linkage between RSAs and Accountable Communities of Health:
The joint HCA DSHS RSA designation also provides the framework for the evolution of a community role in Medicaid purchasing through Accountable Communities of Health (ACH), which were introduced in concept via Washington's State Health Care Innovation Plan (see: http://www.hca.wa.gov/hw/Pages/default.aspx). These are intended to be a regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations. This month the HCA will announce a grant opportunity to support the further design and proof of the ACH concept.

Information will be available at: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx.

Planning for an introductory community role in 2016 Medicaid purchasing, prior to the formal designation of ACHs, will occur later this year.

Alignment of Accountable Communities of Health and Regional Service Areas

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.

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 undesirable, which supports the context and recommendation above. Below the matrix is additional information regarding the role of the backbone support function within the ACH framework.

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 (1):** 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 (2):** 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 (3):** 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 (4):** 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	• This is a potential option for (multiple) RSAs which fall within the geographic planning region for a single Community of Health grantee. • It would still be critical for each RSA to establish its own ACH governance structure; however each ACH governance structure could be supported by one operational arm. The operational would play an "administrative support organization" role.
Potentially viable	1 ACH: Multiple RSAs	• It is possible for one ACH governance model to serve multiple 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.
Undesirable	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 procurement.

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).